

Part
1



REDI: A Client-Centered Counseling Framework

Participant's Handbook



EngenderHealth
for a better life



REDI: **A Client-Centered Counseling Framework**

Participant Handbook

Part 1: Pretraining Materials

Pretraining Handouts

REDI Learning Guides

Take-Home Test



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Section 1: Pretraining Handouts

Introduction

The Purpose of Pretraining Materials

One of the principles of adult learning is that adults learn best when they are exposed to new information more than once and are able to use that information in different ways. For example, you can read about communication skills, but you will understand them much better if you first *read* about them—then *see* them demonstrated—and then *practice* using them yourself.

When learning how to perform a task like client-centered counseling, another principle of adult learning is that it has three components: knowledge, attitudes, and skills. The *knowledge* piece can be covered through reading about and then applying the new information in discussions or case studies. However, *attitudes* refers to how you feel about the people you will be counseling (the clients), the subject matter (sexual and reproductive health [SRH] issues and practices), and the importance of the work itself. This critical component of learning is best addressed through interaction—group discussion, role-play exercises, and practice. The *skills* component is best learned through demonstration and practice.

With a limited amount of time for the training workshop, it is necessary to ask participants to review as much of the factual knowledge as possible *before* attending the training. This structure allows us to dedicate the workshop time to interactive peer discussions, case studies with sample client profiles, skills demonstrations by trainers, skills practice in role-play exercises, and skills practice with actual clients. The Pretraining Handouts introduce the knowledge you need for client-centered counseling. We will further explain, apply, and reinforce this information during the workshop.

Why Do I Need to Complete a Take-Home Test?

The test is designed to guide you through these materials before you attend the training workshop. Its purpose is to help you focus on the key points of each session. You can answer the questions for each session *after* you read the materials, or you can answer them *while* you are reading the materials. This is not a test of how much you know, but of how well you have read the materials. We want you to read the materials until you find the answers.

The session titles indicated in the Pretraining Handouts match the training sessions of the workshop. Some of the training sessions (Sessions 1, 13-14, and 16-18) do not require reading ahead of time. Therefore, there are no Pretraining Handouts for these sessions.

This Training Is Not about Contraceptive Methods

The purpose of this training is to enable you to apply the REDI Framework for Client-Centered Counseling, with a focus on pregnancy prevention and other SRH topics. This training does *not* include knowledge about contraceptive methods; you should have completed a contraceptive technology training *before* coming to this training.

Why Are We Not Using the Term “Family Planning” in this Training?

Family Planning (FP) is a term that has been used in health programs around the world for decades. Those who work in our field commonly use and understand the term. However, people outside our field may not be familiar with the term and it could be confusing to potential clients. For example, does FP help people who do *not* have a family yet? Does it help people who specifically do not want to have a family and need help avoiding pregnancy? Or, is it for people who are ready to have and need help planning a family? This is especially important to consider for programs seeking to reach unmarried women and men, particularly adolescents, and letting them know that they are welcome and will be able to find the services they need at your facility.

In order to emphasize the impact that words can have on clients’ understanding—and particularly on their willingness to seek services at your facility—this curriculum strategically uses other terms for FP, as described below.

- **Pregnancy prevention or preventing pregnancy** refer to the general purpose for clients’ visits and to the decision-making process, which is the focus of counseling. This helps to remind providers and clients alike that there are many ways of preventing pregnancy that include modern methods of contraception as well as traditional methods that have been used by couples for generations (though, often, not very effectively). In other words, pregnancy prevention is not new!
- **Contraception or contraceptive** refer to modern methods of pregnancy prevention.
- **Sexual and reproductive health (SRH)** refers to the entire range of services that promote healthy sexual relationships and childbearing, including pregnancy prevention.
- The generic term **counseling** will replace FP counseling; and, similarly **client**, **provider**, and **clinic** will replace FP client, FP provider, and FP clinic.
- The curriculum will continue to use **family planning** and **FP** to refer to staffing and/or administrative issues. For example, “counseling has benefits for both the client and the FP program.”

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Session 2: Sexual and Reproductive Health and Rights (SRHR)

Introduction to Session 2

Sexual and Reproductive Health and Rights (SRHR)

(page 1 of 2)

By the end of this section, you should be able to:

- Explain the importance of a rights-based approach to sexual and reproductive health (SRH) service provision
- Name three rights related to SRH that are recognized by international conventions
- Define full, free, and informed choice
- Define informed consent
- Name three clients' rights
- Define client-provider interaction, counseling, and client-centered counseling

Essential Ideas

- The *rights-based approach* to SRH affirms that health and rights are inseparable, that individuals have the right and the capacity to make decisions about their lives, and that sexual and reproductive rights are human rights.
- International conventions signed by most countries around the world recognize several *key SRH rights*. These rights include:
 - The right to decide on the number, spacing, and timing of children
 - The right to have the information to make informed decisions
 - The right to attain the highest standards of SRH
 - The right to make these decisions without discrimination, coercion, or violence
- Ensuring *full, free, and informed choice* by individuals and couples is one of the most concrete and significant ways that healthcare workers can support SRHR. (*Informed and voluntary decision making* is sometimes used in place of full, free, and informed choice.)
- Clients' rights describe aspects of service delivery that are essential to ensuring quality of care and to supporting the SRH rights of individuals and couples.

Introduction to Session 2

Sexual and Reproductive Health and Rights (SRHR)

(page 2 of 2)

Essential Ideas (continued)

- *Client-provider interaction* refers to interpersonal communications (verbal and nonverbal) between healthcare staff and the people who seek healthcare services. *Provider* includes everyone in the healthcare setting who interacts with clients. This definition recognizes the importance of nonmedical staff in forming clients' impressions of the healthcare setting and messages that they associate with the healthcare setting.
- *Counseling* is a type of client-provider interaction that involves two-way communication between a provider and a client. The purpose is to confirm or facilitate a decision by the client or help the client address problems or concerns.
- *Client-centered counseling* requires treating each client as an individual and providing input that responds to the client's unique needs and concerns. This has benefits for clients and providers.

Handout 2-A

A Rights-Based Approach to Sexual and Reproductive Health (SRH)

EngenderHealth is committed to the *rights-based approach* to SRH, which affirms that:

- Health and rights are inseparable
- Individuals have the right and the capacity to make decisions about their lives
- Sexual and reproductive rights are human rights

The rights-based approach was adopted at the 1994 International Conference on Population and Development, which was hosted by the United Nations and held in Cairo, Egypt. The participating countries developed and ratified the following description of reproductive rights:

“Reproductive rights” embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to: (1) decide freely and responsibly the number, spacing, and timing of their children, (2) have the information necessary to do so, (3) attain the highest standard of sexual and reproductive health, and (4) make decisions concerning reproduction free of discrimination, coercion, and violence.

*International Conference on Population and Development Program of Action,
1995, Paragraph 7.3*

In 1995, the Fourth World Conference on Women was held in Beijing. The conference platform for action stated, among other things, that *women’s human rights* include “their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence.”

*Fourth World Conference on Women Platform for Action,
1995, Paragraph 96*

Including women’s right to exercise control over their own sexuality as a component of SRHR is an important breakthrough. The right to decide about reproduction and the right “to attain the highest standard of sexual and reproductive health” have little meaning if women cannot decide whether, when, and with whom they will have sex. (Information about sexual rights is included in the Participant Handbook, Part 2, which you will receive at the workshop.)

Handout 2-B

Full, Free, and Informed Choice

Much of the language of SRHR focuses on the right to make decisions freely and responsibly and without coercion, discrimination, and violence. Thus, one of the most concrete and significant ways in which providers can support the SRHR is to ensure full, free, and informed choice by individuals and couples.

- **Full choice:** access to the widest range of methods possible (short-acting, long-acting, permanent, hormonal, nonhormonal, client-controlled, provider-dependent)
- **Free choice:** the ability to choose whether or not to use contraception and what method to use, without barriers or coercion
- **Informed choice:** the ability to make a decision based on comprehensive, accurate, and unbiased information about all contraceptive options, including benefits, side effects, and risks, and with the advantage of counseling about the method chosen¹

Various factors at the policy, service delivery, community, and individual levels affect whether people are able to obtain the information about pregnancy prevention and services they desire. Some of these factors create barriers that limit options and some exert pressures on method selection and uptake. This compromises the voluntary nature of the individual's choice and right to access the services and information they want. It is important for providers to understand that *the concept of full, free, and informed choice extends beyond the point at which services are delivered.*

Informed and Voluntary Decision Making

The terms we use to talk about full, free, and informed choice have changed over the years. At first, family planning programs used “informed choice.” After some years, some programs began using “informed and voluntary decision making.” All of these terms are based on the assumption that individuals have the *right* and the *ability* to make their own healthcare decisions without pressure or coercion and with accurate information and a comprehensive understanding of the consequences related to each option.

Informed Consent

The term “informed consent” is a medical, legal, and rights-based construct whereby clients agree to receive a medical treatment, such as surgery (for contraception or another purpose) or to participate in a study. Informed consent is ideally the result of the client's informed choice. Unfortunately, there are many instances in which a client signs an informed consent form without adequate information and without feeling that they had a choice.

¹ EngenderHealth. *Checkpoints for Choice: An Orientation and Resource Package*. 2014

Handout 2-C

Clients' Rights

All individuals have sexual and reproductive rights. Once an individual decides to become a client, providers have a responsibility to ensure these rights. The International Planned Parenthood Federation originally established 10 “rights of clients.”² EngenderHealth subsequently modified and consolidated these to create the following seven rights:

Information	Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health, sexuality, and overall health. Client educational materials should be made available throughout the healthcare facility.
Informed Choice	Informed choice is a voluntary, well-considered decision that an individual makes based on options, information, and understanding. The decision-making process begins in the community, where people obtain information before coming to a facility for services. It is the provider's responsibility either to confirm a client's informed choice or to help them make informed decisions.
Access to Services	Services must be affordable and available at times and places that are convenient to clients, without physical barriers to the healthcare facility, without inappropriate eligibility requirements for services, and without social barriers such as discrimination based on gender, age, marital status, fertility, nationality or ethnicity, belief, social class, caste, or sexual orientation.
Safety of Services	Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service delivery guidelines, the existence of quality assurance mechanisms within the facility, provision of counseling and instructions to clients, and recognition and management of complications related to medical and surgical procedures.
Continuity of Care	All clients have a right to continuity of services and supplies, including follow-up support and referrals.
Dignity, Comfort, and Expression of Opinion	All clients have the right to be treated with respect and consideration. Providers must ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.
Privacy and Confidentiality	Clients have a right to privacy and confidentiality during delivery of services (for example, during counseling and physical examinations) and in how staff handle clients' medical records and other personal information.

² **Adapted from:** Huezo, C., and Diaz. S. 1993. Quality of Care in Family Planning: Clients' Rights and Providers' Needs. *Advances in Contraception* 9(2):129-139.

Handout 2-D

Client-Provider Interaction, Counseling, and Client-Centered Counseling Definitions (page 1 of 2)

Client-Provider Interaction

Definition. Client-provider interaction is person-to-person communication (verbal and nonverbal) between clients and healthcare staff. Note: Healthcare staff are anyone associated with a service site (e.g., medical and paramedical staff, outreach staff, receptionists, cleaners, and drivers). Clients interact with facility staff from the moment they approach and enter a service site. A client's first impressions of a healthcare facility are usually made through interactions with frontline staff. The client's sense of trust and confidence that they have made the right decision to seek services can be reinforced or undermined by frontline staff.

Principles of client-provider interaction.* The key principles for cultivating good client-provider interaction include the following:

- Treat all clients with respect.
- Tailor the interaction to the individual client's needs, circumstances, and concerns.
- Interact with the client and elicit their active participation.
- Avoid information overload.
- Provide or refer the client for their preferred contraceptive method or address the client's primary concern (for other SRH issues).
- Use and provide memory aids.

Counseling

Definition. Counseling is a type of client-provider interaction that involves two-way communication between a healthcare staff member and a client for the purpose of confirming or facilitating a decision by the client or helping the client address problems or concerns.

Counseling tasks. When providing counseling, healthcare staff are responsible for:

- Helping clients to assess their own needs for services, information, and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients in making their own voluntary and informed decisions by helping them weigh the options
- Helping clients explore possible barriers to the implementation of their decisions and helping them develop the strategies and skills to overcome those barriers so they can implement their decisions
- Answering questions, addressing concerns, and ensuring the client understands all the information they have received

* These key principles for client-provider interaction are adapted from: U.S. Agency for International Development (USAID) and World Health Organization (WHO), 1997. *Recommendations for Updating Selected Practices in Contraceptive Use, Volume II*. Washington, DC, 187-190.

Handout 2-D

Client-Provider Interaction, Counseling, and Client-Centered Counseling Definitions (page 2 of 2)

Principles. Because counseling is a form of client-provider interaction, the key principles for cultivating good client-provider interaction also apply to counseling. In addition, providers should follow these guidelines when counseling clients:

- Create an atmosphere of privacy, respect, and trust.
- Engage in two-way communication with the client.
- Ensure confidentiality.
- Remain nonjudgmental about values, behaviors, and decisions that differ from your own.
- Show empathy for the client's needs.
- Demonstrate comfort in addressing sexual and gender issues.
- Remain patient with the client during the interaction and express interest.
- Provide reliable and factual information tailored to the needs of the client.
- Support the client's sexual and reproductive rights.

Client-Centered Counseling

Definition. Client-centered counseling means treating each client as an individual and providing input based on the client's unique needs and concerns. This benefits both clients and providers:

- Client-centered counseling, including information-giving, is tailored to the individual client's needs. This shows the client you are listening, which indicates respect.
- It saves time for both the client and the provider, by reducing unnecessary discussion.
- It reduces the number of return visits necessitated by not meeting the client's needs the first time.
- It reduces the likelihood of contraceptive discontinuation due to either dissatisfaction (with the counseling or the method) or incorrect use of the chosen method.
- Client-centered counseling respects the client's rights to information; access to services free from discrimination; informed choice; privacy and confidentiality; and dignity, comfort, and expression of opinion.

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Session 3: Decision Making from the *Client's* Perspective

Introduction to Session 3

Decision Making from the *Client's* Perspective

(page 1 of 2)

By the end of this section, you should be able to:

- Explain why it is important to understand the different categories of clients for client-centered counseling
- Define empathy and describe its role in client-centered counseling
- Describe the different informational and emotional support needs of specific categories of clients, populations, or sexual and reproductive health (SRH) groups (e.g., adolescents, HIV-positive clients, men)
- Name five factors that influence clients' decisions about pregnancy prevention
- Define the following terms: sex, gender, and gender roles
- Explain how gender roles can affect SRH outcomes

Essential Ideas

Client Categories

- *Client-centered counseling* allows providers to quickly learn about the client's situation, assess their needs, and tailor the counseling accordingly. This optimizes the amount of information provided to the client and reduces the time needed for counseling.
- Every individual has unique needs and preferences concerning pregnancy prevention. However, specific categories of clients often have similar needs and concerns that are often different from other categories of clients. Knowing these categories can help providers quickly identify the individual's needs.
- Feeling and showing empathy requires understanding the client's needs. Empathy is an important part of building rapport with the client and can guide how providers address client's emotional support needs during the decision-making process.
- First, clients are either (1) *returning*, and likely already using a method, or (2) *new*, and they may or may not have a method in mind. New and returning clients have very different needs.
- Likewise, clients' informational and emotional support needs vary according to their *fertility plans* and the *timing and outcome of their last pregnancy*.
- Within each category, there are different *population groups*—such as adolescents (including unmarried youth), men, clients at high risk of sexually transmitted infections (STIs), and clients living with HIV—who have different informational and emotional support needs.
- Regardless of a client's category, client-centered counseling considers each individual's unique situation, including their medical history and condition and personal and social factors affecting the life of each individual.

Introduction to Session 3

Decision Making from the *Client's* Perspective

(page 2 of 2)

Essential Ideas

Factors that Influence Client Decisions, and the Impact of Gender

- Counseling requires focusing on the circumstances, needs, and values that affect the client's decisions about fertility and sexual health. Although individuals should make their own choices, providers must be aware that a client's choices may be influenced by a number of factors. These factors include:
 - Individual factors
 - Community influences
 - Method characteristics
 - Service factors
 - Other SRH conditions
- **Sex** is the physical and biological characteristics that determine whether a person is male, female, or intersexed. Sex also refers to sexual intercourse.
- **Gender** is a social construct of commonly shared expectations, attributes, and opportunities, based on a person's sex.
- **Gender roles** are social messages about appropriate behavior related to gender. Gender roles can affect SRH outcomes by pressuring individuals to conform to expected sexual behaviors and by limiting access to information and services.
- **Gender power imbalances** within a couple, family, and/or society can affect a client's ability to make pregnancy prevention and other SRH decisions. Gender-based violence (GBV), including intimate partner violence (IPV), often limits a person's ability to make their own decisions, especially about matters relating to sex and SRH.

Handout 3-A

Why Consider Categories of Clients?

Counseling curricula usually focus on helping the new client choose a contraceptive method. This curriculum encourages providers to think about clients more broadly and to consider their individual counseling needs.

We can categorize clients in several different ways to help you understand their needs and tailor your counseling accordingly. For example:

- New clients have different needs than returning clients.
- Clients returning for resupply and/or routine follow-up visits have different needs than those returning with problems.
- Clients wishing to limit childbearing have different needs than those wishing to delay or space births.
- Postabortion and postpartum clients have different needs than those who have not recently been pregnant.
- Men have different SRH needs than women.
- Adolescents have different concerns than adults, especially if they are unmarried.

Understanding who the client is in relation to these categories can help guide the provider in:

- Identifying needs and concerns quickly
- Determining what information to request from and provide to the client
- Providing appropriate reassurance and support
- Instructing clients on and ensuring correct method use

Empathy

Empathy is “the ability to share someone else’s feelings or experiences by imagining what it would be like to be in that person’s situation.”³ Feeling and showing empathy requires an understanding of the client’s needs. Recognizing the categories that describe a client and the general emotional support needs of those categories of clients can help the provider develop and demonstrate empathy. Empathy is an important part of building rapport with the client and can help guide the provision of emotional support to the client during the decision-making process.

³ www.dictionary.cambridge.org

Handout 3-B

Categories of Clients (page 1 of 2)

Basic Needs of All Clients

Some basic needs apply to all clients, regardless of category, as illustrated in the table below.

Need for Information	Emotional Support Needs	Provider's Role
<ul style="list-style-type: none"> • Proper use, effectiveness, associated benefits (e.g., protection from HIV and other STIs), cost, and side effects of various methods of contraception • Signs of possible health risks and complications for each method • Need for protection against HIV and other STIs 	<ul style="list-style-type: none"> • Understanding of individual circumstances • Encouragement • Appreciation • Trust • Feeling welcome • Confidence • Reassurance about concerns and doubts • Privacy • Respect 	<ul style="list-style-type: none"> • Ask about client's circumstances, medical and SRH history, and method preferences • Listen to client's concerns and questions • Validate concerns and fears, as appropriate • Provide emotional support • Provide correct information about methods • Correct misperceptions • Answer questions • Reassure • Refer, as needed

New Versus Returning Clients⁴

The first category to consider is new versus returning clients.

- The traditional approach to counseling focuses primarily on new clients who need to choose a method, but the majority of new clients already know which method they want to use.
- Most returning clients are seeking follow-up treatment or supplies, and most of these clients are satisfied users without any problems or concerns.
- Some returning clients have side effects or other method-related problems. These clients must make different kinds of decisions when they come for services.

New Clients	<i>Clients with a method in mind</i> Decision: Is this method the best choice and can the client use it effectively?	<i>Clients without a method in mind</i> Decision: Which method to use?
Returning Clients	<i>Clients with no major concerns</i> Decision: No decision to make	<i>Clients with concerns about method</i> Decision: Should the client continue to use the method or switch to a different method?

⁴ **Adapted from:** Shelton, J., Kumar, J., and Kim, Y. 2005. Client-Provider Interaction: Key to Successful Family Planning. *Global Health Technical Briefs*. Baltimore: INFO Project.

⁵ For example, a study in Indonesia found that 93% of new clients had a method in mind. Kim, Y. M., Patjuk, F., Basuki, E., and Kols, A. 2003. Increasing Client Participation in Family Planning Consultations: 'Smart Patient' Coaching in Indonesia. *FRONTIERS Final Report*. Washington, DC: Population Council.

Handout 3-B

Categories of Clients (page 2 of 2)

In addition to determining if a client is new or returning, there are several other ways to categorize clients, as detailed below.

Fertility Plans

Clients have different fertility plans at different stages of their lives.

- **Delayers:** Those who do not have any children and do not want children now
- **Spacers:** Clients who have at least one child and want to delay their next pregnancy
(*Note: Providers should encourage clients to wait three years between births in order to reduce maternal and child health risks.*)
- **Limiters:** Clients who do not want any (or any more) children
- **Pregnancy seekers:** Clients who *want to become pregnant* now and may need advice about discontinuing contraceptive use

Pregnancy History

The client is currently:

- Postpartum
- Postabortion
- Interval
- Never pregnant

Population Groups and Clients with other SRH Needs

- Men (married and unmarried)
- Adolescents (married and unmarried)
- Clients requesting emergency contraception
- Clients with high individual risk for STIs
- Clients living with HIV

Handout 3-C

Factors that Influence Client Decisions

- **Individual factors** are specific characteristics of a client and/or partner that make contraceptive use acceptable (or not), and that make some methods more appealing and more likely to be used effectively than others. These include (but are not limited to): the client's age, desired and existing family size (including age and number of the children, if any), health status, risk for contracting STIs and HIV, and socioeconomic status.
- **Intimate relationship factors** include communication and fidelity with/trust in the partner, agreements related to desired family size, sexual communication and satisfaction, abusive behaviors (such as coercion and violence), equity in decision-making, and age difference of partner.
- **Family factors** include expectations of parents and in-laws that influence a couple's behaviors. Families can directly influence family size and contraceptive method use, and in some contexts, the mother-in-law may accompany the client in the consultation area.
- **Community influences** can have a major impact on clients' knowledge and choice of a contraceptive method. Community, in this context, may include peers, co-workers, and local leaders (e.g., religious and tribal leaders). Community influences can also reflect misinformation, social/gender norms, religion, politics, societal pressures, and legal issues/considerations.
- **Societal influences** include national laws and policies related to sexuality and contraception; the healthcare system's approach to client care (which is not always consistent or equitable); and media including advertising, entertainment, and news.
- **Service factors** include provider attitudes, knowledge, and skills; quality of counseling; accessibility of services; availability and affordability of a range of contraceptive methods; user-friendly information, education, and communication (IEC) materials; and supervisory support to ensure the preceding elements are established and continually functional.
- **Method characteristics** reflect compatibility with a client's lifestyle (including their sexual relationships and behaviors) and affect a client's ability to use contraception consistently. Clients must consider method characteristics including: who controls the use of the method, does it require partner cooperation, does it require application with every instance of sexual relations, what are common side effects, and does it offer dual protection from STIs (including HIV) and pregnancy?
- **Other SRH conditions**, beyond those that clients initially identify as the reason for their visit, may affect the options and decisions that clients need to consider.

Handout 3-D

Method Characteristics

Clients have different reasons for preferring different methods. One client may prefer one method based on the ease and comfort of use, another may prefer a different method based on duration of effectiveness, and yet another may prefer a different one based on cost. The table below highlights some method features that influence clients' decisions about contraception.

Ease and Comfort of Use <ul style="list-style-type: none"> • Requires a pelvic exam (or not) • Frequency of use or of clinic visits • Requires touching one's genitals (or not) • Need to interrupt sexual intercourse (or not) • Potential impact on sexual pleasure • Side effects • Nonsurgical or surgical • Risks 	Affordability (time and cost) <ul style="list-style-type: none"> • Need for frequent follow-up visits for method maintenance • Need for hospital visit or stay for surgical method • Follow-up visit only needed in case of discomfort or annual check-up • Freely available or subsidized • Not free, fixed, and varying price at private clinics
Mode of Action <ul style="list-style-type: none"> • Hormonal • Nonhormonal • Barrier 	Ease of Access <ul style="list-style-type: none"> • Public sector • Private sector • Kiosk • Clinic or hospital • Home distributor
Duration of Effectiveness <ul style="list-style-type: none"> • Short-acting • Long-acting reversible • Permanent 	Ease of Discontinuation <ul style="list-style-type: none"> • Client-controlled • Provider-dependent (requires a trained service provider to remove the contraceptive device)
Cultural Acceptability <ul style="list-style-type: none"> • Acceptable or nonacceptable • Ability to keep method use secret (discreetness) 	Control of Method <ul style="list-style-type: none"> • Client • Partner • Provider

Each method has specific characteristics that suit different client preferences even if the client profiles are similar. Here are three clients who are *all 24 years old and have one child*. They each chose a different method, based on method characteristics.

- Maya does not want another child for at least five years and does not want to have to think about contraception during that time. She chose the intrauterine device (IUD).
- Elsa wants to have a child sometime in the next two years and does not mind using a pill every day. She chose oral contraceptives.
- Miriam may want to have a child after two or three years. She has a hard time remembering to take a pill every day. The clinic is near her work place, so it is easy to get the injection every three months. She chose injections.

Handout 3-E

Gender Terms in SRH

Basic Concepts of Sex and Gender

Sex

- The physical and biological characteristics that indicate whether someone is female, male, or intersexed (born with physical and biological characteristics that are both male and female)
- Sexual activity, including sexual intercourse

Gender is the collection of widely shared expectations, attributes, and opportunities, based on someone's sex. Gender is not biological, rather it is constructed by society and includes:

- Ideas about typically feminine/female and masculine/male abilities and characteristics
- Commonly shared expectations about how women and men should behave in various situations

Gender roles or norms are social messages that dictate appropriate or expected behavior for males and females. Gender roles can have a powerful influence on behavior, including health behavior, and a significant impact on pregnancy prevention and other SRH outcomes. For example, gender roles can:

- Pressure individuals to conform to certain expectations of appropriate SRH behavior
- Hinder communication about SRH issues
- Promote preferences for sons or daughters
- Create gender-based barriers to access to SRH services
- Increase HIV and STI vulnerability
- Perpetuate coercive behavior and/or GBV

Handout 3-F

Gender and Power Imbalances and the Gender-Sensitive Approach to Service Delivery

Health Implications of Gender and Power Imbalances

- In many societies, male and female gender roles result in unequal power balances in society and in the home. A female may have to defer to her male partner's decisions related to sex and bearing children. Women with low levels of relationship power are at greater risk for coercion and IPV.
- It is not always easy to detect instances of pressure and coercive behaviors affecting clients' ability to make SRH or contraceptive decisions. Often people (especially women and adolescent girls) find it difficult to discuss these issues. Men, especially young men, also experience pressure and coercion, because of peer pressure, to conform to societal expectations about how a man should express his masculinity. Young men frequently lack the needed awareness of how these types of pressures influence their risk-taking behavior or how they relate to and interact with their sexual partners.
- GBV is violence involving men and women, in which the woman is usually the victim. The violence stems from unequal power relationships between men and women, in society and in families. Women are vulnerable to this specifically because they are women. GBV includes, but is not limited to, physical, sexual, and psychological harm (including abuse, coercion, intimidation, and/or deprivation of liberty within the family or the community). IPV is a form of GBV.

The Gender-Sensitive Approach to Service Delivery

- From a program perspective, the gender-sensitive approach means supporting full, free, and informed choice—regardless of the client's gender—by ensuring adequate information, access to services, and voluntary choice.
- Being gender-sensitive, as a provider, means addressing the effect of the client's gender on the various factors that influence that client's decision-making capabilities and processes.



Session 4: Provider Beliefs and Attitudes

Introduction to Session 4

Provider Beliefs and Attitudes

By the end of this section, you should be able to:

- Explain how providers' beliefs and attitudes can affect their interactions with clients, both positively and negatively
- Explain the importance of being aware of your own beliefs and attitudes so that you can be respectful and nonjudgmental with all clients

Essential Ideas

- *Beliefs* are concepts and ideas that we accept as truth. Our beliefs usually reflect our values, which are shaped by family, culture, and personal experiences.
- *Attitudes* are the ways we think and feel about people and ideas and are often expressed in our behavior.
- Our beliefs shape our attitudes and how we act toward people and ideas. Our beliefs and attitudes are often so ingrained that we are unaware of them until we confront a situation that challenges them.
- How we communicate our beliefs and attitudes (verbally and nonverbally) is an important part of how we interact with clients. The attitudes of both the client and the provider influences every interaction between the client and the provider.
- Everyone has a right to their own beliefs. However, as service providers, we have a professional obligation to fulfill our clients' rights by providing the highest standard of healthcare to each client—even if they have beliefs that are different from our own—and to do so in a respectful and nonjudgmental manner. Being aware of our beliefs and how they may affect others—positively and negatively—will help us to be respectful and nonjudgmental with all clients.

Handout 4-A

Provider Beliefs and Attitudes in Counseling

(page 1 of 2)

Our beliefs are the concepts or ideas that we accept as truth. They help us to explain how things work in the world, what is right, and what is wrong.

Our beliefs usually reflect our values, which are a person's or society's guiding principles about what is correct and desirable, especially regarding personal behavior. Our values are influenced by religion, education, culture, and family and personal experiences.

Our beliefs and values shape our attitudes—which are the ways that we think about people and ideas. Our behaviors—how we act toward other people—reflect our beliefs and attitudes. Our beliefs and attitudes often are so ingrained that we are unaware of them until we confront a situation that challenges them.

How we communicate our beliefs and attitudes (verbally and nonverbally) is an important part of our interactions with clients—and is a key factor in the client's experience. Consider that every interaction that a client has with a healthcare worker—from the time they enter the healthcare system until they leave—affects the client's:

- Willingness to trust and share personal information and concerns
- Ability to listen and retain important information
- Capacity to make decisions that appropriately address their situation and meet their needs
- Ability to commit to appropriate use of a contraceptive method, follow treatment regimens, or implement new health behaviors

Our beliefs and attitudes affect how we treat clients and respond to their concerns, needs, and preferences. Displaying a respectful and nonjudgmental attitude to clients is essential to supporting their rights and ensuring their ability to make full, free, and informed choices.

An Example of How a Provider's Beliefs and Attitudes Can Negatively Impact a Client

Our private reaction to the client's appearance, social class, or reason for seeking healthcare might determine:

- The gentleness or harshness with which we treat them
- How soon we serve them
- Whether we consider their full range of healthcare needs

For example, a provider who thinks youth should not have sex may speak harshly to an adolescent client and not explain about dual protection.

Handout 4-A

Provider Beliefs and Attitudes in Counseling

(page 2 of 2)

Everyone has a right to their own values and beliefs. However, as service providers, we have a professional obligation to provide healthcare to all clients—even if their beliefs are different from our own—and to do so in a respectful and nonjudgmental manner.

Being aware of our beliefs and attitudes and how they may affect others—positively and negatively—is an important first step in helping us separate our personal beliefs and attitudes from those of our clients. Effective providers are able to set aside their personal beliefs and provide services to all types of clients in a nonjudgmental and respectful manner.

All clients, regardless of circumstances, have the right to the highest quality of care and to access information and advice from providers to help them make the reproductive choices that are right for them. When a provider's beliefs make the provider uncomfortable discussing a particular contraceptive method or sexual and reproductive health (SRH) issue with clients, they risk compromising this quality of care. In this case, the provider should refer the client to another service provider and try to overcome the discomfort by learning more about the issue.



Session 5: Communication Skills for Counseling

Introduction to Session 5

Communication Skills for Counseling (page 1 of 2)

By the end of this section, you should be able to:

Nonverbal Communication

- Describe nonverbal behaviors (such as body language) and explain how they can affect the client-provider interaction during counseling
- Describe the effect of tone of voice on communication

Asking Questions

- Describe two types of questions to use to elicit information from clients
- Explain the use and importance of open questions (including feeling/opinion questions) in assessing clients' needs and knowledge
- Describe how to convert closed questions into open questions

Listening and Paraphrasing

- Define active listening and explain its role in counseling
- List at least three tips for active listening
- Define paraphrasing and reflecting
- Name at least two purposes of paraphrasing during counseling

Essential Ideas

Nonverbal Communication

- Nonverbal communication is what we say through body language (including how we move our body, our facial expressions, and our hand gestures) and our tone of voice.
- Body language can have different meanings in different cultures and in different sub-groups (e.g., sex, age, and ethnicity) within a culture.
- In counseling and other client-provider interactions, nonverbal communication—what clients observe and sense about the provider or staff person—may have the greatest impact on clients' perceptions. Nonverbal signals or cues can communicate to clients our interest, attention, warmth, and understanding—or the lack of all these things.

Introduction to Session 5

Communication Skills for Counseling (page 2 of 2)

Essential Ideas

Asking Questions

- Asking questions enables providers to accurately assess a client's pregnancy prevention and other sexual and reproductive health (SRH) needs and knowledge early in the counseling session and to involve the client actively throughout the session. Questions should be used for eliciting information or facts about the client's life and for exploring the client's feelings and opinions. Asking about the client's feelings helps the provider assess and address the client's needs for emotional support as well as other needs.
- Two categories of questions can be used to elicit different kinds of answers: closed questions usually elicit only a very short response, such as "yes" or "no;" open (or open-ended) questions encourage longer, more detailed responses that might include the client's opinion or feelings.
- Both types of questions have an important role to play in counseling. However, providers historically have relied too heavily on closed questions and have missed a lot of information that clients wanted to share but were never asked. Although we do not want to eliminate closed questions, we do want to increase the use of open questions—which can more effectively elicit feelings or opinions—in order to better assess the client's informational and emotional needs and concerns. In addition, encouraging clients to ask questions can often lead to additional information that will help the provider tailor the counseling session.

Listening and Paraphrasing

- Active listening is a primary tool for showing respect and establishing rapport with clients. If a provider does not listen well, clients might assume their situation is not important to the provider or that they are not important to the provider as an individual. Developing the trust needed for good counseling will be more difficult if the provider is not listening effectively.
- Active listening is also a key communication skill for counseling. It is important for efficiently determining the client's needs and concerns and identifying what the client already knows about their situation and options.
- Paraphrasing is a verbal skill used to enhance active listening. Paraphrasing means restating the client's message simply and in your own words. You can use paraphrasing to reflect the client's feelings (i.e., reflecting) or to clarify and better understand what the client has said. Providers can use paraphrasing and reflecting to let the client know that the provider is listening and to encourage the client to continue talking.
- Clients should be encouraged to ask questions during counseling. The questions a client asks can provide additional information about their needs, knowledge, and concerns.

Handout 5-A

Nonverbal Communication

Nonverbal communication is what we say through body language and tone of voice. It includes the way we move our body, our facial expressions, and our hand gestures.

Cultural Differences

Nonverbal cues vary from culture to culture and sometimes among different groups within a culture (e.g., men and women; adolescents and adults). Therefore, the same nonverbal cue (e.g., a smile) might have different meanings in different cultures and even within different population groups in the same culture.

Positive Nonverbal Cues

- Leaning towards the client
- Smiling (in a way that is culturally appropriate) and not showing tension
- Avoiding nervous or inappropriate mannerisms
- Presenting facial expressions that inspire trust
- Maintaining eye contact with the client (in a way that is culturally appropriate)
- Making encouraging gestures, such as nodding one's head

Negative Nonverbal Cues

- Reading from a chart instead of talking directly to the client
- Fidgeting
- Glancing at one's watch
- Yawning
- Looking away from the client, for example, at papers or out the window
- Frowning
- Not maintaining eye contact

Handout 5-B

Session 1 Essential Ideas (page 1 of 2)

Why do we ask questions during counseling?

- To establish and maintain a good relationship with the client by showing concern and interest
- To actively engage the client and gather information about their needs, concerns, and preferences
- To assess the client's SRH needs and knowledge
- To determine the educational or language level that is most appropriate to ensure the client's understanding
- To prioritize key issues to target during the time available for counseling
- To avoid repeating information that the client already knows
- To identify areas of misinformation that need to be corrected

In addition, encouraging clients to ask questions can often lead to additional information that will help identify the client's needs and help the provider tailor the counseling session.

Adapted from: Tabbutt, J. 1995. *Strengthening Communication Skills for Women's Health: A Training Guide*. New York: Family Care International

Handout 5-C

Types of Questions (page 1 of 2)

Closed Questions

Closed questions will usually lead to by a brief and exact response, often just one word, such as “yes,” “no,” or a numerical answer. These are good questions for quickly gathering important medical and background information. For example:

- How old are you?
- How many children do you have?
- Do you have a method in mind?
- Are you confident that you can remember to take a pill every day?
- Is your house far from this clinic?
- When was your last menstrual period?
- Are you currently using a contraceptive method?

You can use closed questions to ask about feelings, but you may receive limited insight. For example, if you ask, “Do you feel okay?” and the answer is “No,” you will need to ask additional questions to determine what is wrong.

Open Questions

Open questions are useful for exploring the client’s opinions and feelings, as well as gathering more in-depth information. Open questions usually require longer responses and are more effective in determining what the client needs—in terms of information and emotional support—and what they already know. Open questions often start with words like how, what, or why.

Providers must be very careful about using appropriate body language when asking a “why” question, which might sound confrontational and intimidating (as though you are questioning or doubting the client). You can soften such “why” questions using the following language:

- “What are your reasons for...?”
- “What made you decide to...?”
- “Can you tell me why...?”

Handout 5-C

Types of Questions (page 2 of 2)

Good examples of open question include:

- How can we help you today?
- What do you like about the method you want to use?
- What have you heard about this method?
- How would you feel if you experienced changes in your monthly bleeding?
- What do you think could have caused this problem?
- What did you do when you had this problem before?
- What questions or concerns does your partner have about using contraception?
- What do you plan to do to protect yourself from contracting another sexually transmitted infection (STI)?
- What made you decide to use the same method as your sister?
- Why do you want to change methods? (*Better: Can you tell me why you want to change methods?*)
- Why did you stop using your last method? (*Better: What made you stop using your last method?*)
- How do you remember to take your pill every day?
- What do you do if you forget to take a pill? What do you do if you forget to take more than one pill?

Some open questions might get very short answers. For example, a question like “What do you know about STIs?” might elicit the response “Nothing.” However, generally, open questions are more likely than closed questions to encourage the client to talk.

Which Type of Question Should I Use for Counseling?

Open and closed questions each play important roles in counseling. However, providers historically have relied too heavily on closed questions and have missed a lot of information that clients wanted to share but were never asked. We do not want to eliminate closed questions, but we do want to increase the use of open questions, which can more effectively elicit feelings or opinions. This will help us better assess and respond to clients’ informational and emotional needs and concerns.

Handout 5-D

Active Listening

Active listening means giving your full attention to a person who is speaking. It involves blocking out distractions and using nonverbal cues to show that you are paying attention. Active listening communicates understanding, interest, empathy, and respect. It is called active listening because it extends beyond simply listening and involves verbal responses—paraphrasing, reflecting, and asking questions—to confirm or clarify what the person means.

Active Listening

- Is different from hearing
- Requires energy, attention, skills, and commitment
- Makes the speaker feel important, respected, and empowered
- Helps the provider quickly determine the client's needs and concerns and identify what the client already knows about their situation and options

Active listening is a primary tool for showing respect and establishing rapport with clients. If a provider does not listen well, a client might assume that their situation is not important to the provider, or that they are not important to the provider as an individual. Developing the trust needed for good counseling will be more difficult if the provider is not listening effectively.

Nonverbal Communication Tips for Active Listening

- Establish and maintain eye contact.
- Demonstrate interest by nodding, leaning toward the client, and smiling.
- Sit comfortably and avoid distracting movements.
- Pay attention to the client: do not engage in other tasks while you are meeting with the client, do not talk to other people, and do not interrupt the client or allow others to interrupt.
- Listen to the client and do not become distracted or think about other things—including what you are going to say next.
- Listen to *what* your clients say and to *how* they say it. Notice the client's tone of voice, facial expressions, gestures, and how they are sitting.
- Imagine yourself in your client's situation as you listen.
- Allow for pauses of silence during your interaction so that the client has time to think, ask questions, and speak.
- Encourage the client to continue speaking by using expressions such as “yes,” “okay,” and “and then what?”

Handout 5-E

Active Listening: Paraphrasing and Reflecting

(page 1 of 2)

Paraphrasing

Paraphrasing is restating what the speaker has said, in your own words. In counseling, the purposes of paraphrasing are to:

- Show that you are paying attention
- Make sure you correctly understand the client
- Summarize or clarify what the client says
- Encourage the client to continue speaking

Reflecting

Reflecting means stating *the feelings* that you perceive from the client's words or body language and confirming these perceptions with the client. It is similar to paraphrasing, but it also focuses on what the client may not be saying in words but may be saying in body language.

Paraphrasing and Reflecting Guidelines

- Listen to the client's basic message.
- Give the client a summary of what you believe is their message. Do not add new ideas.
- Observe the client's response and use it as a cue to confirm (or deny) the accuracy of your paraphrasing, or ask the client to let you know whether you have correctly understood them.
- Do not restate negative statements that people might have made about themselves in a way that confirms this perception. If a client says, "I really acted foolishly in this situation," it is not appropriate to say, "So, what you did was foolish." Instead, try to understand the situation better by asking questions such as, "Why do you feel that way?"
- Do not overuse paraphrasing. Paraphrasing is most appropriate when the speaker hesitates or stops speaking.
- One of your objectives is to encourage the client to continue speaking, so interrupting them is counterproductive.

Handout 1-E

Active Listening: Paraphrasing and Reflecting

(page 2 of 2)

Examples of Paraphrasing and Reflecting

Note: In the examples below, “C” represents a client’s statement, “P” represents a provider *paraphrasing*, and “R” represents a provider *reflecting* the client’s feeling.

C: “I want a method that lasts for two to three years.”

P: “So you do not want to become pregnant for two to three years, but maybe you would like to after that. Is that correct?”

C: “They say that the intrauterine device (IUD) causes pain in the abdomen.”

R: “It sounds like you are concerned about the IUD because of possible side effects.”

C: “I really should not be here. My parents do not know that I am having sex. They would be so upset to know that I am here. But they would be even more upset if I become pregnant!”

R: “It sounds like you are worried that your parents might find out that you are here...”

P: “...But you think they would feel worse if you got pregnant. Is that right?”

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Session 6: Using Simple Language and Visual Aids

Introduction to Session 6

Using Simple Language and Visual Aids

By the end of this section, you should be able to:

- Explain why and how information, education, and communication (IEC) materials should be used during counseling

Essential Ideas

- For effective communication to occur, providers must explain sexual and reproductive health (SRH) issues in ways that clients understand. Using IEC materials during counseling can be helpful.
- Visual aids are one component of IEC materials. Using visual aids can help focus a discussion, show anatomy that is inside the body, and explain physiology or procedures.
- Having visual aids around the facility is helpful but is not sufficient for providing the information clients need for decision making. To be effective, providers must explain visual aids to clients during counseling. After explaining the visual aids, providers should ask questions to ensure understanding.
- Providing contraceptive samples for clients to see and touch is another example of how providers can use IEC materials during counseling.
- Clients can take pamphlets and instruction sheets home to serve as a reminder of what they discussed in counseling. However, the provider should review the information with the client before sending them home with the materials.

Handout 6-A

Tips for Using IEC Materials

IEC materials are items that can help clients understand and/or remember what they discuss with providers during counseling or at the facility. Examples of IEC materials include audiotapes, diagrams, display samples of contraceptives, drawings, models, pictures, posters, take-home pamphlets, videotapes, wall charts, and wallet cards.

Why Do We Use IEC Materials?

- To focus the client's attention
- To start a discussion and help clients ask questions and make decisions
- To show contraceptives that might not be familiar to clients
- To illustrate anatomical or contraceptive features that one cannot see otherwise—such as the position of an intrauterine device (IUD) in the uterus
- To demonstrate what is involved in medical procedures (e.g., IUD insertion)
- To explain physiological processes (e.g., development of a fetus)

Tips for Using Anatomy Drawings or Models

- Let client know that you will show an anatomy drawing before you show it.
- Start by asking the client what the picture looks like to them.
- Next, identify parts of the picture that the client knows and then continue to those with which they are unfamiliar.
- Point to pictures/parts of pictures as you explain them.
- Try to look primarily at the client, rather than the visual aid.

Other Tips and Logistics for Using IEC Materials

- Make sure clients can clearly see the visual materials as you explain them. Small flipcharts are not appropriate for use with large groups.
- Change the charts and posters in the waiting room occasionally. This will draw attention to them and enable clients to learn something new each time they come to the facility.
- Provide sample contraceptives when explaining how to use them. Invite clients to touch them. For example, clients can practice putting a condom on a model penis, a stick, or a banana. Understand that clients might want privacy to practice.
- If possible, give clients pamphlets or instruction sheets to take home. Such materials can be helpful reminders of correct method use. Review the materials with the client before sending them home with them.
- Order more materials before they run out or make your own materials.
- Make sure that materials are appropriate for the cultural context and literacy level of clients.
- All materials should be gender-sensitive and respectful of clients' rights.

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Session 7: Introduction to REDI; R = Rapport Building

Introduction to Session 7

Introduction to REDI; R = Rapport Building

By the end of this section, you should be able to:

- Describe REDI, a framework for counseling
- Explain the importance of using a counseling framework flexibly
- List the steps of the Rapport Building phase of REDI

Essential Ideas

Introduction to REDI

- REDI stands for *Rapport Building, Exploring, Decision Making, and Implementing the Decision*. REDI fosters full, free, and informed choice. In addition, it:
 - Emphasizes the client's right and responsibility for making and implementing sexual and reproductive health (SRH) decisions
 - Provides guidelines to help the provider and client consider the client's circumstances and social context
 - Identifies the challenges a client may face in implementing their decision(s)
 - Helps clients build skills to address those challenges
- The REDI framework provides a structure and guidance for talking with clients, so that providers do not miss important steps in the counseling process. It also strengthens the client-provider relationship.
- REDI provides a useful framework but does not need to be followed in a scripted or strict manner during a counseling session.

R = Rapport Building

- The steps of Rapport Building are:
 - Greet the client with respect
 - Make introductions
 - Assure confidentiality and privacy
 - Explain the need to discuss sensitive and personal issues
 - Use communication skills effectively

Handout 7-A

REDI: Rapport Building Phase (page 1 of 2)

Phase 1: Rapport Building

1. Greet client with respect
2. Make introductions and identify category of the client (i.e., new, satisfied return, or dissatisfied return)
3. Assure confidentiality and privacy
4. Explain the need to discuss sensitive and personal issues
5. Use communication skills effectively (throughout the phases)

Phase 2: Exploring

1. Identify the reason for the visit in detail

For *new clients*:

1. **Individual factors:** Explore the client's SRH history and pregnancy prevention goals
2. **Other key factors:** Explore the client's sexual relationships, social and gender contexts for decision making, and risk of STI/HIV
3. **Explain pregnancy prevention and other SRH options:** Focus on the method(s) of interest to the client, addressing individual and other key factors and risk of STI/HIV

For *return clients*:

2. Explore the client's satisfaction with the current method
3. Confirm correct method use
4. Ask the client about changes in their life (e.g., plans to have children, STI risk and status)

For *dissatisfied clients*:

2. Explore the reasons for the client's dissatisfaction or problems, including the issue, causes, and possible solutions, such as switching methods

Phase 3: Decision Making

1. Summarize from the Exploring phase:
 - a. Identify the decisions the client needs to make or confirm (for satisfied return clients, see if they need other services; if not, go to Phase 4, Step 4)
 - b. Identify relevant options for each decision (e.g., pregnancy prevention, STI/HIV risk reduction)
 - c. Confirm medical eligibility for contraceptive methods the client is considering
2. Help the client consider the benefits, disadvantages, and consequences of each option (provide information to address any remaining knowledge gaps)
3. Confirm that any decision the client makes is informed, well-considered, and voluntary

Phase 4: Implementing the Decision

1. Assist the client in developing a concrete and specific plan for implementing the decision(s) (obtaining and using the contraceptive method chosen, risk reduction for STIs, dual protection, etc.)
2. Identify barriers that the client may face in implementing the plan
3. Develop strategies and skills to overcome the barriers
4. Make a follow-up plan and/or provide referrals, as needed

Handout 7-B

Frameworks and Flexibility

- *A framework is an aid—a means to an end, rather than the end in itself.* The REDI framework provides a structure and guidance for talking with clients, so that providers do not miss important steps in the counseling process. However, counseling should always be client-centered—too often providers focus more on following the steps than on listening to the client and responding to what they are saying. The primary goal of counseling is to understand the client’s needs and help them meet those needs.
- REDI provides a useful framework but *it is not necessary to follow the framework in a scripted or strict manner during a counseling session.* REDI is a suggested guide for the steps and topics to cover while the provider and client engage in an interactive discussion of the client’s desires, needs, and risks.
- This framework supports *clients’ reproductive rights and fosters full, free, and informed choice* of contraceptive methods, based on an understanding of their specific situation and their risks of pregnancy and contracting an STI/HIV.
- No matter which framework you use for counseling, it is important to *personalize counseling sessions by exploring each client’s individual situation*, as opposed to talking generally about contraceptive methods or STI prevention. By personalizing the discussion to the client’s specific situation, you can help clients better understand their own risks so that they do not think of unintended pregnancies and STIs as “things that happen to other people.”

Session 8:
E = Exploring (Steps 1-3)

Introduction to Session 8

E = Exploring (Steps 1-3) (page 1 of 2)

By the end of this section, you should be able to:

- Name the four steps of the Exploring phase of REDI
- Define the terms sex and sexuality
- Describe four aspects of sexuality
- Explain why providers need to be prepared to ask questions about sexual relationships and practices in counseling
- Explain how sexual practices relate to the choice and use of contraceptive methods
- List aspects of the client's gender context that should be addressed in counseling
- Define the term “risk assessment”
- Explain why and how a risk assessment is used in counseling
- Identify at least three reasons why it is difficult for people to perceive their own risks regarding pregnancy and sexually transmitted infections (STIs) and HIV

Essential Ideas

Step 1

- The first step of Exploring is to *identify the reason for the visit in detail*. This is a crucial step for client-centered counseling because it helps the provider to focus on the client's specific needs and concerns and avoid wasting time addressing issues that the client does not need to discuss at this time.

Step 2

- The second step explores *individual factors* of the client's sexual and reproductive health (SRH) history and pregnancy prevention goals. This provides background information that will be crucial in helping the client make decisions about pregnancy prevention and STI/HIV prevention that will meet their individual needs.

Step 3

- The third step explores *other key factors*—the client's sexual relationships, social and gender contexts for decision making, and risk of STI/HIV.
- Sexuality has four aspects: intimacy, sensuality, sexual identity, and sexual health. In SRH counseling, the aspect of sexuality that we focus on is sexual health. We help the client consider the impact of their sexual relationships and practices on their options for contraception and prevention of STIs/HIV.

Introduction to Session 8

E = Exploring (Steps 1-3) (page 2 of 2)

Essential Ideas (continued)

- The client's gender also has an impact on sexual relationships and the social context for decision making. Being *gender-sensitive* as a provider means addressing the impact of the client's gender on decision making. The provider should be prepared to discuss the following with the client:
 - Gender roles
 - Gender preferences in children
 - Gender power imbalances in the client's relationship
 - Gender power imbalances between provider and client

Sexual Practices

- People use contraception because they are sexually active or plan to be. Clients' choice of, use of, and satisfaction with contraceptive methods are often related to the real or perceived effect of contraceptives on their sexual relationships and practices.
- Clients should consider which contraceptive methods will work best with their sexual relationships and practices and which methods might cause problems for them. Such problems could lead to discontinuation or incorrect and/or irregular use of the method. This is one reason why it is necessary for providers to discuss sexual practices in counseling.

Risk of STI/HIV

- Sexual relationships and practices also affect one's individual risk for contracting STIs and inform appropriate approaches to reducing that risk.
- A risk assessment is a counseling process to help clients understand their risk of becoming pregnant or infected with an STI or HIV based on their sexual practices. It also addresses how the level of risk may change depending on changes in their behaviors and circumstances.
- A *risk assessment* helps providers better understand a client's circumstances and behaviors and tailor counseling appropriately.
- People tend to underestimate their risk and perceive themselves to be at lower risk than they actually are. Therefore, providers need to help clients perceive and understand their risks. Then clients can use this information to reduce their risk by changing their behaviors.
- There are biological factors that explain why some sexual practices make clients more vulnerable to becoming infected with HIV or other STIs.

Handout 8-A

REDI: Exploring Phase

Phase 1: Rapport Building

1. Greet client with respect
2. Make introductions and identify category of the client (i.e., new, satisfied return, or dissatisfied return)
3. Assure confidentiality and privacy
4. Explain the need to discuss sensitive and personal issues
5. Use communication skills effectively (throughout the phases)

Phase 2: Exploring

1. Identify the reason for the visit in detail

For *new clients*:

1. **Individual factors:** Explore the client's SRH history and pregnancy prevention goals
2. **Other key factors:** Explore the client's sexual relationships, social and gender contexts for decision making, and risk of STI/HIV
3. **Explain pregnancy prevention and other SRH options:** Focus on the method(s) of interest to the client, addressing individual and other key factors and risk of STI/HIV

For *return clients*:

2. **Explore the client's satisfaction with the current method**
3. **Confirm correct method use**
4. **Ask the client about changes in their life** (e.g., plans to have children, STI risk and status)

For *dissatisfied clients*:

2. **Explore the reasons for the client's dissatisfaction or problems**, including the issue, causes, and possible solutions, such as switching methods

Phase 3: Decision Making

1. Summarize from the Exploring phase:
 - a. **Identify the decisions the client needs to make or confirm** (for satisfied return clients, see if they need other services; if not, go to Phase 4, Step 4)
 - b. **Identify relevant options for each decision** (e.g., pregnancy prevention, STI/HIV risk reduction)
 - c. **Confirm medical eligibility for contraceptive methods the client is considering**
2. **Help the client consider the benefits, disadvantages, and consequences of each option** (provide information to address any remaining knowledge gaps)
3. **Confirm that any decision the client makes is informed, well-considered, and voluntary**

Phase 4: Implementing the Decision

1. **Assist the client in developing a concrete and specific plan for implementing the decision(s)** (obtaining and using the contraceptive method chosen, risk reduction for STIs, dual protection, etc.)
2. **Identify barriers that the client may face in implementing the plan**
3. **Develop strategies and skills to overcome the barriers**
4. **Make a follow-up plan and/or provide referrals, as needed**

Handout 8-B

What Is Sexuality?

Sexuality

- Is an expression of who we are as humans
- Involves the mind and the body
- Includes all of the behaviors, feelings, and thoughts related to being male or female, to being attractive, to being in love, and to being in relationships that include intimacy and physical sexual activity
- Is shaped by our attitudes, behaviors, beliefs, emotions, likes and dislikes, personality, physical appearance, values, and the ways we have been socialized
- Is influenced by cultural, religious, and social norms
- Involves giving and receiving sexual pleasure as well as enabling human reproduction
- Spans our lifetimes—it begins before birth and lasts throughout a person's life

Sexuality includes:

Sex

- The physical and biological characteristics that indicate whether someone is female, male, or intersexed (born with physical and biological characteristics that are both male and female)
- Sexual activity, including sexual intercourse

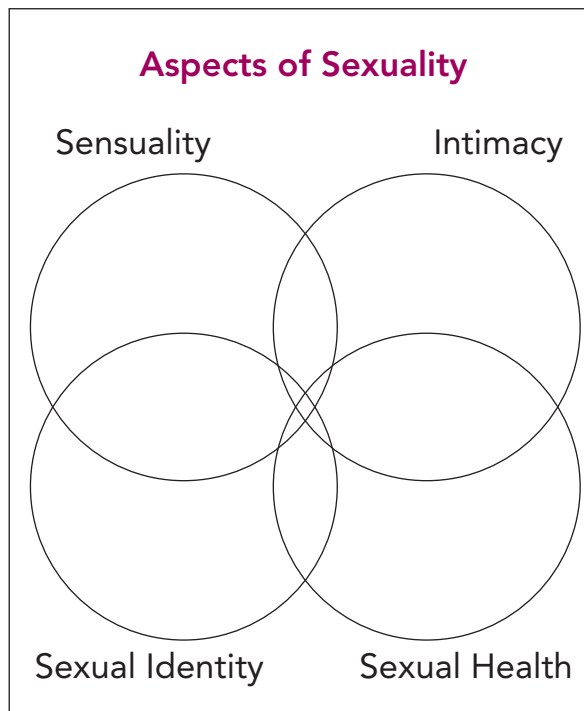
Gender

- *Gender*: How an individual or society defines being female or male
- *Gender roles*: Socially and culturally defined attitudes, behaviors, expectations, and responsibilities attributed to males and females
- *Gender identity*: The personal, private conviction each of us has about being male, female, or intersexed

Handout 8-C

Aspects of Sexuality (page 1 of 2)

Sexuality has four aspects: sensuality, intimacy, sexual identity, and sexual health. Each aspect overlaps with all the others, as symbolized in this diagram.



In counseling, the aspect we focus on primarily is sexual health. However, given the overlapping nature of the four aspects, we often need to explore sexual relationships and practices in order to support the client's sexual health decision making.

1. **Sensuality.** Sensuality is how our bodies derive pleasure. It is the part of our experience that deals with the five *senses*: hearing, sight, smell, taste, and touch. Any of these senses, when enjoyed, can be sensual. Sensuality is also part of the sexual response cycle; it is the mechanism that enables us to enjoy and respond to sexual pleasure.

Body image also is a part of sensuality. Feeling attractive and proud of one's body influences many aspects of life.

The desire to be touched, held, or caressed is an essential aspect of healthy development because it is about appreciating one's body and understanding how it functions. Puberty and adolescence are critical stages in the development of sexuality. The desire to hug, kiss, or be physically intimate with others is an important part of youths' sexual development. This does not mean that youth act out such desires continually or that they should be encouraged to do so, but experiencing such emotions and desires is part of healthy sexual development.

Handout 8-C

Aspects of Sexuality (page 2 of 2)

2. **Intimacy.** Intimacy is the part of sexuality that deals with the emotional aspect of *relationships*. Our ability to love, trust, and care for others is based on our experience with intimacy. We learn about intimacy from our relationships with those around us, particularly relationships within our families. Emotional vulnerability is part of intimacy. To be truly intimate with others, a person must be open and share feelings and personal information. We take a risk when we do these things, but intimacy is not possible otherwise.
3. **Sexual identity.** Every individual has their own personal sexual identity. Sexual identity has four main components:
 - *Biological sex* is our physical status of being either male, female, or intersexed.
 - *Gender identity* is an individual's sense of being male, female, or intersexed—and how they feel about that. Gender identity starts to form at about age two, when little boys and girls realize that they are different from each other.
 - *Gender roles* are the behaviors that society expects us to exhibit that are associated with our biological sex. What behaviors do we expect of men and what behaviors do we expect of women? When did we learn to expect these behaviors? These sets of behaviors are gender roles and they begin to form very early in life.
 - *Sexual orientation* is the final element of sexual identity. Sexual orientation refers to the biological sex to which we are sexually and romantically attracted. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. However, they actually are expressing different gender roles: their masculine or feminine behavior has nothing to do with their sexual orientation. A homosexual man may be very feminine, very masculine, or neither; the same applies to heterosexual men. Also, people may engage in same-sex sexual behavior but not consider themselves homosexual.
4. **Sexual health.** Sexual health is the integration of the emotional, intellectual, physical, and social aspects of being sexual in ways that enrich and enhance us—our personality, communication, and love. Sexual health involves our behaviors related to producing children, enjoying sexual relationships, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and STIs are part of our sexual health. Sexual health also refers to the rights to exercise control over one's sexuality free of coercion or violence and to receive information about sex.

Handout 8-D

Why Is It Important to Address Sexual Relationships and Practices as a Part of Counseling?

- Pregnancy and STIs are the result of sexual relationships. Exploring clients' sexual relationships—rather than making assumptions about them—enables providers to tailor counseling to clients' specific circumstances (e.g., ability to discuss issues and negotiate with their partner, frequency of sex, and number of partners). This leads to better selection of contraceptive methods that meet clients' needs.
- The client's sexual practices can have implications for decision making about contraceptive method choice, use, and STI risk reduction.
 - A client might be reluctant to try a certain method (e.g., condoms) or might stop using a contraceptive method if they perceive it as interfering with sexual acts or decreasing sexual pleasure for the client or the partner.
 - A discussion about STI prevention must include a conversation about which sexual practices are riskier as well as which are safer.
- Clients might have underlying concerns about their sexual relationships and practices that are the real reason for a facility visit or that are more important than the stated reason for their visit. For example, a client's needs might be related to sexual abuse or coercion, rape, or incest; these issues need to be addressed in order to provide effective services.
- Considering sexual relationships and practices during counseling may help improve client satisfaction with services, in general.

Handout 8-E

Considering Sexual Relationships and Practices and Method Characteristics

People use contraception because they are sexually active or plan to be. Clients' use of and satisfaction with contraceptive methods are often related to the real or perceived effect of contraceptives on their sexual relationships and practices.

Clients should consider which contraceptive methods will work best with their sexual relationships and practices and which methods might cause problems for them. Such problems may lead to discontinuation or incorrect and/or irregular use of the method. Here are some of the main points to help the client consider:

- **Spontaneity.** If spontaneity is important, methods tied directly to intercourse, such as condoms or other barrier methods, might not work well.
- **Menstrual changes (e.g., irregular bleeding).** Women considering hormonal methods or an intrauterine device (IUD) should consider whether menstrual changes would be a problem for them or their partners.
- **Frequency of sexual relations.** For some clients, frequency of sexual relations will be a factor in choosing contraceptives. Clients who have sex occasionally or infrequently might prefer a method that can be used as needed, such as condoms, rather than a method that requires doing something every day, like the pill.
- **Male partner will not cooperate with contraceptive use.** For these clients, methods like condoms and natural family planning are not good choices.
- **Secrecy needed.** Clients who need to conceal their sexual activities (e.g., unmarried adolescents) or their use of contraception (e.g., clients whose partners do not approve) might want to consider methods that do not require obtaining supplies or daily use.
- **Permanent methods, reduced fear of pregnancy.** More effective methods, such as permanent methods, give some people a greater sense of security. Without the fear of pregnancy, these people might enjoy sex more.
- **Permanent methods, loss of fertility.** Clients who strongly associate fertility with their sexuality or self-esteem might *not* be comfortable with permanent methods.
- **Multiple partners.** Clients with multiple partners (or whose partners have multiple partners) should consider their need for pregnancy prevention and protection from STIs/HIV. These individuals are at a higher risk for contracting STIs/HIV and might want to consider dual-method use (using one method for contraception and one method for STI protection) or condoms alone for both purposes (however, remembering that condoms are a less effective contraceptive method than some other options).

Handout 8-F

Counseling and Gender Sensitivity

A gender-sensitive provider supports the rights of every client to full, free, and informed choice, regardless of the client's gender. Being gender-sensitive means understanding and addressing the effect of the client's gender on the various factors that influence the client's decision making.

Consider these examples:

- **Gender roles.** Social and cultural norms can determine what information and services the client can (or cannot) access, affect whether a woman is able to seek services and make decisions on her own, and create expectations about family size and timing of births.
- **Gender preferences in children.** Clients' decisions may be influenced by the gender of their existing children or those they expect/hope to have.
- **Gender power imbalances in decision-making.** Is the client able to make their own decisions or does someone else have to be involved?
- **Gender-based violence (GBV).** This includes fear of punishment or injury, including intimate partner violence (IPV), after seeking services or choosing particular contraceptive methods. GBV can affect pregnancy prevention in numerous ways. For example, a woman might choose to use contraception because she does not want to have a child with a partner who is violent toward her. However, she may also fear he will be violent if he discovers her contraceptive use, so she needs to hide it.
- **Gender power imbalances between provider and client.** Some issues to consider:
 - Does a female client feel intimidated by a male provider? Or by male medical staff in general?
 - Does the provider have expectations of how men and women should behave in pregnancy prevention decision-making situations? How does that influence the provider's counseling and rapport with the client?
 - How could the provider's values influence a female client's right to access contraception without the approval of her spouse or family?

Handout 8-G

Risk Assessment

What Is It?

A risk assessment is a counseling process to help clients understand their risk of becoming pregnant or infected with an STI from sexual practices in which they or their partners engage, in order to help them reduce their risk. It also includes addressing how the level of risk might increase or decrease depending on changes in circumstances. For example, a client's risk could increase for any of the following reasons:

- Their uninfected partner becomes infected
- They had one partner and now they have more than one partner
- They have a new partner and do not know their new partner's sexual history
- Their partner changes their mind and decides that they do not want to use condoms
- They develop side effects with a contraceptive method and discontinue its use
- They have gotten married and decided they would like to have a baby soon

The risk of pregnancy and STIs/HIV depends not only on the client's own sexual behaviors but also on their partner's sexual history, current behaviors and practices with other people, and infection status.

Behaviors that may be low-risk in one relationship could be high-risk in another. For example, a typically high-risk behavior such as anal sex carries no risk for STI transmission if neither partner is infected; it also carries no risk for pregnancy. This makes the concept of risk confusing.

Handout 8-H

Helping Clients Understand Risk

Why Is a Client's Perception of Their Own Risk Important?

- Understanding how our behavior puts us at risk of negative consequences is essential for behavior change. People who *perceive* themselves to be at risk of unintended pregnancy or becoming infected with an STI or HIV are more motivated to modify their behaviors in order to protect themselves.
- People generally need to feel ownership of a plan to change their behavior if they are to implement it successfully. If the provider simply tells the client what to do, without working with the client to develop a plan that is meaningful to and realistic for the client, it is unlikely that the client will follow it.

How Can Providers Can Help Clients Perceive and Understand Their Risks?

- Help the client assign risks to their specific circumstances. For example, if a client says that her husband has other partners and does not use condoms, highlight the risk to her.
- Try to personalize clients' risks by tailoring information to the client's situation. For example, if an adolescent girl does not wish to become pregnant but is not using contraception, provide her with brochures specifically designed for youth that discuss the risks and realities of adolescent pregnancy.
- Identify ways that the client has protected their health in the past and draw their attention to these successes. For example, if a client has used oral contraceptives to prevent unintended pregnancy, acknowledge that she perceived a risk of becoming pregnant and took positive action to prevent the risk. Gently suggest that there might be other health risks that she could address as well. For example, if her partner recently sought treatment for an STI, note that any sexual partner of a person with an STI is at risk of contracting that STI.

Relationship Factors in Risk of STIs and HIV

How does an individual's role in a sexual relationship and the context of that relationship affect risk?

- If one or both partners in a relationship have other sexual partners, their risk for STIs increases.
- If one person in a relationship has less power, that person might not be able to negotiate risk reduction with the partner, whether for pregnancy or STIs.
- The partner who is penetrated in vaginal and anal sex is usually at higher risk for STIs than the person who is penetrating their partner. The partner who performs oral sex is at higher risk than the partner who receives it.

Handout 8-1

Why People Underestimate their Risk of Pregnancy or STI/HIV (page 1 of 2)

The client's *perception* of whether they are at risk for unintended pregnancy or STI infection is a crucial starting point for encouraging them to take steps toward reducing risk. However, in many cases, people perceive themselves to be at less risk than they actually are. People have many reasons for underestimating their own risk. Lack of information and lack of understanding of the *relative risk* or *individual risk* underlie most of the reasons, as listed below.

- **Stereotyped beliefs about who is at risk.** Many people mistakenly believe that homosexuals, intravenous drug users, migrant workers, sex workers, and truck drivers are the only people at risk of contracting HIV. People think that because they are in a heterosexual relationship, they are not at risk or that because they are married or in a monogamous relationship, they can trust that their partner will be faithful. For women in particular, messages about being faithful as a way to avoid infection might give a false sense of safety, because they are at risk due to their partners' behavior rather than their own.
- **The illusion of invulnerability.** Some people have a personal belief that they are immune to risk regardless of their behaviors. People generally tend to underestimate their own personal risk in comparison to the risk faced by others who are engaging in the same behaviors. For example, an adolescent girl may think she will not get pregnant even if she has sex without using a contraceptive method because of an "It will not happen to me" mindset. Adolescents, in particular, as part of their emotional development, often think of themselves as invulnerable to many risks.
- **Fatalism.** Fatalism is a belief that circumstances are beyond one's control. Nothing a person does will change what is going to happen. An example of this would be a person who believes that spiritual forces determine how many children one has and that therefore it is not necessary to use contraception.
- **Bigger or more urgent problems.** A person might have other concerns that require immediate attention and that make the threat of STIs or unintended pregnancy a lower priority. People who live in communities with widespread hunger, poverty, or violence, for example, are more likely to prioritize other issues, such as feeding and protecting their children from harm.

Handout 8-1

Why People Underestimate their Risk of Pregnancy or STI/HIV (page 2 of 2)

- **Misconceptions about risk.** Mistaken beliefs can interfere with a person's understanding of what is risky. For example, a person might not fully understand how HIV is spread and think that HIV can be transmitted through contact with toilet seats or through the sharing of eating utensils. Similarly, youth might mistakenly believe that a girl cannot get pregnant the first time she has sex. Clients are often afraid to use the IUD or a hormonal method, but do not understand that the relative risks of pregnancy-related morbidity and mortality are greater for most clients than risks from using these methods.
- **Traditional gender roles and societal expectations.** Different societal expectations and social norms influence clients' behaviors. For example, a woman might suspect that her husband is having extramarital relationships, but it might not be culturally or socially acceptable for her to bring this to his attention. If she feels there is little or nothing she can do about the situation, she may think it is easier for her to not acknowledge the problem or to minimize her perception of the potential risk.

Handout 8-J

Biological Factors and Risk of HIV and Other STIs

What are some biological factors that might increase the risk for STI transmission?

- Persons with *open sores, lesions, or abrasions* on the anus, mouth, penis, or vagina are at higher risk for STI infection if they are exposed during unprotected sex. (Note: “Exposed” means having had sexual intercourse—anal, oral, or vaginal—with someone who has an STI; “unprotected sex” means having had vaginal, oral, or anal sex without using either a male or female condom.)
- The *tissue lining the rectum* is very susceptible to microlesions and tears during anal sex, thus creating entry points for STIs to enter the bloodstream during unprotected sex. This makes anal sex riskier than vaginal or oral sex.
- Adolescent girls, whose *vaginal tissue* is not fully matured, can develop microlesions during intercourse and are thus at higher risk for contracting an STI infection if exposed through unprotected sex. This also applies to perimenopausal women with thinning vaginal tissue.
- Persons with an STI, particularly an ulcerative STI (such as chancroid or syphilis), are more likely to become infected with HIV, if exposed.
- *Uncircumcised men* are more likely to contract HIV if exposed during unprotected vaginal sex than circumcised men.
- A person with *advanced HIV disease* or *AIDS* has a *higher viral load* and is thus more likely to transmit the infection during unprotected sex than an HIV-positive person who is otherwise healthy. A person newly infected with HIV also has a high viral load.
- An HIV-infected pregnant woman who is healthy and well-nourished, and thus has a *lower viral load*, is less likely to transmit the virus to her baby during pregnancy, labor, or breastfeeding.
- An HIV-infected breastfeeding mother is more likely to transmit the virus to her baby while breastfeeding if she has *cracked and bleeding nipples* (due to breast abscess, mastitis, or nipple fissure).

Session 9:
E = Exploring (Step 4)

Introduction to Session 9

E = Exploring (Step 4) (page 1 of 2)

By the end of this section, you should be able to:

- Define “misconceptions” and explain why it is important to address them in counseling
- List the basic principles of information-giving
- Explain how to tailor and personalize information for clients
- List at least three ways to make information understandable
- Provide basic information about healthy timing and spacing of pregnancy
- List the categories of key information that clients need to select a contraceptive method
- Explain the differences between side effects, health risks, and complications
- Describe principles for discussing side effects, health risks, and complications with clients
- List the contraceptive methods that provide the best protection, some protection, and no protection from sexually transmitted infections and HIV
- Define dual protection and dual method use

Essential Ideas

- A *misconception* is a belief that is not true, usually because it is based on incomplete or inaccurate information.
- Misconceptions can lead to discontinuation of contraceptive methods. Thus, correcting misconceptions is an important step to ensuring continued use. If clients understand why misconceptions are untrue, they are more likely to believe the correct information.
- *Principles of information giving include:*
 - Tailoring information to the client’s needs (e.g., new vs. returning clients)
 - Personalizing information
 - Making information understandable
 - Putting risks into perspective
- *Tailoring information* means adjusting the amount and scope of information to the client’s interests and needs.
- *Personalizing information* means putting information in the context of the client’s situation to help the client understand what the information means to them.

Introduction to Session 9

E = Exploring (Step 4) (page 2 of 2)

Essential Ideas (continued)

- Key messages about *healthy timing and spacing of pregnancy (HTSP)* to achieve healthiest pregnancy outcomes are:
 - Wait at least two years after a live birth before trying to become pregnant again
 - Wait at least six months after a miscarriage or abortion
 - Wait until age 18 at least before trying to become pregnant
- *Key information* for clients choosing a contraceptive method:
 - Type of method
 - Effectiveness
 - Side effects, health risks, and complications
 - How to use, how to obtain, or what to expect during the procedure (if applicable)
 - When to return for follow-up care
 - How to prevent STIs/HIV, including dual protection
- *Side effects* are changes in the body in reaction to a contraceptive method. They are common but are generally not harmful and may go away without treatment. A *health risk* is an adverse event or negative health consequence due to using a contraceptive method. *Complications* are specifically related to problems from clinical procedures. Health risks and complications are rare but can be serious and require medical attention.
- All clients should be informed of potential side effects associated with the method(s) they are considering and should be prepared, through counseling, for how to manage them. Although rare, clients should also be told about health risks and possible complications associated with *their chosen method*. Health risks and complications should be explained separately, so that clients do not mistake them for side effects that are more likely to occur.
- Each client should consider their risk for contracting an STI and the need for protection against infection when choosing a contraceptive method.
- Dual protection is a strategy to prevent both pregnancy and transmission of STIs. Dual method use is the use of a condom with another contraceptive method (or emergency contraception).

Handout 9-A

Addressing a Client's Misconceptions

A misconception is a belief that is not true, usually because it is based on incomplete or inaccurate information. Misconceptions about contraceptive methods can lead to clients refusing methods that might work well for them or discontinuing a method after they start. Thus, correcting misconceptions is an important step in ensuring correct and continued use of contraceptive methods.

How to Address Misconceptions

- Ask clients what they have heard about contraceptive methods and what concerns they have about the methods.
- Take the client's concerns and/or misconceptions seriously.
- If there are misconceptions, try to determine where the client heard the misconception.
- Explain, in a respectful manner, why the misconception is not true.
- Provide the correct information. Be aware of traditional beliefs about health, because they can help you understand rumors and also explain health matters in ways that clients can more easily understand and accept.
- Encourage clients to check with a service provider again if they hear something about their method of choice or other methods that concerns them or does not match what they learn at the healthcare facility.

Handout 9-B

Principles of Information Giving

Principles at a Glance

- **Tailor information** to the client's needs
 - Find out the client's need or problem (method in mind? return client?)
 - Find out what the client already knows
 - Identify information gaps to address or misconceptions to correct
- **Personalize information** for the client
 - Put information in terms of the client's situation
 - Help the client understand what the new information means to them personally (e.g., what would it take or mean to start a new method, to cope with side effects, to discontinue or to switch to another method?)
- **Make information understandable** by using understandable language, speaking clearly, and using visual aids
- **Put risks into perspective**, including noting that the risks associated with carrying a pregnancy to term are much higher than risks associated with using a contraceptive method

There are limits to the amount of information that people can understand and remember. This is a key reason why counseling should *not* cover every detail related to every method available.

Tailored information is information that is adjusted in amount and scope, to respond to the client's individual needs and circumstances.

- Ask what the client already knows, identify knowledge gaps, and determine what method the client is interested in.
- Once you have this information, you can provide specific information to help the client make or confirm decisions.
- To avoid overloading and confusing the client, skip information the client already has or that is not relevant.

Handout 9-C

How to Tailor and Personalize Information

How to Tailor Information

- A *new client with no method in mind* will need a *review* or *overview* of all available contraceptive methods. Methods that are irrelevant to the client's needs may be mentioned by name without details (e.g., if the client has stated that they are considering having children in the future, methods like female sterilization and vasectomy should only be mentioned by name because they are permanent). The provider should also tell the client why they are not going into detail about those methods (because the client is still considering having children in the future).
- For *new clients with a method in mind*, information should start with and focus on the preferred method. Providers should briefly mention other methods, particularly those that meet their reproductive intentions, to ensure that the client is aware of them and is making an informed choice. In such cases, if the provider sees an information gap related to other methods and detects that the client that has a method in mind is not fully informed about other options, the provider should give information about other methods, as appropriate (i.e., tailored to the client's situation).
- *Returning clients* do not need to receive a review of contraceptive methods unless they are considering switching to another method. Information should be limited to the problem or need for which the client has come to the facility (e.g., resupply or routine follow-up care).

How to Personalize Information

Personalized information is information placed within the context of the client's situation. Personalizing information helps the client understand what the information means to them in particular. For clients who are considering a method, this means providing concrete examples of what using that method would mean with regard to their circumstances and daily life. Personalizing the information serves as a reality check to help the client understand what the information means and implies for them.

Example: Information for a Woman Deciding Whether to Use Oral Contraceptive Pills

Good: "Pills have to be taken regularly."

Better (tailored): "You will need to take a pill at the same time every day."

Best (tailored and personalized): "To ensure that the pill is effective, you need to take it at the same time every day. But you mentioned that your schedule is different every day. You might take your pill every morning when you get up or every night with your evening meal, but you need to choose one and stick to it. How would this work for you?"

Handout 9-D

How to Make Information Understandable

1. **Start with what is best known.** Start with reviewing information or facts that the client already knows. Then transition to topics that are new to the client, always making linkages between the topics.
2. **Choose appropriate language.** Determine what language and terms to use based on the client's knowledge and comfort.
3. **Use examples from everyday life.** For example, in rural communities, you can use crops as an analogy to convey the benefits of spacing and providing adequate care and nutrition. For example, "Children, like crops, do better when they are spaced and given proper attention and nutrition."
4. **Keep it short.** Choose the most important points that the client must remember.
5. **Keep it simple.** Use short sentences and common words that clients understand.
6. **Put first things first.** Give the most important information first, as clients will remember it best. Follow a logical sequence.
7. **Organize information for the client.** Put information in categories. For example, tell a client: "There are four medical reasons to come back to the clinic."
8. **Highlight what to remember.** For example, tell a client: "These three points are important to remember." Then list the three points.
9. **Show and tell information.** Sample contraceptives, flipcharts, wall charts, and other pictures reinforce the spoken word.
10. **Confirm the client's understanding.** Ask the client to repeat important instructions. This ensures that they understand the information they have received and helps them remember it. You can also use this opportunity to gently correct any errors.
11. **Repeat key information.** The last thing you say should remind the client of the most important instructions.
12. **Send information home.** Give the client simple print materials to take home. Review the materials with the client before they depart.

Handout 9-E

Healthy Timing and Spacing of Pregnancy (HTSP)

(page 1 of 2)

What is HTSP?

HTSP is a way of achieving healthier pregnancies and deliveries and reducing pregnancy-related risks to the health of the mother and babies. HTSP has *three key messages* that should be discussed with clients. These message focus on health risks, benefits, and other circumstances such as their age, fertility and fertility aspirations, access to healthcare services, child-rearing support, social and economic circumstances, and personal preferences. Those key messages are:

- **After a live birth.** To achieve the healthiest pregnancy outcomes, couples should use an effective contraceptive method of choice continuously *for at least two years* (but not more than five years after the last birth) before trying to become pregnant again.
- **After a miscarriage or abortion.** To achieve the healthiest pregnancy outcomes, couples should use an effective contraceptive method continuously *for at least six months* after a miscarriage or abortion, before trying to become pregnant again.
- **For adolescents.** To achieve the healthiest pregnancy outcomes, adolescents should use an effective contraceptive method continuously *until they are 18 years of age* before trying to become pregnant.

Handout 9-E

Healthy Timing and Spacing of Pregnancy (HTSP)

(page 2 of 2)

Counseling Clients for HTSP

1. Explain HTSP messages to clients clearly, in language that they understand.
2. Explain that the couple should use an effective contraceptive method of their choice to time and space pregnancies.
3. Mention the range of contraceptive methods available to the couple, including fertility awareness-based methods.
4. Explain how to obtain and use contraceptive methods.
5. Emphasize the health, social, and economic benefits of practicing HTSP.
6. Remind the clients that HTSP benefits the family and the community.
7. Encourage clients to ask questions and share the information with partners, family members, and friends.

Discuss reproductive intentions with your clients whenever there is an opportunity. Ask if they wish to delay or space the births of children or if they want to limit the number of children they have.

- During antenatal care (checkups before delivery)
- During postpartum care (checkups after delivery)
- During well-baby clinics and services for children under five (such as immunizations)
- During pregnancy-prevention services (especially services for *engaged couples, HIV-positive women who wish to become pregnant, newlyweds, young couples, married couples with children, single mothers, and women who have experienced a miscarriage or abortion*)
- During postabortion care
- During services related to STIs, HIV, and AIDS
- During youth services
- During men's health services
- During community outreach

Adapted from: Extending Service Delivery (ESD) Project. Healthy Timing and Spacing of Pregnancies: A Pocket Guide for Health Practitioners, Program Managers, and Community Leaders. See also: <http://www.who.int/pmnch/topics/maternal/htsp101.pdf>
https://www.globalhealthlearning.org/sites/default/files/reference-files/ESD_PG_spreads_0.pdf

Handout 9-F

Give Key Information on Contraceptive Methods

Clients receive information about contraceptive methods at various times and in varying degrees of detail during counseling. During the Exploring phase of REDI, new clients receive the essential information needed to compare and eliminate contraceptive methods in order to choose the method that best meets their needs. This information includes: type of method, effectiveness, expected side effects, possible health risks and complications, health benefits, how to use and obtain, required follow-up care, and whether it offers protection from STIs/HIV.

Clients might not need all of this information before making a decision. For example, just knowing the effectiveness of methods might be sufficient to help some clients eliminate them. A client desiring permanent contraception can easily eliminate temporary methods, and clients might eliminate hormonal methods, because they cannot tolerate their side effects. Presenting the methods in a structured way—that is, classifying them as temporary or permanent; hormonal or nonhormonal; male or female; short-acting or long-acting—helps both the provider and the client eliminate methods that are not relevant to the client's needs.

Key Information for Clients Choosing a Contraceptive Method

- **Type of method.** This includes whether it is temporary or permanent; hormonal or nonhormonal; short-acting or long-acting; client-controlled, provider-controlled, or partner-controlled; or a barrier method.
- **Effectiveness.** Emphasize that client-controlled methods are only effective if used correctly and consistently.
- **Side effects, health benefits, health risks, and complications.** Provide clear information, ensuring clients understand the difference between side effects, risks, and complications.
- **How to use and obtain or what to expect during a procedure.** Provide brief, specific, and practical information, including time and cost details.
- **When to return.** Inform the client when and how often they will need to return for follow-up visits or resupply. Let them know they should also return if they have any problems, questions, or concerns.
- **Prevention of HIV and other STIs.** Tell clients about dual protection strategies and whether their contraceptive method protects them from STIs/HIV.

Handout 9-G

Talking about Side Effects, Health Risks, and Complications (page 1 of 2)

- **Side effects** are changes in the body that can result from medication, medical treatment, or a contraceptive method. While bothersome, most side effects are tolerable. Most side effects are not harmful and many go away without treatment after a period of time.

Many service providers believe that explaining side effects and possible health risks and complications associated with contraceptive methods will scare away clients. However, research shows that the opposite is true—clients use their method longer when providers have explained side effects in advance.

All new clients should receive information about the side effects of the method(s) they are considering (during the Exploring phase) and should prepare (with counseling) for how to manage them (during the Decision Making and Implementing the Decision phases). Providers should personalize information about side effects so that clients can understand the implications for their lives and make informed decisions. The provider should ask the client how they would feel if the side effects occurred. Some side effects, such as prolonged bleeding, might have social or cultural implications (e.g., not being able to have sex, not being able to enter a house of worship, being isolated).

- A **health risk** is “an adverse event or negative health consequence due to a specific event”⁶ (in this case, the use of a contraceptive method). **Complication** is the term used to describe conditions that are specifically related to a clinical procedure, such as the puncturing of the wall of the uterus during insertion of an intrauterine device (IUD), infection at the insertion site of an implant, or bleeding after a vasectomy.

Health risks and complications are much rarer than side effects, but they can be serious and often require medical attention. They can result from medication, medical treatment, using a contraceptive method, or a medical or surgical procedure.

During the Decision-Making phase, providers should tell clients that health risks and complications are possible but rare and briefly explain what they are. To avoid confusion with common side effects, explain health risks and complications separately. In the Implementing phase, explain the warning signs of any possible health risks and complications with the chosen method and inform clients of what to do if they experience any of those signs.

Adapted from: Rinehart, W., Rudy, S., and Drennan, M. 1998. GATHER Guide to Counseling. *Population Reports*, series J, no. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

⁶“Medical Definition of Health Risk,” www.medicinenet.com

Handout 9-G

Talking about Side Effects, Health Risks, and Complications (page 2 of 2)

Discussing Common Side Effects

- Always explain possible side effects.
- Explain that most people do not experience side effects, but that many do (i.e., they are common, but not everyone experiences them).
- Ask how the client would feel and cope if faced with the side effects.
- Explain why and how side effects occur.
- Explain that side effects are usually harmless and not signs of danger.
- Explain that some side effects go away without treatment and many others can be treated.
- Reassure clients that they are always welcome to return with any concerns or questions.
- Reassure clients that they are always welcome to change methods.
- Discuss social and cultural implications of side effects, such as taboos related to bleeding.
- Help clients anticipate possible side effects and develop strategies for coping with them.

Discussing Health Risks and Complications

- Always tell clients about possible health risks and complications.
- Put information on health risks and complications into perspective (help the client compare the risk to other risks, such as risks related to pregnancy, delivery, or a surgical operation).
- Explain health risks and complications separately from side effects.
- Explain signs of health risks and complications clearly and urge the client to seek immediate help should they experience any of the signs.
- Have clients repeat, in their own words, the signs of health risks and complications.
- Explain and reassure clients that:
 - Health risks and complications are very rare.
 - They are always welcome to return with any concerns or questions.

Handout 9-H

Contraceptive Methods and Protection against STIs and HIV⁷

Best Protection

- **Condoms (male and female)** offer the best protection against STIs/HIV but are not 100% effective.
- **Dual-method use** (including condoms with every act of intercourse) also offers the best protection against STIs/HIV.
- **Abstinence from all sexual contact** provides effective protection, but only when practiced continuously.

Some Protection

- **Spermicides** offer some protection against STIs, but do not protect against HIV. Further, frequent use can cause irritation, which may facilitate HIV transmission. (Note: Nonoxynol-9 has been shown to kill HIV in a laboratory, but this has not been proven in actual use.)
- **Diaphragms** can help protect against some STIs, pelvic inflammatory disease, and cervical dysplasia/cancer, but do not protect against HIV.

No Protection

- **Fertility awareness**
- **Lactational amenorrhea method (LAM)**
- **IUDs**
- **Combined oral/injectable contraceptives** (Note: Some evidence suggests that there may be an increased risk of chlamydial cervicitis among combined oral contraceptive users at high risk of STIs.)
- **Progestin-only oral, injectable, and implant contraceptives**
- **Emergency contraception**
- **Tubal occlusion** (Note: Since sterilization clients usually do not return to clinics, it is particularly important to discuss STIs/HIV prevention before the procedure.)
- **Vasectomy** (Note: Semen does not contain sperm after a vasectomy but can contain STIs/HIV.)
- **Coitus interruptus** (Note: There is a slightly reduced risk; however, pre-ejaculatory fluid can contain STIs/HIV.)

Remember

- STIs and HIV are transmitted in other ways besides vaginal or anal sex.
- There is a small risk of transmission of STIs and HIV through oral sex, too.

⁷ EngenderHealth. 2002. *Integration of HIV/STI Prevention, Sexuality, and Dual Protection in Family Planning Counseling: A Training Manual*. New York: EngenderHealth

Handout 9-1

Dual Protection and Dual Method Use⁸

Dual Protection

Dual protection is a strategy for preventing STI/HIV transmission *and* unintended pregnancy. There are three main strategies for dual protection:

1. Use of condoms (male or female):

- Condoms alone protect against both pregnancy and STI/HIV

2. Dual-method use:

- Use of a condom plus another contraceptive method, for extra protection against pregnancy
- Use of a condom plus emergency contraception, if the condom fails
- Use of a contraceptive method plus *selective* condom use (e.g., using the pill with a primary partner—if the primary partner is monogamous—but using the pill *plus* condoms with other partners)

3. Avoiding risky sexual behaviors through:

- Abstinence
- Avoiding all types of penetrative sex
- Delaying sexual debut (for young people)
- Mutual monogamy between uninfected partners, combined with a contraceptive method

How Counseling about Dual Protection Supports Full, Free, and Informed Choice

- Counseling about dual protection ensures that clients are knowledgeable and aware of their risks for STIs/HIV *and* unintended pregnancy when making decisions about pregnancy prevention.
- Clients are not making truly informed choices about pregnancy prevention unless they are aware of their risks and how effective the various contraceptive methods are for preventing STIs. Counseling about dual protection ensures that clients are aware of their risks and informed about strategies for prevention.

⁸ **Adapted from:** EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York: EngenderHealth.

Session 10:
D = Decision Making

Introduction to Session 10

D = Decision Making

By the end of this section, you should be able to:

- List the steps of the decision-making process
- Identify signs of a power imbalance between the provider and the client, possible implications for the client, and ways the provider can overcome a power imbalance

Essential Ideas

- During the Decision Making phase of counseling, the provider helps the client to:
 1. Summarize the Exploring phase in terms of decision making:
 - 1.A) Review decisions the client needs to make or confirm
 - 1.B) Identify relevant options for each decision
 - 1.C) Confirm medical eligibility for method(s) client is considering
 2. Consider the benefits, disadvantages, and consequences of each option
 3. Confirm that any decision is informed, well-considered, and voluntary
- The Decision Making phase of counseling is key to supporting the rights of individuals to make their own sexual and reproductive health (SRH) decisions, without pressure or coercion. However, a power imbalance between the provider and the client may exist, due to differences in education, social status, or gender. This can result in the provider pressuring the client without realizing it.
- Signs of a power imbalance include the provider acting like they are the expert and doing all the talking. This can lead to the client not trusting the provider, not sharing relevant information, and leaving the clinic with unanswered questions and/or with a contraceptive method that they did not want.
- Strategies to overcome such a power imbalance include recognizing that the client is the expert on their situation and needs, improving communication skills to encourage the client's participation, and following the phases and steps of REDI, to stay client-centered. This is especially important during the Decision Making phase of REDI.

Handout 10-A

REDI: Decision Making Phase

Phase 1: Rapport Building

1. Greet client with respect
2. Make introductions and identify category of the client (i.e., new, satisfied return, or dissatisfied return)
3. Assure confidentiality and privacy
4. Explain the need to discuss sensitive and personal issues
5. Use communication skills effectively (throughout the phases)

Phase 2: Exploring

1. Identify the reason for the visit in detail

For *new clients*:

1. **Individual factors:** Explore the client's SRH history and pregnancy prevention goals
2. **Other key factors:** Explore the client's sexual relationships, social and gender contexts for decision making, and risk of STI/HIV
3. **Explain pregnancy prevention and other SRH options:** Focus on the method(s) of interest to the client, addressing individual and other key factors and risk of STI/HIV

For *return clients*:

2. **Explore the client's satisfaction with the current method**
3. **Confirm correct method use**
4. **Ask the client about changes in their life** (e.g., plans to have children, STI risk and status)

For *dissatisfied clients*:

2. **Explore the reasons for the client's dissatisfaction or problems**, including the issue, causes, and possible solutions, such as switching methods

Phase 3: Decision Making

1. Summarize from the Exploring phase:
 - a. **Identify the decisions the client needs to make or confirm** (for satisfied return clients, see if they need other services; if not, go to Phase 4, Step 4)
 - b. **Identify relevant options for each decision** (e.g., pregnancy prevention, STI/HIV risk reduction)
 - c. **Confirm medical eligibility for contraceptive methods the client is considering**
2. **Help the client consider the benefits, disadvantages, and consequences of each option** (provide information to address any remaining knowledge gaps)
3. **Confirm that any decision the client makes is informed, well-considered, and voluntary**

Phase 4: Implementing the Decision

1. **Assist the client in developing a concrete and specific plan for implementing the decision(s)** (obtaining and using the contraceptive method chosen, risk reduction for STIs, dual protection, etc.)
2. **Identify barriers that the client may face in implementing the plan**
3. **Develop strategies and skills to overcome the barriers**
4. **Make a follow-up plan and/or provide referrals, as needed**

Handout 10-B

Power Imbalances between Client and Provider

(page 1 of 2)

The decision-making phase of counseling is key to supporting the rights of individuals to make their own SRH decisions, without pressure or coercion. During this phase, it is important for the provider to assist the client in reaching their own decision. In addition, the provider should ascertain whether other people (including providers) are pressuring the client into doing something that they do not want to do or are denying them access to services.

There may be a power imbalance between clients and providers, based on the provider's (usually) higher level of education, their status as a health professional, and/or if the provider is male and the client is female. In many cultures, clients show their respect for providers by *not* speaking unless directly encouraged to do so. This typical client-provider dynamic is not helpful in counseling and can lead to the provider making assumptions about the client and directing the decision making, without fully understanding the client's needs. That is why the provider needs to be sensitive to signs of a power imbalance and ensure the client makes their own decision.

What Are Signs of a Power Imbalance Between a Provider and Client in a Counseling Session?

- The provider fails to address the client respectfully at the beginning and/or throughout the session.
- The provider takes an authoritative attitude (“I’m the expert”).
- The provider does not establish or maintain eye contact.
- The provider does not encourage the client to ask questions.
- The provider does all the talking and does not listen to the client when they do speak.
- The provider does not allow the client to make decisions.

What Impact Could a Power Imbalance Have on a Client?

- The client does not trust the provider.
- The client does not reveal relevant information about their life.
- The client hesitates to ask questions.
- The client is unable to make their own decision.
- The client leaves the facility with unanswered questions and needs or with a method that they did not want.

Handout 10-B

Power Imbalances between Client and Provider

(page 2 of 2)

What Should a Provider Do to Overcome Barriers Caused by this Imbalance?

- The provider should explore their own values, beliefs, and attitudes to prevent them from interfering with the client-provider interaction.
- The provider should acknowledge that each client is an expert on their own life.
- The provider should accept that decisions made *for* the client and not *by* the client may not be easy to implement and may not be sustainable.
- The provider should improve communication skills, to emphasize active listening and to encourage the client to talk.
- The provider should follow the steps of REDI and stay client-centered.

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Session 11:

I = Implementing the Decision

Introduction to Session 11

I = Implementing the Decision (page 1 of 2)

By the end of this section, you should be able to:

- List the steps of the Implementing the Decision phase of REDI
- Identify the components of an implementation plan
- Describe how to help clients develop a plan to implement their decisions
- Identify the essential information on method use to review with clients
- Describe how to help clients identify challenges in using their method choice and develop strategies and skills to overcome the challenges
- Explain how they can help clients discuss pregnancy prevention and other sexual and reproductive health (SRH) issues, including risks associated with sexually transmitted infections (STIs) and HIV, with their partners—and their limits as providers in doing so

Essential Ideas

- When a provider and a client work on a plan for implementing a decision, the plan must be guided by the client's choices and circumstances. The provider's role is to help the client address key considerations and be sure that the plan fits into the realities of the client's life and is one that they feel confident implementing.
- In this phase, the counseling is finally focused solely on the method the client has chosen. Some information about the method was provided during the Exploring and Decision Making phases, but it should be reviewed as the client considers their implementation plan for this particular method. Specifically, the provider will:
 - Review information about how to use the method
 - Help the client *identify possible barriers* to using the method
 - Assist the client to *strategize how to overcome* those barriers
 - Be clear about *follow-up visits or referrals*
- Plans involving behavior change must be specific. Ask questions that will enable the client to say aloud the specific steps that they will take and to think through the sequencing of those steps.
- Skills and strategies that clients might need to develop if they are to implement their decisions include strategies for communicating and negotiating with their partner(s) as well as skills in using condoms and other contraceptive methods correctly.

Introduction to Session 11

I = Implementing the Decision (page 2 of 2)

Essential Ideas (continued)

- Clients may feel that they cannot discuss pregnancy prevention and other SRH issues with their partners. Identifying the reasons why they feel this way is an important first step in helping clients determine whether they can find ways to start these important conversations.
- The provider can suggest strategies to help the client communicate more effectively with their partner. However, clients know best about their relationships and providers should not force them to have such conversations. Providers should know where they can refer clients for more help if there are indications of intimate partner violence (IPV) or abuse.
- The dual benefit of using condoms is important information that might help clients more easily negotiate condom use with their partners. Providers should not assume that clients know how to use condoms. Helping clients build skills in using condoms deserves special attention.

Handout 11-A

REDI: Implementing the Decision Phase

Phase 1: Rapport Building

1. Greet client with respect
2. Make introductions and identify category of the client (i.e., new, satisfied return, or dissatisfied return)
3. Assure confidentiality and privacy
4. Explain the need to discuss sensitive and personal issues
5. Use communication skills effectively (throughout the phases)

Phase 2: Exploring

1. Identify the reason for the visit in detail

For *new clients*:

1. **Individual factors:** Explore the client's SRH history and pregnancy prevention goals
2. **Other key factors:** Explore the client's sexual relationships, social and gender contexts for decision making, and risk of STI/HIV
3. **Explain pregnancy prevention and other SRH options:** Focus on the method(s) of interest to the client, addressing individual and other key factors and risk of STI/HIV

For *return clients*:

2. **Explore the client's satisfaction with the current method**
3. **Confirm correct method use**
4. **Ask the client about changes in their life** (e.g., plans to have children, STI risk and status)

For *dissatisfied clients*:

2. **Explore the reasons for the client's dissatisfaction or problems**, including the issue, causes, and possible solutions, such as switching methods

Phase 3: Decision Making

1. Summarize from the Exploring phase:
 - a. **Identify the decisions the client needs to make or confirm** (for satisfied return clients, see if they need other services; if not, go to Phase 4, Step 4)
 - b. **Identify relevant options for each decision** (e.g., pregnancy prevention, STI/HIV risk reduction)
 - c. **Confirm medical eligibility for contraceptive methods the client is considering**
2. **Help the client consider the benefits, disadvantages, and consequences of each option** (provide information to address any remaining knowledge gaps)
3. **Confirm that any decision the client makes is informed, well-considered, and voluntary**

Phase 4: Implementing the Decision

1. **Assist the client in developing a concrete and specific plan for implementing the decision(s)** (obtaining and using the contraceptive method chosen, risk reduction for STIs, dual protection, etc.)
2. **Identify barriers that the client may face in implementing the plan**
3. **Develop strategies and skills to overcome the barriers**
4. **Make a follow-up plan and/or provide referrals, as needed**

Handout 11-B

Step 1. Assist the Client to Make a Concrete Plan

What Is in an Implementation Plan?

The plan should include:

- Where and when to obtain the method
- How to use the method, including whether return visits are required
- The economic (cost), family, and social implications

Be Specific!

Any plans involving behavior change must be specific. This means that when a client says they will change a certain behavior, the provider needs to ask questions that will enable the client to say aloud the specific steps that they will take and to think through the sequence of those steps to change the behavior. Asking a client, “How will you do that?” is important in helping them develop a plan. For example:

- If a client decides to use *oral contraceptives*, the provider should ask how the client will remember to take it every day. (Strategies for remembering may include talking to the partner about using the pill, remembering to take a pill at the same time each day by placing the pill package near the toothbrush, and marking reminders on a calendar to return to the facility for resupply every three months.)
- If the client decides to start using *condoms*, the provider should ask questions such as: “How often? Where will you get the condoms? How will you pay for them? How will you tell your partner that you want to use them? Where will you keep them so you will have them with you when you need them?”
- For *injectables*, the provider should ask how the client will remember to return for repeat injections at the appropriate time.
- If the client chooses a method that is not immediately available on-site (perhaps it requires scheduling at a later date or a referral to another facility), the provider should counsel and provide the client with *another temporary method* that they can use in the interim.

Handout 11-C

Essential Information on Method Use to Review with Clients

1. **When** to start using the method, for lactational amenorrhea method (LAM), male or female condoms, oral contraceptives, Standard Days Method, and spermicides; or when to see a provider for a method-related procedure, for implants, injectables, intrauterine devices (IUDs), tubal ligation, and vasectomy

(Note: Consider the circumstances of clients who have just given birth or had a miscarriage or abortion and the guidelines specific to these cases—see the WHO Medical Eligibility Guidelines (Handout 10-D in the Participant Handbook, Part 2, which will be distributed in the training) and/or the *Global Family Planning Handbook*.)

2. **Where** to obtain the method or supplies
3. **How to use** the chosen method (for LAM, male and female condoms, oral contraceptives, spermicides, and Standard Days Method) or how to obtain it (for implants, injectables, IUDs, tubal ligation, and vasectomy)
4. **Tips for remembering** to use the method correctly, for example, how to remember to take pills daily or when to return for repeat injections
5. **Common side effects** and how to deal with them
6. **Warning signs** of health risks and complications and what to do if they occur
7. **How to prevent STIs/HIV**, including how to use condoms and where to obtain them
8. **How to communicate with partner** about use of contraception and/or condoms
9. **When and where to go** for resupply or follow-up treatment

Handout 11-D

Step 2. Identifying Barriers and Step 3. Developing Strategies to Overcome Them

Step 2. Identify Barriers that the Client Might Face in Implementing the Plan

- What problems does the client think they might have? Examples include dealing with side effects, returning to the facility for follow-up or resupply, taking a pill at the same time every day, and purchasing supplies at the pharmacy.
- Ask about possible consequences of the plan (like the partner's reaction to the decision) and what social supports are available to the client. Who in the client's life can help the client implement the plan? Who might create obstacles? The questions to ask the client might include the following:
 - “How will your partner(s) (or other person from the family or community) react?”
 - “Do you fear any negative consequences?”
 - “How will the plan affect your relationship with your partner(s)?”
 - “Can you communicate *directly* about the plan with your partner(s)?” or “Will indirect communication be more effective at first?”
- Does the client think that they might have trouble (for example, related to costs, time required, or transportation needed) accessing needed services or supplies?

Step 3. Develop Strategies and Skills to Overcome the Barriers Identified

- Provide the client with written information, if available.
- Practice using a condom, if necessary.
- Help the client think through what they can or want to do if the partner does not agree with the choice of method.
 - Offer ideas for improving the client's skills in communicating and negotiating with their partner about pregnancy prevention, dual protection, condom use, or sexuality. For example, if a client feels that it might be difficult to negotiate condom use for STI prevention purposes, discuss whether it might be easier to introduce condoms as a means of preventing pregnancy.
 - Help the client practice communicating and negotiating by role playing situations that may occur.
- Make an alternate plan—that is, if the plan does not work, what can the client do instead?

Handout 11-E

Helping Clients Address Barriers to Talking about Pregnancy Prevention and Other SRH Issues with Partners (page 1 of 2)

Determine Why the Client Does Not Want to Talk with their Partner

Clients might feel that they cannot discuss pregnancy prevention and other SRH issues and concerns with their partners. Identifying why they feel this way is an important first step in helping clients determine whether they can find ways to start these important conversations with their partners.

Do Not Try to Force Communication with their Partner

Providers should respect the client's reasons for feeling they cannot talk with their partner(s), even if the provider does not agree with the client's feelings or perceptions about their situation. If a client does not feel they are able to discuss pregnancy prevention or issues related to sexual activity in their relationship, they should not be forced to do so. Providers should encourage these clients to return for further discussion. In the end, the client knows their relationship best.

Some clients may be struggling with deeper fears or social concerns, such as instances of IPV or sexual abuse, as their reasons for not talking with their partners. Addressing these might require additional or different counseling skills. In such cases, the provider should refer the client for more help. All providers should know of referral options for clients who need more help. (Note: This topic is discussed in detail in Session 15.)

Handout 11-E

Helping Clients Address Barriers to Talking about Pregnancy Prevention and Other SRH Issues with Partners (page 2 of 2)

Things to Remember

- The issue of a power imbalance or violence often arises naturally when the provider addresses negotiation. Here are some questions that will help elicit information related to power imbalances and potential violence:
 - How do you and your partner talk about pregnancy prevention? What about STI/HIV prevention?
 - If you do not talk about pregnancy prevention with your partner, what makes it difficult? What would happen if you tried?
 - If you do, how does it work for you?
- You can role play with the client to allow them to practice approaches to talking with their partner. Sometimes it is helpful at first for clients to practice playing the role of the partner while the provider plays the role of the client and models ways to discuss these issues. Then, switch roles to give the client an opportunity to practice saying these things themselves.
- Providers should be nonjudgmental of the client as well as of the partner. Criticizing the partner might threaten the client's sense of well-being or security and interfere with the counseling relationship.
- Providers should respect the client's willingness and ability to negotiate with the partner. If clients say that they cannot discuss this with their partner, explore the options. If there are no other options, schedule a follow-up visit (with the client) and/or refer the client to a social worker with the necessary resources to address the problem.

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Session 12: Counseling Return Clients

Introduction to Session 12

Counseling Return Clients

By the end of this section, you should be able to:

- Describe basic principles of counseling return clients
- Explain basic differences between counseling *satisfied* and *dissatisfied* return clients
- List possible reasons for return visits
- Describe appropriate provider attitudes and approaches for addressing the concerns of return clients

Essential Ideas

- Return clients comprise a significant portion of the clients who come to facilities for services. Return visits provide the opportunity for providing continuous support to the client—that is, the opportunity to ensure that the client is satisfied with their contraceptive method, that they are using it safely and correctly, and that their other sexual and reproductive health (SRH) needs are met in a timely manner. Return visits are considered part of the Implementing the Decision phase of REDI counseling, during which providers continue helping the client to implement their initial decision.
- The phases of the REDI framework should be tailored to the assessed need of the return clients. Clients with problems or concerns (*dissatisfied clients*) require careful attention and counseling. Return clients with no problem (*satisfied clients*) require the service or supplies they came for, without unnecessary delays.
- Meeting the expressed needs of the client, as well as inquiring about unexpressed SRH needs, is one of the provider's primary tasks. If the provider or the facility cannot meet the client's particular need, the client should receive a referral to another service provider or facility.

Handout 12-A

Basic Principles of Counseling Return Clients

- Many of the clients who come to pregnancy prevention service settings are return clients.
- Return visits are an opportunity to provide continuous support to the client—that is, an opportunity to ensure that clients are satisfied with their contraceptive method, that they are using it safely and correctly, and that their other SRH needs are met in a timely manner.
- Return visits are considered part of the Implementing the Decision phase of REDI counseling during which providers continue helping the client to implement their initial decision.
- Providers must assess each individual client's needs and then provide appropriate counseling and services as efficiently as possible. This requires a balanced approach:
 - Do not serve return clients in a cursory manner, based on the assumption that they have already been using their chosen method and do not need follow-up support.
But also,
 - Do not force return clients to listen to information that they do not need.
- The provider should ask open-ended questions to determine whether the return client has any problems related to their method or other SRH concerns. Then, the provider should confirm that the client is using the method correctly and encourage the client to ask any questions they might have.
- If the client has questions or concerns, is experiencing problems, or has had a change of circumstances, the provider should explore and address these issues. If the provider or the facility cannot meet the client's particular need, the client should receive a referral to another service provider or facility.
- If the client is happy with their method and is using it correctly, the provider should provide a resupply and remind them of when to return, without any unnecessary delays.

Handout 12-B

Comparing REDI for Satisfied Return Clients and REDI for Dissatisfied Return Clients

The phases of the REDI framework should be tailored to the assessed need of the return clients. Clients with problems or concerns require careful attention and counseling relevant to the reason for the visit. Return clients with no problem should receive the service or supplies they came for, without unnecessary delays. *(For detailed steps, see Learning Guides 3 and 4.)*

Rapport Building	
Same for new and return clients and for satisfied and dissatisfied return clients	
Exploring	
Satisfied	Dissatisfied
1. Explore the client’s satisfaction with the current method	1. Clarify the client’s dissatisfaction with the current method
2. Confirm correct method use	2. Ask how method is being used
3. Ask the client about changes in their life	3. Ask the client about changes in their life
	4. Explore in-depth the reasons for the client’s dissatisfaction or the problems
	5. Give information, as needed, about options
Decision Making (based on information shared above)	
Satisfied	Dissatisfied
1. Help client identify what services they need during this return visit	1. Identify what decisions the client needs to make
	2. Identify relevant options for each decision
	3. Help the client weigh the benefits, disadvantages, and consequences of each option
	4. Encourage the client to make their own decision
Implementing the Decision	
Satisfied	Dissatisfied
1. Make a follow-up plan and/or provide referrals, as needed	1. Assist the client in making a concrete and specific plan for implementing the decision(s)
	2. Make a follow-up plan and/or provide referrals

Handout 12-C

Reasons for Return Visits and Appropriate Provider Responses (page 1 of 2)

Reasons for Return Visits	Appropriate Provider Attitudes and Counseling Responses
<ul style="list-style-type: none"> • Resupply of a method 	<ul style="list-style-type: none"> • Ask whether the client is satisfied and if they are experiencing any problems • Inquire about correct use • Provide resupply without delay, if there are no problems
<ul style="list-style-type: none"> • Follow-up of a method or procedure 	<ul style="list-style-type: none"> • Ask whether the client is satisfied and if they are experiencing any problems • Inquire about correct use • Provide appropriate services, such as checking placement of an intrauterine device (IUD)
<ul style="list-style-type: none"> • Concerns 	<ul style="list-style-type: none"> • Take the client's concerns seriously • Explore the concerns and the underlying reasons for the concerns (e.g., side effects, misconceptions, rumors) • Address concerns through counseling, clinical management (if needed), and other service options, including switching to another method
<ul style="list-style-type: none"> • Side effects 	<ul style="list-style-type: none"> • Explore the nature of side effects to see if the side effects are within the expected and acceptable range • If appropriate, counsel the client to assure them that the side effects are harmless, experienced by many, and transient (see Handout 12-H in Participant Handbook, Part 2, which will be distributed in the training) • Manage side effects as per established guidelines (see Handout 12-I in Participant Handbook, Part 2) • Give the client the option to switch to another method if they find the side effects intolerable
<ul style="list-style-type: none"> • Other problems related to method use (economic, social, partner-related) 	<ul style="list-style-type: none"> • Explore the nature of problems and the underlying reasons for the problems • Explore options for eliminating the problem, including switching to another method
<ul style="list-style-type: none"> • Desire to switch methods 	<ul style="list-style-type: none"> • Explore the client's reasons for wanting to switch • Confirm that the client is making a full, free, and informed choice • Provide appropriate services

Handout 12-C

Reasons for Return Visits and Appropriate Provider Responses (page 2 of 2)

Reasons for Return Visits	Appropriate Provider Attitudes and Counseling Responses
<ul style="list-style-type: none"> • Desire to discontinue using the method 	<ul style="list-style-type: none"> • Explore the client's reasons for wanting to discontinue • Counsel about other contraceptive options, if appropriate • Provide appropriate services
<ul style="list-style-type: none"> • Desire to become pregnant 	<ul style="list-style-type: none"> • Explore when the client wants to conceive • Provide the needed service, if a provider intervention (such as removal of an IUD) is needed to discontinue the method • Counsel about or refer for preconception and pregnancy care
<ul style="list-style-type: none"> • Change in client's circumstances (change of partner, marital status, risk for STIs/HIV) 	<ul style="list-style-type: none"> • Explore the change with the client and its implications for the client's needs for pregnancy prevention and SRH • Help the client identify the decisions to make, if any • Provide the counseling and services needed
<ul style="list-style-type: none"> • Warning signs/symptoms of health risks or complications 	<ul style="list-style-type: none"> • Explore the nature of the symptoms • If the client is experiencing a health risk/complication, manage or refer, as appropriate
<ul style="list-style-type: none"> • Other SRH problems (such as an infection) 	<ul style="list-style-type: none"> • Explore the nature of the problem • Manage or refer, as appropriate
<ul style="list-style-type: none"> • Other health problems 	<ul style="list-style-type: none"> • Explore the nature of the problem • Manage or refer, as appropriate
<ul style="list-style-type: none"> • Complaints that are unrelated to the method 	<ul style="list-style-type: none"> • Explore the nature of the problem • Assure the client that their complaints are not related to the contraceptive method • Manage or refer, as appropriate
<ul style="list-style-type: none"> • Desire to have a partner or a relative counseled 	<ul style="list-style-type: none"> • Thank the client • Praise the partner or relative for coming • Provide counseling and services, as appropriate
<ul style="list-style-type: none"> • Accompanying a friend or relative 	<ul style="list-style-type: none"> • Thank the client • Praise the friend or the relative for coming • Provide counseling and services, as appropriate
<ul style="list-style-type: none"> • Express gratitude 	<ul style="list-style-type: none"> • Thank the client • Inquire if they have other SRH needs



Session 15: Counseling Specific Categories of Clients

Introduction to Session 15

Counseling Specific Categories of Clients

By the end of this section, you should be able to:

- Explain how permanent methods differ from temporary methods and why they warrant special attention during counseling
- List the topics that you should cover when counseling for permanent methods
- List three factors contributing to sound decision making and three factors contributing to possible regret with permanent methods
- List the seven information elements of informed consent for permanent methods
- Identify special issues to address when counseling postpartum clients
- Identify special issues to address when counseling postabortion clients
- Identify special issues to address when counseling unmarried youth
- Identify special issues to address when counseling male clients
- Identify special issues to address when counseling couples
- Identify special issues to address when counseling clients living with HIV
- Identify special issues to address when counseling women who are experiencing intimate partner violence (IPV)

Essential Ideas

- In many family planning programs, services focus on married women. However, other individuals—including adolescents, unmarried people, and men—also need and have the right to access pregnancy prevention services, and have particular needs that should be considered and addressed. Clients interested in permanent methods, those seeking postpartum and postabortion contraception, and those living with HIV also have particular needs for information and counseling to prevent regret.
- Counseling sometimes reveals that the client is experiencing abuse and/or IPV. This requires a special approach to counseling to protect the health and possibly life of the client.

Handout 15-A

Counseling Clients for Permanent Methods

(page 1 of 3)

Overview

- Because sterilization is permanent and requires surgery, counseling for sterilization services requires special attention.
 - The provider's role is to ensure that the client's decision is voluntary, informed, and well considered. Ultimately, the decision to undergo sterilization is the client's.
 - To ensure that clients make well-considered decisions, counseling must cover all seven elements of informed consent. The provider must answer all of the client's questions and ensure that they understand all of the information provided during the counseling session.
 - During counseling, providers should screen clients for factors that might contribute to future regret. Since a reversal is not a realistic option for many clients and does not always ensure pregnancy, clients should consider the decision carefully. Providers should carefully counsel clients who might later regret their decision and encourage them to take more time to think about the decision.
 - Providers should document the client's informed consent before the procedure, in accordance with the governing laws of each country. The provider should verify the client's decision to undergo a sterilization procedure again *immediately before the procedure*.
-
- Counseling clients who are interested in permanent methods requires particular care because female sterilization and vasectomy are *surgical procedures* and have *associated risks*, such as anesthesia-related problems, bleeding, infection, and method failure. The provider should also inform the client that they should consider the procedure *permanent*.
 - Research shows that clients want to know about the procedure itself (e.g., about the anesthesia process and potential pain) and about what to expect after surgery. Before deciding to undergo sterilization, the client should receive *detailed information about the surgical procedure*, including the following:
 - Where and when it will be done
 - How long it will take
 - The type of anesthesia that will be used
 - What to expect in terms of pain
 - How long they will be in the hospital (if applicable)
 - How long they will be unable to work
 - Possible risks and complications
 - How the procedure might affect their sexual relationships
- The provider must also answer all of the client's questions and ensure they understand all of the information given during the counseling session.

Handout 15-A

Counseling Clients for Permanent Methods

(page 2 of 3)

- Providers should inform clients about *risks* associated with any method. It is important to provide this information carefully, so as not to frighten the client. Although there are risks associated with these operations and complications are possible, they rarely occur. One way of helping clients understand the risks associated with sterilization and vasectomy is by putting them in context, comparing them to the risks associated with other reproductive health–related risks, such as those associated with pregnancy and childbirth. For example, the risk of any complication like bleeding, infection, etc. from using any method of contraception, including sterilization, is much lower than the risk from pregnancy.*

* EngenderHealth. 2002. *Contraceptive Sterilization: Global Issues and Trends*. New York: EngenderHealth.

Handout 15-A

Counseling Clients for Permanent Methods

(page 3 of 3)

- These are some of the factors that providers consider when screening clients for possible regret.

Factors Contributing to Sound Decision Making	Factors Contributing to Possible Regret
<ul style="list-style-type: none"> • Mature age • Desired family size achieved • Partner agreement • Marital stability • Well-considered decision 	<ul style="list-style-type: none"> • Young age • No or few (from the client's perspective) children • Partner's doubt • Pressure from partner, relatives, or service providers • Marital instability • Unrealistic expectations • Unresolved conflict or doubt • Excessive interest in reversal • Decision made under stress (during labor or immediately before or after an abortion)

- The provider should document the client's informed consent before the procedure, in accordance with the governing laws of each country (see Handout 15-B). The provider must ensure the client understands the content of the consent form. For example, some clients may need to have the consent form read to them and explained in simple language. The provider must verify the client's decision to undergo a sterilization procedure again *immediately before the procedure*.
- Providers must understand the policies, laws, and regulations related to female sterilization and vasectomy in their country. Some countries have legal restrictions, including age or parity requirements.

Handout 15-B

Informed Consent for Sterilization

Informed consent is the client's agreement or permission given under their own free will after making an informed, voluntary decision for sterilization, and after receiving counseling.

Informed consent for sterilization consists of *seven information elements*:

1. *Temporary methods of contraception are available to me and my partner.*
2. *The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.*
3. *This surgical procedure involves risks, in addition to benefits, which have been explained to me, and I understand the information that has been given to me. Among the risks is the possibility that the procedure might fail.*
4. *If the procedure is successful, I will be unable to have any more children.*
5. *The effect of the procedure should be considered permanent.*
6. *The procedure does not protect me or my partner against infection with sexually transmitted infections (STIs), including HIV and AIDS.*
7. *I can decide not to have the operation at any time before the procedure is performed, even on the operating table, without losing the right to medical, health, or other services or benefits.*

Voluntary decision making and informed consent are clients' rights. Ensuring voluntary decision making and informed consent:

- Increases the client's satisfaction
- Lessens the possibility of the regret later
- Protects the facility and its staff against charges of *involuntary* sterilization and potential legal action

Providers should document informed consent after the client requests the procedure and after the provider verifies that the client's decision is voluntary, informed, and well considered. If someone other than the surgeon obtains the client's informed consent, it should be confirmed again *by the surgeon* immediately before the procedure.

Handout 15-C

Postpartum Counseling (page 1 of 2)

Overview

- Different types of contraceptive methods are appropriate at different times following delivery.
- The ideal time to provide counseling for postpartum contraception is during the *antenatal* period.
- The next appropriate time is *after delivery*, but before the client leaves the facility.
- Counseling clients just before delivery is inappropriate, due to the amount of pain and stress that the client may be experiencing.

Counseling Related to a Recent Pregnancy

To achieve the healthiest pregnancy outcomes possible, couples should wait at least two years after a live birth and at least six months after a miscarriage or abortion *before trying to become pregnant* again. This will roughly result in the recommended three-year gap between births.

The ideal time to initiate counseling for postpartum contraception is during the antenatal period. Early counseling allows sufficient time for the clients to make their decisions without the stress associated with the delivery. It also helps to ensure that clients receive their method of choice immediately after giving birth (*immediately postpartum*), which is particularly important for clients who choose postpartum intrauterine device (IUD) or female sterilization.

Counseling clients immediately before delivery is *not* appropriate. If absolutely necessary, counseling can be provided before delivery, but only in the early phase of labor. However, sound decision making may be impaired by the stress the client is experiencing. Therefore, the provider has the responsibility to confirm that they are making an informed, voluntary, and sound decision. If the client exhibits signs of stress, the provider should postpone the client's counseling and decision making.

The next appropriate opportunity to counsel the client is after delivery but before she leaves the facility. While it may be too late to provide the client's method of choice during or at the end of the delivery, counseling at this time may help ensure that the client obtains her method of choice *before discharge* or that she schedules a time to return later for a *follow-up visit* to obtain her method.

Handout 15-C

Postpartum Counseling (page 2 of 2)

Another consideration is the *types of contraceptive methods* that are appropriate at *different times following delivery*. For postpartum women, an important factor to consider is breastfeeding. Breastfeeding women can use most methods, as noted in the chart below.

Earliest Time That a Woman Can Start a Contraceptive Method after Childbirth

For maximum protection, a woman should *not* wait until the return of monthly bleeding to start a contraceptive method but should instead start as soon as guidance allows (see table below).

Contraceptive Method	Fully/Nearly Fully Breastfeeding	Partially Breastfeeding	Not Breastfeeding
Implants	Immediately		
Lactational amenorrhea method (LAM)	Immediately	LAM is not applicable	
Male or female condoms	Immediately		
Progestin-only pills	Immediately		
Spermicide	Immediately		
Vasectomy	Immediately or during partner's pregnancy [†]		
Copper IUD	Within 48 hours, otherwise wait four weeks		
Hormonal IUD	Within 48 hours, otherwise wait four weeks		
Female sterilization	Within seven days, otherwise wait six weeks		
Diaphragm	Six weeks after childbirth		
Progestin-only injectables	Six weeks after childbirth [‡]	Immediately	
Combined injectables ¹⁰	Delay her first injection until 6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first	Delay her first injection until at least 6 weeks after giving birth	Any time on days 21-28 after giving birth
Combined pills	6 months after giving birth or when breast milk is no longer the baby's main food—whichever comes first	6 weeks after giving birth	Any time on days 21-28 after giving birth
Fertility awareness methods	When normal secretions return (symptoms-based methods) or after three regular menstrual cycles (calendar-based methods). This is later for breastfeeding women than for those who are not breastfeeding.		

[†] If a man has a vasectomy during the first six months of his partner's pregnancy, it will be effective by the time she delivers her baby.

[‡] Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.

Sources (see also footnotes):

Postpartum Family Planning Counseling. Republic of Turkey Ministry of Health General Directorate of MCHFP and EngenderHealth. 1999.

⁹ http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1

¹⁰ World Health Organization (WHO). 2018. *Global Family Planning Handbook*, pp. 11-13.

Handout 15-D

Postabortion Counseling (page 1 of 2)

Overview

- Fertility returns very quickly postabortion. Therefore, providing pregnancy prevention counseling and methods are key elements in postabortion care.
- Any contraceptive method can be started immediately postabortion.
- Counseling before the procedure is appropriate if the client is not under stress. The next appropriate time to counsel a postabortion client is after the procedure but before she leaves the facility.

Key Points

Fertility returns very quickly postabortion. A woman can become pregnant *within the first two weeks* following a first-trimester miscarriage or abortion, and within four weeks following a second-trimester miscarriage or abortion. Therefore, she needs protection from pregnancy almost immediately. For couples who want to become pregnant again as soon as possible, they should wait six months after abortion or miscarriage; hence, contraception is important to delay pregnancy until that time.

Any contraceptive method can be used immediately postabortion. See the table on the next page for more information.

The provider should determine the best time to initiate counseling for postabortion contraception.

- *Counseling before the procedure* is an appropriate option if the client is not under stress related to the procedure. This allows the client to receive her method of choice immediately after the procedure, which is especially important for the postabortion IUD. However, if there are signs of stress before the procedure, the provider should postpone the client's counseling and decision making.
- The next appropriate opportunity to counsel such a client is *after the procedure but before she leaves the facility*. At this point, it may be too late to provide some methods (such as the IUD), but it may help ensure that a client obtains her method of choice before discharge or that she sets up a time to return later to obtain it at a follow-up visit.

Remember, as with all clients, *the provider has the responsibility to confirm that the client is making an informed, voluntary, and sound decision.*

Handout 15-D

Postabortion Counseling (page 2 of 2)

How Soon a Woman Can Start a Contraceptive Method after a Miscarriage or Abortion

For maximum protection, a woman should *not* wait until her next monthly bleeding to start a contraceptive method. Instead, she should start as soon as the guidance allows.

Contraceptive Method	Special Considerations
Immediate Start	
Combined patch	No special considerations
Implants	
Injectables (combined or progestin-only)	
Male or female condom	
Oral contraceptives (combined or progestin-only)	
Vasectomy	
Withdrawal	
Cervical cap	
Combined vaginal ring	<ul style="list-style-type: none"> Once any injury to the genital tract is healed
Spermicide	
Diaphragm	<ul style="list-style-type: none"> Once any injury to the genital tract is healed; must be refitted after uncomplicated first-trimester miscarriage After uncomplicated second-trimester miscarriage, delay use for six weeks
Copper IUD	<ul style="list-style-type: none"> Provided there is no infection and any injury to the genital tract is healed IUD insertion after a second-trimester abortion requires a specially trained provider
Hormonal IUD	
Female sterilization	<ul style="list-style-type: none"> Provided there is no infection and any injury to the genital tract is healed Must be decided upon in advance, not while the woman is sedated, under stress, or in pain
Delayed Start	
Fertility awareness Methods	<ul style="list-style-type: none"> Delay until there are no noticeable secretions or bleeding related to injury or infection There must be no infection and any injury to the genital tract must be healed For calendar-based methods, delay until the woman has had at least one monthly bleed after all such secretions and bleeding has stopped

Handout 15-E

Counseling Unmarried Adolescents¹¹

Unmarried adolescents should be able to access sexual and reproductive health (SRH) services for two main reasons:

- Unmarried adolescents have a *right* to quality SRH services, including accurate information.
- Unmarried adolescents *need* SRH services to prevent unplanned pregnancy and STIs.

Unmarried adolescents are at risk for SRH problems when they:

- Lack knowledge and information
- Lack access to services and programs
- Face social and psychological barriers to accessing services that are available

When providing counseling to unmarried adolescents, providers have a responsibility to:

- Be a reliable, factual source of information about SRH, including pregnancy and STI prevention
- Create an atmosphere of privacy, respect, and trust, so that young people feel comfortable asking questions, voicing concerns, and discussing intimate sexual issues
- Offer choices, accept their right to choose, and do not judge the choices made

¹¹ **Adapted from:** EngenderHealth. *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum. Participant's Handbook*, p. 63. 2003: New York, NY, U.S.A.

Handout 15-F

Counseling Male Clients¹²

Service providers' feelings about gender and gender roles affect their ability to provide effective counseling services to men and couples. Just like clients, providers grow up receiving messages about the different roles men and women play in society, the rights and responsibilities attached to these roles, and the inequities women have endured because of those roles. These messages affect providers' life experiences and understanding of gender as well as their beliefs, opinions, and values about working with men and couples.

Although gender roles and expectations vary between and within different cultures, values, and attitudes about gender often arise in relation to SRH. Providers who are aware of their values about working with men, as well as how those values may affect their interactions with clients and couples, are better prepared to provide effective counseling—*by avoiding the impact of biases* described below.

Provider Bias against Men

Since many providers have not had experience or training in working with men, they may hold attitudes or biases against men that may reduce their effectiveness in meeting the clients' needs. The potential outcomes of a bias against men are:

- Making men feel uncomfortable and unwelcome
- Making assumptions about male clients and their sexual behaviors
- Failing to provide accurate information about male contraceptive methods or STI prevention
- Violating rights of privacy and confidentiality

Provider Bias toward Men

Even though provider bias is often directed *against* male clients, there is also evidence of provider bias *toward* men.¹³ The potential outcomes of a bias toward men are:

- Paying more attention to men and ignoring their partners during couples counseling
- Serving male clients immediately and making female clients wait for services
- Omitting information about male contraceptive methods to men and/or their partners, as a way of taking the responsibility for contraception off men
- Providing information about a female client's condition to her male partner, while not sharing this information with the client herself or without her permission

¹² EngenderHealth. 2003. *Counseling and Communication with Men* (Participant's Handbook), pp. 2.1-2.8.

¹³ Ringheim, K. 2001. *Interacting with Male Clients: Special Considerations for Providers*. Paper read at the American Public Health Association Annual Meeting, October 21-25, Atlanta, Georgia.

Handout 15-G

Working with Couples (page 1 of 2)

Overview

- Couples who discuss pregnancy prevention with each other are generally more likely to use contraception effectively. However, the provider should *talk to each partner separately* at some point in the counseling, in case there are issues or information that either partner is not comfortable sharing with the other.
- During couples counseling, the provider needs to:
 - Maintain *confidentiality* on any issue that the client or the partner discusses separately with the provider
 - Observe and consider *power and gender dynamics* within the couple and between provider and the clients
 - Ensure voluntary decision making for *the partner who will be using* the contraceptive method

Client Confidentiality

If the provider meets individually with one or both partners, the provider needs to maintain confidentiality for any information shared during those individual discussions—including any discussion related to contraceptive use, STIs, or multiple partners. It is important for the provider *not* to violate either partner's right to privacy and confidentiality, even if the provider thinks it is in the best interest of one of the partners. During individual meetings, the provider should assess the risk of encouraging a client to disclose such information to their partner.

Techniques and Tips for Couples Counseling Sessions

- Set the tone of the session by explaining protocol (e.g., starting with individual counseling and then bringing the couple together), the purpose, and basic steps of the counseling session
- Involve both partners by asking for information and opinions from both individuals
- Acknowledge the importance of couples working together

Handout 15-G

Working with Couples (page 2 of 2)

When working with male partners as part of a couple, the provider has an opportunity to encourage and reinforce the man's role in SRH and his *and* his partner's well-being. This curriculum focuses on decision making related to pregnancy and STI/HIV prevention, but couples counseling can also enhance the man's role in safe motherhood/antenatal care, postabortion care, and violence prevention.

Decision Making about Pregnancy Prevention¹⁴

Couples who *discuss* pregnancy prevention together are more likely to *use* contraception, use it effectively, and have fewer unintended pregnancies. Including the male partner in decision making about pregnancy prevention involves:

- Discussing with couples the spacing and the number of pregnancies they desire
- Encouraging men to support their partner's use of contraception
- Educating couples about contraceptive methods that require men's active participation
- Motivating men to consider contraceptive methods that require their participation, such as condoms, withdrawal, natural family planning, and vasectomy

STI/HIV Prevention

Involving men in prevention is crucial to reducing transmission of STIs, particularly HIV. A couple's approach to STI/HIV testing and treatment can address the potential for treatment noncompliance, reinfection, and relationship violence. Including the male partner in STI/HIV prevention counseling involves:

- Generating awareness about men's role in protecting themselves and their partners from STIs/HIV
- Educating couples about the correct and consistent use of condoms
- Motivating men to get tested and treated for STIs

¹⁴ EngenderHealth. *Counseling and Communicating with Men: Participant Handbook*. New York, 2003, pp. 4.25-4.28.

Handout 15-H

Counseling for Clients Living with HIV¹⁵

Overview

- People living with HIV:
 - Can enjoy a healthy sexual life
 - Can use contraceptive methods and avoid further transmission of HIV (*detailed information will be provided during the training*)
 - Can have a healthy baby (*detailed information will be provided during the training*)

Ways to Lower Risk

- **Mutual faithfulness**, meaning that two partners are faithful to each other
- **Limited number of sexual partners**
- **Safer sex**, for example, using condoms or avoiding penetrative sex (see textbox below)

- **Examples of activities with no risk:** hugging, kissing on lips, individual or mutual masturbation, massage
- **Examples of sexual practices with low risk:** anal or vaginal intercourse using condom, oral sex (safer with condoms or other barrier method)
- **Examples of sexual practices with high risk:** anal or vaginal intercourse without a condom

These apply whether clients have partners of the same or opposite sex.

- **Early treatment of STIs and avoidance of sex**, if the client or their partner has an STI
- **Not having sex**, but being prepared to use condoms if client returns to sexual activity

¹⁵ This content is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs. 2007. *Family Planning: A Global Handbook for Providers*. Baltimore and Geneva; and WHO. 2006. *Reproductive Choices and Family Planning For People Living With HIV: Counseling Tool*. Geneva.

Handout 15-I

Intimate Partner Violence (IPV)

Note: **Gender-based violence** (GBV) is violence involving men and women, in which the woman is usually the victim. The violence stems from unequal power relationships between men and women, in society and in families. The violence is directed specifically against a woman because she is a woman. IPV is an example of gender-based violence (except in cases where the partners are the same gender).

What is IPV?¹⁶

IPV is a pattern of abusive behaviors and actions that is perpetrated by one person against their intimate partner. IPV includes physical, sexual, and psychological harm. An intimate partner may be a (current or former) spouse, lover, or boyfriend/girlfriend.

Most often, men are perpetrators of IPV. *This does not mean that all men are perpetrators.* Men who do this frequently think and believe they have the right to control their partner, because they see their partner as subordinate to themselves.

Victims of IPV are most often women. Women are often socialized at a very early age to ignore and/or silence their opinions and thoughts. They are also taught that their body is not entirely their own. Because of this, it can be hard for women to recognize when they may be experiencing IPV. In addition, cultural beliefs about the gender roles of women can normalize the abuse she is experiencing.

¹⁶ *Integration of Family Planning and Intimate Partner Violence Services: Trainer's Guide.* The Respond Project/EngenderHealth. "Trainer's Tool 1.5: PowerPoint Presentation—Dynamics of IPV."

Handout 15-J

The Impact of IPV on Decision Making about Pregnancy Prevention

Many clients experience IPV—worldwide estimates suggest approximately 30% of women who have been in a relationship have experienced IPV. That rate varies between countries and is as high as 70% in some countries. This means that many of the clients we see may be in a violent relationship.

Many clients—particularly women—face challenges in discussing pregnancy prevention with their partners under the best of circumstances. How are these challenges more complicated when there is IPV or abuse in the relationship?

- Fewer contraceptive options might be feasible for a woman who is in a controlling or abusive relationship.
- A woman may prioritize protecting herself from the IPV, over considering what would best meet her SRH needs.
- The woman might suffer from depression or a sense of hopelessness as result of the abuse and therefore might not take care of herself by practicing safer sex or contraception.

How might a partner try to control the woman's use of contraception?

- By hiding or destroying the woman's birth control pills
- By intentionally breaking condoms or removing a condom during sex
- By not withdrawing during intercourse (if that was the agreed upon method of contraception)
- By pressuring the woman to become pregnant or, conversely, forcing her to get an abortion
- By monitoring the woman's time and movements so she cannot come to the clinic as a new client, or return for resupplies and follow-up treatment

Handout 15-K

Addressing IPV within Counseling

When IPV Is Suspected during Counseling

It is not the provider's job to address the client's IPV problem. Addressing IPV with a client requires specialized counseling skills as well as additional time and resources. However, providers should familiarize themselves with services available locally for people dealing with abusive relationships. All providers should know where to refer clients for more help.

- When there is violence in the client's relationship, or the client fears it might occur, the provider should *not* pressure the client to discuss contraception with her partner. Pursuing the issue could place the client's health and life in danger.
- Instead, the provider should continue with counseling, considering how IPV might impact method choice and use.

The Provider's Role in Counseling Clients Experiencing IPV

- Be nonjudgmental toward the client.
- Be supportive of the client's efforts to obtain contraception and to prevent STI/HIV.
- Take IPV into consideration while providing counseling, for example:
 - Ask, "Do you need a contraceptive method that you can hide from your partner?"
 - Ask, "What would you do if your partner discovers your contraceptive method?"
- Show the client a list of local facilities that provide IPV counseling and assistance. Do not insist that the client take the information home but ensure that they know where to go for further help.

How a Provider Might Increase the Risk of Violence to a Client: Do Not Do These Things!

- Providing counseling in a space where other people can hear the conversation
- Discussing a woman's injuries in a space where an abusive partner can overhear
- Breaching confidentiality by sharing information about pregnancy, STIs, or sexual abuse with another family member without the woman's consent



Section 2: Learning Guides

Learning Guide 1

Phases and Steps of REDI

Phase 1: Rapport Building

1. Greet the client with respect
2. Make introductions and identify the category of the client (i.e., new, satisfied return, or dissatisfied return)
3. Assure confidentiality and privacy
4. Explain the need to discuss sensitive and personal issues
5. Use communication skills effectively (throughout the phases)

Phase 2: Exploring

1. Identify the reason for the visit in detail

For new clients:

2. **Individual factors:** Explore the client's sexual and reproductive health (SRH) history and pregnancy prevention goals
3. **Other key factors:** Explore the client's sexual relationships, social and gender contexts for decision making, and risk of sexually transmitted infection (STI) or HIV
4. **Explain pregnancy prevention and other SRH options:** Focus on the method(s) of interest to the client, addressing individual and other key factors and risk of STI/HIV

For return clients:

2. Explore the client's satisfaction with the current method
3. Confirm correct method use
4. Ask the client about changes in their life (e.g., plans to have children, STI risk and status)

For dissatisfied clients:

2. Explore the reasons for the client's dissatisfaction or problems, including the issue, causes, and possible solutions, such as switching methods

Phase 3: Decision Making

1. Summarize from the Exploring phase:
 - a. Identify the decisions the client needs to make or confirm (for satisfied return clients, see if they need other services; if not, go to Phase 4, Step 4)
 - b. Identify relevant options for each decision (e.g., pregnancy prevention, STI/HIV risk reduction)
 - c. Confirm medical eligibility for the contraceptive method(s) that the client is considering
2. Help the client consider the benefits, disadvantages, and consequences of each option (provide information to address any remaining knowledge gaps)
3. Confirm that any decision the client makes is informed, well-considered, and voluntary

Phase 4: Implementing the Decision

1. Assist the client in developing a concrete and specific plan for implementing the decision(s) (obtaining and using the contraceptive method chosen, risk reduction for STIs, dual protection, etc.)
2. Identify barriers that the client may face in implementing the plan
3. Develop strategies to overcome the barriers
4. Make a follow-up plan and/or provide referrals, as needed

Learning Guide 2

REDI Guide for Counseling New Clients

Rapport Building	
Steps/Sub-steps	Guidance
1. Greet client with respect	<ul style="list-style-type: none"> • Welcome the client politely • Invite the client to sit; help the client feel comfortable and relaxed
2. Make introductions and identify category of client— <i>new, satisfied return, or dissatisfied return</i>	<ul style="list-style-type: none"> • Introduce yourself • Ask general questions (such as name, age, number of children, contact information); record as needed • Ask the purpose of visit (new or return client) (<i>For return clients, use other learning guides</i>)
3. Assure confidentiality and privacy	<ul style="list-style-type: none"> • Make the client feel comfortable by assuring them that all information discussed will remain confidential • Create an atmosphere of privacy throughout the counseling session by ensuring the client that no one can interrupt or overhear your conversation, even if you are not able to use a separate room
4. Explain the need to discuss sensitive and personal issues	<ul style="list-style-type: none"> • Explain the reasons for asking questions about sexual relationships • Make clear the relevance of these issues to the client's potential risk for becoming pregnant and/or contracting HIV and other sexually transmitted infections (STIs) • Explain that these issues are discussed with all clients and that they do not have to answer any questions they are uncomfortable with
5. Use communication skills effectively (<i>throughout the phases</i>)	<ul style="list-style-type: none"> • Show friendliness by smiling; maintain eye contact with the client • Use simple and clear language; ask open-ended questions • Encourage the client to ask questions and to express their concerns • Actively listen to the client; answer all of the client's questions • Paraphrase the client to ensure correct understanding • Do not interrupt the client unless absolutely necessary; remain nonjudgmental

Learning Guide 2

REDI Guide for Counseling New Clients

Exploring	
Steps/Sub-steps	Guidance
1. Reason for the visit, in detail	
	<ul style="list-style-type: none"> • Explore the needs, problems, concerns, thoughts, and feelings that led the client to seek services • Ask the client if they have a method in mind
2. Individual factors: Explore the client's sexual and reproductive health (SRH) history and pregnancy prevention goals	
2-A. Explore the client's reproductive history, including most recent pregnancy and pregnancy prevention goals	<p>Ask about:</p> <ul style="list-style-type: none"> • Pregnancy history and outcome, number and ages of children • Date of last birth and current breastfeeding status • Whether the client has had a recent abortion/miscarriage • Whether the client wants more children; if yes, when, to determine nature of contraceptive protection desired (duration, effectiveness, etc.) • Current and past use of contraception • What the client knows about contraceptive methods
2-B. Rule out pregnancy now	<p>Ask about:</p> <ul style="list-style-type: none"> • Date of last monthly bleeding • Whether client has had unprotected intercourse since last monthly bleeding (see Pregnancy Checklist cue card)
2-C. Explore factors related to monthly bleeding	Determine the nature of monthly bleeding (how long? how much bleeding? how much pain/cramping?), particularly for clients interested in an intrauterine device (IUD), pills, injectables, and implants
2-D. Explore any signs and history of STIs, including HIV	<p>Ask about:</p> <ul style="list-style-type: none"> • Any unusual vaginal or penile discharge, pain with sex, or lower abdominal pain (current or recent) • History of STIs within the last three months • Partner's STI history, if known, or presence of current vaginal or penile discharge in partner • HIV status of client and partner, if known (for referral, possible treatment, or special counseling for sero-discordant couples)

Learning Guide 2

REDI Guide for Counseling New Clients

Exploring	
Steps/Sub-steps	Guidance
3. Other key factors: Explore the client's sexual relationships, social and gender contexts for decision-making, and risk of STIs/HIV	
3-A. Explore the client's sexual relationship(s)	Ask about: <ul style="list-style-type: none"> • The client's sexual relationship(s) • Nature of sexual relationship(s) that might affect contraceptive choice and use (frequency/regularity of sex, number of partners, possible partner absence, whether partner has other partners) • Current and past history of violence and/or rape • Questions, concerns, and problems client has about sexual relationships and practices • Ability to communicate with the partner(s) about SRH decisions
3-B. Explore the client's social and gender contexts for decision making	Ask about: <ul style="list-style-type: none"> • Partner, spouse, and family involvement and support for contraceptive use, with particular emphasis on method(s) of interest • Other factors (e.g., cultural, religious, socioeconomic issues; tensions within the extended family; and fear of violence) that might influence choice and use of contraceptive method(s) of interest
3-C. Explore the client's risk of STI/HIV	<ul style="list-style-type: none"> • Explore what the client knows about HIV and other STIs, their prevention, dual protection, and condom use • Address knowledge gaps by tailoring information to the needs of the client (such as transmission of STIs and need for dual protection) • Remind the client that STI risk is related to the clients' and their partners' individual sexual practices and discuss the risks of various sexual practices, as needed • Ask the client if they feel at risk for contracting STIs/HIV, or thinks that their partner might be at risk

Learning Guide 2

REDI Guide for Counseling New Clients

Exploring	
Steps/Sub-steps	Guidance
4. Explain pregnancy prevention and other SRH options:	Focus on the method(s) of interest to client, addressing individual and other key factors and risk of STIs/HIV
	<ul style="list-style-type: none"> • Explain healthy timing and spacing of pregnancies, if needed • Starting with the client's preferred method (if any), explore what the client already knows • Address knowledge gaps and misconceptions in the areas below by <i>tailoring</i> the information to the client's needs: <ul style="list-style-type: none"> ◦ Effectiveness, including how the method(s) works ◦ Side effects, health benefits, health risks, and complications ◦ How to use and where to obtain the method(s) or what to expect during the procedure (for IUD, injectables, implants and sterilization) ◦ When to return ◦ Whether the method provides protection against STIs/HIV ◦ How to ensure dual protection, if needed (for example, importance of condoms as the only method that protects against pregnancy and STIs/HIV and other options for dual protection) • Show sample(s) of method(s) and encourage the client to touch them; provide brochures or other printed information • Ask what questions client has

Learning Guide 2

REDI Guide for Counseling New Clients

Decision Making (based on information exchanged in Exploring phase)	
Steps/Sub-steps	Guidance
1. Summarize the Exploring phase in terms of decision making	
1-A. Review the decisions the client needs to make or confirm	<ul style="list-style-type: none"> • Explain the importance of the client making their own decisions • Help client prioritize the decisions that need to be made on the day of the visit, including: <ul style="list-style-type: none"> ◦ Which contraceptive method to use ◦ Whether to take action to reduce risk of contracting STIs/HIV (based on risk assessment in Exploring phase) ◦ Seeking healthcare for a problem or complying with a treatment, or other decisions
1-B. Identify relevant options for each decision	<ul style="list-style-type: none"> • Encourage the client to ask questions • Discuss pregnancy prevention, dual protection, and STI prevention options in greater detail, making sure the discussion centers on options that are appropriate to clients' individual needs
1-C. Confirm medical eligibility for contraceptive methods the client is considering	<ul style="list-style-type: none"> • Review the World Health Organization (WHO) Medical Eligibility Criteria to determine what conditions would pose a risk for the client for each method considered • Ask the client if they have any of those health conditions • If yes, explain the possible risks of using that method with those health conditions and encourage client to consider another method
2. Help the client consider the benefits, disadvantages, and consequences of each option	
	<ul style="list-style-type: none"> • Help the client anticipate the potential outcomes (positive or negative) of and barriers to each option, including: <ul style="list-style-type: none"> ◦ How they and their partner would react or feel if they were to experience common side effects ◦ Possible impact of the method on sexual relations, religious practices, or family life ◦ Recurrent cost, need for resupply, etc. ◦ The protection the method provides or lacks against HIV and other STIs • Ask the client what else they need to be able to make a decision, and provide information and emotional support accordingly
3. Confirm that any decision the client makes is informed, well-considered, and voluntary	
	<ul style="list-style-type: none"> • Reconfirm the selection of the method of interest by asking the client what their decision is • Confirm that any and all decisions are well-considered, informed, voluntary, and free of pressure from spouse, partner(s), family members, friends, or service providers

Learning Guide 2

REDI Guide for Counseling New Clients

Implementing the Decision (after client has confirmed their desire for the method selected)

Steps/Sub-steps	Guidance
<p>1. Assist the client in developing a concrete and specific plan for implementing the decision(s)</p>	<ul style="list-style-type: none"> • Help the client plan: <ul style="list-style-type: none"> ◦ <i>When to start</i> using the method ◦ <i>Where to obtain</i> the method and supplies ◦ <i>How to prevent STIs/HIV</i> ◦ <i>How to communicate with partner</i> about use of contraceptive method and/or condoms • Review (as needed): <ul style="list-style-type: none"> ◦ <i>How to use</i> the chosen method—particularly for oral contraceptives, male and female condoms, spermicides, Standard Days Method, and lactational amenorrhea method (LAM)—and provide tips for remembering to use the method correctly ◦ <i>How to obtain</i> the chosen method—particularly for IUDs, implants, injectables, female sterilization, and vasectomy ◦ Common <i>side effects</i> and how to deal with them ◦ <i>Warning signs</i> of health risks/complications and what to do if they experiences them ◦ <i>How to use condoms</i> (with a provider demonstration and return demonstration by the client)
<p>2. Identify barriers that the client may face in implementing the plan</p>	<ul style="list-style-type: none"> • Discuss potential barriers, such as: <ul style="list-style-type: none"> ◦ Side effects ◦ Partner reaction ◦ Cost of the method—including need to return to the clinic for resupply or reinjection (and related transportation issues) ◦ Ease or difficulty using the method (especially with the condom)

Learning Guide 2

REDI Guide for Counseling New Clients

Implementing the Decision (after client has confirmed their desire for the method selected) *continued*

Steps/Sub-steps	Guidance
3. Develop strategies and skills to overcome the barriers	<ul style="list-style-type: none"> • Review what to do when faced with side effects or difficulties • Provide the client with written information, if appropriate and available • Discuss and practice communicating and negotiating with partner for pregnancy prevention and dual protection • Confirm the client knows how to use a condom; demonstrate and/or practice • Help the client develop an alternative plan, in case the decision cannot be implemented • Discuss the option to switch to another method if the client is dissatisfied or if needs change • Discuss the availability and use of emergency contraception, if needed
4. Make a follow-up plan and/or provide referrals, as needed	<ul style="list-style-type: none"> • Agree on the timing of medical follow-up visit or resupply; make appointment, if needed • Refer the client for care, discontinuation, supplies, switching, or for tangential service (e.g., for intimate partner violence) • Confirm the client understands all the information • Remind the client to return or call if they have questions, concerns, or problems, or needs help with partner negotiations and ongoing method use

Learning Guide 3

REDI Guide for Counseling *Satisfied Return* Clients

Rapport Building	
Steps/Sub-steps	Guidance
1. Greet client with respect	<ul style="list-style-type: none"> • Welcome the client • Invite the client to sit; help the client to feel comfortable and relaxed
2. Make introductions	<ul style="list-style-type: none"> • Introduce yourself • Ask the client's name; refer to the client records (if available) and confirm general information (such as age, number of children, contact information); record as needed • Confirm the purpose of this visit (<i>satisfied return client</i>)
3. Assure confidentiality and privacy	<ul style="list-style-type: none"> • Make the client feel comfortable by assuring them that all information discussed will remain confidential • Create an atmosphere of privacy throughout the counseling session by ensuring that no one can interrupt or overhear your conversation, even if you are not able to use a separate room
4. Explain the need to discuss sensitive and personal issues	<ul style="list-style-type: none"> • Explain the reasons for asking questions about sexual relationships • Make clear the relevance of these issues to the client's potential risk for becoming pregnant and/or contracting HIV and other sexually transmitted infections (STIs) • Explain that these issues are discussed with all clients and that they do not have to answer any questions they are uncomfortable with
5. Use communication skills effectively throughout	<ul style="list-style-type: none"> • Show friendliness by smiling; maintain eye contact with the client • Use simple and clear language; ask open-ended questions • Encourage the client to ask questions and to express their concerns • Actively listen to the client; answer all of the client's questions • Paraphrase the client to ensure correct understanding • Do not interrupt the client unless absolutely necessary; remain nonjudgmental

Learning Guide 3

REDI Guide for Counseling *Satisfied Return Clients*

Exploring	
Steps/Sub-steps	Guidance
1. Explore the client's satisfaction with the current method	<ul style="list-style-type: none"> • Ask how satisfied the client is with their current method • Probe for any misconceptions the client might have • Check if the client has any questions or concerns or problems, especially regarding side effects
2. Confirm correct method use	Ask the client to describe how they are using the method
3. Ask the client about changes in their life	<p>Ask about:</p> <ul style="list-style-type: none"> • Changes in medical history or circumstances since last visit and questions or concerns they might have about their health • Changes in partners (or any new partners) since last visit • Any concerns that they might be exposed to STIs/HIV through their partner(s); dual-method use <p>If any changes necessitate the review of the client's decisions about pregnancy or STI prevention, refer to the Decision Making section of the REDI Guide for Counseling New Clients</p>
Decision Making (based on information exchange above)	
1. Help client identify what services they need during this return visit	<p>Ask about:</p> <ul style="list-style-type: none"> • Resupply with method • Regular well-woman visits • Other reproductive health services or referrals
Implementing the Decision	
1. Make a plan for follow-up and/or provide referrals as needed	<ul style="list-style-type: none"> • Agree on the timing of medical follow-up visit or resupply (make appointment, if needed) • Refer for care or other services • Confirm the client understands all the information • Remind the client to return or call if they have questions, concerns, or problems or need help with partner negotiations and ongoing method use

Learning Guide 4

REDI Guide for Counseling *Dissatisfied Return* Clients

Rapport Building	
Steps/Sub-steps	Guidance
1. Greet client with respect	<ul style="list-style-type: none"> • Welcome the client • Invite the client to sit; help the client feel comfortable and relaxed
2. Make introductions	<ul style="list-style-type: none"> • Introduce yourself • Ask the client's name; refer to the client records (if available) and confirm general information (such as age, number of children, contact information); record as needed • Confirm the purpose of this visit (<i>dissatisfied return client</i>)
3. Assure confidentiality and privacy	<ul style="list-style-type: none"> • Make the client feel comfortable by assuring them that all information discussed will remain confidential • Create an atmosphere of privacy throughout the counseling session by ensuring that no one can interrupt or overhear your conversation, even if you are not able to use a separate room
4. Explain the need to discuss sensitive and personal issues	<ul style="list-style-type: none"> • Explain the reasons for asking questions about sexual relationships • Make clear the relevance of these issues to the client's potential risk for becoming pregnant and/or contracting HIV and other sexually transmitted infections (STIs) • Explain that these issues are discussed with all clients and that they do not have to answer any questions they are uncomfortable with
5. Use communication skills effectively throughout	<ul style="list-style-type: none"> • Show friendliness by smiling; maintain eye contact with the client • Use simple and clear language; ask open-ended questions • Encourage the client to ask questions and to express their concerns • Actively listen to the client; answer all of the client's questions • Paraphrase the client to ensure correct understanding • Do not interrupt the client unless absolutely necessary; remain nonjudgmental
Exploring	
1. Clarify the client's dissatisfaction with the current method	<ul style="list-style-type: none"> • Ask why the client is dissatisfied with their current method (probe for any misconceptions the client might have) • Ask what questions or concerns or problems the client has
2. Confirm correct method use	Ask the client to describe how they are using the method

Learning Guide 4

REDI Guide for Counseling *Dissatisfied Return* Clients

Exploring <i>continued</i>	
Steps/Sub-steps	Guidance
3. Ask the client about changes in their life	<p>Ask about:</p> <ul style="list-style-type: none"> • Changes in medical history or circumstances since the last visit and questions or concerns they might have about their health • Changes in partners (or any new partners) since last visit • Any concerns that they might be exposed to STIs/HIV through their partner(s); ask about dual-method use • If any changes necessitate review of the client's decisions about pregnancy or STI prevention, refer to the Decision Making section of the REDI Guide for Counseling New Clients
4. Explore in-depth the reasons for the client's dissatisfaction or the problems	<ul style="list-style-type: none"> • Explore the problems and the reasons for dissatisfaction, discuss possible solutions, and encourage the client to ask questions • Tailor the discussion to the problem (see Handout 12-H for possible reasons for dissatisfaction and options for the client)
Decision Making (based on information exchange above)	
1. Identify what decisions the client needs to confirm or make	<ul style="list-style-type: none"> • Explain the importance of the client making their own decisions • Help the client prioritize the decisions that need to be made on the day of the visit, including: <ul style="list-style-type: none"> ◦ Continuing with the current contraceptive method ◦ Switching to another method ◦ Discontinuing contraception ◦ Reducing STI/HIV risk and/or generating dual protection ◦ Complying with treatment and/or referral
2. Explore relevant options for each decision	Encourage the client to ask questions, making sure the discussion centers on options that are appropriate to the client's individual needs (see Handout 12-G)

Learning Guide 4

REDI Guide for Counseling *Dissatisfied Return* Clients

Decision Making (based on information exchange above) <i>continued</i>	
Steps/Sub-steps	Guidance
<p>3. Help the client weigh the benefits, disadvantages, and consequences of each option</p>	<ul style="list-style-type: none"> • Help the client anticipate the potential outcomes (positive or negative) of and barriers to each option, including: <ul style="list-style-type: none"> ◦ How the partner would react to the decision ◦ The risk of unintended pregnancy (for those who decide to discontinue contraception) ◦ The risk of contracting STIs/HIV (for those who decide to discontinue dual protection or condom use) ◦ Cost, side effects, health benefits, and health risks (for those switching to another method) ◦ Negotiating condom use with partner • Ask the client what else they need to be able to make a decision; provide information and emotional support accordingly
<p>4. Encourage the client to make their own decision</p>	<ul style="list-style-type: none"> • Confirm that any and all decisions are well-considered, informed, and voluntary • Confirm that the decision(s) can actually be implemented (given the relationship with spouse/partner, family situation, economic situation, anticipated problems, and barriers)

Learning Guide 4

REDI Guide for Counseling *Dissatisfied Return* Clients

Implementing the Decision	
Steps/Sub-steps	Guidance
1. Assist the client in making a concrete and specific plan for implementing the decision(s)	<p>Help the client plan for and implement their decision:</p> <ul style="list-style-type: none"> • <i>Clients who decide to continue with their current method:</i> Help them develop strategies to deal with the side effects and problems they are experiencing (see the Implementing the Decision section of REDI Guide for Counseling New Clients) • <i>Clients who decide to switch to another method:</i> Help them obtain and use the method correctly; provide the information and skills needed for correct use, especially for condoms (see the Implementing the Decision section of REDI Guide for Counseling New Clients) • <i>Clients who decide to discontinue contraception:</i> Help them obtain the services they need or refer them, as necessary; for clients who want to discontinue use of an intrauterine device (IUD) or implants, explain removal procedures and answer any questions they have
2. Make a follow-up plan and/or provide referrals	<ul style="list-style-type: none"> • Agree on the timing of medical follow-up visit or resupply; make appointment, if needed • Refer for continued care, discontinuation, supplies, switching, or other services (e.g., for intimate partner violence) • Confirm the client understands all the information • Remind the client to return or call if they have questions, concerns, or problems or need help with partner negotiations and ongoing method use

Section 3:
Take-Home Test

Take Home Test

Purpose and Instructions

The test is designed to guide you through the Pretraining Handouts before you attend the workshop. Its purpose is to help you to focus on the key points of each session. You can answer the questions for each session *after* you read the materials, or you can answer them *while* you are reading the materials. This is not a test of how much you know, but of how well you have read the materials. We want you to read the materials until you find the answers.

Session 2.

Rights in Sexual and Reproductive Health (SRH)

Questions 1-3. Write the letter for the correct definition on the line in front of each term.

1. _____ Full, free, and informed choice	A. Affirming that health and rights are inseparable, and that individuals have the right and capacity to make decisions about their lives
2. _____ The rights-based approach to SRH service delivery	B. A medical, legal, and rights-based construct for when clients agree to receive medical treatment or take part in a study, after making an informed choice
3. _____ Informed consent	C. Access to the widest possible range of contraceptive methods and the ability to decide, without barriers or coercion, and based on complete, accurate, and unbiased information about all pregnancy prevention options

4. _____ Which of the following is **not** considered to be one of the rights in SRH?
- The right to decide on the number, spacing, and timing of children
 - The right to attain the highest standards of SRH
 - The right to SRH services free of charge
 - The right to make SRH decisions without discrimination, coercion, or violence
5. _____ Which of the following is **not** required for a client to be able to make a full, free, and informed choice?
- Service provider's recommendation
 - Availability of appropriate information
 - Voluntary decision-making process
 - Availability of adequate service options
6. _____ Which of the following is **not** considered to be one of the clients' rights?
- Privacy and confidentiality
 - Choice of the provider's gender
 - Safety of services
 - Continuity of care
7. Principles of client-provider interaction apply to interactions between clients and any healthcare staff.
True _____ False _____
8. The purpose of counseling is to explain contraceptive methods to clients.
True _____ False _____

Session 3.

Decision Making from the Client's Perspective

Questions 9-11. Write the letter for the correct definition on the line in front of each term.

9. _____ Spacers	A. Clients who do not have any children and do not wish to have any in the near future
10. _____ Limiters	B. Clients who have at least one child and want to delay their next pregnancy
11. _____ Delayers	C. Clients who have all the children that they want

12. _____ Why is it important to identify what category (or categories) a client fits into?
- A. Because providers want their clients to be accepted in their own families and communities
 - B. Because knowing the client's category can help the provider identify the individual client's needs more quickly and effectively
 - C. Because clients in some categories should not use contraception

13. Feeling and showing empathy is an important part of building rapport with the client. Being aware of the client's category/categories and needs can help the provider to develop and show empathy more quickly.

True _____ False _____

Questions 14-18. Match the factor that can influence client decision making with the appropriate examples.

14. _____ Individual factors	A. Opinions of peers, coworkers, and community leaders; media, entertainment, and advertising
15. _____ Community influences	B. HIV status, having recently given birth, having recently experienced a miscarriage or abortion
16. _____ Service factors	C. Common side effects, who controls the use of the contraceptive method, cost
17. _____ Method characteristics	D. Availability and affordability of a range of methods; provider attitudes, knowledge, and skills
18. _____ Other SRH conditions	E. The client's age, health status, and socioeconomic status; communication with and trust in the partner; expectations of the client's family (including parents, in-laws, etc.) about number and sex of children

Session 4.

Provider Beliefs and Attitudes

Questions 19-21. Match the definitions with the terms.

19. ____ Attitudes	A. The ways that we think about people and ideas
20. ____ Beliefs	B. The ways that we act in situations and toward other people
21. ____ Behaviors	C. Concepts or ideas that we accept as truth and which help us explain how things work in the world

22. Everyone—including both clients and providers—has the right to have their own beliefs about SRH.

True _____ False _____

23. It is important for providers to be aware of their beliefs about pregnancy prevention and SRH in order to teach them to clients.

True _____ False _____

Session 5.

Communication Skills for Counseling

Questions 24-26. Match the definitions with the communication skill.

24. ____ Body language	A. Recognizing the emotions behind what the client is saying and checking your interpretation
25. ____ Reflecting	B. Restating the client's message simply and in your own words
26. ____ Paraphrasing	C. What we communicate through our movements, such as hand gestures and facial expressions

27. Body language has the same meaning in all cultures.

True _____ False _____

28. _____ Which of these is **not** a reason why we ask questions during counseling?
- A. To establish and maintain a good relationship by showing concern and interest
 - B. To assess the client's pregnancy prevention needs and knowledge
 - C. To determine the language level that will be best understood by the client
 - D. To actively engage the client and encourage them to talk about their needs, concerns, and preferences
 - E. None of the above—these are all good reasons for asking questions
29. Open questions are good for quickly gathering factual information from the client.
True _____ False _____
30. _____ Which of these is **not** a tip for active listening?
- A. Think about similar situations in your own life as you listen to the client
 - B. Pay attention to the client—do not do other tasks or allow interruptions (if possible)
 - C. Listen to *what* your client says and *how* they say it
 - D. Allow for pauses of silence so that your client has time to think

Session 6.

Using Simple Language and Visual Aids

31. _____ Which of these is not a reason why providers use information, education, and communication materials during counseling?
- A. To get the client's attention
 - B. To allow providers to skip some steps of counseling when they are short on time
 - C. To demonstrate what is involved in medical procedures, for example for insertion of an intrauterine device (IUD)
 - D. To explain anatomical features that one cannot see

Session 7.

R = Rapport Building

32. Name each phase of REDI:

R = _____

E = _____

D = _____

I = _____

33. The benefit of following a counseling framework, like REDI, is that it provides a structure for talking with clients, so providers do not miss important steps.

True _____ False _____

34. In order to be effective, the provider needs to follow the REDI steps in the order in which they are listed.

True _____ False _____

35. _____ Which of these is **not** a sub-task under Rapport Building?

- A. Assure confidentiality and privacy
- B. Explain the need to discuss sensitive and personal issues
- C. Explore the client's SRH history and pregnancy prevention goals
- D. Greet the client with respect

Session 8.

E = Exploring (Steps 1-3) (page 1 of 2)

36. _____ Which of the following statements is **incorrect**?

- A. Sexuality is influenced by culture, religion, and social norms
- B. Sexuality is the same thing as sexual intercourse
- C. Sexuality involves giving and receiving sexual pleasure, as well as enabling human reproduction
- D. Sexuality involves the mind and the body

Aspects of Sexuality

Questions 37-40. Write the letter for the correct definition on the line in front of each term.

37. _____ Sensuality	A. The individual's sense of who they are, as a sexual being; it includes biological sex, gender identity, gender roles, and sexual orientation
38. _____ Intimacy	B. The part of sexuality that deals with the emotional aspect of relationships
39. _____ Sexual identity	C. The integration of the emotional, intellectual, physical, and social aspects of being sexual in ways that enrich and enhance our lives
40. _____ Sexual health	D. How our bodies derive pleasure, including through hearing, sight, smell, taste, and touch

41. _____ People who perceive themselves to be at risk will be more motivated to make changes to protect themselves from unintended pregnancy or from the transmission of sexually transmitted infections (STIs) and HIV. However, many people perceive themselves to be less at risk than they actually are.

Which of these is **not** a reason why people underestimate their risk of unintended pregnancy or STI/HIV?

- A. Complete faith in the healthcare system to make everything okay
- B. Stereotyped beliefs about who is at risk
- C. Being convinced that "it will not happen to me"
- D. Believing that whether they become pregnant or infected (or not) is beyond their control

Session 8.

E = Exploring (Steps 1-3) (page 2 of 2)

Questions 42-45. Write the letter for the correct definition on the line in front of each term.

42. _____ Gender	A. An individual's sense of being male or female and how they feel about that
43. _____ Gender roles	B. Addressing the effect of gender on the client's decision making
44. _____ Gender identity	C. How an individual or society defines being female or male
45. _____ Gender sensitivity	D. Socially and culturally defined attitudes, behaviors, expectations, and responsibilities attributed to males and females

46. Someone with an STI, particularly an ulcerative STI, is more likely to become infected with HIV if exposed.
True _____ False _____

Session 9.

E = Exploring (Step 4) (page 1 of 2)

47. _____ Which of the following is *incorrect* about giving information to clients?
- A. First, the counselor should explore what the client already knows
 - B. Information should be tailored to the client's needs
 - C. The counselor should start with the method used most frequently in the country
 - D. The counselor should check whether the client understands the information given during the counseling session
48. _____ Which of the following is *incorrect* about clients' misconceptions?
- A. Misconceptions can lead to discontinuation of contraceptive methods
 - B. Try to find out where the client heard the misconception or rumor
 - C. If clients understand why misconceptions are untrue, they are more likely to believe the correct information
 - D. Sometimes it helps to make jokes about the client's misconceptions
49. Tailoring information means focusing on what the client needs to know. Personalizing information means explaining that information in terms of the client's specific situation.
True _____ False _____
50. _____ Which of the following is *incorrect* about making information understandable?
- A. Keep it short and simple
 - B. Use language the client understands
 - C. Try not to confuse the client by repeating key information
 - D. Check the client's understanding by asking them to repeat key information back to you
51. _____ Which of the following is *not* key information for clients choosing a contraceptive method?
- A. What kind of method it is (how it works)
 - B. Side effects, health risks, and complications
 - C. History of use of the method in the country
 - D. Whether the method prevents HIV and other STIs

52. _____ Which of the following is **not** part of explaining side effects to clients?
- A. Why and how the side effects occur
 - B. Many side effects go away without treatment; others can be treated
 - C. What the client would do if side effects occur
 - D. Side effects should never be a reason to stop using the method

Session 9.

E = Exploring (Step 4) (page 2 of 2)

Contraceptive Methods and Risk of STI/HIV

Which of the methods listed in the second column offer the:

53. _____ Best protection against STI/HIV?	A. Spermicides
54. _____ Some protection against STI/HIV?	B. Combined orals/injectables
55. _____ Protection against some STIs but not HIV?	C. Abstinence from penile/vaginal and penile/anal intercourse
56. _____ No protection against STI/HIV?	D. Male condoms

57. _____ Which of the following is **not** a strategy for dual protection?
- A. Emergency contraception
 - B. Avoiding risky sexual behaviors
 - C. The use of condoms alone
 - D. Dual-method use

Session 10.

D = Decision Making

58. _____ Which of the following is **not** a step in helping the client make or confirm a decision about pregnancy prevention?
- A. Confirm the client's medical eligibility for whatever methods they are considering
 - B. Help the client weigh the benefits, disadvantages, and consequences of each method
 - C. Confirm that any decision is informed, well-considered, and voluntary
 - D. Schedule a return visit for the chosen method
59. Because providers are trained counselors, they do not have to worry about pressuring the client to choose a particular method.
- True _____ False _____

Session 11.

I = Implementing the Decision

60. Considering the financial cost of using a method is part of a concrete plan for implementing the client's decision.
- True _____ False _____
61. In the Implementing the Decision phase, it is not necessary to review information about how to use the method and how to deal with side effects, since that has been covered in the Exploring and Decision Making phases of REDI.
- True _____ False _____
62. _____ Which of the following is **not** an appropriate suggestion to help clients discuss pregnancy prevention and other SRH issues with partners?
- A. Identify areas of family life or relationships that they do discuss; see if there is a way that these issues can serve an entry point for the discussion
 - B. Start the conversation by saying that this is something that they heard about at the healthcare facility and that they wonder if their partner knows anything about it
 - C. Say that the provider says there are some decisions that they need to make together (exploring the possibility of a joint visit by the client and the partner)
 - D. None of the above—these are all possible suggestions, depending on the client's relationship with their partner

Session 12.

Counseling Return Clients

63. There are different approaches to counseling return clients, depending on whether they are satisfied or dissatisfied with their method.

True _____ False _____

64. Rapport building and use of communication skills are still important for return clients, whether they are satisfied clients or not.

True _____ False _____

65. _____ Which of the following is **not** an appropriate response to a satisfied return client?

- A. Review other methods that would fit the client's needs, in case they become dissatisfied later
- B. Ask if the client is experiencing any problems
- C. Inquire about correct use of the method
- D. Provide resupply without delay, if there are no problems

Session 15.

Counseling Specific Categories of Clients (page 1 of 2)

66. _____ Which of these is a factor contributing to sound decision making for sterilization?

- A. Young age
- B. Desired family size achieved
- C. Pressure from partner, relatives, or service providers
- D. Decision made during labor or immediately after an abortion

67. The ideal time to counsel clients for postpartum contraception is just before delivery, to make sure they do not miss the opportunity to leave with a method.

True _____ False _____

68. The reason why providing pregnancy prevention counseling and contraceptive methods is a key element of postabortion care is because fertility returns very quickly after a miscarriage or abortion.

True _____ False _____

69. Use of any contraceptive method can be initiated immediately postabortion.

True _____ False _____

Session 15.

Counseling Specific Categories of Clients (page 2 of 2)

Working with Couples

70. _____ Which of these statements is **not** true about counseling couples?
- A. You should always try to meet individually with one or both partners before a couples meeting
 - B. If the provider meets individually with one or both partners, they need to maintain confidentiality for any information shared
 - C. The service provider's biases for or against men generally have no impact on couples counseling
 - D. If one partner does all the talking, the provider should encourage the other partner to express their opinions

Counseling for Clients Living with HIV

71. Contraception for a woman living with HIV is so important because it is unlikely that she can have a healthy baby.
True _____ False _____
72. People with STIs, living with HIV and AIDS, or who are on antiretroviral therapy can start and continue to use most contraceptive methods safely.
True _____ False _____

Addressing Intimate Partner Violence (IPV) within Counseling

73. _____ Which of these is **not** a way that a male partner might try to control a woman's use of contraception?
- A. Hiding or destroying her birth control pills
 - B. Pressuring her to become pregnant
 - C. Encouraging her to express her opinions about contraceptive methods
 - D. Limiting her movements outside the home
74. _____ Which of these is **not** part of the provider's role when IPV comes up in counseling?
- A. Encourage the client to discuss the IPV in detail, before continuing with pregnancy prevention counseling
 - B. Be nonjudgmental toward the client
 - C. Consider IPV implications when discussing contraceptive methods
 - D. Do not insist that the client take home written information about referral organizations