REDI: A Client-Centered Counseling Framework

Participant's Handbook

EngenderHealth
for a better life

REDI:
A Client-Centered Counseling Framework

Participant Handbook

Part 2: Training Handouts
Sessions 1 to 18

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Training Handouts Table of Contents

Session 6: Using Simple Language and Visual Aids

Session 7: R = Rapport Building

Session 8: E = Exploring—Steps 1-3

Session 9: E = Exploring—Step 4

Session 10: D = Decision Making

Training Handouts for Sessions 1 to 18

- Please note that these handouts continue the numbering from the Pretraining Handouts in Part 1 of the Participant Handbook.
- Also, note that the first handout in each session in this volume (Part 2) shows the *Learning Objectives* and *Essential Ideas* for the training session. These are similar to but slightly different from the Learning Objectives and Essential Ideas for the same session in the previous volume (Part 1) because the training activities will focus on *applying* what you learned previously as well as *exploring attitudes* and *developing skills*.

Session 1:
Welcome and Introductions

Handout 1-A

Session 1 Essential Ideas

Essential Ideas—Session 1

- The overall goal of this training is to improve your knowledge, attitudes, and skills in assessing and addressing clients' pregnancy prevention needs and preferences, by providing individualized, client-centered counseling.
- Client-centered counseling considers the clients' circumstances and broader sexual and reproductive health (SRH) needs and preferences, and their impact on the choice and use of contraceptive methods. Through client-centered counseling, you will be better able to:
  - Support clients in exercising their SRH rights and in making full, free, and informed choices
  - Assess and respond to clients' informational, decision-making, and emotional needs
  - Help clients make practical and actionable decisions and plans
  - Support clients in using their chosen method successfully and in coping with common side effects
- The overall objectives of this course are to enable you to:
  - Explain the importance of quality, client-centered counseling for ensuring full, free, and informed choice in decision making about pregnancy prevention
  - Communicate effectively with clients
  - Assess each clients' individual pregnancy prevention needs and preferences, knowledge, and concerns, and work with clients to address them effectively and efficiently
  - Identify the key decisions clients need to make; assist and support clients through the decision-making process by discussing various options and their consequences
  - Assist clients in creating strategic plans to implement decisions about pregnancy prevention

Handout 1-B

Workshop Agenda (page 1 of 3)

Day 1

Session	Time
Session 1: Pretest, Welcome, and Introduction; Correcting Pretraining Take-Home Test (*for Sessions 2-6*)	**8:30 a.m.** 90 min
Session 2: What Is Client-Centered Counseling?	65 min
Break	15 min
Session 3: Decision Making from the Client's Perspective	75 min
Lunch	45 min
Session 4: Provider Beliefs and Attitudes	40 min
Session 5: Communication Skills for Counseling	75 min
Break	15 min
Session 6: Using Simple Language and Visual Aids	80 min
Wrap-Up	15 min **5:05 p.m.**

Handout 1-B

Workshop Agenda (page 2 of 3)

Day 2

Warm-Up; Correcting Pretraining Take-Home Test (*for Sessions 7-9*)	**8:30 a.m.** 15 min
Session 7: R = Rapport Building	45 min
Session 8: E = Exploring—Steps 1-3 (Activities A-D)	1 h 10 min
Break	15 min
Session 8: E = Exploring—Steps 1-3 (Activities E-G)	1 h 30 min
Lunch	45 min
Session 9: E = Exploring—Step 4	2 h 20 min
Break	15 min
Condom Race and Practice Demonstration	30 min
Wrap-Up	15 min **4:30 p.m.**

Day 3

Warm-Up; Correcting Pretraining Take-Home Test (*for Sessions 10-12 and 15*)	**8:30 a.m.** 15 min
Session 10: D = Decision Making	1 h
Session 11: I = Implementing the Decision	1 h
Break	15 min
Session 12: Counseling Return Clients	1 h 20 min
Lunch	45 min
Session 13: Counseling Practice Role Plays	3 h 10 min
Wrap-Up	15 min **4:30 p.m.**

Handout 1-B

Workshop Agenda (page 3 of 3)

Day 4

Session 14: Counseling Practice with Clients; Reflections	**8:30 a.m.**
• Activity A. Orientation to Counseling Practice with Clients	15 min
• Activity B. Counseling Practice with Clients (including 1 hour travel to and from)	3 h 45 min
Lunch	45 min
• Activity C. Reflections on Counseling Practice with Clients	15 min
• Activity D. Trainers' Observations	15 min
Session 15: Counseling Specific Categories of Clients	2 h
Break	*Includes 15-min break*
Posttest	30 min
Wrap-Up	15 min **4:30 p.m.**

Day 5

Session 16: Counseling Practice with Clients; Reflections	**8:30 a.m.**
• Activity A. Counseling Practice with Clients (including 1 hour travel, to and from)	3 h 45 min
Lunch	45 min
• Activity B. Reflections on Counseling Practice with Clients	10 min
• Activity C. Trainers' Observations	10 min
Session 17: Action Plans	45 min
Session 18: Posttest (correcting), Workshop Evaluation, and Closing	40 min **2:45 p.m.**

Handout 1-C

Action Plan Worksheet (page 1 of 2)

Based on what you learned today, what changes would you like to see in your own service provision, or in your clinic's services, that could strengthen client-centered counseling?

Day 1

1.
2.
3.
More?

Day 2

1.
2.
3.
More?

Handout 1-C

Action Plan Worksheet (page 2 of 2)

Based on what you learned today, what changes would you like to see in your own service provision, or in your clinic's services, that could strengthen client-centered counseling?

Day 3

1.
2.
3.
More?

Day 4

1.
2.
3.
More?

Session 2:
What is Client-Centered Counseling

Handout 2-E

Session 2 Learning Objectives and Essential Ideas

(page 1 of 2)

Learning Objectives

By the end of the session, you will be able to:

- Explain the relationship between client-provider interaction, counseling, and client-centered counseling
- Explain why client-centered counseling is important for pregnancy prevention services
- Explain why it is important to recognize the client as an expert
- Identify specific tasks that need to be completed in client-centered counseling
- Identify one benefit of client-centered counseling for the client and one benefit for the family planning program
- Identify two consequences of poor counseling
- Identify two reasons why providers may not provide good counseling
- Identify two standards of behavior for client-centered counseling

Essential Ideas—Session 2

Building on the Essential Ideas from the Pretraining Handouts, Session 2

- Counseling is a form of client-provider interaction, focused on helping the client make decisions or address problems. Ideally, all counseling should be client-centered, but sometimes it is more focused on the provider's tasks, knowledge, and time constraints. Being client-centered means being focused on the client's needs, preferences, and concerns.
- During counseling, it is important to recognize the client as the other expert in the room. This not only shows respect, but it is also the most efficient and effective way to learn about the client's needs, concerns, preferences, and knowledge about pregnancy prevention and other areas of sexual and reproductive health (SRH).
- The tasks of client-centered counseling include:
  - Help clients assess their own needs.
  - Provide personalized information to address identified needs.
  - Help clients make informed and voluntary decisions by weighing options.
  - Help clients plan how to implement their decisions.
  - Answer questions and address concerns.
- There are benefits of client-centered counseling for the client and for the family planning program. One benefit for both is increased method continuation.

Handout 2-E

Session 2 Learning Objectives and Essential Ideas
(page 2 of 2)

- Consequences of poor (or no) counseling include method discontinuation, unwanted pregnancies, health risks, dissatisfaction with services, and clients unable to exercise their SRH rights or achieve their reproductive intentions.
- Reasons why providers do not provide good counseling include inadequate training or supervisory support, lack of communication skills, and discomfort discussing SRH issues with clients.
- Quality counseling is the main safeguard for the client's right to full, free, and informed choice. In addition, counseling can support clients' other rights.
- Standards of behavior for client-centered counseling include completing all of the tasks of counseling while treating clients with respect, ensuring confidentiality, and encouraging the client's participation.

Handout 2-F

Review of Sexual and Reproductive Health and Rights (SRHR) Worksheet

SRHR Terms	Definition
1. ___ **Full choice**	A. Person-to-person communication (verbal and nonverbal) between clients and anyone working at a service site
2. ___ **Free choice**	B. A medical, legal, and rights-based construct whereby clients agree to receive medical treatment (such as surgery for a contraceptive method) as a result of the client's informed choice
3. ___ **Informed choice**	C. Privacy and confidentiality; safety of services; and dignity, comfort, and expression of opinion
4. ___ **Reproductive rights**	D. The ability to make a decision based on complete, accurate, and unbiased information about all contraceptive options, including benefits, side effects, and risks, as well as additional counseling about the method chosen
5. ___ **Some of the client's rights**	E. The ability to choose whether or not to use contraception and what method to use—without barriers or coercion
6. ___ **Client-provider interaction**	F. All couples and individuals can decide freely and responsibly the number, spacing, and timing of their children, with access to necessary information, and freedom from discrimination, coercion, and violence
7. ___ **Informed consent**	G. Access to the widest range of methods possible (short-acting, long-acting, permanent, hormonal, nonhormonal, client-controlled, provider-dependent, etc.)

Handout 2-G

The Importance of Client-Centered Counseling

(page 1 of 2)

Why Is Client-Centered Counseling Important?

- It protects clients' right to full, free, and informed choice—an essential SRH right.
- It is an essential element of quality services.
- It is a key determinant of voluntary adoption and continued use of a contraceptive method.
- It helps clients execute their reproductive health decisions.

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Two Experts in the Room: The Client…

The client has thoughts, feelings and opinions about:

- Fertility plans
- Past experiences with pregnancy prevention
- Relationship(s) with partner(s)
- Social circumstances
- Other unexpressed needs

Source: R. Islam/EngenderHealth

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…and the Provider

The provider has:

- Knowledge of:
  - Healthy timing and spacing of pregnancy
  - Contraceptive methods
  - Other SRH services
- Skills to:
  - Communicate and build trust
  - Assess needs
  - Tailor information
  - Help clients weigh options and make decisions

Source: Zeleman Production/EngenderHealth

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3

Tasks of Client-Centered Counseling

- Help clients assess their healthcare, informational, and emotional support needs
- Provide personalized information
- Help clients make informed and voluntary decisions by enabling them to weigh the options
- Help clients plan how to execute decisions effectively
- Answer clients' questions and address concerns

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Benefits of Client-Centered Counseling for the Client

- It helps clients feel respected.
- It supports clients' rights.
- It helps clients make decisions that best suit their circumstances.
- It increases client satisfaction—with methods and services.

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Benefits of Client-Centered Counseling for *the Program*

Providing tailored information can:

- Save time
- Reduce the need for return visits
- Increase method continuation (*and increased continuation rates contribute more to contraceptive prevalence than increases in new users!*)

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Handout 2-G

The Importance of Client-Centered Counseling

(page 2 of 2)

Counseling and Method Continuation

- Continuation with a method increases with respectful and responsive providers.
- Counseling about side effects significantly increases continuation.
- Clients who receive the method they want are more likely to continue use.

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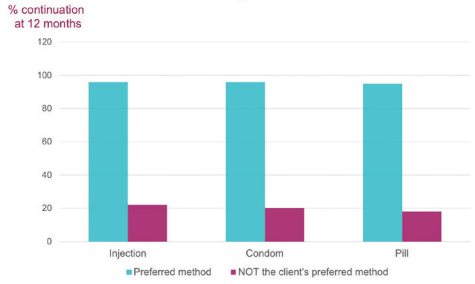
Clients Who Receive The Method They Want Are More Likely To Continue Use



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Telling Clients About Side Effects

- Many providers think they will scare clients away by talking about side effects. *But…*
- Research shows that counseling about side effects *increases* continuation.
- Not knowing about side effects is a major reason for clients *discontinue* use of pills and injectables.

Why do you think counseling about side effects would increase continuation?

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Consequences of Poor Counseling

Effects	Outcomes
Improper method use	Unwanted pregnancy
Fear of and dissatisfaction with side effects	Discontinuation
Failure to recognize serious warning signs	Health risks
Dissatisfaction with services and method	Drop out Poor word of mouth Low utilization
All of the above	Prevents clients from exercising their SRH rights and/or meeting their reproductive intentions

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Handout 2-H

Standards of Behavior for Providers Trained in Client-Centered Counseling

In client-centered counseling, the provider:

- Treats all clients with respect
- Is gentle and soft-spoken with all clients
- Assures clients of confidentiality
- Encourages clients' active participation in the counseling process
- Tailors the interaction to the individual clients' needs
- Addresses clients' needs or concerns regarding pregnancy prevention and other areas of SRH
- Provides clients with their preferred method (if appropriate)
- Ensures that clients know how to use the method and knows when to return to the clinic

These are the standards for all those trained with this curriculum (EngenderHealth's REDI: A Client-Centered Counseling Framework).

Further Reading

Handout 2-I

Sexual Rights

The working definition of sexual rights states that:

> *Sexual rights embrace human rights that are already recognized in national laws, international human rights documents, and other consensus statements. They include the right of all persons, free of coercion, discrimination, and violence, to:*
>
> - *The highest attainable standard of sexual health, including access SRH care and services*
> - *Seek, receive, and impart information related to sexuality*
> - *Sexuality education*
> - *Respect for bodily integrity*
> - *Choose their partner*
> - *Decide to be sexually active or not*
> - *Consensual sexual relations*
> - *Consensual marriage*
> - *Decide whether and when to have children*
> - *Pursue a satisfying, safe and pleasurable sexual life.*[1]

The right to "respect for bodily integrity"—the right to exercise control over what one does with their own body—is a right of all people, regardless of gender. However, the World Conference on Women Platform for Action (see Pretraining Material 2-A) highlights women's rights in this area because women are often the ones for whom this right is compromised.

The idea of "sexual rights" is controversial in some places. Some governments and the UNFPA use instead "sexual and reproductive health and reproductive rights" to avoid any controversy associated with sexual rights. "Sexual rights" are not currently acknowledged as human rights under any international treaty, but advocacy is underway change this.

[1] Defining sexual health: Report of a technical consultation on sexual health, 28–31 January 2002, Geneva (WHO 2006), http://www.who.int/reproductivehealth/publications/sexual_health/defining_sexual_health.pdf

Further Reading

Handout 2-J

Principles of Rights and Empowerment

Family Planning 2020 (FP2020)— Rights and Empowerment Principles for Family Planning

In addition to the seven clients' rights described in the presentation and in Pretraining Handout 2-C, you may see references to 10 principles established by the Rights and Empowerment Working Group of FP2020.[2] These principles are based on the human rights principles described by the United Nations Committee on Economic, Social, and Cultural Rights and the United Nations Educational, Scientific and Cultural Organization. FP2020 established a common understanding of different rights as they relate to family planning service delivery and decision making. The 10 principles are:

- Agency and Autonomy
- Availability
- Accessibility
- Acceptability
- Quality
- Empowerment
- Equity and Non-Discrimination
- Informed Choice
- Transparency and Accountability
- Voice and Participation

[2] http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/08/FP2020_Statement_of_Principles_11x17_EN_092215.pdf

Further Reading

Handout 2-K

Essential Skills and Needs of All SRH Staff to Improve Client-Provider Interaction and Counseling

Few SRH programs can afford to pay staff whose only responsibility is to be a counselor. Further, few sites have private spaces designated only for counseling. Thus, *all* staff need to develop counseling skills and approaches to incorporate into *all* of their interactions with clients, always respecting physical and auditory privacy and including the following essentials:

- Compassion
- Common sense
- Communication skills
- Comprehensive, understandable information

Addressing Staff Needs to Improve Client-Provider Interaction and Counseling

Most interventions aimed at improving the quality of client-provider interactions and counseling focus on training, yet training is only one of the prerequisites for excellence in staff performance. All of the healthcare staff needs[3] listed below are important for improving the quality of client-provider interaction and counseling.

Facilitative supervision and management. Healthcare staff function best in a supportive work environment with facilitative management and supervision to motivate and enable them to perform their tasks well and better meet the needs of their clients.

Information, training, and development. For a facility to provide quality health services, staff must possess and continuously acquire improved knowledge, skills, and attitudes that support the provision of the best pregnancy prevention and overall health services possible.

Supplies, equipment, and infrastructure. In order for healthcare staff to provide quality services, they need reliable and sufficient supplies, functioning equipment, and adequate infrastructure.

[3] Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129-139.

Session 3:
Decision Making From the Client's Perspective

Handout 3-G

Session 3 Learning Objectives and Essential Ideas

Learning Objectives

By the end of the session, you will be able to:

- Explain why empathy is important in client-centered counseling
- Explain why it is important to understand the different categories of clients for client-centered counseling
- Explore the factors that influence decision making about pregnancy prevention through participants' own life experiences
- Describe the gender-sensitive approach to sexual and reproductive health (SRH) service delivery
- Identify potential needs and concerns of clients by applying your understanding of the client categories, factors influencing decision making, and the impact of gender

Essential Ideas—Session 3

Building on the Essential Ideas from the Pretraining Handouts, Session 3

- Feeling and showing empathy is the basis for understanding the client's needs. It is important for building rapport with the client and addressing the client's emotional support needs during the decision-making process.
- Every individual has unique needs and preferences concerning pregnancy prevention. However, specific categories of clients often have similar needs and concerns, which may be quite different from other categories of clients. Knowing these categories can help providers identify the individual's needs more quickly.
- Regardless of which category a client fits into, client-centered counseling considers each individual's unique situation, including their medical history, their condition, and the personal and social factors affecting their life.
- Gender is an aspect of each individual's experience that has an impact on the social factors affecting decision making. However, the impact of gender varies widely by individual and culture. Other factors (such as economic power) may also influence the decision making within a relationship or family.
- Once we are aware of the impact of gender on pregnancy prevention decision making for an individual, we can be sensitive to it and offer counseling that addresses gender inequities. We do this by providing adequate information, facilitating access to services, and ensuring voluntary choice, regardless of the client's gender.
- Focusing on the client's perspective is the core of client-centered counseling. The use of client profiles will help the participants practice focusing on the issues and specific needs, conditions, and concerns affecting various types of clients.

Handout 3-H

The Possible Impact of Gender on Clients' Decision Making about Pregnancy Prevention

(page 1 of 2)

Individual Factors

- The client's age: It is more acceptable for young men to be having sex than young women. It is easier for young men to buy condoms than it is for young women to buy condoms or to acquire other contraceptive methods.
- The client's age: Women may feel embarrassed going to an SRH clinic if they are old enough for their children to be having children. However, they may be sexually active and need protection from sexually transmitted infections (STIs) including HIV, if not also for pregnancy prevention.
- Desired family size: Couples may want to continue having children until they have the desired number of male children.

Intimate Relationships Factors

- Communication between partners about sex may be difficult or non-existent. The norm may be for the woman to take care of all things related to child rearing, including pregnancy prevention. On the other hand, the norm may be that the man is in charge and the woman makes no decisions and has no input in this area.
- Intimate partner violence: If the man is abusive or controlling, the woman may be taking a big risk to try to make any decisions about preventing pregnancy.

Family Factors

- Parents and in-laws can directly influence family size and contraceptive use, and in some contexts, the mother-in-law will even be present with the client in the consultation area. Families in some places also force women and girls into marriages. In these cases, there is little or no decision-making role for the woman.

Community Influences

- Community and social influences often drive individual and family factors for SRH decision making. Different religions may prescribe specific gender roles, particularly regarding sex and child-rearing. Different cultures may have different expectations for family size and the desired gender of children. There may be social pressure on a couple (and particularly the woman) to have a baby soon after marriage to prove the woman's fertility.
- Peer relationships can also play a role in decision making about sex and SRH. Peer pressure may make young men want to prove themselves sexually, sometimes without regard to preventing pregnancy or STIs/HIV and, in some cases, without regard to women's consent. Peer pressure may also make a young woman prefer a contraceptive method that her friends are using.

Handout 3-H

The Possible Impact of Gender on Clients' Decision Making about Pregnancy Prevention

(page 2 of 2)

Societal Influences

- There may be laws or policies that limit a woman's role in decision making about pregnancy prevention, particularly concerning sterilization or abortion.
- Media, entertainment, and advertising often reflect the culture's established gender norms, although they may sometimes challenge these norms, too. These challenges may come from different generations or different subgroups within a community. Either way, these influencers often have powerful messages about the expectations for men and women in terms of appearance, social behavior, and sexual relationships.

Service Factors

- In spite of the general international acceptance of sexual and reproductive rights, there may be service delivery guidelines in a particular country that are based on gender norms.
- More often, gender norms are enforced in the service delivery setting through the expectations and behaviors of service providers. Service providers have grown up with their own family, community, and social influences regarding gender, and they may impose their norms on clients, if they are not aware of the importance of not doing that.
- Information, education, and communication (IEC) materials may also reinforce gender norms of the dominant culture. Visual images of who receives pregnancy prevention services are important gender cues that are often overlooked.

Method Characteristics

- The question of who controls use of a contraceptive method is affected by gender norms. If the man will not cooperate in use of a contraceptive method, the woman needs one that does not require his cooperation—for example, an intrauterine device (IUD) or hormonal contraceptive method.
- If a woman is "not supposed to be" using a contraceptive method, she will need one that she can hide from her partner or her family.
- If a woman is limited in her ability to come to a clinic, she will need a long-acting method that does not require regular resupply.

Other SRH Conditions

- Stigma surrounding HIV infection (and STIs in general) in women may be higher than for men, so women may be less likely to know their status and to seek treatment.
- There may be gender-related differences of opinion related to spacing. Women are more likely to want to wait for a time after a pregnancy (to rest) before conceiving again, while men and mothers-in-law may want another children right away, particularly (in some cultures), if the last child was a girl.

Handout 3-I

The Needs of Different Categories of Clients and the Provider's Role (page 1 of 5)

This chart highlights the special needs of different categories of clients. Note that most clients fit more than one category.

New Versus Returning Clients

Type of Client	Special Information Needs	Special Emotional Support Needs	Provider's Role
New client—no method in mind	Information about appropriate methods	Feeling welcome Encouragement	Explore the client's situation, intentions, and method preference Discuss methods suited to the client's needs
New client—method in mind	Information about chosen method only, if it meets the client's needs	Feeling welcome Encouragement	Explore the client's preference by ensuring that it is well considered Explain why, if the client's preferred method does not meet their needs or is not medically appropriate Check whether the client wants to consider other options Support the client's choice
Returning client—satisfied	None	Appreciation (that they returned as scheduled)	Confirm whether or not the client is using the method correctly Provide services or supplies Ask about changes in circumstances that could affect risk for STI/HIV transmission or the appropriateness of the current method
Returning client—with concerns or problems	Information about: • Side effects and signs of a complication • How to manage the side effect, complication, or problem	Attentiveness to the problem Reassurance Flexibility in addressing the problem	Explore concerns about the method and confirm correct use Explore the client's medical condition and/or check whether the problem is associated with current use of other medications Help manage problems or side effects Assist the client in deciding whether to switch to another method If desired, provide or refer the client for a new method of contraception

Handout 3-I

The Needs of Different Categories of Clients and the Provider's Role (page 2 of 5)

Clients Categorized by Fertility Plans

Type of Client	Special Information Needs	Special Emotional Support Needs for this Group	Provider's Role
Delayer	Information about long-acting methods	None	Explore the client's situation, intentions, and method preference Discuss methods suited to the client's needs
Spacer	Information about temporary methods, including long-acting methods	None	Explore the client's situation, intentions, and method preference Discuss methods suited to the client's needs
Limiter	Information about long-acting and permanent methods	Acceptance as well as support for considering possible regret Reassurance about concerns and doubts	Ensure the client's decision is well considered in terms of permanence and possible regret Discuss methods suited to the client's needs Help the client communicate, discuss, and negotiate with their partner about use of the method
Wanting to conceive	Information about: • How to discontinue the a contraceptive method (if applicable) • Recommended spacing between pregnancies (if applicable) • Preconception care and antenatal care	Reassurance about concerns and doubts about pregnancy, if any	Explore if the client is aware of the recommended spacing between pregnancies (if applicable) Provide information on preconception care and antenatal care

Handout 3-I

The Needs of Different Categories of Clients and the Provider's Role (page 3 of 5)

Clients Categorized by Timing of Last Pregnancy

Type of Client	Special Information Needs	Special Emotional Support Needs for this Group	Provider's Role
Postabortion (or miscarriage)	Information about: • Timing of return of fertility • Methods available for postabortion use	Privacy, respect, and trust Understanding of physical and psychological distress Reassurance about concerns and doubts	Explore underlying reasons for the miscarriage, abortion, or unwanted pregnancy (if applicable) to tailor counseling accordingly Help the client understand immediate return of fertility and consequent need for contraception, if pregnancy is not desired
Postpartum	Information about: • Timing of return of fertility • Issues related to contraceptive use and breastfeeding • Methods available for use in the postpartum period • Effect of contraceptive methods on baby and breastmilk	Understanding of physical and psychological distress Reassurance about concerns and doubts	Help the client understand the relationship between breastfeeding and contraception, including the lactational amenorrhea method (LAM) as a pregnancy prevention option
Interval; or never pregnant	See *Clients Categorized by Reason for Visit*		

Handout 3-I

The Needs of Different Categories of Clients and the Provider's Role (page 4 of 5)

Clients Categorized by Population Group

Type of Client	Special Information Needs	Special Emotional Support Needs for this Group	Provider's Role
Men	Information about: • SRH issues, including contraceptive methods for men and STIs/HIV prevention • The role of men in preventing STIs and planning pregnancy	Feeling welcome Privacy, respect, and trust Encouragement Appreciation	Explore information needs Ensure knowledge of how to use contraceptive methods Affirm appropriate behaviors to prevent STIs/HIV
Unmarried youth	Reliable, factual, and relevant information on SRH, including contraceptive methods and STIs/HIV prevention	Feeling welcome Privacy, respect, and trust Encouragement Appreciation	Serve as a reliable source of information Do not be judgmental Support the client's rights to information and services
Clients with high risk for STIs	Information about: • How contraceptive methods relate to individual risk for contracting STIs • Condoms and dual protection • Risk reduction	Feeling welcome Privacy, respect, and trust Encouragement Appreciation	Help the client weigh options, considering their unique situation Address need for protection against STIs, including dual-method use (or dual protection) as an option
Clients living with HIV	Information about: • How contraceptive methods relate to presence of HIV • Condom use • Risk reduction • Prevention of mother-to-child transmission, if they decide to conceive	Feeling welcome Privacy, respect, and trust Encouragement Appreciation	Make the client feel welcome, despite their HIV status Reassure the client that most contraceptive methods can be used by people living with HIV Help the client weigh options, considering their condition Address the client's need for protection against STIs, including dual-method use (or dual protection) as an option

Handout 3-I

The Needs of Different Categories of Clients and the Provider's Role (page 5 of 5)

Clients Categorized by Population Group and Other SRH Needs

Type of Client	Special Information Needs	Special Emotional Support Needs for this Group	Provider's Role
Clients requesting emergency contraception	Information about: • The limited timeframe for effectiveness of emergency contraceptive pills (ECPs) • The fact that using ECPs does not cause abortion • Where to obtain the ECPs, how to use them, and possible side effects including expected changes in monthly bleeding • Other options, if the ECPs do not work • Pregnancy prevention options to help avoid future need for ECPs, if they do work	Feeling welcome Privacy, respect, and trust Support for carefully considering decision-making options within a limited timeframe for the ECP's effectiveness Reassurance (in case it's too late to use ECPs)	Make the client feel welcome Avoid being judgmental Emphasize the limited time for decision-making, while helping the client carefully consider all options Reassure the client that ECPs do not cause abortion Encourage the client to return for a contraceptive method and STIs/HIV protection after using the ECPs

Session 4:
Provider Beliefs and Attitudes

Handout 4-B

Session 4 Learning Objectives and Essential Ideas

Learning Objectives

By the end of the session, you will be able to:

- Explain the importance of being aware of your own beliefs and attitudes toward issues related to sexual and reproductive health (SRH) so that you can be respectful and nonjudgmental with all clients
- Apply your understanding of that importance to an examination of providers' beliefs and attitudes

Essential Ideas—Session 4

Building on the Essential Ideas from the Pretraining Handouts, Session 4

- *Beliefs* are concepts and ideas that we accept as truths. 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, which are often expressed in our behavior.
- Our beliefs shape our attitudes and thus the way we act toward people and ideas (our behaviors). 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. Attitudes of clients and providers influence every interaction between clients and healthcare staff.
- Everyone has a right to their own *beliefs*. However, as service providers, we have a professional obligation to respect our clients' rights (*attitude*). We show this by providing the highest standard of healthcare to each client—even if they have beliefs that are different from our own—and doing so in a respectful and nonjudgmental manner (*behavior*). 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.

Session 5:
Communication Skills for Counseling

Handout 5-F

Session 5 Learning Objectives and Essential Ideas
(page 1 of 2)

Learning Objectives

By the end of the session, you will be able to:

Nonverbal Communication

- Apply what you have learned about nonverbal behaviors to identify positive and negative nonverbal cues in your own culture
- Practice communicating emotions through tone of voice and body language

Asking Questions

- Apply what you learned about closed and open questions to categorize questions that providers typically ask clients during counseling
- Practice changing closed questions into open questions

Active Listening

- List at least three nonverbal indicators of active listening
- Identify examples of paraphrasing and reflecting in demonstrations by the training team
- Explain which communication purpose(s) were addressed in each example

Essential Ideas—Session 5: Nonverbal Communication

Building on the Essential Ideas from the Pretraining Handouts, Session 5

- Nonverbal communication is what we say through body language and tone of voice.
- Body language can have different meanings in different cultures and in different subgroups (e.g., sex, age, ethnicity) within a culture.
- In counseling and other client-provider interaction, nonverbal communication—what the client observes and senses about the counselor or staff person—may have the greatest impact on what clients hear and perceive. Nonverbal signals or cues can communicate to clients our interest, attention, warmth, and understanding—or the lack of all these things.

Handout 5-F

Session 5 Learning Objectives and Essential Ideas

(page 2 of 2)

Essential Ideas—Session 5: Asking Questions

- Asking questions enables providers to accurately assess a client's pregnancy prevention and other sexual and reproductive health 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 and opinions helps the provider assess and address the client's needs for emotional support as well as their informational and physical needs.
- Two categories of questions can be used to elicit different kinds of answers: *Closed* questions usually elicit one-word or very short responses, such as "yes" or "no." *Open* questions encourage longer, more detailed responses that might include the client's opinion or feelings.
- Both types of questions are important in counseling. However, providers have historically 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 often leads to additional information that will help the provider tailor the counseling session.

Essential Ideas—Session 5: Active Listening

- Active listening is a primary tool for showing respect and establishing rapport with clients. If a provider does not listen well, clients might assume that their situation is not important to the provider, or that they are not important to the provider as individuals. 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 clients' needs and concerns and identifying what the client already know 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. Paraphrasing and reflecting lets the client know that the provider is listening and encourages 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.

Session 6:
Using Simple Language and Visual Aids

Handout 6-B

Session 6 Learning Objectives and Essential Ideas

Learning Objectives

By the end of the session, you will be able to:

- Identify local terms that clients use to describe reproductive anatomy and physiology, as well as sexual practices
- Use simple language and visual aids to explain basic sexual and reproductive health (SRH) terms

Essential Ideas—Session 6

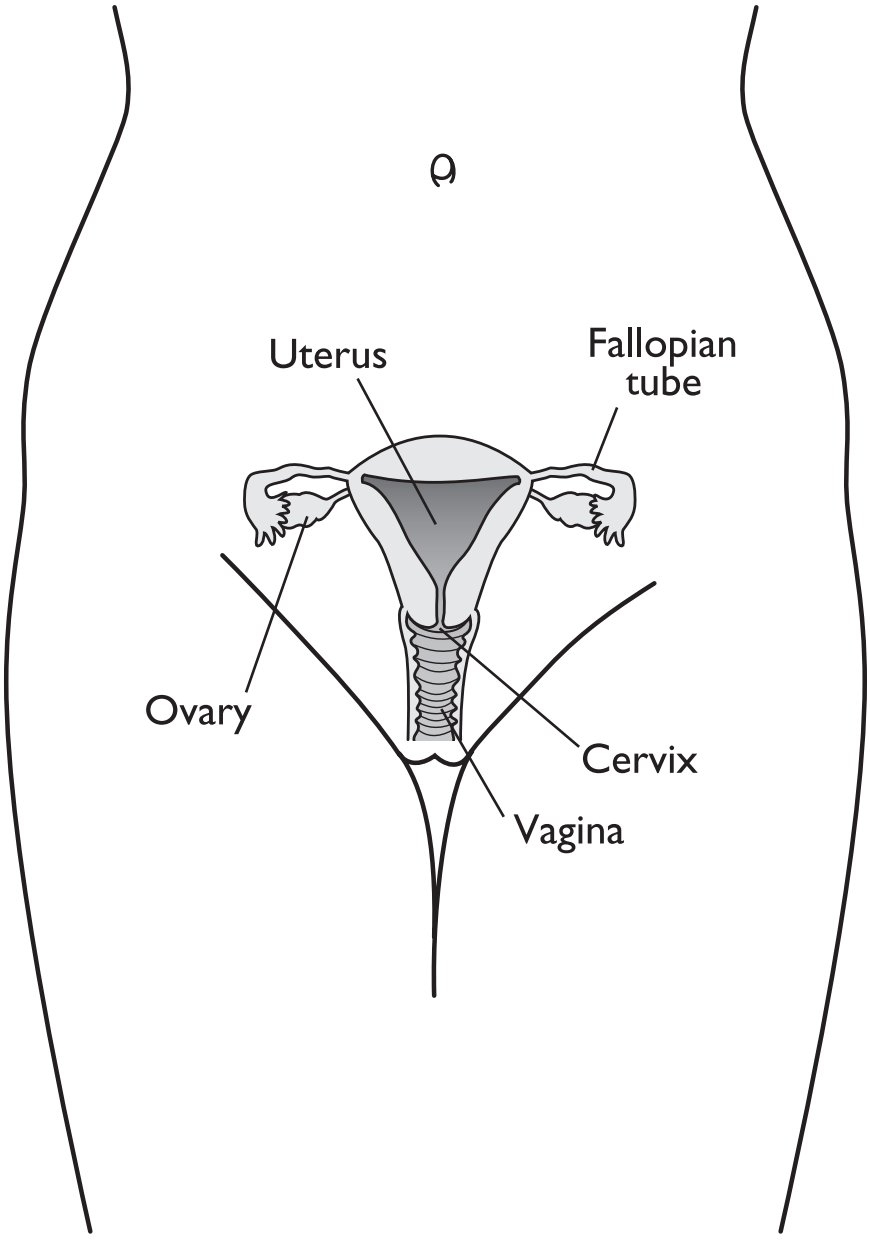
Building on the Essential Ideas from the Pretraining Handouts, Session 6

- For effective communication to occur, providers must explain SRH issues in ways that clients understand.
  - *Asking what the client already knows is essential.* This lets the provider know what type of terminology—i.e., slang, common words, or medical terms—the client will understand.
  - Choosing the correct words to use when discussing pregnancy prevention and other SRH issues can be a challenge for providers. Sometimes the words that providers would normally use are too clinical or might be considered offensive. Providers must become familiar with the words that clients will understand and are comfortable using.
  - Providers should not feel obliged to use words they themselves consider offensive. However, they should be able to identify the words a client uses for particular body parts or sexual activity and explain to the client that when a particular medical term is used, it refers to that.
  - If a provider is comfortable enough to use local colloquialisms, using them may help clients to overcome their embarrassment about discussing these subjects. Helping providers feel more comfortable using colloquial terms and hearing them from clients is an important aspect of this training.
- Having visual aids around the facility can be helpful but by themselves are not enough to provide the necessary education. Use visual aids to help explain contraceptive methods or procedures.
- To be effective, providers must explain visual aids to clients. Find out first what they mean to the client. Build on that information to explain key concepts. After explaining the visual aids, providers should ask questions to check for understanding.

Handout 6-C

Female Reproductive Anatomy Drawing

(page 1 of 2)

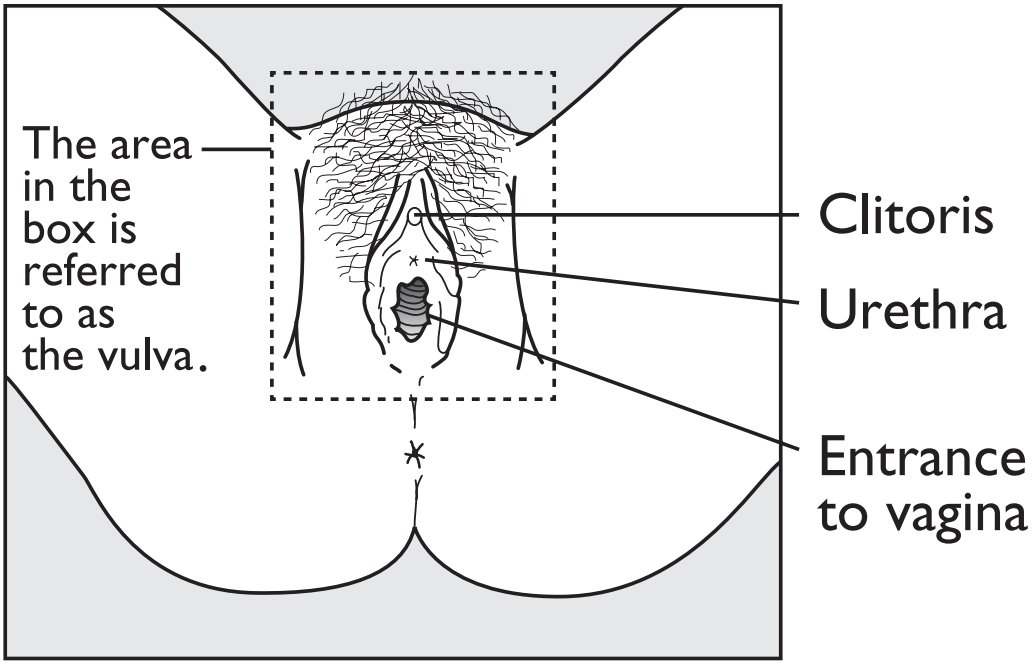


Illustrstion by David Rosenzweig

Handout 6-C

Female Reproductive Anatomy Drawing

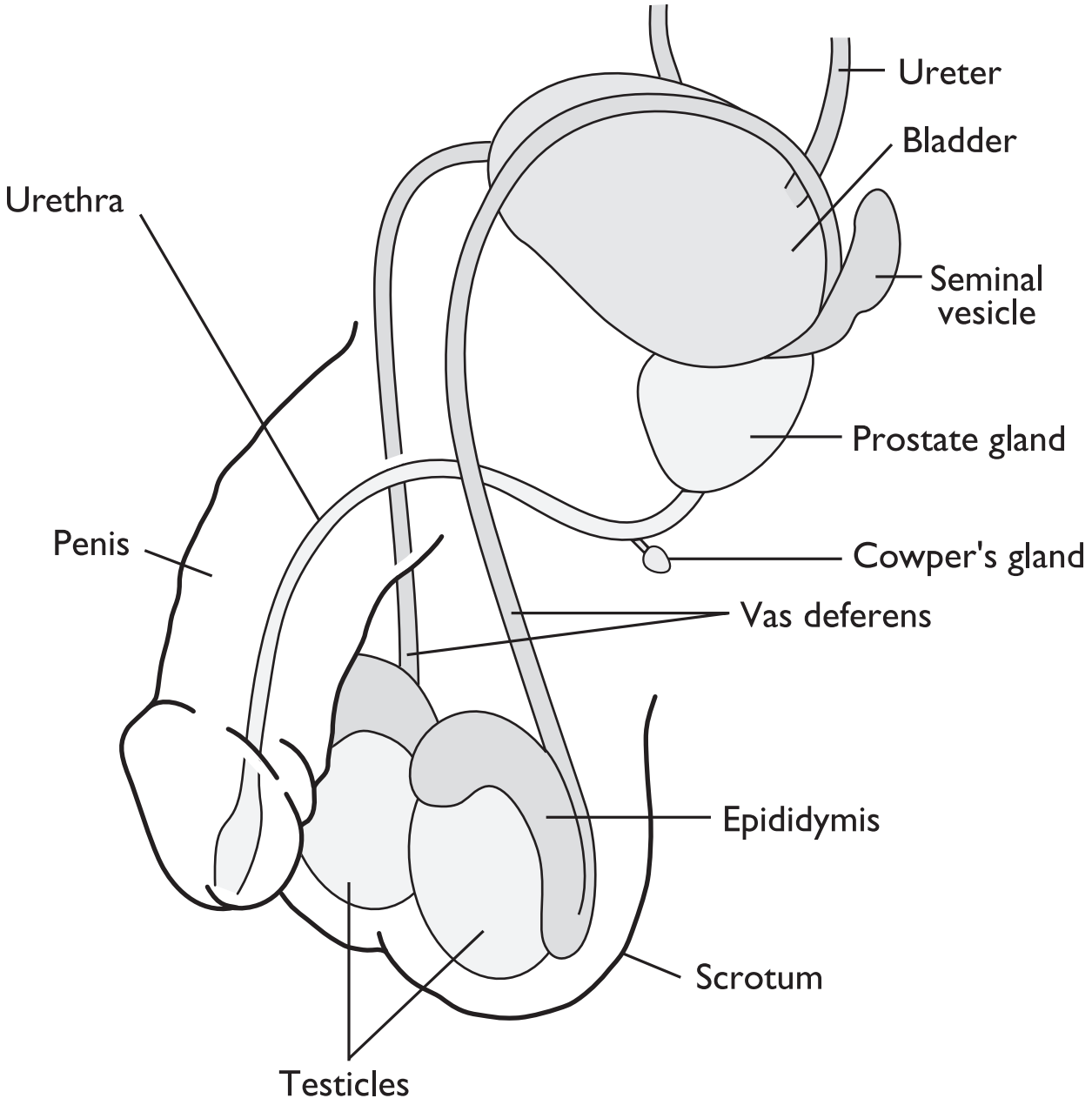
(page 2 of 2)



Illustrstion by David Rosenzweig

Handout 6-D

Male Reproductive Anatomy Drawing



Illustrstion by David Rosenzweig

Further Reading

Handout 6-E

Using Simple Language and Visual Aids During Counseling

- If the provider does *not* find out first what the client already knows, this can lead to three common errors: (1) explaining information at a level beyond the client's comprehension, (2) wasting time explaining what the client already knows (and perhaps insulting and/or frustrating the client in the process), and/or (3) not correcting misinformation.
- Explaining information in simple terms can be a challenge for providers. Even when we feel that we know something very well, it can be hard to find simple ways to explain it. This gets easier with practice.
- The information-giving process in counseling can be extremely efficient if basic information about anatomy and physiology and key medical terms are explained in group education before counseling. Then, during counseling, you can quickly review the information to see what the client did or did not understand and what questions the client still has.
- Talking about sexual body parts and processes makes many people very nervous. Many people show nervousness by laughing. This is normal and good for relieving some of the tension. However, training and counseling must be conducted in a respectful manner. Just as making sexual jokes is not appropriate in the training, likewise it should not be allowed between clients and providers.

Further Reading

Handout 6-F

Female and Male Reproductive Systems

(page 1 of 3)

Female Anatomy and Physiology

Women have two *ovaries*, which produce eggs and female hormones. Female hormones give women their female characteristics (e.g., breasts and the way their voices sound) and their sex drive. One of the ovaries releases one egg once a month; the release of the egg is called *ovulation*.

Each ovary connects to the *uterus* (or womb) by a *fallopian tube*. The ovary releases an egg during ovulation, which travels through one of the fallopian tubes to the uterus.

The *cervix* is the narrow neck of the uterus that connects the uterus with the vagina. The *vagina* is the passage that connects the uterus with the outside of the body.

To start a pregnancy, a man and a woman have sexual intercourse and the man ejaculates in the woman's vagina. The ejaculated *sperm* from the man then travels from the vagina through the cervix and the uterus until it reaches the fallopian tubes. *Fertilization (or conception)* occurs when the man's sperm enters the egg; this usually happens in the fallopian tube. *Pregnancy* occurs when a fertilized egg travels down the fallopian tube and attaches itself to the inside wall of the uterus. This is where the fertilized egg grows into a baby over the course of nine months.

When a woman of reproductive age is not pregnant, her uterus sheds its lining every month, which includes a lot of blood. This is called *menstruation*. Menstrual blood travels from the woman's body through the cervix and then through the vagina. The vagina is also the passage (birth canal) through which a baby passes during delivery. The cervix has to widen to let the baby out. This occurs when a pregnant woman goes into labor.

The *clitoris* is a small bud of tissue and nerve endings covered with a soft fold of skin. It is located above the urinary opening, which is just above the opening to the vagina. The clitoris is very sensitive to touch. During sexual arousal, the clitoris swells and becomes erect. It plays an important role in a woman's sexual pleasure and climax (*orgasm*). The *vulva* is the area around the opening of the vagina, including the folds of skin (*labia*), the clitoris, the urinary opening, and the opening to the vagina itself. Many areas of the vulva are also sensitive to touch and also play a role in female orgasm.

Further Reading

Handout 6-F

Female and Male Reproductive Systems

(page 2 of 3)

Male Anatomy and Physiology

The *testicles* produce sperm and male hormones. Male hormones give men their masculine characteristics (e.g., facial hair and muscles) and sex drive (desire for sexual intercourse).

The *scrotum* is the sack of skin that holds the two testicles.

Sperm are the cells (or "seeds") that enter a woman's egg during fertilization. The testicles produce the sperm, which are then stored in the *epididymis*, a long, curled-up tube above each testicle.

When the man's body is ready to release sperm, the sperm leave the epididymis and travel through the *vas deferens*. The vas deferens loop over the bladder and join the *seminal vesicles*, which are the two pouches located on either side of the prostate gland. One vas deferens leads from each testicle to a seminal vesicle. The seminal vesicles add fluid that energizes the sperm.

The *prostate gland* is located at the base of the bladder. It produces the majority of the fluid that makes up semen. The prostate fluid is alkaline (basic), which protects the sperm from the acidic environment in the woman's vagina.

Semen is the liquid that comes out of the penis when a man climaxes and ejaculates. It contains sperm and fluids from the seminal vesicles and the prostate gland. Sperm make up only a tiny amount of the semen. After a man has a *vasectomy*, semen is still produced, but it no longer contains sperm.

Semen passes from the prostate gland, through the *urethra*, and out through the *penis*. During *sexual intercourse*, the man puts his penis into the woman's vagina and releases semen during *ejaculation*. The urethra is also the tube that carries urine from the bladder when a man urinates. However, when a man ejaculates, a valve at the base of the bladder closes so that no urine is released with the semen.

Cowper's glands are two small glands that release clear fluid into the penis just before ejaculation. Their purpose is to help clean out the acid in the urethra (from urine) before the sperm pass through. This fluid can also contain some sperm or infectious microorganisms. Because the man cannot feel or control this fluid when it comes out, it is important for him to use a condom for all contact between his partner and his penis, if there is any concern about pregnancy or disease.

Adapted from: AVSC International, 1995.

Further Reading

Handout 6-F

Female and Male Reproductive Systems

(page 3 of 3)

Other Reproductive Health Terms[4]

An *abortion* is when a pregnancy is ended prematurely (before survival outside the uterus is possible). Abortions may be spontaneous (i.e., a miscarriage) or induced (when the woman does something or a medical procedure is performed to end the pregnancy).

When a couple has sex but the man or woman (or both) do something to stop the man's sperm from joining the egg, this is known as *contraception*.

Discharge is anything moist that comes from the vagina or penis, not including urine. Different types of discharge throughout the month are normal for women, including blood during a woman's menstruation and a clear, slippery or sticky wetness around the time of ovulation. A change in the character of the discharge, such as a change in the way the discharge looks or smells, might be a sign of an infection. This applies to men and women. The discharge might become white, yellow, or slightly greenish; it might smell like yeast or cheese. When men or women experience abnormal discharge, they need to know that they should see a service provider and that treatment might be necessary.

In countries where *female genital cutting* (also referred to as *female genital mutilation* or *female circumcision*) is practiced, either the clitoris alone or the clitoris and the labia are removed. Some types of cutting also involve sewing the labia together.* Female genital cutting is a harmful practice that can lead to serious complications, including difficulty during childbirth.

The *genitals* are the external sexual organs, usually considered to include the penis, scrotum, vagina, labia, and clitoris.

A *miscarriage* occurs when a woman is pregnant but the lining of the womb comes out, along with the developing fetus before it is old enough to survive outside the womb. This ends the pregnancy.

Sexually transmitted infections (STIs) are infections that are passed from person to person, primarily by sexual contact. They are also known as *sexually transmitted diseases (STDs)* or *venereal disease (VD)*. Some STIs can be passed to a baby during pregnancy, delivery, or breastfeeding. Other STIs can be passed through unclean surgical instruments, injection needles, and skin-cutting tools, as well as through blood transfusions.

Adapted from: AVSC International, 1995. *Family planning counseling: A curriculum prototype*. New York.

[4] Arkutu, A.A. 1995. *Healthy women, healthy mothers: An information guide*. 2nd Edition. New York: Family Care International.

Session 7:
R = Rapport Building

Handout 7-C

Session 7 Learning Objectives and Essential Ideas

Learning Objectives

By the end of the session, you will be able to:

- Describe in detail the steps of Phase 1: Rapport Building
- Explain the importance of showing respect for clients
- Describe at least two ways to show respect for clients
- Explain how praise and encouragement can help build rapport between provider and client
- Explain how the Rapport Building phase of REDI supports sexual and reproductive health (SRH) and clients' rights

Essential Ideas—Session 7

Building on the Essential Ideas from the Pretraining Handouts, Session 7

Overview of REDI

- REDI stands for Rapport Building, Exploring, Decision Making, and Implementing the Decision.
- As a framework for counseling, REDI provides structure and guidance for talking with clients.
- Frameworks are useful but focusing on the client is the most important part of counseling—*not* following a script.

R = Rapport Building

- To *build rapport* means to establish a harmonious relationship, with good communication and an understanding of each other's ideas and feelings.
- *Respect* means valuing the person as an individual. This may manifest differently in different cultures.
- Giving genuine *praise* and *encouragement* to clients will show them that you respect their efforts to deal with their health problems, no matter how misguided or uninformed you think those efforts may be.
- The Rapport Building phase of REDI is essential to supporting three of the seven client's rights: (1) privacy and confidentiality; (2) dignity, comfort, and expression of opinion; and (3) access to services, without social barriers or discrimination.
- By establishing a trusting relationship with the client, the provider sets the stage for open and honest sharing about the client's needs and preferences in the following phases, which is the foundation for helping the client to make full, free, and informed SRH decisions.

Handout 7-D

Showing Respect

We show respect differently in different cultures and different settings. Here are some ideas for how to show respect for clients in the healthcare setting. Some of these may not be acceptable in your setting. Think about what *would* be acceptable.

Showing Respect to Clients

- Smile
- Stand up to greet the client
- Say "hello" and/or "welcome"
- Shake hands
- Invite the client to sit
- Introduce yourself
- Address the client by name
- Maintain eye contact (if culturally appropriate)

Handout 7-E

Praise and Encouragement

Praise

Praise is the expression of approval or admiration. Praising reinforces good behavior by identifying and supporting the good things a client has done. For example, praising clients:

- Shows that you respect their concerns for their health
- Acknowledges difficulties they might have overcome to come to the healthcare facility
- Expresses approval for positive choices and actions

Encouragement

Encouragement means giving support, courage, confidence, and hope. In the healthcare setting, giving encouragement means letting clients know that you believe they can overcome their problems and helping them find ways to do so. For example, encouraging clients:

- Highlights hopeful possibilities
- Focuses on what they have done well and urges them to continue
- Tells them that they are already helping themselves by coming to the health facility

Client's Situation and Statement	Provider's Response
Woman who comes late for an injection of Depo-Provera: "I wanted to come for my injection before now, but I could not find anyone to look after my children."	"I know that can be difficult. It sounds like you are a caring mother."
Woman who comes to the healthcare facility with a side effect: "I hope you can help me, my mother-in-law did not think it was necessary for me to come."	"It must have been difficult for you to decide to come to the clinic. It is good that you came now. Let's see what we can do to help you."
Parent of an adolescent: "My teenage daughter has been sleeping with her boyfriend because of pills she got from this health center!"	"I can understand your concern, and I'm glad you came to discuss this."
Adolescent: "I've been using the pill, but I forgot a couple and now my period is late."	"You might be worried and it's good that you came to the clinic. I can help you to determine whether you might be pregnant."

Handout 7-F

SRH Rights and Clients' Rights

SRH Rights

Rights related to SRH are recognized by international conventions signed by most countries of the world. These rights include:

- The right to decide on the number, spacing, and timing of children
- The right to have the information to do so
- The right to attain the highest standards of SRH
- The right to make these decisions without discrimination, coercion, or violence

Clients' Rights[1]

All individuals have sexual and reproductive rights. Once an individual decides to become a client, providers have a special responsibility to ensure these rights within the service delivery setting. According to EngenderHealth, every client has the right to:

- Information
- Informed choice
- Access to services
- Safety of services
- Continuity of care
- Dignity, comfort, and expression of opinion
- Privacy and confidentiality

[1] See Pretraining Handout 2-C: Clients' Rights for more details on each right.

Handout 7-G

Comparison of Counseling Frameworks

Here is a comparison of four different counseling frameworks for contraceptive services:

- REDI (EngenderHealth)
- The four steps of counseling from the Training Resource Package (TRP) for Family Planning (Johns Hopkins University, United States Agency for International Development, World Health Organization, United Nations Population Fund)[2]
- GATHER (now part of the Health Education and Training Project of The Open University)[3]
- The Balanced Counseling Strategy (BCS) and BCS+ (Population Council, from the *K4Health* website)[4]

REDI	TRP	GATHER	BCS/BCS+
Rapport Building	1. Establish rapport and assess needs and concerns	Greet Ask	Pre-Choice Stage
Exploring	2. Provide information to address needs and concerns	Tell	Method Choice Stage
Decision Makingg	3. Help client make informed decision or address a problem	Help	
Implementing the Decision	4. Help carry out client's decision	Explain Return	Post-Choice Stage
			BCS+
			All of the above, as well as: STI/HIV Prevention, Risk Assessment, and Counseling and Testing Stage

[2] https://www.fptraining.org/projects/family-planning-counseling
[3] http://www.open.edu/openlearnworks/mod/oucontent/view.php?id=138&printable=1
[4] https://www.k4health.org/sites/default/files/Users%20Guide%2B_0.pdf

Session 8:
E = Exploring—Steps 1-3

Handout 8-K

Session 8 Learning Objectives and Essential Ideas
(page 1 of 4)

Learning Objectives

By the end of the session, you will be able to:

Exploring—Step 1. Reason for the Visit (In Detail)

- Describe how to explore (in detail) the reason for the client's visit

Exploring—Step 2. Individual Factors: Explore the Client's Sexual and Reproductive Health (SRH) History and Pregnancy Prevention Goals

- Name the four sub-steps for exploring individual factors influencing the client's decision-making for pregnancy prevention

Exploring—Step 3. Other Key Factors: 3-A (Sexual Relationships) and 3-B (Social and Gender Context)

- List two reasons why questions about sexual relationships may need to be discussed in counseling
- Explain why it is important for you to be aware of your own attitudes about sexual practices, in order to be nonjudgmental when counseling clients
- Explain why it is important to address clients' social and gender contexts when assisting them to make decisions about pregnancy prevention

Exploring—Step 3. Other Key Factors: 3-C (Risk Assessment)

- Apply your knowledge of risk assessment for pregnancy, HIV, and other sexually transmitted infections (STIs) to client case scenarios
- Explain how particular sexual practices can be high-risk in one situation and low-risk in another
- Explain, in simple terms, which practices (sexual and otherwise) put people at risk for pregnancy, HIV, and other STIs

Exploring—Step 3. Other Key Factors: How to Ask Sensitive Questions

- Describe a strategy to introduce questions about sexual relationships during counseling
- List three questions that you can ask to learn about clients' sexual relationships, in terms of decision making about STI and pregnancy prevention
- List three questions you can ask to help clients consider the social and gender contexts of their decision making about pregnancy prevention
- Describe a strategy to help clients consider their own risk of STI/HIV

Handout 8-K

Session 8 Learning Objectives and Essential Ideas
(page 2 of 4)

Essential Ideas—Session 8

Building on Essential Ideas from the Pretraining Handouts, Session 8

Steps 1 (Reason for the Visit) and 2 (Individual Factors)

- The first step of Exploring is to explore, in detail, *the client's reason for the visit*. 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 to avoid wasting time addressing issues that the client does not need to discuss at this time.
- The second step is to consider the *individual factors* of the client's reproductive history, pregnancy prevention goals, and current SRH condition. This provides background information that will be crucial in helping the client make decisions about pregnancy and STI/HIV prevention that will meet the client's needs. This step has four sub-steps:
  - 2-A. Explore the client's reproductive history (including recent pregnancy) and pregnancy prevention goals
  - 2-B. Rule out pregnancy now
  - 2-C. Explore factors related to monthly bleeding
  - 2-D. Explore the client's signs and history of STIs, including HIV
- Although REDI is a flexible framework, we recommend gathering this information from the client *before* starting the next step of exploring sexual relationships, STI/HIV risk, and social and gender contexts. This information will help to guide that exploration into more sensitive and emotional areas of counseling.

Steps 3-A (Sexual Relationships) and 3-B (Social and Gender Contexts)

- In counseling, the aspect of sexuality that we focus on is sexual health. We help clients consider the impact of their sexual relationships on their choice of contraceptive methods and means of preventing STI/HIV.
- Considering the social context of decisions is an important part of helping clients to make well-considered, voluntary decisions. Social context encompasses the people (partners, family members, and friends) and the factors that influence a client's decisions—including the client's power to make their own decisions about sexual intercourse and reproduction.
- Other factors that affect decision-making capabilities include the client's socioeconomic situation, particularly regarding the cost of contraception, and cultural and religious expectations and pressures.
- 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 aware of:

Handout 8-K

Session 8 Learning Objectives and Essential Ideas

(page 3 of 4)

Steps 3-A (Sexual Relationships) and 3-B (Social and Gender Contexts)

- Gender roles
- Gender preferences regarding children
- Gender power imbalances in the client's relationship(s) that may affect decision-making
- Gender power imbalances between provider and client

- People use contraception because they are sexually active or plan to be, and they do not want to become pregnant. Clients' choice of, use of, and satisfaction with contraceptive methods are often related to the real or perceived effect of contraceptives on their sexual practices. Sexual practices also affect the client's risk of STIs. Thus, although providers rarely ask clients directly about specific sexual practices, it is necessary for providers to be able to discuss sexual practices in counselling, when needed.
- The provider should not question or judge sexual practices that are personally unacceptable to the provider. Rather, the provider should recognize that such practices exist and help clients consider those practices when they are making decisions about pregnancy prevention and STI prevention.

Step 3-C (Risk of STI/HIV)

- Sexual relationships and practices affect one's individual risk for contracting HIV and other STIs. We include a risk assessment in counseling to help clients consider their risk for STI/HIV transmission when choosing a contraceptive method and to help them avoid risky behaviors.
- Sexual practices that are low-risk for STI/HIV in one relationship may be high-risk in another, depending on factors such as the partner's sexual history, the client's (and the client's partner's) sexual relationships with other people, and the client's and partner's infection status.
- Because the concept of risk is confusing, it is especially important to use simple and clear explanations during counseling to help clients better understand the distinct risks associated with pregnancy and STI/HIV transmission. Here are some examples:
  - *Risk for pregnancy:* Any behavior that allows the man's semen to enter the woman's vagina
  - *Risk for STI transmission:* Any behavior (not just sexual) that allows contact with the infected area of another person
  - *Risk for HIV transmission:* Any behavior (such as sexual contact or blood contact) that exposes one person to the body fluids (including blood, semen, vaginal fluid) of an infected person

Handout 8-K

Session 8 Learning Objectives and Essential Ideas
(page 4 of 4)

Step 3. How to Ask Sensitive Questions

- Sexual relationships should never be the first thing that a provider discusses with a client.
- When initiating a discussion about sexual relationships, the provider should:
  - Explain the reasons for asking questions about sexual relationships
  - Explain that this topic is discussed with all clients
  - Explain that what is shared is confidential and assure the client of privacy
  - Explain that the client does not have to answer questions if they do not wish to

Handout 8-L

Pregnancy Checklist

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions.

NO	1.	Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	2.	Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3.	Have you had a baby in the last 4 weeks?	YES
NO	4.	Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	5.	Have you had a miscarriage or abortion in the past 7 days?	YES
NO	6.	Have you been using a reliable contraceptive method consistently and correctly?	YES

If the client answered **NO** to ***all of the questions,*** pregnancy cannot be ruled out. Client should await menses or use a pregnancy test.

If the client answered **YES** to ***at least one of questions*** and she is free of signs or symptoms of pregnancy, provide client with desired method.

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Handout 8-M

How Do We Use the Risk Assessment in REDI?

The risk assessment is used in different ways in the different phases of REDI.

Exploring

We learn about clients' relationships, sexual behaviors, and other factors that might put them at risk. We provide information that clients need to make decisions about reducing their risks.

Decision Making

We help clients choose behaviors, contraceptive methods, and medical treatments that will reduce their risks.

Implementing the Decision

We help clients plan for how they will change behaviors, how they will communicate with their partners, how they will cope with any problems or challenges that they might encounter, and how they will deal with related life and lifestyle changes.

Handout 8-N

Risk Assessment of Case Scenarios

For each case scenario, write the risk level (*high, medium, low,* or *no risk*) for the underlined person/persons in the box under each condition (*pregnancy, STI, HIV*).

Case Scenario	*What is the risk of…?*		
	Pregnancy	**STI**	**HIV**
1. Monogamous couple using withdrawal method			
2. A 40-year-old sterilized man with multiple female partners (some of whom are sex workers)			
3. A 36-year-old sterilized woman with two children who occasionally has sex with men other than her husband			
4. A woman aged 24 years, with husband aged 30 years old, and one child aged 18 months; couple has been practicing withdrawal but now want an intrauterine device (IUD); the husband's ex-girlfriend before marriage was diagnosed to be HIV-positive			
5. A young married couple that practices various sexual behaviors; the wife complains of stomach cramps and itching in the genital area wants to change from IUD to implants; they do not want to have children for another 2 years			
6. A 34-year-old man whose wife uses an IUD; the man is sexually active with his wife and also has a male sexual partner			
7. A 26-year-old woman, with one child aged 2 years, who is using injectables; husband occasionally wants anal sex as a variation			

Handout 8-O

Sexual Practices and Risk Levels

	No Risk	Low Risk	Medium Risk	High Risk
Pregnancy	• Abstinence • Anal sex using a condom • Anal sex without using a condom • Deep (tongue) kissing • Masturbation • Oral sex on a man • Oral sex on a woman	• Rubbing genitals together without penetration, unclothed • Vaginal sex with a single partner, always using a condom • Vaginal sex with multiple partners, always using a condom	• Not applicable	• Unprotected vaginal sex with a monogamous, uninfected partner • Unprotected vaginal sex with any partner
HIV	• Abstinence • Masturbation • Sitting on a public toilet seat (provided there is no exchange of body fluids) • Unprotected vaginal sex with a monogamous, uninfected partner	• Anal sex using a condom (more risky than vaginal sex with a condom) • Deep (tongue) kissing • Rubbing genitals together without penetration, unclothed • Vaginal sex with a single partner, using a condom • Vaginal sex with multiple partners, always using a condom	• Oral sex on a man • Oral sex on a woman	• Anal sex without using a condom • Unprotected vaginal sex with any partner whose HIV status and/or number of other partners is unknown
Other STIs	• Abstinence • Masturbation • Sitting on a public toilet seat (provided there is no exchange of body fluids) • Unprotected vaginal sex with a monogamous, uninfected partner	• Deep (tongue) kissing • Vaginal sex with a single partner, always using a condom • Vaginal sex with multiple partners, always using a condom	• Anal sex using a condom	• Anal sex without using a condom • Oral sex on a man (less risky than anal or vaginal sex) • Oral sex on a woman (less risky than anal or vaginal sex) • Rubbing genitals together without penetration, unclothed • Unprotected vaginal sex with any partner

Note: This continuum can change based on social and individual factors, such as involvement with other partners (HIV and STI risk) or whether the woman is in her fertile time (for pregnancy risk).

Handout 8-P

Simple Explanations of Risk

Provide a Simple Explanation of Risk

Because the concept of risk is confusing, it is important to use simple and clear explanations to help clients better understand the distinct risks associated with pregnancy and STIs/HIV. Here are some examples:

- **Risk for pregnancy:** Any behavior that allows the man's semen to enter the woman's vagina
- **Risk for STI:** Any behavior (not just sexual) that allows skin-to-skin contact with the infected area of another person
- **Risk for HIV:** Any behavior (such as sexual contact, blood contact, and mother-child contact) that exposes one person to the body fluids (including blood, breastmilk, semen, or vaginal fluid) of an infected person

Other Factors

The risk of pregnancy and transmission of HIV and other STIs depends on the client's sexual practices with their partner(s) *and* on other factors such as:

- The sexual history of the client's partner
- The client's sexual relationships with other people
- The infection status of the client and their partner

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, they might not be able to negotiate risk reduction with the partner, for pregnancy or STIs.
- The "receiver" in vaginal and anal sex is usually at higher risk for STIs than the "giver." The partner who performs oral sex is at higher risk than the partner who receives it.

Handout 8-Q

Introducing the Subject of Sexual Relationships in Counseling[5] (page 1 of 2)

Introducing the Subject of Sexual Relationships

When counseling clients, providers often need to ask very personal and sensitive questions. This can be challenging for the client, who may not be accustomed to discussing personal issues with someone who is not a family member, or with anyone at all. It can also be challenging for providers, because they too might not be accustomed to discussing such issues and may fear embarrassing themselves and the client.

Sexual relationships should never be the first thing a provider addresses with the client. It is best to start with general, open-ended questions to establish rapport and start the conversation. Specifically, the provider should ask open-ended questions to determine the client's reason for the visit, understand their general health, and identify their particular concerns. This will help set the tone for the sensitive questions that the provider will need to ask later.

It is important to explain to clients why providers need to ask personal and sensitive questions and to help them feel more at ease when answering. The provider and the client may never be totally comfortable with these discussions, but it is important to get key information about behaviors and relationships that might put the client at risk for unintended pregnancy, STIs, and other SRH problems or that might affect the client's choice of a contraceptive method. The provider's own comfort and confidence in asking such questions will help the client feel comfortable.

On the next page, we provide sample statements for these *four important points* to explain to the client:

1. *Explain the reasons* for asking such questions
2. Assure the client that providers *discuss this topic with all clients*
3. Note that what is shared in counseling is *confidential*, and assure the client that providers will safeguard their privacy
4. Explain that *the client does not have to answer questions* they do not want to answer

[5] EngenderHealth. 2003. *Comprehensive counseling for reproductive health*. New York.

Handout 8-Q

Introducing the Subject of Sexual Relationships in Counseling (page 2 of 2)

Sample Statements for Introducing Sexual Relationships

These sample statements are merely a guide for providers. *Providers should introduce the discussion in their own way*, depending on what is appropriate for the local culture, the service-delivery setting, the client, and the client's needs.

Points to Explain	Sample Statements
To put the client at ease, remind the client that you explained earlier *why you might need to ask sensitive questions*, including questions about their sexual relationships and practices. Assure the client that the questions relate to potential healthcare options and the decisions made during the visit.	"Remember how I explained earlier that I would need to ask you some personal, sensitive questions about your life? These will be about your sexual life because it affects your health concerns and contraceptive choices. It is important for me to ask you these questions so that I can help you make decisions that are right for you."
Explain that, given the serious nature of HIV and other STIs, *it is the policy of this health facility to discuss STIs and their relevance to choices about contraceptive methods with everyone*. Reassure the client that the questions are routine and that providers ask all clients the same questions.	"As you may know, sexually transmitted infections, or STIS, including HIV, are occurring more and more frequently these days. We discuss this with all our clients because anyone who is at risk of pregnancy may also be at risk of STI/HIV. If it is not relevant to you personally, you might be able to share this information with someone else who needs it."
What is shared in counseling is confidential. Explain your facility's confidentiality policy to the client. The general standard in counseling is that you only share the client's information with other healthcare staff and only when necessary (e.g., for a second opinion from a colleague). *Ensuring privacy* for your conversation is the first step in maintaining confidentiality.	"I want you to know that what you share with me will stay with me only. Nobody will overhear us. If I need to ask another staff member about your problem, I will first ask you whether it is okay to discuss your problem with them. This is our policy."
The client does not have to answer all questions. If the client is not comfortable answering a particular question, they have the right not to answer.	"If there are any particular questions you do not feel comfortable answering, feel free to let me know. You do not have to answer all questions if you do not want to."

Handout 8-R

Sample Questions to Explore Clients' Sexual Relationships, Decision Making, and Risk of STI/HIV (page 1 of 3)

Points from the REDI Framework	Sample Questions to Ask Your Client
Introduction • Reasons for asking sensitive questions • Discussed with all clients • Confidentiality • Client does not have to answer	See Handout 8-Q.
Step 3-A: Sexual Relationships • The client's sexual relationships • The nature of those relationships	*Note: Confirm marital status before asking one of the following sets of questions.* • Are you married or living with someone? *If married or living with someone, ask:* • How long have you been married or living with this person? • Do you have any other partners? *If not married or living with someone, ask:* • Are you in a relationship with somebody now that involves sex (or will involve sex)? • How long have you been with this person? • Do you have any other partners? *For those in any intimate relationship, ask:* • Overall, how do you feel about your relationship(s)? • How do you feel about how your partner(s) treat you? • Do you ever feel your partner(s) try to control you? • Do you ever feel threatened or afraid of your partner(s)?

Handout 8-R

Sample Questions to Explore Clients' Sexual Relationships, Decision Making, and Risk of STI/HIV (page 2 of 3)

Points from the REDI Framework	Sample Questions to Ask Your Client
Step 3-A: Communication with Partner • How the client communicates with their partner(s) about pregnancy prevention and SRH issues *Note: Ask each question for all partners, if the client has more than one partner.*	• How do you talk about pregnancy prevention with your partner? (*Probe: Who starts these conversations? Do you usually agree on pregnancy prevention?*) • If you do not discuss this, why not? • How do you talk about sex with your partner? (*Probe: Who starts these conversations? Do you usually agree about sex including when and how to have it?*) • If you do not discuss this, why not? • How do you talk about HIV and other STIs with your partner? • If you do not discuss this, why not? • Does your partner support you in using contraception? • *If the answer is "no,"* does this mean you want to conceal the contraceptive method from your partner? • What is your partner's attitude about whose responsibility it is? • Is your partner willing to use a contraceptive method/a condom? • Does your partner have preferences or concerns regarding specific methods?
Step 3-B. Social Context for Decision Making • The partner's role in pregnancy prevention and SRH decision making • Other people involved in the client's pregnancy prevention and SRH decision making • Other factors that could influence the client's pregnancy prevention and SRH decision making	*For those in any intimate relationship, ask:* • What decisions can you make in your relationship? • Who generally makes important decisions in your household? • How do you make decisions about pregnancy prevention? Is anyone else involved in your decision making? What is your partner's role in decision making about pregnancy prevention? • Who influences your decisions about how many children to have and when to have them? How do they do that? • Are there any other factors we have not yet discussed that would affect your decisions about family size and contraception?

Handout 8-R

Sample Questions to Explore Clients' Sexual Relationships, Decision Making, and Risk of STI/HIV (page 3 of 3)

Points from the REDI Framework	Sample Questions to Ask Your Client
Step 3-C. Risk of STI/HIV • Explore what the client knows about STI/HIV • Address knowledge gaps (tailor information) • See if the client thinks they or their partner(s) is/are at risk of contracting STI or HIV	Before we talk about contraceptive options, we like to talk with each client about their risk of contracting an STI or HIV. • What do you know about signs of STIs? *If nothing, then briefly explain.* • Have you ever noticed anything like these signs in your partner(s)? What about you? • What do you know about how STIs are contracted/transmitted? *If nothing, then briefly explain.* • How likely do you think it is for you or your partner to contract an STI or HIV? Why do you think that? • Do you know if your partner(s) has/have any other sexual relationships? If yes, probe: ◦ What do you know about your partner's/partners' other sexual relationships? ◦ How do you feel about that? ◦ Have you ever spoken to your partner(s) about their other partners? ◦ Do you know if your partner(s) uses/use condoms with other partners? Have you asked your partner(s) to do so?
Other • Questions, concerns, or problems the client has about sexual relationships and/or practices	Is there anything else about your sexual relationships, practices, or decision making that you want to ask about or discuss?

Session 9:
E = Exploring—Step 4

Handout 9-J

Session 9 Learning Objectives and Essential Ideas
(page 1 of 2)

Learning Objectives

By the end of the session, you will be able to:

- Describe in detail the subtasks of REDI, Phase 2: Exploring—Step 4
- Explain how to assess clients' information needs (what topics to cover and in how much depth)
- Identify common misconceptions about contraceptive methods
- Demonstrate how to address some of those misconceptions
- Explain basic principles of information-giving and key areas of information to cover
- Describe principles of talking to clients about side effects, health risks, and complications
- List three ways of achieving dual protection
- Explain how the Exploring phase of REDI supports sexual and reproductive health (SRH) and clients' rights
- Practice Rapport Building and Exploring through role-play exercises with client profiles

Essential Ideas—Session 9

Building on Essential Ideas from the Pretraining Handouts, Session 9

- The fourth step in Exploring is to "Explain pregnancy prevention and other SRH options—focusing on the method(s) of interest to the client." The sub-steps are:
  - Review healthy timing and spacing of pregnancies (HTSP) (if needed)
  - For contraceptive methods:
    - Find out what the client already knows
    - Correct misconceptions (if any)
    - Provide more information (as needed)
  - Show method samples, provide brochures, ask what questions the client has
- Clients need to know that they have options in their choice of a contraceptive method and what those options are. However, not *all* clients need comprehensive information about *all* methods. That is why the client-centered approach to counseling involves *tailoring* the amount and scope of information to the client's interests and needs. The provider should also *personalize* the information, which means providing the customized information in terms of what it means for the client. Steps 1-3 in Exploring will enable the provider to tailor and personalize information-giving in Step 4.

Handout 9-J

Session 9 Learning Objectives and Essential Ideas
(page 2 of 2)

Essential Ideas—Session 9

- There are limits to the amount of information people can understand and retain—this is a major reason why counseling should not cover *all* details related to *every* method available. The information imparted to clients should be brief and nontechnical and supported by visual aids and method samples.
- The key to assessing clients' information needs is to *ask what they already know*. This allows the provider to identify gaps in knowledge and misconceptions, and to save time by *not* repeating information that the client already understands.
- Responding to common rumors and misconceptions is necessary to address knowledge gaps. Providers should be respectful and accurate in addressing misconceptions. Respect is an important aspect, as it will help to maintain the trust built between the provider and the client.
- Providing information that is *tailored* and *personalized* to the client's needs is a key feature of client-centered counseling. It is more effective for meeting clients' needs and saving time versus repeating the same information to every client, whether it is appropriate or needed.
- Providing information about possible side effects is important. It enables the client to make an informed choice and to be prepared to cope with side effects, if they occur. There is a more detailed discussion regarding side effects in the Decision Making phase.
- Considering possible health risks and complications is also important for informed choice; however, these topics are usually introduced in the Decision Making phase. Once a client selects a method, providers will need to give information about warning signs of complications and how to respond to such signs in the Implementing the Decision phase.
- Three ways to achieve dual protection are to:
  - Use a condom alone
  - Use a condom with another contraceptive method (dual method use)
  - Avoid risky behaviors
- The Exploring phase of REDI supports the client's SRH rights by helping the clients understand their personal risks for unintended pregnancy and for contracting a sexually transmitted infection (STI), including HIV. The provider then offers accurate and understandable information about the full range of options available to the client for pregnancy prevention and reducing risk of contracting an STI/HIV (including information on side effects). This addresses the "full" and "informed" aspects of full, free, and informed choice.

Handout 9-K

Principles of Giving Information: Summary

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 that need to be addressed or misconceptions that need to be corrected

Personalize information for the client:

- Provide information that responds to the client's situation
- Help the client understand what the new information means to them personally (e.g., what would it require or mean to start a new method, to cope with side effects, to discontinue, or to switch to another method)

Make information understandable for the client:

- Use language the client can understand
- Speak clearly
- Use visual aids

Put risks into perspective:

- For example, the risks associated with carrying a pregnancy to term are much higher than risks associated with using a contraceptive method

Further Reading

Handout 9-L

Dealing with Rumors in the Community

- Find a credible, respected person (such as a community leader or satisfied user) who can tell people the truth and counter the rumor. Meet with that person, explain the situation/rumor, provide correct information, and seek their help in ensuring that community members receive the correct information.
- Try to determine why the rumor started. If there was a method-related complication that led to serious illness or death, it might be necessary to provide accurate and understandable information to the public to counter the rumors and fears that resulted.
- If rumors appear in the media, your facility director might wish to act at the institutional level.
- Encourage people to check first with service providers before they repeat rumors. Make use of outreach workers, if they are available locally, to detect and correct rumors.

Further Reading

Handout 9-M

Using REDI to Give Key Information on Contraceptive Methods (page 1 of 5)

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 that will help them compare and eliminate undesirable contraceptive methods in order to select the method that best meets their needs. This information includes: what the method is, its effectiveness, expected side effects, possible health risks and complications, health benefits, how it is used and obtained, when the client should return for follow-up, and whether it offers protection from HIV and other STIs.

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 a number of methods. A client desiring permanent contraception can easily eliminate temporary methods, and some clients might eliminate hormonal methods immediately, if 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 the provider and the client eliminate methods that are irrelevant for the client.

Before the *Decision Making* phase of REDI, clients will have narrowed their choices to one or two methods. Then, before they make their decision, they will need more detailed information on those methods in order to compare them to each other and determine their suitability for their personal circumstances. At this point, the provider should help the client consider the consequences of each option (see Session 10).

During the last phase of REDI, *Implementing the Decision*, the information clients receive should focus on specifics related to how to use the chosen method, problems or barriers that might arise during use (e.g., side effects), and what the client should do if they occur (see Session 11).

Further Reading

Handout 9-M

Using REDI to Give Key Information on Contraceptive Methods (page 2 of 5)

Key Information for Clients Choosing a Contraceptive Method[1]

Effectiveness. Providers should explain effectiveness in easily understood terms. Providers must emphasize that client-controlled methods (e.g., barrier methods, natural family planning, the lactational amenorrhea method, and oral contraceptives) can effectively prevent pregnancy but only if *correctly* and *consistently* used. On the other hand, long-term and permanent methods (e.g., implants, intrauterine devices or IUDs, and sterilization) are nearly 100% effective once properly administered by the provider.

Counseling can help clients weigh the tradeoffs between effectiveness and other features of various methods and consider the use of short-term methods in the context of their (and their partner's) daily lives. For clients choosing short-term methods, counseling should include plans for correct, consistent use. Issues to consider include whether the client is able and willing to delay intercourse in order to insert a spermicide, take a pill every day at the same time, or return for the next injection at the required time. It is also useful for clients to receive information on how to use oral contraceptives as emergency contraception and where prepackaged emergency contraceptives are available.

Side effects, health benefits, health risks, and complications. Clients need information about common side effects and how to manage them. Information on the health benefits of methods helps clients make their decisions. Clients should also be advised about signs of possible health risks and complications and urged to seek immediate help should they occur. Providers should invite clients to return for advice if they have problems and reassure them that they can change methods if they are dissatisfied.

Demographic and Health Surveys and other research studies have identified side effects and perceived health problems as the major reasons clients give for discontinuing contraceptive use; and fear of these effects is major reason for not adopting modern methods in the first place.[2] One African study found that women who receive inadequate counseling about side effects are more likely to stop using their method when they experience side effects, while those who are fully counseled on side effects are likely to continue using contraception—either with the same method or a different, more acceptable method.[3] In China, women who received pretreatment counseling about the side effects of depot medroxyprogesterone acetate (DMPA) and ongoing support while using the method were almost four times more likely than women not counseled to continue with that method.[4]

Further Reading

Handout 9-M

Using REDI to Give Key Information on Contraceptive Methods (page 3 of 5)

Women who experience side effects for which they are not adequately prepared may worry that their health is endangered or that the side effect, even if not dangerous, might be permanent and debilitating.[5] They may even blame the method for unrelated ailments. Such worry, followed by discontinuation, is likely to discourage others from using the method, because concerns spread by word of mouth.[6] In addition, if clients have misperceptions—such as about the health and/or libido effects of male and female sterilization, the health consequences of menstrual disruption, the possibility of an IUD traveling outside the uterus, or the accumulation of pills in the body—respectful clarification is necessary.

Provider should explain possible *health risks or complications and their warning signs* separately from side effects. The client should not be given the false impression that rare complications are as common as side effects. See Pretraining Handout 9-G for guidance on how to cover side effects and health risks and complications during counseling.

Providers and clients should discuss other important features—such as the advantages and disadvantages—of the method. However, providers should consider that perceptions of advantages or disadvantages vary widely among individuals and couples. For example, some women will want the highly effective, continual protection offered by the IUD or implant, while others will feel uncomfortable with the idea of having a foreign object in their body or will want to directly control when to stop using a method. Some clients will want methods with the fewest side effects and others will want a method that does not require application at the time of having intercourse. Clients also assess the mode of application differently: some favor injections, while others shun them; some reject implants because they might be seen and recognized by others, while others cannot remember to take pills; some want condoms because they offer dual protection, while others find them unpleasant.

How to obtain and how to use a method or what to expect during a method-related procedure. Clients need brief, specific, and practical information on how to use their selected method and an explanation of how the method works. This is particularly important if the client has misconceptions (e.g., that the oral contraceptives need be taken only when intercourse occurs).

Further Reading

Handout 9-M

Using REDI to Give Key Information on Contraceptive Methods (page 4 of 5)

Clients also need information on how and where to obtain their selected method and—for implants, injectables, IUDs, and sterilization—what to expect during the procedure they will undergo. Clear, specific instructions are associated with better client adherence and outcomes. Providing instructions is essential for counseling on user-dependent methods, such as barrier methods and oral contraceptives. Clients might need to develop strategies for how to use these methods consistently and correctly, and they need the counselor's advice on what to do if the method fails (e.g., a condom breaks) or is used incorrectly (e.g., pills are missed).

Programs that offer or refer women for reproductive health education support the correct use of contraceptive methods by increasing clients' knowledge of the reproductive system, how pregnancy occurs, and how contraception works. In cases where the client's method of choice cannot be provided immediately (e.g., scheduling female sterilization at a later date is required, or the client must visit another site for implant insertion), the provider should counsel and provide the client with a method to use in the interim (condoms, etc.).

When to return. Clients need advice on when to return for follow-up or resupply. The follow-up visit is a good time to reinforce the importance of correct and consistent use of client-controlled methods and to ask whether the client is experiencing any unpleasant side effects that need management. If a client has developed medical contraindications to the method or has experienced a change in life stage, circumstances (e.g., a desire to conceive in six months), or lifestyle (e.g., the client now has multiple partners), the client should return to the facility and might wish to change or discontinue contraceptive methods. In addition to scheduling return visits, providers should tell clients that they are welcome to return to the facility any time they have questions or concerns. Clients choosing implants might need help remembering when to have the implants removed—scheduling follow-up visits can help—and should be told that they can have the implants removed at any time before that date as well. In addition, the provider should give the client a piece of paper that shows the date of the return appointment.

Prevention of HIV and other STIs. As the prevalence of HIV and other STIs has increased, providers are increasingly integrating risk assessment and prevention messages into counseling. Programs are also increasingly finding ways to approach treatment and referrals for STIs. Clients should know whether their contraceptive method protects them against STIs, and that abstinence and the consistent use of condoms are the most effective means of protection available.[7]

Further Reading

Handout 9-M

Using REDI to Give Key Information on Contraceptive Methods (page 5 of 5)

Clients who use long-term and permanent methods might be less likely to use condoms for protection, possibly because they no longer associate having intercourse with the need for protection. Some—especially young adults or teens—might incorrectly believe that all contraceptives protect against HIV and other STIs. A study of adolescents in Jamaica found that only about 25% of them knew that oral contraceptives did not provide such protection.[8] Providers should help clients assess their level of STI risk, stressing that the behavior of their partner can also put a client at risk.[9] Providers should convey this information in a way that is sensitive to the client (e.g., by saying "Many women are not aware…"). Clients at high risk need special encouragement, skills, and support to use condoms in addition to any other method they select. Counseling the couple might be the most effective approach; if this is not possible, helping clients build skills for negotiating condom use and communicating with partners about intercourse may be an important way to support clients.

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4. Lei, Z., Wu, S.C., Garceau, R.J., Jiang, S., Yang, Q.Z., Wang, W.L., et al. 1996. Effect of Pretreatment Counseling on Discontinuation Rates in Chinese Women Given Depo-Medroxyprogesterone Acetate for Contraception. *Contraception* 53(6):357–361.
5. Mtawali, G., Curtis, K., Angle, M., and Pina, M. 1994. Contraceptive Side Effects: Responding to Clients' Concerns. *Outlook* 12(3):X-X.
6. Bongaarts, J. and Watkins, S.C. 1996. Social Interactions and Contemporary Fertility Transitions. *Population and Development Review* 22(4):639–682.
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8. Eggleston, E., et al. 1996. Sexual Activity and Family Planning: Behavior, Attitudes and Knowledge among Young Adolescents in Jamaica. Paper presented at the annual meeting of the Population Association of America, New Orleans, USA, May 8–11.
9. Caraël, M., et al. 1994. Extramarital Sex: Implications of Survey Results for STI/HIV Transmission. *Health Transition Review* 4 Suppl:153.

Further Reading

Handout 9-N

What Happens When HTSP Messages Are Not Considered

- When pregnancies are too close together

  Less than 24 months from the last live birth to the next pregnancy:

  - Newborns can be born too soon, too small, or with a low birth weight
  - Infants and children may not grow well and are more likely to die before the age of five

  Less than six months from the last live birth to the next pregnancy:

  - Mothers may die in childbirth
  - Newborns can be born too soon, too small, or with a low birth weight
  - Infants and children may not grow well and are more likely to die before the age of five
- When pregnancies are too far apart (more than five years)
  - Mothers are at a higher risk of developing preeclampsia, a potentially life-threatening complication of pregnancy
  - Newborns can be born too soon, too small, or with a low birth weight
- When pregnancies occur too soon (less than six months) after a miscarriage or abortion
  - Mothers are at a higher risk of developing anemia or premature rupture of membranes
  - Newborns can be born too soon, too small, or with a low birth weight
- When first pregnancies occur to adolescents less than 18 years old
  - Mothers are at a higher risk of developing pregnancy-induced hypertension, anemia, and prolonged or obstructed labor
- Newborns may die, be born too soon, too small, or with a low birth weight

Additionally, the potential health risks associated with short pregnancy spacing intervals and/or having a pregnancy too early in life are exacerbated for women who already have preexisting health problems, such as HIV, anemia, malnutrition, malaria, tuberculosis, heart disease, and diabetes.

Adapted from Pathfinder International's Extending Service Delivery project's Healthy Timing and Spacing of Pregnancies: A Pocket Guide for Health Practitioners, Program Managers and Community Leaders. https://www.globalhealthlearning.org/sites/default/files/reference-files/ESD_PG_spreads_0.pdf

Session 10:
D = Decision Making

Handout 10-C

Session 10 Learning Objectives and Essential Ideas

(page 1 of 2)

Learning Objectives

By the end of this session, you will be able to:

- Describe in detail the steps of REDI, Phase 3: Decision Making
- Describe how to focus on key decisions, list relevant options, and confirm medical eligibility (Step 1)
- Describe how to help clients choose contraceptive methods that respond to their needs and preferences by considering benefits, disadvantages, and consequences of each option (Step 2)
- Describe how to support clients in making their own decisions, without exerting pressure (Step 3)
- Explain how this phase supports sexual and reproductive health (SRH) and clients' rights

Essential Ideas—Session 10

Building on Essential Ideas from the Pretraining Materials, Session 10

- During the Decision Making phase of counseling, the provider:
  1. Summarizes (with the client) 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) the client is considering
  2. Help the client consider the benefits, disadvantages, and consequences of each option
  3. Confirm that any decision is informed, well-considered, and voluntary
- In Step 1-A of Decision Making, explicitly stating the decisions that a client needs to make or confirm helps the client to focus and reinforces the fact that the client is expected to make their own decision. In Step 1-B, the provider lists the options available that meet that client's needs. In Step 1-C, the provider consults medical standards—such as the medical eligibility criteria established by the World Health Organization (WHO)—to identify possible health consequences of methods being considered.
- In Step 2 of Decision Making, the provider helps the client select the best method for their needs. The provider presents the relevant options in a personalized way, by relating the benefits and disadvantages to the unique situation of the client. This step also serves as a reality check for the client regarding the possible consequences of their choice, considering the client's sexual, social, and gender contexts.

Handout 10-C

Session 10 Learning Objectives and Essential Ideas
(page 2 of 2)

- Step 3 is key to supporting the rights of clients to make their own decisions, without pressure or coercion. During this phase, it is important for the provider to assist the client in making their own decision. In addition, the provider should ascertain whether other people (including providers) are pressuring the client in any way or denying the client access to services. Sometimes there is a power imbalance between the provider and the client (e.g., due to differences in education and/or social status) that can result in the provider pressuring the client without realizing it.
- Helping a client make decisions without exerting pressure has been a major challenge for providers. Providers often either tell the client what method to use, or give information but do not assist the client in making a decision. The counseling approach taught in this curriculum aims to resolve these two extremes through a client-centered process.
- The Decision Making phase of counseling supports the rights of each client to make a *full* (not denying access to services), *free* (without pressure from others), and *informed* (considering all benefits, disadvantages, and consequences) *choice*. It also supports the client's right to dignity, comfort, and expression of opinion.

Handout 10-D

Decision Making Steps in Detail (page 1 of 2)

1. Summarize the Exploring Phase in Terms of Decision-Making

1-A. Identify the decisions that the client needs to make or confirm in the counseling session. Depending on the client's needs, there might be more than one decision that the client needs to make or confirm in this counseling session. Explicitly stating these decisions in the Decision Making phase of REDI helps the client focus on the issue(s) and reinforces the fact that the client is expected to make their own decisions.

- *Decisions for new clients* include whether to use a contraceptive method, which method to choose, whether it is necessary to reduce the risk of contracting HIV and other sexually transmitted infections (STIs), and whether to use a method that provides dual protection against pregnancy and STIs. For some new clients, this might be the first time that they have had to make a decision about having a child. Other new clients might already have a method in mind; these clients need information, guidance, and support to confirm whether their decision is appropriate.

1-B. Explore relevant options for each decision. This task requires an organized and logical approach that responds to the expressed needs of the client. Provider should list (although not necessarily explain) all available options and then help the client eliminate those that are not relevant to their situation.

- *Options for new clients* include all available contraceptive methods that are appropriate for the client, dual-protection options, and other STI risk reduction options.
- *New clients with a method in mind* will need to confirm their decision. In these situations, the provider should give balanced information tailored about the particular method the client has in mind and make sure the client is making a well-considered decision by providing key information on other methods that would be appropriate, given the client's expressed need. The provider does not need to provide comprehensive information about each method but should provide enough detail that the client can eliminate some methods.

1-C. Confirm the medical eligibility of the contraceptive method(s) the client is considering. Follow the steps in the Learning Guide. Due to common power imbalances in the client-provider relationship, providers must be careful not to *impose* medically correct decisions on their clients. Rather, they should encourage clients to make decisions based on their individual preferences and situation, *while considering* current standards, such as the WHO's medical eligibility criteria.

Handout 10-D

Decision Making Steps in Detail (page 2 of 2)

2. Help the Client Consider the Benefits, Disadvantages, and Consequences of Each Option

Present the options in a personalized way by relating them to the unique situation of the client and explaining the implications of choosing that particular option.

- *For new clients without a particular method in mind*, this may mean reviewing the detailed information about methods—including side effects, health benefits, and health risks, as well as discussing what is required to obtain those methods (one-time and recurring costs of time and travel to clinic) and how each option may reduce the risk of contracting HIV and other STIs.
- *For new clients with a method in mind*, providers should provide similar information, but with an emphasis on the client's preferred method and a limited discussion of the essential information (e.g., benefits, disadvantages, and consequences) of other options for the client to consider. After receiving this information, clients might opt for a method different from the one they originally had in mind.

This step also serves as a reality check for the client regarding the possible impact of their method choice on sexual relations, religious practices, and family life. The provider can help by asking questions about how the client would feel or what they might do in certain situations. For example:

- "How would you feel about taking the pill every day?"
- "What will your husband think of using a condom?"
- "What might make it difficult for you to come back to the clinic every three months for the injection? What would you do about that?"

3. Confirm that any Decision Is Informed, Well-Considered, and Voluntary

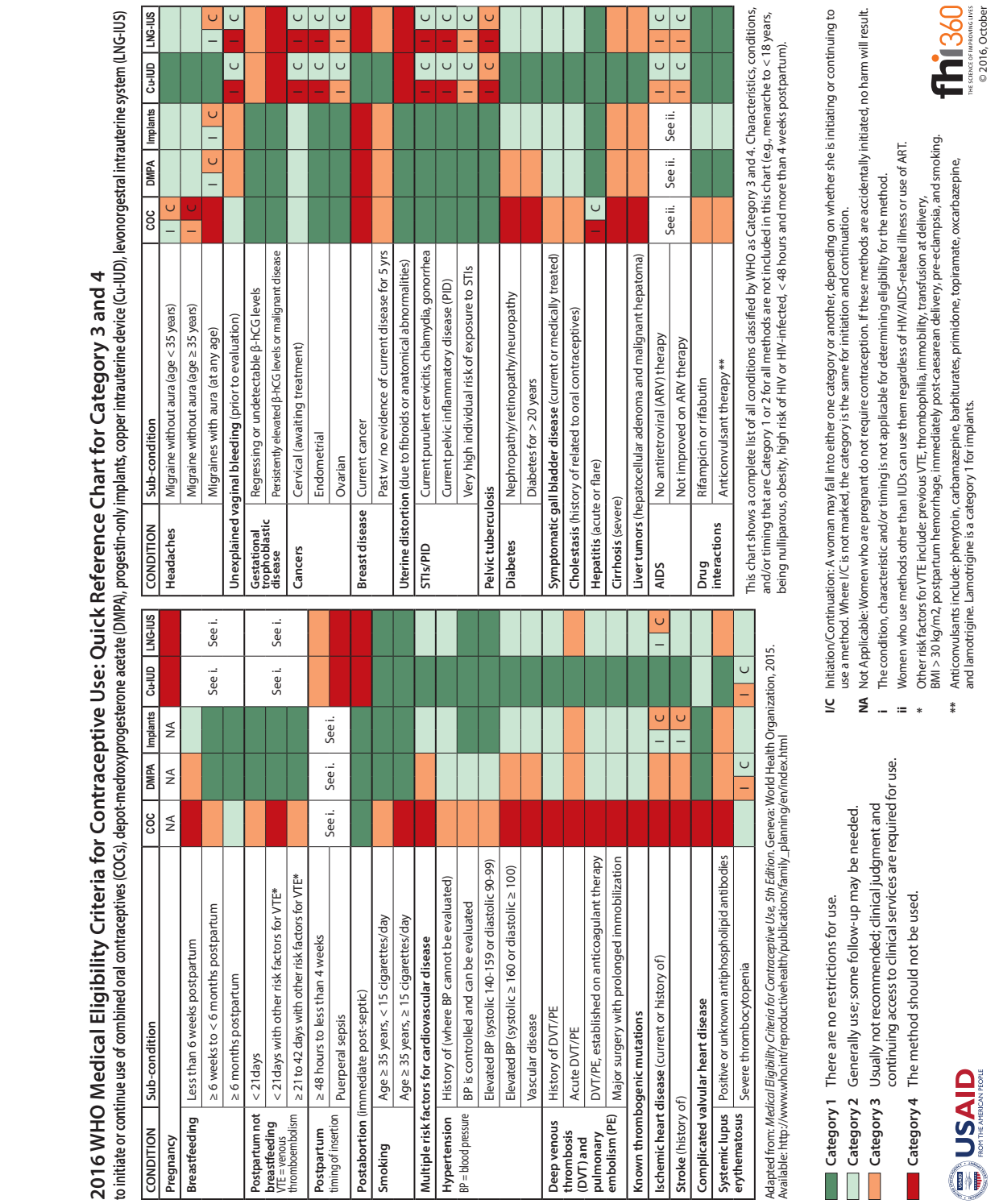
The provider's primary role in this phase is to help the client finalize their decision. Helping a client make a decision, without exerting pressure is often challenging for providers. Providers often either (1) tell the client what method to use, or (2) give information but do not assist the client in making a decision. The counseling approach taught in this curriculum aims to resolve these two extremes through a client-centered process.

An additional challenge is that every client is different in terms of the amount of guidance needed from the provider. This is why the client-centered approach—treating each client as an individual and providing input based on the client's unique needs and concerns—is the key for this step in the REDI process.

The counselor should ensure that the client's decision is a well-informed and appropriate choice. The counselor can reflect back the decision by asking, "What is your decision?" or paraphrasing, "So, you have decided to…"

Handout 10-E

2015 Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use



2016 WHO Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart for Category 3 and 4

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD), levonorgestral intrauterine system (LNG-IUS)

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Pregnancy		NA	NA	NA		
Breastfeeding	Less than 6 weeks postpartum					
	≥ 6 weeks to < 6 months postpartum				See i.	See i.
	≥ 6 months postpartum					
Postpartum not breastfeeding VTE = venous thromboembolism	< 21 days					
	< 21 days with other risk factors for VTE*				See i.	See i.
	≥ 21 to 42 days with other risk factors for VTE*					
Postpartum timing of insertion	≥ 48 hours to less than 4 weeks	See i.	See i.	See i.		
	Puerperal sepsis					
Postabortion (immediate post-septic)						
Smoking	Age ≥ 35 years, < 15 cigarettes/day					
	Age ≥ 35 years, ≥ 15 cigarettes/day					
Multiple risk factors for cardiovascular disease						
Hypertension BP = blood pressure	History of (where BP cannot be evaluated)					
	BP is controlled and can be evaluated					
	Elevated BP (systolic 140-159 or diastolic 90-99)					
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)					
	Vascular disease					
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE					
	Acute DVT/PE					
	DVT/PE, established on anticoagulant therapy					
	Major surgery with prolonged immobilization					
Known thrombogenic mutations						
Ischemic heart disease (current or history of)				I C	I C	
Stroke (history of)				I C		
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I C		I C	

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Headaches	Migraine without aura (age < 35 years)	I C				
	Migraine without aura (age ≥ 35 years)	I C				
	Migraines with aura (at any age)		I C	I C		
Unexplained vaginal bleeding (prior to evaluation)					I C	I C
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels					
	Persistently elevated β-hCG levels or malignant disease					
Cancers	Cervical (awaiting treatment)				I C	I C
	Endometrial				I C	I C
	Ovarian				I C	I C
Breast disease	Current cancer					
	Past w/ no evidence of current disease for 5 yrs					
Uterine distortion (due to fibroids or anatomical abnormalities)						
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I C	I C
	Current pelvic inflammatory disease (PID)				I C	I C
	Very high individual risk of exposure to STIs				I C	I C
Pelvic tuberculosis					I C	I C
Diabetes	Nephropathy/retinopathy/neuropathy					
	Diabetes for > 20 years					
Symptomatic gall bladder disease (current or medically treated)						
Cholestasis (history of related to oral contraceptives)						
Hepatitis (acute or flare)		I C				
Cirrhosis (severe)						
Liver tumors (hepatocellular adenoma and malignant hepatoma)						
AIDS	No antiretroviral (ARV) therapy	See ii.	See ii.	See ii.	I C	I C
	Not improved on ARV therapy				I C	I C
Drug interactions	Rifampicin or rifabutin					
	Anticonvulsant therapy**					

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. Characteristics, conditions, and/or timing that are Category 1 or 2 for all methods are not included in this chart (e.g., menarche to < 18 years, being nulliparous, obesity, high risk of HIV or HIV-infected, < 48 hours and more than 4 weeks postpartum).

Adapted from: *Medical Eligibility Criteria for Contraceptive Use, 5th Edition*. Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

Category 1 There are no restrictions for use.
Category 2 Generally use; some follow-up may be needed.
Category 3 Usually not recommended; clinical judgment and continuing access to clinical services are required for use.
Category 4 The method should not be used.

I/C Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where I/C is not marked, the category is the same for initiation and continuation.
NA Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.
i The condition, characteristic and/or timing is not applicable for determining eligibility for the method.
ii Women who use methods other than IUDs can use them regardless of HIV/AIDS-related illness or use of ART.
* Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m2, postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.
** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

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Handout 10-F

Decision Making Sample Scenario (page 1 of 2)

Instructions

This scenario starts when the Rapport Building and Exploring phases of counseling are complete. The "provider" boxes are numbered to make it easier to report your responses. It is the same "provider" throughout.

You Have Two Tasks

Task A. Read each provider statement, decide which step of Decision Making the provider is covering, and write the step number—*Step 1-A, 1-B, 1-C, 2, or 3*—in each box labeled "Provider" (see Learning Guides 1 or 2).

Task B. For the provider's questions or statements that you have identified as "Step 2," draw a line around the words or sentences where the provider is addressing one of these topics:

- *Side effects*
- Possible *impact* of the contraceptive method on sexual relations, religious practices, and/or family life
- Recurring *costs* for the method, plus time and travel for repeat clinic visits
- Protection against *STI/HIV*

Then, write the words italicized above (e.g., *impact*) to show what topic the provider is addressing.

Provider (1)	Now, let us review the decisions you need to make. You said that you want to use a contraceptive method. Now that we have discussed all available methods, you need to decide which method to use. Do you need any more information?
Client	No, I am interested in the intrauterine device (IUD). I think I will have it.
Provider (2)	Since you do not want any more children, the IUD will work for you because it provides long-term protection. The implant also provides long-term protection, but you said you do not want a hormonal method. I also told you about female sterilization and vasectomy, but they involve surgery and are considered permanent.
Client	Yes, I like the IUD.

Handout 10-F

Decision Making Sample Scenario (page 2 of 2)

Provider (3)	Okay. Let me remind you of the side effects that you might experience in the first few months. You might have longer periods and more cramping during periods. How do you feel about this? Do you think you can tolerate it?
Client	That is fine, if it is only for the first couple of months.
Provider (4)	What about your husband? How would he feel about your using an IUD?
Client	He never interferes with that. He does not want any more children, and he supports me in doing something to prevent that.
Provider (5)	You will need to come to the facility after your first period following the IUD insertion. Can you do that?
Client	Oh, that is no problem. I come to town every Wednesday for the market.
Provider (6)	Okay. What about the cost?
Client	Well, it is fine since I will pay only once.
Provider (7)	That is right. And, we do not charge anything for the follow-up visit after your first period.
Client	Good to know.
Provider (8)	Finally, I want to make sure you understand that the IUD offers no protection from contracting an STI or HIV if you have sex with someone who is infected.
Client	As far as I know, my husband is faithful, and I do not plan to be unfaithful—ever. (smiles)
Provider (9)	So, what is your decision?
Client	I want the IUD.

Session 11:
REDI: I = Implementing The Decision

Handout 11-F

Session 11 Learning Objectives and Essential Ideas
(page 1 of 2)

Learning Objectives

By the end of this session, you will be able to:

- Describe in detail the steps of REDI, Phase 4: Implementing the Decision
- Apply what you learned (in the Pretraining Handouts) about how to do these steps with a profiled client
- Identify reasons why clients might not want to talk with their partners about pregnancy prevention and sexual and reproductive health (SRH)
- Practice responding to some of these reasons
- Explain how this phase supports SRH and clients' rights

Optional: Condom Race—Steps for Using Condoms

- List the steps for using a male condom in the correct order
- List the steps for using a female condom in the correct order (if the female condom is used in the activity)
- Identify challenges to dual protection

Optional: Condom Demonstration

- Demonstrate how to use a male condom

Essential Ideas—Session 11

Building on Essential Ideas from the Pretraining Handouts, Session 11

- In the Implementing the Decision phase, the provider helps the client develop a plan for implementing their decision(s) and ensures the plan is realistic for the client's life. Focusing (finally!) on the contraceptive method the client has chosen, the provider will:
  - *Review information* about how to use the method
  - Help the client *identify possible barriers* to using the method
  - Assist the client in *strategizing how to overcome* those barriers
  - Be clear about required *follow-up visits or referrals*
- One barrier clients may face is communicating with partners about their pregnancy prevention or SRH decision(s). There are many reasons why clients may feel that they cannot discuss pregnancy prevention and 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.

Handout 11-F

Session 11 Learning Objectives and Essential Ideas
(page 2 of 2)

- Partner communication is important, but remember—clients know best about their relationships and *should not be forced* 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 Implementing the Decision phase of REDI supports two of the client's rights—safety of services and continuity of care. Safety is addressed (for new clients) by providing clear instructions about how to use the chosen method, about side effects, and about warning signs of health risks or complications. Continuity of care is addressed by ensuring that the client has access to resupply (if needed), is aware of necessary follow-up, and is referred for services not available at the facility.
- Clients need to be aware of potential barriers to implementing their decision and have strategies to overcome those barriers, in order to attain the highest standard of SRH.

Condom Race—Steps for Using Condoms

- By this point, the provider should have informed the client about the risk of HIV and other sexually transmitted infections (STIs) and helped them assess their individual risk (during the Exploring phase). All clients who have been identified as being at risk and who have decided to reduce their risk should now receive counseling about *condom use*.
- *Do not assume clients know how to use condoms*. Helping clients build skills in using condoms deserves special attention. Whether condoms are used for pregnancy prevention, for protection against STIs, or for dual protection, it is important to build these skills during counseling.
- Challenges that clients face in dual-method use include cost, difficulty convincing a partner to use condoms when the woman is already using a contraceptive method, and disrupting the spontaneity of sex. The dual benefit of using condoms is important information that might help clients more easily negotiate condom use with their partners.

Handout 11-G

Suggestions to Help Clients Talk about Pregnancy Prevention and Other SRH Issues with Partners

If the client is open to talking with their partner, they can try the approaches below.

- Identify areas of family life or relationships that they *do* feel comfortable discussing. See if there is some way that these issues can serve an entry point for this discussion.
- Start the conversation by saying that this is something that they heard about at the healthcare facility and they wonder if their partner knows anything about it.
- Say that they have some health issues that the provider wants to discuss with the partner, in light of the partner's role in the family. Alternatively, say that there are some decisions that they need to make as a couple, which could benefit from a joint visit by the client and the partner.
- Identify family members (of either partner) who might be supportive and ask them to help begin communication about these issues with the partner.

Handout 11-H

Examples of Barriers to Talking with Partners about SRH Concerns

Clients' Reasons	Possible Deeper Personal and Social Factors
"I cannot tell him that I want to use a contraceptive method because he thinks that it goes against our religion."	Following social norms and values
"My partner does not want to discuss pregnancy prevention because she wants to have more children."	Following social norms and values
"My partner will think I am cheating if I ask him to use condoms."	Fear of losing the relationship; fear of violence
"We love each other, so why should we use condoms?"	Denial
"We do not talk about things like that."	Following social norms and values; fear of change; power imbalance in the relationship; potential for or past violence
"People like me do not get HIV or other STIs."	Misinformation about how HIV and other STIs are transmitted; denial; lack of understanding of personal risk
"My partner will think I have HIV or another STI if I ask him to use condoms, and he will kick me out of the house and tell everyone about it."	Power imbalance; fear of retribution; fear of loss of support; fear of violence
"I do not want my partner to know that I have other sexual partners."	Fear of a negative reaction; fear of violence; fear that the partner will want to end the relationship
"I cannot tell him that I am unhappy with our sex life—he will find someone else."	Fear of abandonment
"I cannot tell him that it hurts because it is a woman's obligation to have sex with her husband any way that he wants."	Following social norms and values; power imbalance; fear of violence
"I cannot tell her that I have an STI because then she will know that I cheat on her."	Fear of a negative reaction
"I cannot ask him about his smelly discharge because he will be embarrassed."	Fear of hurting feelings or embarrassing partner

Adapted from: EngenderHealth. 2003. Comprehensive Counseling for Reproductive Health: An Integrated Curriculum. New York: EngenderHealth.

Handout 11-I

Steps for Using Male and Female Condoms

(page 1 of 3)

Steps for Using a Male Condom[6]

Basic Steps	Important Details
1. Use a new condom for each act of sex.	• Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date; do this only if a newer condom is not available. • Tear open the package carefully. Do not use teeth, fingernails, or anything that can damage the condom.
2. Before any physical contact, place the condom on the tip of the erect penis, with the rolled side out.	• For the most protection, put the condom on before the penis makes any genital, oral, or anal contact.
3. Unroll the condom all the way to the base of the erect penis.	• The condom should unroll easily. Forcing it on could cause it to break during use. • If the condom does not unroll easily, it may be backwards, damaged, or too old. Discard it and use a new condom. • If the condom is on backwards and another one is not available, turn it over and unroll it onto the penis.
4. Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.	• Withdraw the penis. • Slide the condom off, without spilling semen. • If having sex again or switching from one sex act to another, use a new condom.
5. Dispose of the used condom safely.	• Wrap the condom in its package and put in the rubbish bin or latrine. • Do *not* put the condom into a flush toilet, as it can cause problems with plumbing.

[6] World Health Organization, 2018 edition. *Family Planning: A global handbook for providers*.

Handout 11-I

Steps for Using Male and Female Condoms

(page 2 of 3)

Steps for Using a Female Condom

Basic Steps	Important Details
1. Use a new female condom for each act of sex.	• Check the condom package. Do not use if torn or damaged. Do not use a condom past the expiration date; do this only if newer condoms are not available. • If possible, wash your hands with mild soap and clean water before inserting the condom.
2. Before any physical condom, insert the condom into the vagina.	• For the most protection, insert the condom before the penis comes in contact with the vagina. The female condom can be inserted up to eight hours before sex. • Choose a position that is comfortable for insertion—lie down, sit, squat, or raise one leg. • Rub the sides of the female condom together to spread the lubricant evenly. • Grasp the ring at the closed end and squeeze it so it becomes long and narrow. • With the other hand, separate the labia and locate the opening of the vagina. • Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About two to three centimeters of the condom and the outer ring should remain outside the vagina.

[7] World Health Organization, 2018 edition. *Family Planning: A Global Handbook for Providers*. https://www.fphandbook.org/explaining-how-to-use-female-condoms

Handout 11-I

Steps for Using Male and Female Condoms

(page 3 of 3)

Steps for Using a Female Condom

Basic Steps	Important Details
3. Ensure that the penis enters the condom and stays inside the condom.	• The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again. • If the condom is accidentally pulled out of the vagina or the outer ring is pushed into the vagina during sex, put the condom back into place.
4. After the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina.	• The female condom does not need to be removed immediately after sex. • Remove the condom before standing up, to avoid spilling semen. • If the couple has sex again, they should use a new condom. Reuse of female condoms is not recommended.
5. Dispose of the used condom safely.	• Wrap the condom in its package and put it in the rubbish bin or latrine. • Do *not* put the condom into a flush toilet, as it can cause problems with plumbing.

Handout 11-J

Challenges to Dual Method Use

What are possible challenges that clients face in dual-method use?

- Using two methods can cost twice as much.
- It is more difficult to remember to use or carry two contraceptive methods.
- The client might have less incentive to use two methods because one might be sufficient for preventing pregnancy or STI transmission.
- It might be hard enough to convince a partner to use one method, let alone two.
- Using two methods might be disruptive to the spontaneity of sex, depending on the methods selected.

Consider this: Pregnancy prevention might be a greater motivator for condom use than prevention of STIs/HIV. Therefore, the dual benefit of using condoms is important information that might help clients more easily negotiate condom use with their partners.

Further Reading

Handout 11-K

Condom Excuses and Possible Responses

(page 1 of 3)

1. "I cannot feel anything when I wear a condom."

Possible response: "I know there is a little less sensation, but there is not a lot less. Why don't we put a drop of lubricant inside the condom? That will make it feel more sensitive." (*Note:* Lubricants should be water-based.)

2. "I do not need to use a condom. I have not had sex in ___ months, so I know I do not have any diseases."

Possible response: "That is good to know. As far as I know, I am disease-free, too. But I would still like to use a condom because either of us could have an infection and not know it."

3. "If I have to stop and put it on, I will not be in the mood anymore."

Possible response: "I can help you put it on. That way, you'll continue to be aroused, and we will both be protected."

4. "Condoms are messy, and they smell funny."

Possible response: "It is really not that bad. And, sex can be a little messy sometimes. But this way, we will be able to enjoy it and both be protected from pregnancy and HIV and other STIs."

5. "Let's not use condoms just this once."

Possible response: "No. Once is all it takes to become pregnant or contract an infection."

6. "I do not have a condom with me."

Possible response: "That is okay. I do."

7. "You never asked me to use a condom before. Are you having an affair?"

Possible response: "No. I just think we made a mistake by never using condoms before. One of us could have an infection and not know it. It is best to be safe."

Further Reading

Handout 11-K

Condom Excuses and Possible Responses

(page 2 of 3)

8. "If you really loved me, you would not make me wear one."

Possible response: "If you really loved me, you would want to protect me—and yourself—from infections and pregnancy so that we can be together and healthy for a long time."

9. "Why are you asking me to wear a condom? Do you think I am dirty or something?"

Possible response: "It is not about being dirty or clean. It is about avoiding pregnancy and the risk of infection."

10. "Only people who have anal sex need to wear condoms, and I am not like that."

Possible response: "That is not true. A person can get an infection during any kind of sex, including what we do together."

11. "Condoms do not fit me."

Possible response: "Condoms can stretch a lot—in fact, they can stretch to fit over a person's head! So we should be able to find one that fits you."

12. "Why should we use condoms? They just break."

Possible response: "Actually, they told me that condoms are tested before they are sent out—so while they have been known to break, it rarely happens, especially if you know how to use one correctly—and I do."

13. "What happens if it comes off? It can get lost inside you, and you will get sick or even die. Do you want that?"

Possible response: "It is impossible for the condom to get lost inside me. If it came off, it would be inside my vagina, and I could just reach in and pull it out."

14. "If you do not want to become pregnant, why don't you just take the birth control pill?"

Possible response: "Because the birth control pill only protects against pregnancy. The condom protects against pregnancy and STIs."

Further Reading

Handout 11-K

Condom Excuses and Possible Responses

(page 3 of 3)

15. "My religion says that using condoms is wrong."

Possible response: "It might help to talk with one of your religious leaders. Many people from different religions use condoms, even though their religion is against it. They figure that preventing infection or unintended pregnancy is more important than worrying about the morality of condoms."

16. "Well, I am not going to use a condom, and that is that. So let's have sex."

Possible response: "No. I am not willing to have sex without a condom."

17. "No one else uses them. Why should we be so different?"

Possible response: "Because a lot of people who did not use them have contracted HIV."

18. "You are a woman. How can you possibly ask me to use a condom? How can I respect you after this?"

Possible response: "You should respect me even more because I am acting responsibly. I am suggesting this because I care about you and respect myself enough to protect myself. That is enough for me."

Session 12:
Counseling Return Clients

Handout 12-D

Session 12 Learning Objectives and Essential Ideas
(page 1 of 2)

Learning Objectives

By the end of this session, you will be able to:

- Recap possible reasons for return visits
- Explain how to use different REDI steps for satisfied and dissatisfied return clients
- Identify the three main reasons for method discontinuation
- Describe how to support clients who want to discontinue their method
- List steps for managing side effects and other problems
- Explain how this approach supports clients' sexual and reproductive health (SRH) rights

Essential Ideas—Session 12

Building on Essential Ideas from the Pretraining Materials, Session 12

Return Clients

- Return clients constitute a significant portion of the clients who come to facilities for services. Providers should tailor the phases of the REDI framework to respond to the needs of the return client. Clients with problems or concerns should receive careful attention and counseling relevant to the reason for the visit. Return clients with no problem should receive their requested services and/or supplies without unnecessary delays.

Switching Methods or Discontinuing Contraception

- Clients generally cite one or more of the following three reasons for wanting to switch or discontinue contraceptive methods:
  - Side effects or other health or social problems
  - Concerns caused by lack of accurate information
  - Wanting to conceive or no longer needing protection
- Providers should address side effects and other problems with counseling. Switching methods may be the best option, if the problems are unmanageable otherwise.
- Providers can also address misconceptions or lack of information through counseling. However, the client may still prefer to switch methods. It is better to let a client switch methods than insist they continue with a method they do not like, which could lead to discontinuation.
- Discontinuing contraception is obviously necessary if the client is ready to conceive. In these cases, prenatal counseling is advisable.

Handout 12-D

Session 12 Learning Objectives and Essential Ideas
(page 2 of 2)

Essential Ideas—Session 12

Building on Essential Ideas from the Pretraining Materials, Session 12

- For both discontinuation and switching, the provider supports clients' rights by ensuring that the client is making an informed, voluntary, and well-considered decision. The provider does this by determining the client's reasons and offering relevant information and options to the client (rather than discouraging a change) and by maintaining a trustful relationship through counseling.

Managing Side Effects and Other Problems

- Fears or concerns about potential and actual side effects are the main reasons for clients' discontinuation of their chosen method. Addressing and managing such concerns can help many clients to continue using their method.
- Providers should take clients' complaints seriously, explore them in detail, and offer information and support to help clients cope with the situation.
- In addition to providing counseling, most providers are also responsible for managing side effects and health risks or complications by either treating the problem or referring the client for treatment elsewhere.
- If the provider cannot resolve the clients' concerns and complaints through counseling and treatment, the client should have the option of switching to another method.

SRH and Client's Rights

- Counseling return clients is an important part of supporting clients' rights to:
  - Access to services (for resupplies and for clients who want to switch methods)
  - Informed choice (the right to switch methods or to discontinue contraception)
  - Safety of services (careful follow up on side effects and warning signs of health risks and/or complications)
  - Continuity of care (ensuring that the client is able to obtain resupplies when needed)

Handout 12-E

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

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-F

How Would You Respond? Worksheet

Instructions

1. Write the category of reasons next to the example, using the letters below.
2. Discuss how you would respond, as the provider.

Categories of Reasons

A. Side effects or other health or social problems related to the current method

B. Concerns caused by lack of accurate information

C. Decision to conceive or no longer needs protection

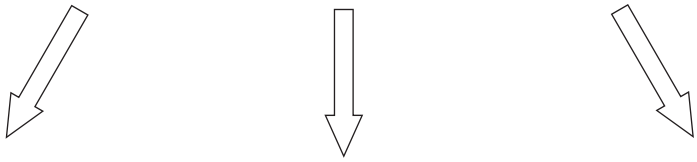
Category	Examples of Reasons for Switching or Discontinuation
	1. Client returns saying that she does not want to have the injection anymore because of the excessive irregular bleeding she has had in the last six months.
	2. Client asks to have her intrauterine device (IUD) removed because her husband feels it during intercourse.
	3. Client asks for a vasectomy reversal, saying that he and his new wife want to have a child.
	4. Client asks to have her implant removed because she wants to get pregnant now.
	5. Client says that her doctor diagnosed her with high blood pressure and told her to stop taking the pill.
	6. Client asks to have her IUD removed because of the headaches she has been having since it was inserted.
	7. Client is using injectables but asks for another method because she has heard that the injections can cause infertility.

Handout 12-G

Supporting Clients Who Want to Switch Methods or Discontinue Contraception

1. Explore the underlying reason for the client's desire to discontinue the method.

"Why does the client want to discontinue the method?"



A. Because of side effects or other health and social reasons	**B.** Because of concerns related to inadequate information	**C.** Because the client wants to conceive (or preserve a pregnancy resulting from method failure) or no longer needs protection (e.g., change of circumstances, no longer at risk of pregnancy)
2. A) Explore the reason in depth; see if you can address it through treatment or other precautions,[8] or if it requires further investigation. **B) Suggest switching to another method** if it is medically warranted.	**2. Explore the concerns and misconceptions in depth, correct as needed, and address knowledge gaps.**	**2. Counsel the client** and **provide the service** as needed (e.g., removal of the IUD or implant). **3. Refer the client for preconception or antenatal care** and encourage her to return after pregnancy.
3. *Option 1:* If the client decides to continue using the current method, **provide appropriate counseling and services.** *Option 2:* If the client still wants to discontinue the method, **offer the option of switching to another method** and provide counseling and services as needed. *Option 3:* If the client still wants protection against pregnancy but cannot yet decide on another method, **remind the client about the pregnancy risk and encourage the client to come back later.**		

[8] For example, treating irregular bleeding during the initial injections, or counseling and providing correct information to the client's partner, to counter misinformation

Handout 12-H

Exploring Reasons for Dissatisfaction and Considering Options (page 1 of 2)

Exploring: Reasons for Dissatisfaction	Decision Making: Consider Options for Client
Side effects and what the client has done or what can be done to manage side effects (including treatment and switching to another method)	• Tolerate/accept side effects, after learning that they are harmless • Wait till they subside • Treat side effects • Switch to another method
Rumors about the method that bother the client	• Continue using the method after being relieved by the provider's explanation • Switch to another method
Difficulty in accessing services for routine revisits or resupply	• Find another service site that is easier to access • Switch to another method that does not require frequent access to services
Lack of partner or family support for using the method	• Try new strategies to convince partner/family • Switch to another method
Incorrect method use: Discuss how to use the method and a backup method correctly, and discuss potential need for and use of emergency contraception pills	• Start using the method correctly • If correct use is inconvenient, switch to another method
Suspected pregnancy: Ask client about her and her partner's reaction to possible pregnancy and explain options for pregnancy testing	• If a pregnancy test is negative, discuss client's contraceptive options • If screening suggests risk of pregnancy and it is within five days of unprotected intercourse, discuss emergency contraception • If a pregnancy test is positive, discuss client's options

Handout 12-H

Exploring Reasons for Dissatisfaction and Considering Options (page 2 of 2)

Exploring: Reasons for Dissatisfaction	Decision Making: Consider Options for Client
Change in reproductive goals/desire for pregnancy: Congratulate and counsel client on what to do for a healthy pregnancy	• Switch to another method • Discontinue contraception • Discuss what to do for a healthy pregnancy
Warning signs of health risks and/or complications: Explain that screening/other exams, tests, and treatment are required during visit, or refer if needed	• Comply with suggested treatment option • Select referral options • Discontinue or switch to another method
Change in individual risk for sexually transmitted infection (STI): Help client perceive their risk and explain risk reduction and dual-method use	• Behavior change to reduce risk • Dual-method use • Condom use

Handout 12-I

Steps for Managing Side Effects and Other Problems

Steps for Managing Side Effects and Other Problems	
• Always acknowledge clients' complaints. • Take clients' complaints seriously. • Gain a full understanding of the complaint: ask and listen![9] ◦ Is it a side effect that will go away without treatment? ◦ Is it a side effect that requires treatment, a sign of a health risk or complication, or another problem?	
For Side Effects or Problems that Do *Not* Require Treatment	**For Side Effects or Problems that *Do* Require Treatment, or for Health Risks and Complications**
• Inform and reassure: ◦ Explain to the client why and how side effects occur ◦ Assure the client that the side effect or complaint is benign and not a sign of a serious health problem ◦ Explain what the client can do to cope with the inconvenience caused by the side effect ◦ Remind the client of the warning signs of health risks and complications ◦ Remind the client that they are always welcome to return with any concerns or questions ◦ Remind the client that they are always welcome to change methods	• Discuss and/or offer medical management as appropriate: ◦ Discuss medical treatment options ◦ Treat side effects or complications as per established guidelines, or refer the client if treatment is unavailable at your facility ◦ If the client is not satisfied with these options, offer them the option of switching to another method

[9] **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.

Session 13:
Counseling Practice Role Plays

Handout 13-A

Session 13 Learning Objectives and Essential Ideas

Learning Objectives

By the end of this session, you will be able to:

- Practice counseling clients in role plays, applying all of the counseling skills covered in this workshop and using the REDI framework for different profiles of clients
- Explain the logistics for the counseling practicum with actual clients over the next two days

Essential Ideas—Session 13

- This session provides all participants the opportunity to practice counseling and to receive feedback on their performance. This is a proven approach for adults seeking to acquire counseling skills. As adult learners, participants learn from each other through individual feedback in pairs and general feedback in plenary.
- Supervised practice with actual clients is better than role playing for developing counseling skills. For the next two days, participants will spend the mornings at a service facility, where (working in pairs) each participant will counsel an actual client. A trainer will observe each pair and provide written and verbal feedback to each participant while at the service site. Once participants are back in the workshop setting, they will have a chance to reflect on their experiences and observations and share lessons learned.
- By dividing the practice sessions in this manner, each participant will have a chance to improve by applying feedback and learning from the first practice day to the second. Thus, it is essential that all participants have a chance to practice counseling with a client each day.

Handout 13-B

Important Features of REDI (page 1 of 2)

How does the REDI framework ensure that counseling is client-centered?

- The framework starts with and maintains focus on the client's individual circumstances. Each counseling session is tailored to the specific needs of the individual client, taking into consideration their unique circumstances, needs, and desires. This includes, for example, whether they are new or returning; whether they have a specific method in mind, concerns about the method they are using, or changes in their circumstances; and whether they are a member of a special population group.
- The REDI framework treats the client as a unique individual with different and interrelated needs and circumstances. In addition to helping providers with counseling for pregnancy prevention, it helps providers explore and address clients' needs and problems in other sexual and reproductive health (SRH) areas—such as sexuality and prevention/treatment of sexually transmitted infections (STIs) in an integrated way.
- REDI also takes into consideration whether the client will be able to implement their decision to use contraception. It helps the provider guide the client through a reality check, identify potential barriers, and develop strategies to overcome them. Therefore, the Implementing the Decision phase of REDI evolves differently based on each client's unique needs and circumstances.

How much time do providers in your facility generally spend counseling each client? Do you have ideas about how to make counseling more efficient and effective in your practice setting?

- Providers can save time with *new clients* by first learning about the client's situation and then limiting the information provided in the session to what is relevant, rather than providing detailed information on every method as a standard practice. By not overwhelming the client with unnecessary information, the provider saves time and better meets the client's needs.
- For *return clients*, providers can save time by determining whether the client has any concerns or problems and then focusing on those issues, if necessary.
- Providers might initially require more time to follow the framework because they will need to adjust to the new way of interacting with clients.

Handout 13-B

Important Features of REDI (page 2 of 2)

Why does the framework address clients' social context and personal relationships?

Clients need to make realistic decisions that they can implement successfully and safely. Examining the social context helps them to understand the potential outcomes of their decisions. Questions might include the following:

- Who has the decision-making power in your relationship and who influences decisions (e.g., partners, family members, friends)?
- What will happen if your partner or family discovers you are secretly using contraception (e.g., will your partner have an objection or even a violent reaction if you insist on using contraception in general or a particular method)?
- What will happen you experience side effects such as bleeding (which is significant in many religions and cultures)?
- What economic pressures might affect your decisions (e.g., can you afford a continual supply of condoms or other methods)?

How does this framework ensure full, free, and informed choice?

- **Full choice** is about ensuring that the client has access to and awareness of the full range of methods available. This does not mean that the client must know everything about every method. With REDI, the provider tailors information-giving to focus on the methods that could meet the client's needs and fit their circumstances.
- **Free choice** is about the ability to choose, without barriers or coercion. REDI helps the provider to explore with the client whether there may be pressure from partners, family, community members, and even service providers influencing the client. It helps the provider to ensure that the decision the client makes is voluntary and free from coercion.
- **Informed choice** refers to the client's ability to make a decision based on comprehensive, accurate, and unbiased information about contraceptive options, including benefits, side effects, and risks. Along with preventing pregnancy, counseling helps clients consider their personal risks and ways to prevent contracting/transmitting HIV or other STIs. But with REDI, this discussion goes beyond health issues. The provider helps the client reach realistic decisions after having considered the potential impact of their choice on family, social, and sexual relationships, and helps the client anticipate potential barriers to the implementation of their decisions and ways to overcome such barriers.

Handout 13-C

Orientation to Counseling Practicum with Client
(page 1 of 2)

1. **Clinic activity description.**
   - The goal is for each participant to conduct a counseling session with at least one client on each of the last two days of the training—i.e., a minimum of two actual counseling sessions.
   - Participants will complete the counseling practicum in pairs. While one participant is counseling a client, the other participant and one of the trainers will observe. The clinic provider will be there to complete standard paperwork and provide any clinical services after the counseling.
   - The practicing participant will reflect on their performance and receive feedback immediately after the counseling session is finished.
   - When participants are not with clients, they will be in a separate space where they can work on case scenarios with their counseling partners (Handout 14-A).

2. **Needed attire.** This may include white coats, depending on the facility.

3. **Client consent.** The clinic provider will obtain the consent of the client before bringing the client into the counseling room. Clients will be informed (by the provider) that they will receive counseling from a trainee, with the provider and two observers in the room, and that they have the option of accepting this or seeing a regular clinic provider. Actual services (e.g., implant insertion) will be performed by the clinic provider.

4. **Confidentiality.** After the client consents, they will enter the counseling/observation room. The provider will introduce the practicing trainee, the trainer, and the observing trainee to the client and reassure the client that everything will remain confidential and that the no one will not interfere with the counseling session.

5. **Rules of respect in the counseling room.** The trainer and the observing participant should not interfere at all during the entire counseling of the client.

Handout 13-C

Orientation to Counseling Practicum with Client
(page 2 of 2)

6. **The feedback process.**
   - Feedback begins immediately after the client leaves the room. If the counseling space is needed for service delivery for the client, the feedback will happen in a separate space.
   - First, the practicing participant will complete a brief self-assessment (of what they did well and how they can improve).
   - The observing participant will give feedback next, using Learning Guide 1 and/or the more detailed Learning Guides 2, 3, and/or 4.
   - The trainer will rate the participant using Handout 13-D: Counseling Skills Observation Checklist and provide a verbal summary during this session.

7. **Rotation.** When both members of a training pair have counseled one client, they will return to the group waiting area and another training pair will enter the counseling room to practice.

8. **Timing and logistics.** The counseling practicum will occur before lunch. Transportation will be provided between the workshop site and the service facility. There will be additional training sessions after lunch, including a feedback session linking with the counseling practicum.

9. **Second day of practicum.** Participants will repeat the practicum activity on the last day of training. The reason for dividing the practice sessions over two days is to give participants the opportunity to improve by applying feedback they receive and their own learning from the first practicum day to the second. Thus, it is essential that all participants have a chance to practice counseling with a client on both days.

Handout 13-D

Counseling Skills Observation Checklist

Instructions to the observer. Confirm that the client has consented to be observed. When observing, be as discreet as possible (try to sit so that you are behind the client but not directly in view of the provider and make notes quickly). For each question, circle the response that most appropriately represents your observation of what happened during the interaction. Note that "the provider" refers to "the trainee" when this is used during trainings. *Please remember: you should not intervene in the consultation at any point.*

Facility name:	Type of facility:
Subdistrict:	District:
Region (if applicable):	Country:

Study client number:	
Service provider code:	Designation of the provider:
Date of visit:	

Observer's name:	Start time:

REDI: Tasks During Counseling	Responses		
Rapport Building			
1. Did the provider *greet the client with respect*?	1 – Yes	2 – No	0 – NA
2. Did the provider *make introductions*?	1 – Yes	2 – No	0 – NA
3. Did the provider *identify the category of the client*—new, satisfied return, or dissatisfied return?	1 – Yes	2 – No	0 – NA
4. Did the provider assure the *client of confidentiality* throughout counseling?	1 – Yes	2 – No	0 – NA
5. Did the provider *ensure privacy* throughout counseling?	1 – Yes	2 – No	0 – NA
6. Did the provider *explain the need to discuss sensitive and personal issues*?	1 – Yes	2 – No	0 – NA
7. Did the provider *use communication skills effectively*? (see #31-34 for detail)	1 – Yes	2 – No	0 – NA

Exploring			
	For <u>new</u> clients only. *For return clients,* ***skip to ⇨ 18***		
8. Did the provider *explore, in detail, the client's reason for the visit*?	1 – Yes	2 – No	0 – NA
9. Did the provider explore *the client's reproductive history, including recent pregnancy and prior experiences with contraceptive methods, and pregnancy prevention goals*?	1 – Yes	2 – No	0 – NA
10. Did the provider *rule out pregnancy*?	1 – Yes	2 – No	0 – NA
11. Did the provider *explore the factors related to monthly bleeding*?	1 – Yes	2 – No	0 – NA
12. Did the provider *explore the client's signs and history of STIs, including HIV*?	1 – Yes	2 – No	0 – NA
13. Did the provider *explore the client's sexual relationships*?	1 – Yes	2 – No	0 – NA
14. Did the provider *explore the client's social and gender contexts for decision making*?	1 – Yes	2 – No	0 – NA
15. Did the provider *explore the client's risk of STI/HIV*?	1 – Yes	2 – No	0 – NA
16. Did the provider *explore the client's current knowledge about pregnancy prevention, focusing on the method(s) of interest to the client*?	1 – Yes	2 – No	0 – NA
17. Did the provider *explain pregnancy prevention and other SRH options, focusing on the method(s) of interest to the client*?	1 – Yes	2 – No	0 – NA
	For <u>return clients</u> only. *For new clients,* ***skip to ⇨ 22***		
18. Did the provider *explore the client's satisfaction with their current method*?	1 – Yes	2 – No	0 – NA
19. Did the provider *confirm correct method use*?	1 – Yes	2 – No	0 – NA
20. Did the provider *ask about changes in the client's life* (e.g., plans about having children and STI risk and status)?	1 – Yes	2 – No	0 – NA
	For <u>dissatisfied return clients</u> only. *If satisfied return client,* ***skip to ⇨ 22***		
21. Did the provider *explore the reasons for the client's dissatisfaction or the problems*, including the issues, causes, and possible solutions (such as switching methods)?	1 – Yes	2 – No	0 – NA

Decision Making			
22. Did the provider *summarize the decisions that the client needs to make or confirm? (for satisfied return clients, go to* **27**)	1 – Yes	2 – No	0 – NA
23. Did the provider *identify relevant options for each decision* (e.g., pregnancy prevention, STI/HIV risk reduction)?	1 – Yes	2 – No	0 – NA
24. Did the provider *confirm medical eligibility for contraceptive methods the client is considering*?	1 – Yes	2 – No	0 – NA
25. Did the provider *help the client consider the benefits, disadvantages, and consequences of each option* and provide information to fill any remaining knowledge gaps?	1 – Yes	2 – No	0 – NA
26. Did the provider *confirm that any decision the client makes is informed, well-considered, and voluntary*?	1 – Yes	2 – No	0 – NA
Implementing the Decision (Providers may not need to cover all of these tasks with return clients unless they have made a new decision during this counseling session. In those cases, score as not applicable [NA].)			
27. Did the provider *assist the client to make a concrete and specific plan for implementing the decision(s)*?	1 – Yes	2 – No	0 – NA
28. Did the provider help the client *identify barriers that the client may face in implementing the plan*?	1 – Yes	2 – No	0 – NA
29. Did the provider help the client *develop strategies to overcome the barriers*?	1 – Yes	2 – No	0 – NA
30. Did the provider help the client *make a plan for follow up and/or provide referrals as needed*?	1 – Yes	2 – No	0 – NA
Communication Skills (to be used throughout)	1 – Yes	2 – No	0 – NA
31. Did the provider *ask open-ended questions* to encourage the client to speak?	1 – Yes	2 – No	0 – NA
32. Did the provider *listen to the client* without interrupting?	1 – Yes	2 – No	0 – NA
33. Did the provider *give correct information to the client, using clear and simple language* to ensure informed choice?	1 – Yes	2 – No	0 – NA
34. Did the provider *use visual aids* (e.g., brochures, flipcharts, contraceptive samples, posters)?	1 – Yes	2 – No	0 – NA

Additional comments:

Observation Summary (*Tick as appropriate*):	
Total score from the observation: # of Yes's _____ # of No's _____	
Competent in counseling (85% or more Yes's) _____	**Not competent in counseling (less than 85% Yes's)** _____
Action Plan – Check all that apply	
_____ Could become competent with additional experience (more cases) supervised by a competent provider/trainer	
_____ Follow-up visit in 1-3 months to assess the competency of the counselor	
_____ Other (specify)	
Assessor's signature	Date

Session 14:
Counseling Practice with Clients (First Round)

Handout 14-A

Counseling Case Studies (page 1 of 3)

Client Profiles for Case Studies
1. Sita is 27 and has two children aged five and three. She is using an intrauterine device (IUD) but suffers from frequent abdominal pain so she wants to have the IUD removed and try the five-year implant that her neighbor has used. Her husband is very aggressive and often hits her when he is angry or drunk. He does not want her to use any contraception and does not know about the IUD.
a) What categories of client is Sita? b) What decisions does she need to make? c) What are her options for each decision? d) What barriers might she face to using contraception or protecting herself from sexually transmitted infection (STI)/HIV? e) What strategies could she use to overcome those barriers?
2. Elena is 19 years old and unmarried. She has been sexually active for two years with the same partner. They wanted to get married but did not have enough money for a traditional ceremony. Now they have decided to get married without the ceremony. They have used condoms and withdrawal. Since they have decided to marry, they are having sex more often. Elena desperately wants something more effective to prevent pregnancy before they get married.
a) What categories of client is Elena? b) What decisions does she need to make?c) What are her options for each decision? d) What barriers might she face to using contraception or protecting herself from STI/HIV? e) What strategies could she use to overcome those barriers?

Handout 14-A

Counseling Case Studies (page 2 of 3)

3. Lucina is 32 years old and seven weeks pregnant. She has four children—the youngest is 11 months. She is sure that she does not want this pregnancy to continue. Her husband is with her and he agrees with her decision. She has come to the health center requesting an abortion. She will be able to get a manual vacuum aspiration at the facility, but was referred to you for counseling to prevent pregnancy after the procedure first.

a) What categories of client is Lucina?

b) What decisions does she need to make?

c) What are her options for each decision?

d) What barriers might she face to using contraception or protecting herself from STI/HIV?

e) What strategies could she use to overcome those barriers?

4. Sheela is 31 years old. She has a daughter aged five and a son aged three. She and her husband have decided that she should have the female sterilization. They have a good relationship and no problems.

a) What categories of client is Sheela?

b) What decisions does she need to make?

c) What are her options for each decision?

d) What barriers might she face to using contraception or protecting herself from STI/HIV?

e) What strategies could she use to overcome those barriers?

Handout 14-A

Counseling Case Studies (page 3 of 3)

5. Wonder is 25 years old and eight months pregnant. She has two children—one is three years old and the other is 10 months old. She came to the clinic for an antenatal check-up. The antenatal care provider walked her to your area, to make sure she is prepared to use a contraceptive method after delivery.

a) What categories of client is Wonder?

b) What decisions does she need to make?

c) What are her options for each decision?

d) What barriers might she face to using contraception or protecting herself from STI/HIV?

e) What strategies could she use to overcome those barriers?

6. Solomon is 24 years old. He works in the city in a hotel a few hours away from his home in the suburbs. He has a girlfriend with whom he spends his afternoon free time. They usually practice oral sex and the withdrawal method to avoid pregnancy. He has not used condoms because his girlfriend and he are scared it may tear and cause a pregnancy. But the last time they had sex, he did not withdraw in time, and now he's worried she may be pregnant. He has come to the clinic on his own.

a) What categories of client is Solomon?

b) What decisions does he need to make?

c) What are his options for each decision?

d) What barriers might he face to using contraception or protecting himself from STI/HIV?

e) What strategies could he use to overcome those barriers?

Session 15: Counseling Specific Categories of Clients

Handout 15-L

Session 15 Learning Objectives and Essential Ideas

Learning Objectives

By the end of this session, you will be able to:

- Explain the importance of being aware of your attitudes (either positive or negative) toward specific categories of clients
- Apply this awareness to case studies
- Identify key points to address when counseling clients for permanent methods, postpartum clients, postabortion clients, clients infected with HIV, unmarried adolescent clients, male clients, couples, and clients who are experiencing intimate partner violence (IPV)
- Explain how using a client-centered approach to counseling and following the REDI steps will allow you to effectively address the needs of a client in any category

Essential Ideas—Session 15

Building on Essential Ideas from the Pretraining Materials, Session 15

- In many service settings, pregnancy prevention efforts focus on married women. However, other individuals—including unmarried people, adolescents (married or unmarried), and single men—also have needs and rights related to pregnancy prevention services that must be considered and addressed. Similarly, clients interested in permanent methods and those in need of postpartum or postabortion contraception have particular needs for information and counseling.
- Counseling can sometimes reveal a relationship marked by a power imbalance and/or IPV. This requires a special approach to counseling to protect the health and possibly life of the client.
- By applying the principles of client-centered counseling and following the steps of REDI, providers *should* adequately address each client's unique needs and concerns. However, providers may have biases (positive or negative) about particular categories of clients, which may hinder the provider's ability to support each client's right to full, free, and informed choice for (or against) contraception. Recognizing these biases is the first step toward being able to set them aside and fully supporting each client's sexual and reproductive health (SRH) rights through counseling.

Handout 15-M

Key Points for Counseling Specific Categories of Clients (page 1 of 3)

Counseling Clients Interested in Permanent Methods (see also Handout 15-N)

- Because sterilization is *permanent* and requires *surgery*, counseling for sterilization services requires special attention.
- The counselor'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 of the seven elements of informed consent. The counselor must provide answers to all of the client's questions and ensure the client understands all of the information provided during the counseling session.

Postpartum Counseling

- Clients should wait at least two years after a live birth before trying to conceive again.
- Different types of contraceptive methods are appropriate at different times after delivery.
- Consider the client's breastfeeding plans.
- The ideal time to provide counseling for pregnancy prevention 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 not appropriate, due to the amount of stress that she may be experiencing at that time.

Postabortion Counseling

- Pregnancy prevention counseling and providing access to contraception are key elements of postabortion care. Clients can start any contraceptive method immediately postabortion.
- If not using contraception, a woman can become pregnant again in as few as 11 days following an abortion.
- For a desired pregnancy, experts recommend waiting at least six months before trying to conceive.
- Counseling *before the procedure* is only an option if the client is receptive and not under stress. The next appropriate time to counsel a postabortion client is *after the procedure* but *before she leaves the facility*.

Handout 15-M

Key Points for Counseling Specific Categories of Clients (page 2 of 3)

Counseling Unmarried Adolescents

When counseling unmarried adolescents, providers have several responsibilities.

- Be a reliable, factual source of information about SRH, including pregnancy prevention and prevention of sexually transmitted infections (STIs).
- Create an atmosphere of privacy, respect, and trust to encourage youth to feel free to ask questions, voice concerns, and discuss intimate sexual issues.
- Offer choices, accept the client's right to choose, and do not judge the choices they make.

Consider:

- Does the name of your service site make youth and unmarried people feel welcome? For example, does the term "family planning" discourage unmarried clients or those who do not yet have a family?
- What specific terms or words could you use to let unmarried adolescents know they can obtain pregnancy prevention services at your facility?

Counseling Male Clients

- Providers—just like clients—grow up receiving messages about gender and the different rights and responsibilities of men and women in society. These messages can affect providers' attitudes about working with men and couples.
- Be aware of your attitudes about working with men, to reduce or avoid the impact of biases.
- Treat a male client just like any other client!

Counseling Couples (see also Handout 15-O)

- Talk separately with the primary client (the one who will be using the contraceptive method) to make sure they are comfortable being counseled as a couple. Also, determine if there are issues that they do not want to discuss with their partner. Then, maintain confidentiality for the primary client (if needed).
- Acknowledge the importance of couples working together for both partners' SRH goals.
- Actively involve each partner by asking them each for their information and opinions.
- Pay attention to power and gender dynamics within the couple relationship and between provider and clients.
- Ensure voluntary decision making for the partner who will be using the contraceptive method.

Handout 15-M

Key Points for Counseling Specific Categories of Clients (page 3 of 3)

Counseling Clients Living with HIV (see also Handouts 15-P and 15-Q)

Make sure that clients know that people living with HIV:

- Can have a healthy sex life
- Can use most contraceptive methods safely (see note below)
- Can prevent further transmission of HIV
- Can have a healthy baby

Note: Clients who are *living with AIDS and are not well* should not use an intrauterine device (IUD) or be sterilized. This is the only restriction on contraceptive methods.

Counseling Clients Experiencing IPV

How does IPV affect decision making and use of contraceptives?

- The client may need to hide the contraceptive method from their partner.
- The client may have limited access to clinic services.
- The partner may hide or destroy birth control pills.
- The partner may not cooperate with partner-dependent methods, such as condoms or withdrawal.
- The partner may pressure or force a pregnancy or an abortion.

The provider's role in counseling for clients experiencing IPV:

- Do not judge the client (or the partner).
- Support the client's efforts to prevent pregnancy and to prevent contraction or transmission of an STI or HIV.
- Consider the impact of IPV on method choice and use.
  - Ask: Do you need a method that you can hide from your partner?
  - Ask: What would you do if your partner finds out you are using this method?
- Show the client a list of local facilities that provide IPV counseling and assistance. Do not insist that the client take the information but ensure the client knows where to go for further help.
- Protect the client's confidentiality!

Further Reading

Handout 15-N

Preventing Regret after Decision Making for Permanent Methods (page 1 of 2)

Counseling for permanent methods should address the factors discussed below.

Clients who undergo female sterilization or vasectomy when they are *very young* or who have *few or no children* are more likely to regret their decision later. As their circumstances change, they may wish to have children. The definitions of "young" and "few children" vary from country to country, depending on the typical age at marriage, the ages at which women normally bear children, and typical family size.

Pressure from family members to undergo female sterilization or vasectomy can lead to a decision that does not reflect the client's wishes.

Health providers may be perceived as pressuring clients, because they often have a higher social status and influence and are considered more knowledgeable. This is likely when there are medical indications to prevent pregnancy. However, when a client is forced into a decision, or the client perceives they are being forced into a decision, regret is likely.

Unresolved doubts are an indication that clients are not entirely sure of their decisions and may regret their decision in the future. Examples of issues that might lead to regret include religious or cultural norms that do not support limiting childbearing, personal feelings about ending fertility, and concerns about possibly wanting more children if a child dies or if the client remarries.

A reversal is usually not a realistic option. It is a difficult procedure to perform, it is not always available, and where it is available, it is often too expensive for most clients. In addition, some clients might not be medically eligible for the procedure. Clients who think that female sterilization and vasectomy are reversible are more likely to be disappointed and regret their choice. Therefore, the provider must review the client's decision carefully, stressing the intended permanence of these procedures.

Decisions made under stress might be regretted if and when the situation causing the stress is resolved. For example, if a marriage or other long-term relationship ends, a client might remarry (or form new relationships) and wish to have children with a new partner.

Further Reading

Handout 15-N

Preventing Regret after Decision Making for Permanent Methods (page 2 of 2)

Delivery and abortion are not usually optimal times for deciding to end fertility. The combination of physical and emotional stress and pain, required sedatives, and pressure from others might lead a woman to make a choice she otherwise would not make. Sometimes, however, clients have already carefully considered their decision about female sterilization. For example, in many countries, women counseled during antenatal care may decide to have female sterilization at the time of delivery. Performing the procedure at the time of delivery or after an abortion can be appropriate in these cases.

Providers should weigh each individual's circumstances carefully before deciding to offer and perform the surgery.

- If a client decides to be sterilized shortly before or after a delivery or an abortion, it might be best to provide the client with a temporary method until after the postpartum period or until fully informed consent can be ensured. For postpartum clients, the health of the newborn should be a consideration for any decision related to sterilization.
- Fully informed and voluntary consent cannot be obtained if a woman is sedated, in labor, or experiencing stress before, during, or after a pregnancy-related event or procedure.
- In most cases, women with postpartum or postabortion complications (e.g., anemia, infection, and/or hemorrhage) should not undergo a sterilization procedure until these conditions are resolved.

Further Reading

Handout 15-O

Key Considerations for Couples Counseling

Most often, providers start counseling with an individual client. Then, either the provider or the client suggests or requests that the partner be included in the counseling session. The partner should be included only if the client consents to it.

Seeing Partners Separately

Couples communication holds both promise and risk for making healthy, responsible decisions. Communicating with a couple can encourage shared decision making, gender equity, effective use of contraceptives, and agreement about desired family size. However, there may be times when communication with the couple *only* is not desirable. Providers must assess the potential risks of meeting with couples together (not separately) and monitor their interaction for possible unintended outcomes.

If possible, providers should meet individually with one or both partners before meeting with the couple together. Protocols that require this can be useful for providers to explain the need for an individual meeting to a couple, client, or partner who resists that idea. In addition, during this individual meeting, providers can screen for IPV and/or gender-based violence (GBV).

Understanding Power and Gender Dynamics

Gender dynamics can heavily influence counseling sessions with couples. It is essential for service providers to understand their own biases either against or in favor of men and to recognize any power dynamics that might be occurring in a couple. If a provider senses that they cannot discuss certain issues with a couple during counseling, they might need to discuss these issues with each partner separately.

In situations in which one partner dominates the other, the provider needs to encourage the "weaker" partner to express their concerns to ensure that any counseling addresses both partners' issues. (In many cultures, men are usually the decision makers and the woman is subordinate.) Providers can also explore relationship power dynamics to screen for possible IPV/GBV but must be careful not to assume the presence of violence based on a communication pattern (male dominance) that may simply reflect cultural norms.

Further Reading

Handout 15-P

Contraceptive Methods for Clients with STIs, HIV, or AIDS (page 1 of 3)

Clients with STIs, HIV, and AIDS, or on antiretroviral (ARV) therapy can start and continue to use most contraceptive methods safely. There are a few limitations, however, related primarily to the IUD and sterilization. Here is a general summary for female clients:

For an HIV-infected woman who does not have AIDS: All methods are considered category 1 (no restrictions) by the World Health Organization (WHO).

For a woman who has AIDS but is doing well on ARV therapy: All methods are WHO category 1, except the IUD which is category 2 (generally use).

For a woman who has AIDS and is not doing well: All methods are WHO category 1, except the IUD, which should not be inserted, and sterilization, which should be delayed.[1]

- *Male and female condoms* are the only methods that prevent both pregnancy and infection. It is important to use them correctly with *every* individual act of vaginal or anal intercourse.
- *All hormonal methods* (e.g., implants, injectables, and oral contraceptives) can be safely used. Rifampicin, which is used for tuberculosis treatment, usually reduces the effectiveness of implants and oral contraceptives. Some ARVs (protease inhibitors and nonnucleoside reverse transcriptase inhibitors, or NNRTIs) *may* reduce the effectiveness of hormonal methods, but this has not been proven. NRTIs are not a concern.
- *Fertility awareness-based methods* can be safely used. However, in case of an infection that causes vaginal discharge or fever, fertility awareness–based methods may be less effective, if they rely on the woman's temperature or normal discharge to indicate ovulation.

[1] https://www.globalhealthlearning.org/course/family-planning-101/page/client-who-infected-hiv

Further Reading

Handout 15-P

Contraceptive Methods for Clients with STIs, HIV, or AIDS (page 2 of 3)

- The *lactational amenorrhea method (LAM)* risks passing HIV to the baby. Women with HIV should be counseled to choose the feeding option that suits their situation.
  - Women living with HIV or AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding (between 5 and 20 of every 100 infants breastfed by mothers with HIV will become infected).
  - Women taking ARV medications can use LAM. ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk.
  - Rapid weaning also decreases the risk of HIV transmission. Women living with HIV or AIDS should stop breastfeeding after two days and within three weeks.
  - Replacement feeding poses no risk of HIV transmission and is recommended for the first six months after childbirth if—and only if—replacement feeding is *acceptable, feasible, affordable, sustainable,* and *safe*. If replacement feeding does meet these five criteria, exclusive breastfeeding for the first six months is the safest option for the baby and is compatible with LAM.
- For IUDs, spermicides, and sterilization, there are special considerations (see table).

In general, contraceptives and ARV medications do not interfere with each other. It is not certain whether some ARV medications make low-dose hormonal contraceptives less effective. However, if they do, condom use will address the issue.

Further Reading

Handout 15-P

Contraceptive Methods for Clients with STIs, HIV, or AIDS (page 3 of 3)

Special Contraceptive Considerations for Clients Who Have STIs, Who Have HIV, or Who Are Receiving ARV Therapy

Method	Clients Who Have STIs	Clients Living with HIV or AIDS	Clients Receiving ARV Treatment
IUD (copper-bearing or hormonal)	Clients with a high individual risk for gonorrhea and chlamydia, or who currently have gonorrhea, chlamydia, purulent cervicitis, or pelvic inflammatory disease (PID) should not have an IUD inserted. Clients who become infected with gonorrhea or chlamydia or who develop PID can safely continue to use an IUD during and after treatment.	• Clients with HIV but not AIDS can have an IUD inserted. • Clients with AIDS should not have an IUD inserted unless they are clinically well on ARV therapy. Clients who develop AIDS while using an IUD can safely continue using the method.	Clients who are not clinically well should not have an IUD inserted.
Spermicides	Clients with STIs can safely use spermicides, including with diaphragm or cervical cap.	Clients at high risk of HIV and those infected with HIV or AIDS should not use spermicides.	
Tubal Ligation	Clients with gonorrhea, chlamydia, purulent cervicitis, or PID, should delay sterilization until the condition is cured.	Clients experiencing an AIDS-related illness should delay sterilization.	
Vasectomy	Clients with an active STI, balanitis, epididymitis, orchitis, or a scrotal skin infection should delay sterilization until the condition is cured.	Clients experiencing an AIDS-related illness should delay sterilization.	

Further Reading

Handout 15-Q

Counseling Clients Living with HIV about Becoming Pregnant (page 1 of 2)

It is the client's decision to become pregnant. However, it is important for them to consider the risks and potential challenges related to bearing children when they are living with HIV.

What are the Risks?

Pregnancy risks and risks of infecting the baby are not as high as many people think. However, clients should be encouraged to consider all risks before deciding to try to become pregnant.

Risks to Baby

- If the mother is living with HIV, three out of 10 babies may contract HIV during pregnancy, childbirth, or breastfeeding. Most babies are not infected. Treatment lowers this risk to 1 of 10 babies who will become infected.
- If the mother is living with HIV, there is greater chance of stillbirth, premature birth, or low birth weight.

Risks to Mother

- HIV infection raises the risk of childbirth-related complications (such as anemia and fever), this is especially common with caesarean section deliveries.
- Pregnancy will *not* accelerate the course of HIV infection, but it is best to avoid pregnancy in some health situations (see "What Else Should a Woman Consider before Becoming Pregnant?").

Risks to Partner

- If the woman is uninfected and the man is infected, she will risk contracting HIV to become pregnant.
- If the man is uninfected and the woman is infected, he can avoid HIV risk by using artificial insemination, if the service is available.

Further Reading

Handout 15-Q

Counseling Clients Living with HIV about Becoming Pregnant (page 2 of 2)

What Else Should a Woman Consider before Becoming Pregnant?

Her Health Now

- *Pregnancy is possible*, if her health is good, if her CD4 count is greater than 200 cells/mm^3* or she is at clinical Stage 1 or 2 (where CD4 count is not available), if she is on prophylaxis to prevent opportunistic infections or is on ARVs (if eligible), and if she has no sign or symptoms of tuberculosis. (*Consider starting women with CD4 counts 200-350 cells/mm3 on ARVs before pregnancy.)
- *Delay pregnancy and revaluate later*, if pregnancy now may cause problems, (e.g., if her health is worsening, if her CD4 count is less than 200, if her tuberculosis status is unknown, if she is not taking prophylaxis to prevent opportunistic infections, or if she is in her first six weeks of ARVs).
- *Pregnancy is not a good idea now* if her health is poor (e.g., if she is in clinical Stage 3 or 4, if she is on tuberculosis treatment, if her CD4 count is less than 100, or if she is waiting to start ARVs).

Medical Care for Her and Baby

Are services available and accessible? Where are they?

Partner Support

- Does she have a steady partner?
- Does her partner know her HIV status?
- Is her partner supportive, and will he help with the baby?
- Does her partner know his own status? Is he willing to be tested? What is his health status?

Family Support

- Is her family supportive? Or, would they reject a child with HIV?
- Are family members located nearby? Can/will they help?

Taking about Her HIV Status

Has she told others? Is she planning to? Who can she not tell?

Feeding Her Baby

Will she be able to feed her infant in a recommended way to reduce the risk of transmitting HIV?

Further Reading

Handout 15-R

Challenging Moments in Counseling (page 1 of 2)

Challenges	Appropriate Provider Responses
1. Client becomes silent	• Empathize with the client; tell them you understand they might feel shy, and that many clients feel the same way. • Remind the client that everything discussed is confidential. • Reassure the client that nobody will overhear your discussion. • Stress the importance of understanding the client's needs and situation to be better help them. • Find out if there is a language barrier. • Check that the client is hearing properly. • Review your own communication skills.
2. Client cries	• Show the client that you care in the way that is *culturally appropriate* (e.g., holding the client's hand, touching them on the shoulder, or giving a tissue). • Show your understanding by reflecting the feelings of the client (e.g., saying "you must be very sad," or "this must be worrisome"). • Reassure the client that you will help them. • Explain that many clients in the same situation were able to overcome this problem. • Switch to another topic and continue with counseling.
3. Client refuses help	• Try to identify the cause for the refusal and address it accordingly. • Tell client that they are free to decide what to do. • Explain that you are talking to them as a friend and not dictating anything. • Reassure the client that you are there to help any time.
4. Client feels unimportant	• Tell the client that you care about them. • Praise the client for having come to the facility. • Try to understand why the client feels that way. • Reassure the client that they are very important to their children and family.

Further Reading

Handout 15-R

Challenging Moments in Counseling (page 2 of 2)

5. Client is uncomfortable with the provider (because of gender difference, age difference, or similar difference)	• Remind the client that anything discussed is confidential. • Praise the client for coming to the facility. • Explain that you see many male and female clients from different age groups, backgrounds, etc. • Ask if the client would be comfortable more with another service provider. • Empathize with the client and explain that you understand how they feel.
6. Client accuses a provider (not you)	• Find out if the client's allegation is true. ◦ If yes, explore and address the issue with the responsible provider. ◦ If no, find the cause of the accusation and manage it. • Show empathy by saying that the client might feel angry and that you understand their feelings.
7. Provider believes that there is no solution to the client's problem	• Seek assistance from peers, supervisors, or other health facilities. • Tell the client that you will help them resolve the issue.
8. Provider makes a mistake(s)	• Apologize and correct the mistake (if you have contradicted yourself, admit that you have made a mistake and provide the correct information).
9. Provider does not know the answer to the client's question	• Admit that you do not know the answer. • Seek assistance from colleagues or supervisors. • Check reference materials. • Refer the client to another provider.
10. Provider does not have enough time	• Use strategic questioning techniques to elicit the information as quickly and efficiently as possible. • Prioritize the client's problems (if they have more than one problem) and address the most urgent problem first; make an appointment to resolve the other problem(s). • Refer the client to another provider who is not busy.

Session 17:
Action Plans

Handout 17-A

Session 17 Learning Objectives and Essential Ideas

Learning Objectives

By the end of this session, you will be able to:

- Identify specific changes to make in your own counseling and in counseling services in your facility, based on what you learned in this training
- Develop action plans for implementing those changes

Essential Ideas—Session 17

- Lasting change does not happen overnight or even over the course of a single workshop. When developing individual action plans, you should focus on a few *key actions* and *strategies* to apply to your work. These should be small, concrete changes that give you the opportunity to practice what you learned and to see how it works.
- Big changes will likely take more time, be more difficult to implement, and require a champion to promote them within the work setting. You may need to speak with managers, supervisors, and staff in the workplace about the importance of the new ideas and approaches discussed in this training.
- These action plans will be reexamined during follow-up visits after the training (see Session 18). You should share your plans with your supervisor when you return to your workplace, to ensure that your supervisor understands, agrees with, and supports the plans. The action plans will also remind you of your commitments and help track your progress toward the goal of improved quality of services.

Handout 17-B

Action Plan (page 1 of 2)

What three things would I like to do differently *when counseling clients* at my facility?

Specific Changes or Activities to Implement Immediately	Possible Challenges or Barriers	Strategies for Overcoming Challenges	Timing

Handout 17-B

Action Plan (page 2 of 2)

What three things would I like to do to *support and improve counseling services* at my facility?

Specific Changes or Activities to Implement Immediately	Possible Challenges or Barriers	Strategies for Overcoming Challenges	Timing

Further Reading

Handout 17-C

Examples of Action Plan Barriers and Strategies

(page 1 of 2)

Barriers and Strategies

Listed below are examples of barriers that providers might identify and some *possible strategies* for addressing those barriers. This list may help you identify barriers that are specific to your situation or service site and strategies that you might apply or might need to develop to address these specific barriers. There are three main ways in which barriers can be addressed:

F = Facilitative supervision and management
I = Information, training, and development
S = Supplies, equipment, and infrastructure

Barriers to Effective Counseling	Strategies for Overcoming Barriers
Lack of time for counseling	**F:** • Reorganize facility flow to use time more efficiently and free up staff time for counseling. • Reprioritize counseling and allow staff to spend more time on counseling. • Involve frontline staff in intake and group education to cover basic informational tasks of counseling. (The appropriate strategy will depend on the specifics of the problem, available resources, and views/influences of administrators and supervisors.)
Lack of space to ensure privacy	**F/S:** • Partition or curtain off large rooms (e.g., waiting areas) to provide visual privacy. • Set aside one area of a large room with chairs arranged far enough away to provide listening privacy. • Use semiprivate spaces (e.g., examining rooms or administrative offices) that are not always in use. • Use space outdoors that is comfortable and private. • Schedule services so that some rooms that are not used during certain hours can be used as private space for ensuring privacy during counseling.
Lack of support or awareness from co-workers and supervisors for necessary changes (e.g., space and time)	**F/I:** • Orient the entire staff, including supervisors, to the importance of counseling, changes that might be necessary, benefits of such changes, and contributions they can offer. • Explain the benefits expected. • Ask supervisors for help prioritizing quality counseling services for the facility and its staff.

Further Reading

Handout 17-C

Examples of Action Plan Barriers and Strategies

(page 2 of 2)

Embarrassment about discussing issues of sexuality	**F/I:** • Orient and ask supervisors for help reinforcing the importance of discussing issues of sexuality, acknowledging that it can be embarrassing for providers (and clients), and solving problems that arise (e.g., through role playing). • Arrange for trainers or supervisors to provide follow-up support to address this issue (whether providers mention it or not) and provide reinforcements for overcoming the embarrassment. • Form peer support groups of providers who completed the training and can help each other by acknowledging that embarrassment is normal and by providing tips for overcoming the embarrassment.
Reluctance to identify clients' needs that cannot be met at the facility	**F/I:** • Ask managers and supervisors to identify other facilities where needed services are available. • Work with supervisors and managers to explore whether referral mechanisms exist and how to use or improve them. • Ask supervisors to encourage use of referral systems.
Pressure from administrators to meet service-delivery targets	**F/I:** • Orient supervisors and administrators on the importance of quality of care, clients' rights, and the benefits of meeting clients' needs (as opposed to the emphasis on targets). • Emphasize the importance of having satisfied and continuing clients, rather than more but dissatisfied clients who discontinue contraceptive use and spread negative reports about the pressure at your facility.