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**Introduction to
Men's Reproductive
Health Services—
Revised Edition**



USAID
FROM THE AMERICAN PEOPLE



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for a better life

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Introduction

This text is designed to provide health care workers with the skills and sensitivity needed to work with male clients and provide men's reproductive health services. The text contains information that health care workers may use when initiating, providing, or expanding a men's reproductive health services program.

While reproductive health services have traditionally been used by women, the importance of providing such services to men has received increased international support in recent years. In part, this has been the result of international conferences, such as the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994 and the Fourth World Conference on Women, held in Beijing, Republic of China, in 1995. In addition, the widespread transmission of HIV infection/AIDS and other sexually transmitted infections (STIs)—particularly in developing countries—has turned public attention to the need for both men and women to understand which behaviors may increase the risk for contracting and transmitting such infections. The widespread transmission of these infections has also heightened men's awareness of how the power imbalances that exist between men and women may play a role in increasing women's risk for STIs and other illnesses.

The text is organized into chapters covering the different areas that constitute men's reproductive health services. After introducing some general concepts about the delivery of men's reproductive health services, the text explains male sexual and reproductive anatomy and physiology, sexuality, contraception, STIs, and managing a men's reproductive health services program. In addition to information, the text contains diagrams, charts, and other graphic materials that may be adapted for use at a facility that offers men's reproductive health services.

Throughout the text, the term *service providers* will be used to refer to the staff at a health care facility (including outreach staff) who provide clinical, counseling, or educational services. Service providers may include doctors, medical officers, nurses, nurses' aides, midwives, counselors, health educators, outreach workers, and medical or surgical assistants. Similarly, the term *frontline staff* will be used to refer to all other staff or volunteers at a facility who provide support services, such as answering the telephone and assisting clients in the reception/waiting area. Frontline staff may include clinical assistants, receptionists, switchboard operators, doormen, guards, janitors, records staff, appointment clerks, accounts clerks, lab technicians, interpreters, drivers, and maintenance workers. Finally, the term *administrators* will be used to refer to the staff at a health care facility who manage service provision and make policy decisions that affect the day-to-day operation of a health care facility. Administrators may include regional supervisors, site supervisors, and service providers who oversee the work of other providers or of frontline staff.

1

Delivering Men's Reproductive Health Services

This chapter provides an overview of men's reproductive health services and explores the benefits and drawbacks of offering men's services for your clients, your facility staff, your facility as a whole, and the community.

The Importance of Involving Men in Reproductive Health

In many parts of the world, the reproductive health needs of men have not been adequately met. Reproductive health and family planning services, where they exist at all, have usually focused on the needs of the female partner. The reasons for this are complex, but those providing reproductive health services around the world now believe that this is a missed opportunity to improve the reproductive health of both men and women.

Why Involve Men?

- Women traditionally have been the focus of family planning programs. Women have often borne all of the responsibility for their reproductive health care, whether for the purpose of controlling fertility, protecting against sexually transmitted infections (STIs), or caring for a pregnancy. Today, many factors suggest that these issues are better addressed by women *and* men.
- When men are involved in reproductive health decisions and concerned about equity, both men and women are more likely to communicate with each other, make joint decisions about contraceptive use, discuss how many children they would like to have, and be actively involved in child rearing and domestic chores.
- Women have suffered as a result of men's absence from reproductive health care. For example, some women have needed to be treated repeatedly for the same STI because their partners do not have access to or will not seek care.
- Men often play a critical role in women's reproductive health. Frequently, they decide if and when a couple uses contraception (either to protect against disease or pregnancy), how and when to make resources available to a female partner to help her get care, and whether and when a female partner seeks antenatal care. Men have also been shown to play a key role in deciding whether and when a pregnant woman seeks emergency obstetric care and by what means of transport she arrives at the health care facility—the factors that have the most direct impact on outcomes for the mother and the infant.
- Men's reproductive health needs have not been adequately met, which often can leave them at great risk for negative reproductive health outcomes, such as HIV, other STIs, reproductive health cancers, etc.

Specific Issues to Address with Men

There is a growing recognition of the importance of involving men in a broad range of reproductive health issues, as follows.

Family Planning

- Many women say they want to delay or end childbearing but are not using contraception. The lack of support by their partners for contraceptive use, whether real or perceived, is one of the major factors for this unmet need.¹
- Studies have found that women are much more likely to continue using a contraceptive method if their partners approve of family planning. Contraceptive continuation rates have also been found to be higher if a partner is involved in family planning counseling.²

HIV/AIDS

- Efforts to stem the HIV/AIDS crisis can be successful only with the help of men. Men have more opportunity to contract and transmit HIV, they usually determine the circumstances of intercourse, and they often refuse to protect themselves or their partners.³
- Additionally, if providers of services aimed at preventing HIV infection do nothing to address the specific needs of men, these men may find themselves at elevated risk of becoming infected with HIV.

STIs

- Like HIV, other STIs can be prevented through condom use, which requires male participation.
- STIs are easier to detect in men than in women because men are more likely to exhibit signs and symptoms in comparison to women. Therefore, syndromic management (treatment of STIs based on signs and symptoms) of STIs is much more likely to be effective with male clients.
- If STIs in men are left untreated, these infections will continue to spread throughout communities. Women often need to be treated repeatedly for the same STI because their partners do not have access to or will not seek care.
- And just as with HIV, if providers of services aimed at preventing STIs do nothing to meet the specific needs of men, these men may find themselves at elevated risk of becoming infected with STIs.

Men's Roles in Safe Motherhood

- Men can play a critical role in preventing maternal mortality.
- Frequently, men decide if and when a couple uses contraception, and whether and when a female partner seeks antenatal care.
- Men have been shown to play a key role in deciding whether and when a pregnant woman seeks emergency obstetric care and by what means of transport she arrives at the health care facility—the factors that have the most direct impact on outcomes for the mother and the infant.

1 USAID Interagency Gender Working Group (IGWG). No date. *Involving men in sexual and reproductive health*. Presentation developed by Men and Reproductive Health Subcommittee, IGWG.

2 Ibid.

3 Foreman, M. 1998. *AIDS and men: Old problem, new angle*. Panos HIV/AIDS Briefing No. 6. London: Panos Institute.

Violence against Women

- Gender-based violence is directly related to women's sexual and reproductive health. It is a risk factor for several conditions, including unintended pregnancy, STI transmission, high-risk pregnancy, depression, and low self-esteem.⁴

Ways in Which Involving Men in Reproductive Health May Benefit the Community

Providing men's reproductive health care services may result in the following important benefits:

- Greater access to quality reproductive health services by women and men
- Higher rates of diagnosis and treatment for STIs, which, in turn, reduce the number of reinfections
- Fewer new cases of HIV and other STIs
- Early detection and successful treatment of prostate and testicular cancer
- Fewer adolescent pregnancies
- Better understanding of infertility problems
- Greater male involvement with children and contributions to parenting
- Better understanding of maternal health issues, maternal health care, and ways to recognize an obstetric emergency
- Better understanding of domestic violence and ways to enhance men's ability to communicate in nonviolent ways, including legal protection for survivors
- Better understanding of gender roles, traditional inequities between men and women, and how changing gender roles might benefit everyone
- Better understanding of sexuality and the different ways in which women and men experience sexual pleasure
- More intimate and sexually satisfying relationships between sex partners
- Increased communication between partners regarding reproductive and sexual health concerns
- Improved health overall for women, men, and children

Will Providing Services to Men Jeopardize Women's Programs?

Many people are concerned that providing reproductive health services to men will steer limited resources away from programs for women. This does not need to happen, though, because:

- Rather than shifting the focus away from women and toward men, the goal of providing men's reproductive health services is to create programs that benefit both men and women. Even so, careful monitoring must be integrated into programs to make sure that paying more attention to the needs of male clients does not come at the expense of the needs of female clients.

⁴ Heise, L., Ellsberg, M., and Gottemoeller, M. 1999. Ending violence against women. *Population Reports*, series L, no. 11. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

- The profits from a few men's reproductive health programs have been used to subsidize services for women. However, more research is needed to understand the true costs of providing health care services to both women and men.

Providing Services Does Not Have to Cost a Lot of Money

Creating special programs to provide reproductive health services to men might increase costs at some facilities. But this is not always the case. Many facilities have found creative ways to design services that incorporate both women's and men's needs. For example, a facility can provide services to men and women at different times of the day or offer to counsel both members of a couple, if the client wishes. In addition, some programs have used the profits gained from men's services to subsidize women's services. Many ideas have yet to be explored to determine how best to meet women's and men's needs in ways that are free or low-cost.

The Range of Men's Reproductive Health Services

One of the first steps in developing (or in considering developing) a men's reproductive health program is understanding the entire range of services that might be offered and then deciding which of these services your health care facility can provide. Every facility has resource constraints and must, therefore, decide which services are possible and are needed to serve its particular community.

The men's reproductive health model is a comprehensive list of services that could possibly be offered in a men's reproductive health program. Health experts in Africa, Asia, Latin America, the Middle East, and North America developed this model to help facilities consider which services a men's reproductive health program might include; no such model of men's services previously existed in the family planning and reproductive health community.

The men's reproductive health model divides men's reproductive health services into three categories: (1) screening, (2) clinical diagnosis and treatment, and (3) information, education, and communication (IEC). The model is specific to men's reproductive health services and includes limited information about general health screening or treatment, which may also be needed in a local community. However, men's reproductive health services may be incorporated into existing health services or may serve as a way to identify men's other health needs and refer men for other health services.

While a men's reproductive health program may provide services for a variety of health problems, the most common reproductive health problems in men are:

- Prostate cancer
- Testicular cancer
- Sexual dysfunction, including erectile dysfunction (impotence)
- Infertility
- STIs

The men's reproductive health model is provided on the next few pages.

The Men's Reproductive Health Model

Part 1: Screening

The service provider obtains a medical history of every client (including past surgeries, illnesses, and inherited traits) and performs a routine physical examination. *Note:* Screening for particular conditions should be performed only if treatment or referral for treatment is available.

Type of Screening	The service provider asks about or checks...	If necessary, the service provider delivers services or refers the client to another facility for...
Sexual and reproductive history	<ul style="list-style-type: none"> • Sexual experience and behavior, including the sex of the client's partner(s) • Any incidence of sexual abuse or domestic violence • Contraceptive use (especially condoms) • Desires/concerns of fatherhood 	<ul style="list-style-type: none"> • Services for survivors and perpetrators of sexual abuse and domestic violence • Counseling on paternal rights and responsibilities, single-fatherhood support groups, parenting classes
Age-appropriate routine physical examination (as required for sports, jobs, etc.)	<ul style="list-style-type: none"> • Blood pressure, lipid profile, heart/lungs, breasts for lumps, urine sample • Urinary difficulties or concerns (may include dipstick urinalysis and check for nitrites) • Nutrition/diet habits • Development 	<ul style="list-style-type: none"> • Dental care • Vaccinations • Dietary education • Baldness (if problematic for the client) • Job training, educational programs, employment/ counseling services
Cancer evaluation	<ul style="list-style-type: none"> • Family history of prostate, testicular, colon, skin cancer • Whether the client has ever had a prostate exam, testicular exam, colonoscopy, skin cancer screening 	<ul style="list-style-type: none"> • Follow-up testing and treatment for cancer, as needed
Substance abuse and mental health needs	<ul style="list-style-type: none"> • Use of such substances as alcohol, tobacco, drugs, steroids • Depression • Difficulty managing anger • Difficulty managing anxiety 	<ul style="list-style-type: none"> • Substance-abuse treatment • Mental health care/stress management • Counseling on violence prevention • Services for runaways/ homeless persons

The Men's Reproductive Health Model (continued)

Part 2: Clinical Diagnosis and Treatment

The service provider delivers services if screening identified a need for them.

Type of screening/ service	The service provider delivers services or refers the client to another facility for...
Sexual dysfunction and other disorders of the male reproductive system	<ul style="list-style-type: none">• Erectile dysfunction (impotence)• Premature ejaculation• Acne and skin lesions of the genital tract (including colposcopy for warts)• Disorders of the reproductive system• Hernias• Varicoceles• Urological disease (e.g., benign prostate hyperplasia)• Counseling
Sexually transmitted infections (STIs), including HIV infection	<ul style="list-style-type: none">• Blood test for HIV infection and other STIs• Urethral swabs (to test for chlamydia and gonorrhea)• Premarital blood test• Treatment of STIs, including gonorrhea, syphilis, chlamydia, human papillomavirus (HPV), genital warts, and HIV/AIDS
Fertility evaluation	<ul style="list-style-type: none">• History, examination, and semen analysis• Blood test for paternity• Semen analysis• Infertility services• Sperm bank
Vasectomy	<ul style="list-style-type: none">• Prevasectomy counseling• Vasectomy• Postvasectomy semen analysis• Vasectomy reversal

The Men's Reproductive Health Model (continued)

Part 3: Information, Education, and Communication (IEC)

The service provider discusses the client's options and gives all clients educational information.

Service	The service provider discusses...	If necessary, the service provider delivers services or refers the client to another facility for...
Education on sexuality and physiological development	Basic sexuality and fertility, including: <ul style="list-style-type: none"> • Normal age-related changes (including height/weight) • Changes in sexual functioning during the reproductive life span • Penis size • Male and female anatomy and physiology • Sexual orientation • Sexual abuse and domestic violence • Statutory rape awareness • Male role definitions 	<ul style="list-style-type: none"> • Counseling on abnormal development • Counseling on gender-identity issues • Counseling on sexual abuse and domestic violence
Education and counseling on contraception	<ul style="list-style-type: none"> • All female and male contraceptive methods 	
Education and counseling on STIs, including HIV infection	<ul style="list-style-type: none"> • The definitions, symptoms, and prevention techniques for all STIs, including HIV infection 	
Education on genital health and hygiene	<ul style="list-style-type: none"> • Penile hygiene • How to perform a testicular self-examination • Factors contributing to prostate cancer 	
Information and education on communication skills relating to sexual and reproductive behavior	<ul style="list-style-type: none"> • Male and female sexuality, relationships, sexual decision making • The male partner's role in pregnancy, abortion, hysterectomy • Postpartum syndrome • Premarital considerations 	<ul style="list-style-type: none"> • Mastectomy partner counseling • Genetic counseling

A Framework for Working with Men

Counseling is an integral component of a comprehensive effort to meet men's reproductive health needs. Reproductive health programs use many approaches to involve men. Most of these approaches fall into one of four categories:

- **Social marketing/persuasion/motivation:** Prompting behavior change in clients by marketing a product, service, or action
- **Community education/information-giving:** Transmitting or exchanging information in a community setting to help clients understand the importance of reproductive health issues
- **Counseling:** Exchanging information in a service-delivery setting in order to create awareness of reproductive health issues and help clients confirm or reach informed and voluntary decisions about their reproductive health care
- **Clinical services:** Providing men's reproductive health services in a clinical setting; these include treatment for STIs, sexual dysfunction, and other disorders of the male reproductive system, as well as vasectomy, fertility evaluation, and cancer evaluation services

Figure 1-1 provides a visual representation of the relationships among these four approaches.

Figure 1-1. The Relationships among the Four Approaches to Involving Men in Reproductive Health Services



The four parts of the pyramid indicate the number of clients that benefit from each particular approach and are in a specific order. The number of clients affected by these four approaches is largest at the bottom of the pyramid and gets smaller from bottom to top. For example, social marketing/persuasion/motivation can reach more clients than clinical services can, so it occupies a larger section of the pyramid. The pyramid itself represents the logical progression of a client coming for services. Since social marketing may create interest, the client may then seek information. Once the client has this information, he may seek counseling. If the client receives counseling, he may then decide that a clinical service is necessary.

The variations among the four approaches are shown below.

The Differences among the Four Approaches to Involving Men in Reproductive Health Services

Approach	Goal	Content	Direction	Biased or Objective	Example
Social marketing/ persuasion/ motivation	To influence behavior in a particular direction	Persuasion, focus on benefits	One-way	Biased	Sign or poster that encourages family planning use
Community education/ information-giving	To provide facts and raise awareness	Facts, skill building	One-way or two-way	Biased or objective	School health talks, informational pamphlets
Counseling	To ensure clients' informed and voluntary choice	Facts; clients' feelings, needs, concerns	Two-way	Objective	One-on-one discussion about family planning decisions
Clinical services	To provide medical services to clients	Medical services, family planning methods, medication	One-way	Objective	Vasectomy, STI diagnosis and treatment

The following examples demonstrate how the various approaches to working with men can be implemented in a reproductive health program.

Social Marketing/Persuasion/Motivation

- A television advertisement urges men to use condoms.
- A sign or poster shows a photograph of a couple entering a family planning clinic together.
- A radio spot encourages men to bring their wives to a facility for antenatal care.
- A brochure explains how vasectomy can improve men's lives.

Community Education/Information Giving

- A health care worker tells a group of men that their pregnant wives should eat a balanced diet.
- A theater group acts out domestic violence situations and then discusses them.
- A group of young men participate in school programs in which they give talks about preventing HIV or unintended pregnancy.
- A poster explains signs and symptoms of STIs in men.

Counseling

- A doctor responds to a client's concern about vasectomy by explaining that the procedure will not adversely affect his sexual performance.
- A midwife assists a couple living in a village develop a labor and delivery plan.
- A service provider helps a couple assess their risk for HIV.
- A couple talk with a nurse about which family planning method would be best for them.

Clinical Services

- A doctor visits a factory to provide STI diagnosis and treatment to male employees.
- A nurse conducts a digital rectal exam for prostate cancer screening.
- A lab does a fertility workup on a male client.
- A doctor performs a vasectomy.

Advantages of and Challenges to Providing Men's Reproductive Health Services

As discussed at the beginning of this chapter, there are many advantages and benefits to providing men's reproductive health services. However, there are also many potential challenges to providing successful services. Often, members of particular groups may perceive the advantages of and challenges to providing men's reproductive health services differently from other groups. These groups may include potential male clients, female clients, facility staff, and members of the community, including religious, civic, and youth groups, local leaders, businesspeople, local health care providers, and traditional healers.

General Challenges or Concerns

On the whole, potential challenges to or concerns about providing men's reproductive health services may include:

- Staff resistance or ambivalence toward men or toward providing men's reproductive health services
- No clear definition of men's reproductive health services
- No clear sense of men's need and/or desire for reproductive health services
- Lack of funding
- Lack of staff dedicated to the men's reproductive health program
- Lack of support for the men's reproductive health program by facility administrators or health officials
- Lack of IEC materials focused on men
- Lack of marketing of available men's reproductive health services

Specific Challenges or Concerns

Some possible advantages of and concerns about providing men's reproductive health services, as perceived by the members of particular groups, are shown on the next few pages.

Possible Perceived Advantages of and Concerns about Providing Men's Reproductive Health Services

Group	Possible advantages/ benefits	Possible disadvantages/ concerns
Potential male clients	<ul style="list-style-type: none"> • Better reproductive health, prevention of STIs • Possibility of increased intimacy with sex partners, greater satisfaction with sexual relations, and fewer problems with sexual dysfunction • Greater knowledge and ability to make decisions about their own and their family members' health 	<ul style="list-style-type: none"> • Discomfort interacting with female staff • Stigma or embarrassment associated with visiting a facility, especially if the facility has traditionally offered services for women only • Confidentiality concerns • Cost • Fear that they will receive bad news about their medical condition
Female clients receiving services at the facility	<ul style="list-style-type: none"> • Healthier spouses/partners • Support/shared responsibility for their use of contraception and STI prevention • Greater male understanding of women's reproductive and sexual health needs • Chance to deal with infertility problems • Possibility of increased intimacy and more equal relationship with sex partners, as well as greater satisfaction with sexual relations • Improved ability to guide their children • Help in addressing partner's problems with alcohol and/or domestic violence 	<ul style="list-style-type: none"> • Discomfort with men learning about women's bodies • Loss of control over family planning information • Concerns about confidentiality when visiting the facility • Less staff time spent on women's services • More clients overall at the facility • Fear of physical violence (real or threatened) from male partner after learning that either partner has an STI

(continued)

Possible Perceived Advantages of and Concerns about Providing Men's Reproductive Health Services *(continued)*

Group	Possible advantages/ benefits	Possible disadvantages/ concerns
Health care facility staff	<ul style="list-style-type: none"> • Opportunity for learning new things and for future career growth • Opportunity to hire more/some male staff • Create/legitimize new role for male nurses • Presence of male staff adds a sense of security at night or at certain locations • Involvement of husbands/ partners can provide better help to some female clients • Become better able to help their own family/sons 	<ul style="list-style-type: none"> • More work • Want to work with women/do not want to work with men • Discomfort working with male clients • Diverting resources from female clients • Concerns about staff and client safety • Concerns about maintaining confidentiality of female clients • Fear that the presence of male staff will change the dynamics in the facility • Problems of women supervising men
Members of the community	<ul style="list-style-type: none"> • Healthier individuals, couples, and families leads to a healthier community • Help with problems of rape, sexual abuse, domestic violence • Increased contraceptive use (for those in favor) • Place to refer men 	<ul style="list-style-type: none"> • Fear that sex education and related services will lead to increased promiscuity in adults and adolescents • Increased abortion • Increased contraceptive use (for those opposed)

Ways to Address Challenges

Ways to address challenges or barriers to successful men's reproductive health services include:

- Providing training to make staff more comfortable working with male clients, including attitudinal, management, clinical, and sexuality training
- Creating new funding streams and/or new ideas for generating revenue
- Including men's reproductive health services in the facility's mission statement
- Gaining support from the facility's Board of Directors, top management, and key staff
- Creating a new organizational chart for the facility
- Collecting and distributing IEC materials or implementing an IEC campaign
- Implementing a social marketing campaign or an aggressive outreach campaign or peer program
- Distributing condoms throughout the community
- Forming collaborations with other facilities in the community

Addressing Staff Concerns about Working with Male Clients

For a men's reproductive health program to be successful, it must have the support of facility staff, administrators, and community members. Helping individuals sort through their perceptions of the advantages and challenges of a new program or service takes skill and effort. Addressing concerns and pointing out *realistic* potential benefits as early in the planning process as possible may help avoid or address problems and reduce false expectations of what a program can deliver.

Staff Concerns

Any change in one's work situation may create circumstances that require some adjustment. Some of these changes may be positive, while others may be negative. When men's reproductive health services are initiated or expanded, staff members' anxieties and negative feelings about providing services to men can affect how the staff view the program. When one acknowledges these difficulties, it is possible to see the need to develop approaches to address them and to remove barriers to providing services to men.

An effective way of addressing these concerns is to recognize where they come from and to focus on the resources available to staff in addressing them. A staff member's straightforward and professional manner will be reassuring for new clients, who are also likely to feel somewhat nervous and uncomfortable.

The chart on the next few pages shows some personal concerns that facility staff may have about offering men's reproductive health services and provides some possible strategies to address them. (Programmatic concerns are addressed in Chapter 8: Provision of Men's Reproductive Health Services.)

Possible Staff Concerns and Strategies to Address Them *(continued)*

Concern	Possible Strategies
A male client will walk into a restroom or examination room where a woman is being examined.	<ul style="list-style-type: none"> • Plan separate men’s and women’s restrooms or ensure that restrooms have locks. • Display clear signs indicating service areas for men and women (if they are separate). • Schedule men’s services at different times from women’s services. (This is optional. With general health services, for example, both male and female clients may be scheduled for services at the same time.) • Ensure that services are organized so that clients are carefully clothed in shared spaces; provide exam gowns for clients to cover themselves, if necessary.
A male client will flirt with or make sexual remarks to a staff member.	<ul style="list-style-type: none"> • Remember that sexual advances or flirtation may reflect anxiety or uncertainty about appropriate behavior in an unfamiliar situation. • Do not make flirtatious remarks or jokes; act businesslike and in a formal manner at all times. • Ignore the remark. If the behavior continues, remind the client that his behavior is inappropriate. • If the behavior still continues, walk away and ask another staff member or a supervisor to deal with the client.
A male client will be reluctant to receive services from a female staff member.	<ul style="list-style-type: none"> • If a male staff member is available, arrange to have the client see him. • If a male staff member is not available, reschedule the client’s appointment for a time when a male staff member is available, or refer the client to another facility for services.
A male client will accuse a staff member of being ignorant or incompetent.	<ul style="list-style-type: none"> • While instances of incompetence may exist, it is common for individuals to address their feelings of unhappiness or loss of control by blaming others. • Tell the client that you are sorry he is displeased with the service. If you have been acting in accordance with specified facility protocols, tell him so. • Ask the client if he would like to see a different service provider or staff member or be referred elsewhere for care. If the client agrees to see a different staff member, ask the staff member to find out what the client’s expectations were—that is, what happened that he interpreted as incompetence? A respectful hearing may serve to dissipate the client’s negative feelings and offer an opportunity for correcting misconceptions. • After the client leaves, ask your co-workers whether they can think of any more effective ways of addressing the client’s problem (e.g., different tests or procedures, better explanations to clients, staff training).

(continued)

Possible Staff Concerns and Strategies to Address Them *(continued)*

Concern	Possible Strategies
A male client will become disruptive, angry, or threatening.	<ul style="list-style-type: none"> • Politely ask the client to leave the facility. • Call a supervisor to ask the client to leave. • If the behavior is extremely disruptive, the client refuses to leave, or the client seems threatening, ask staff to usher other clients and staff out of the facility, and call security or the police. • If a particular client is regularly disruptive, prohibit him from returning to the facility. If he returns, call for assistance as soon as he appears. • Excuse yourself and leave the room; allow the client to calm down on his own and do not argue with him. Find another staff member to accompany you when you go back into the room. • When you feel more secure (either because the client has calmed down or because you have a companion), ask the client to explain what was bothering him. Address the anger in a factual, calm manner.
A male client will rape or pose other physical risks to clients or staff.	<ul style="list-style-type: none"> • Physical risks, such as attacks or rapes, are not specific to facilities where men's services are provided—they are criminal acts and should be treated as such. • If appropriate and feasible, request that police train the staff in addressing personal safety issues.
A male client will develop an erection during an examination or procedure.	<ul style="list-style-type: none"> • Tell the client that erections can occur in response to anxiety and as a reflex to physical touch during an examination, and then inform him of the examination steps you plan to perform next.
A male homosexual client will cause staff and other clients to feel uncomfortable.	<ul style="list-style-type: none"> • Homosexual men need and have a right to the same types of care as heterosexual men. Address all clients in a neutral, professional manner.

2

Male Sexual and Reproductive Anatomy and Physiology

This chapter provides an overview of the male reproductive system. Specifically, it provides information about male sexual and reproductive anatomy and physiology, including erection and ejaculation.

Communicating with Clients about Sexual Anatomy and Behaviors

In this chapter and in much of this book, explicit terms are used to describe sexual organs, sexual function, and sexual behaviors. Many people, including service providers, are uncomfortable using slang and sometimes medical terms for sexual anatomy and behaviors. Male clients coming to a health care facility seeking information about services may use common, slang, or colloquial terms to describe their bodies, sexual behaviors, and sexual function. Therefore, it is important for health care staff to understand both the medical and the common or slang terms used in their local area and to be comfortable hearing (and perhaps using) common or slang terms in order to communicate effectively with clients.

Health care staff have several ways to help clients learn and use the medical terms. For example, a service provider might say to a client, “You have a sore on your dick? [Note: Or some other culturally appropriate slang word for “penis.”] Oh, another word for *dick* is *penis*. I will probably call it a penis more often, but it means the same thing.” In this way, the client learns the medical term without feeling criticized or unknowledgeable for having used the slang term.

Medical terms that you may hear at your facility include:

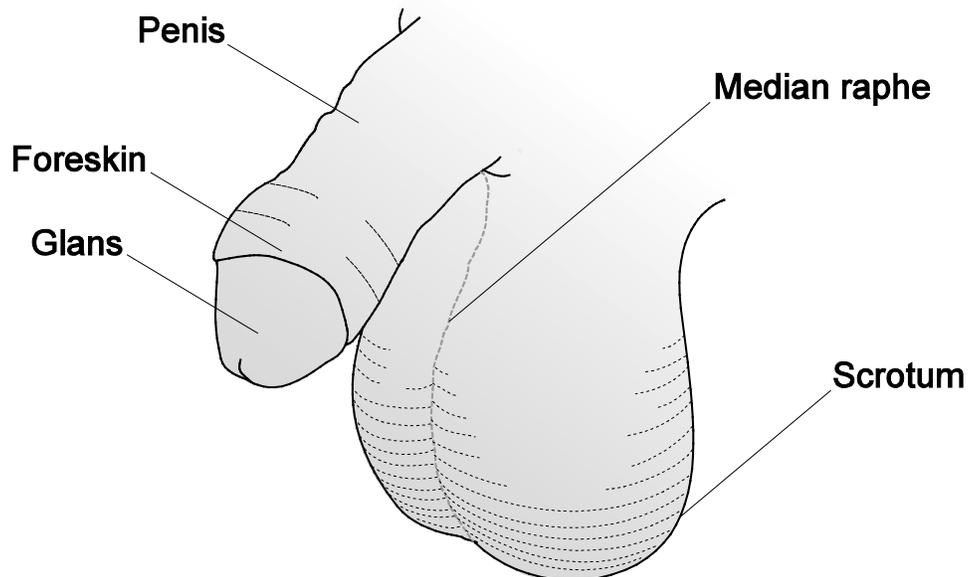
- **Body parts:** penis, scrotum, testes/testicles/male gonads, clitoris, vagina, breasts, anus
- **Sexual behaviors and related terms:** erection, masturbation, sexual intercourse, penile-vaginal sex, oral sex (*fellatio* when performed on a man, *cunnilingus* when performed on a woman), anal sex, withdrawal, ejaculation, orgasm, condom, impregnate

Overview of the Male Reproductive System

External Male Genitals

As shown in Figure 2-1, the external male genitals are the penis, the glans, the foreskin, and the scrotum.

Figure 2-1. External Male Genitals



The **penis** is a tubular structure with the capacity to be flaccid or erect; it is very sensitive to stimulation. The head of the penis, the **glans**, includes the most highly innervated, or sensitive, part of the penis and is covered by the **foreskin** in men who are not circumcised. The penis provides passage for both urine and semen.

As is the case with other human characteristics, adult penis size and shape vary. The size of a penis when it is flaccid does not predict what size it will be when it is erect. Most men have an erect penis length in the range between 12 and 18 cm (5 to 7 inches), roughly the same as the length of most women's vaginas. Some variation also occurs in penis diameter. Average diameter (width) of an erect penis is 4 cm (1.6 inches).

Although concern about penis size is common, true *microphallus* (abnormal smallness of the penis) is rare. To assess the normality of penis size, the stretched penile length (SPL) of a flaccid penis is determined. Microphallus is defined as an SPL of less than 4 cm (1.6 inches) for prepubertal boys or less than 10 cm (4 inches) for adult men.

The **scrotum** is a pouch hanging directly under the penis that contains the testes. The scrotum both protects the testes and contracts to raise or lower the testes toward and away from the body in order to maintain the optimal temperature for sperm production within the scrotum, 34°C (93°F). The **median raphe** is a seam or ridge that appears at the place where the two halves of the scrotum join together.

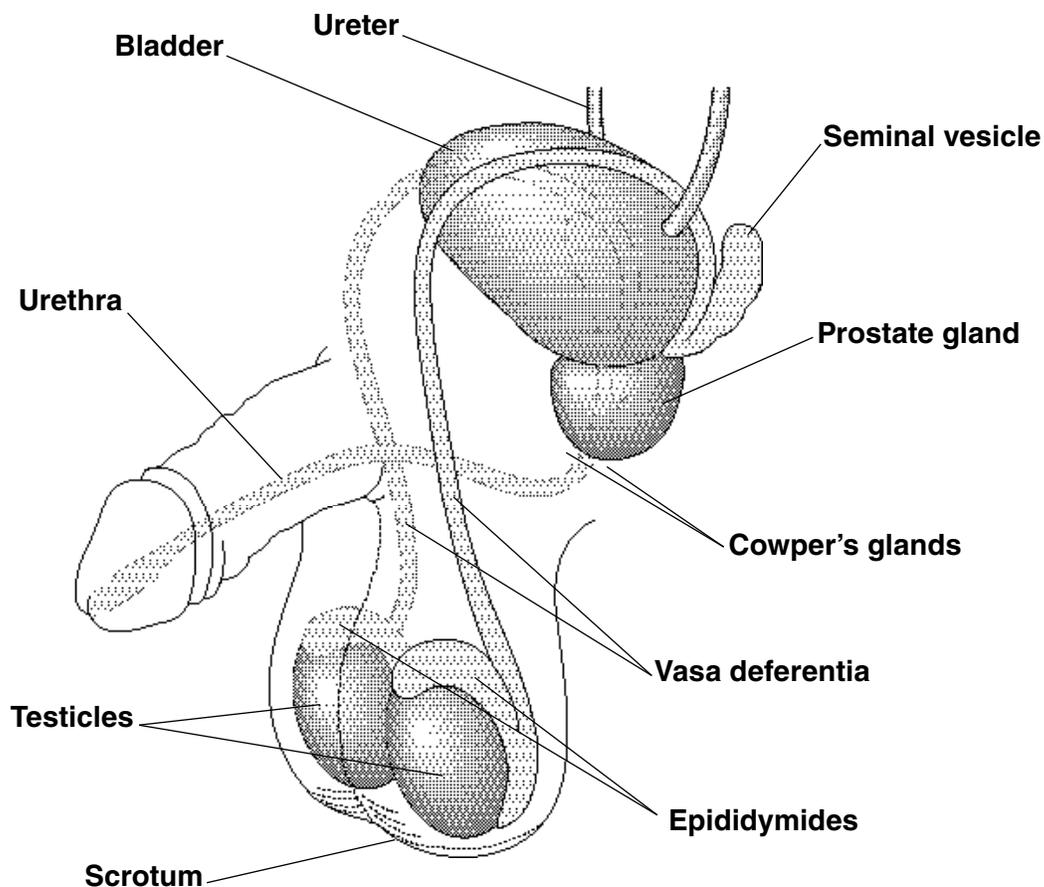
Overview: Male Circumcision

Male circumcision is the surgical removal of the foreskin, the skin that covers the glans of the penis. Although male circumcision is commonly practiced in many countries, its health benefits are uncertain; however, several studies show that circumcised boys are less likely to develop urinary tract infections than uncircumcised boys. But because these infections are relatively uncommon and easily treated, it is unclear whether male circumcision is a reasonable preventive measure. Current studies are looking at the relationship between male circumcision and the transmission of sexually transmitted infections (STIs). In low-resource settings, where male circumcision is performed by service providers without proper medical training, risks associated with the procedure include tetanus infection, severe blood loss, disfigurement, and even death.

Internal Male Genitals

As shown in Figure 2-2, the internal male genitals are the testes, the epididymides, the vasa deferentia, the seminal vesicles, the prostate gland, and the Cowper's glands.

Figure 2-2. Internal Male Genitals



The **testes**, which are located in the scrotum, are the paired organs that produce sperm and male sex hormones. They are highly innervated and sensitive to touch and pressure. The testes produce **testosterone**, which is the hormone responsible for the development of male sexual characteristics (a man's deepened voice and prominent facial hair) and sex drive (libido). The **epididymides** (singularly, an **epididymis**) are the two highly coiled tubes against the back of the testes where sperm mature and are stored until they are released during ejaculation. The **vasa deferentia** (singularly, a **vas deferens**) are the paired tubes that carry the mature sperm from the epididymis to the urethra.

The **seminal vesicles** are the pair of glandular sacs that secrete some of the fluid that makes up semen, the white, milky fluid in which sperm are transported. Seminal fluid provides both the medium for transport of and nourishment for the sperm. The **prostate gland** is a walnut-sized glandular structure that also secretes fluid that makes up semen. A muscle at the bottom of the prostate gland keeps sperm out of the urethra until ejaculation, the process of releasing semen, begins. This same muscle also keeps urine from coming out during ejaculation. The prostate gland is very sensitive to stimulation and can be a source of sexual pleasure. The (urinary) **bladder** is a hollow organ that serves as a reservoir for urine. The **ureters** are two long, narrow tubes that transport urine from the kidneys to the bladder.

The **Cowper's glands** are two pea-sized glands at the base of the penis under the prostate that secrete a clear fluid into the urethra during sexual arousal and before ejaculation. This fluid, which is sometimes known as pre-ejaculate or "pre-cum," acts as a lubricant for the sperm and coats the urethra while flowing out of the penis.

Erection and Ejaculation

Erection is the process by which the penis fills with blood and becomes firm and erect. It occurs through a complex interaction of mental and/or physical stimulation. Sexual thoughts or feelings may trigger erections, as may either direct stimulation on or near the penis or other types of physical touch on the body. Erection can also occur for reasons other than sexual arousal. Erection occurs naturally during sleep and has even been observed on male fetuses in utero.

The process of **ejaculation** begins when a man reaches a peak level of sexual arousal through stimulation of the penis, known as *ejaculatory inevitability*. At this moment, sperm are released from the epididymides and travel through the vasa deferentia, passing through the seminal vesicles and the prostate, where the sperm mix with the seminal fluid to form **semen**. Through quick, pleasurable muscular contractions known as an **orgasm**, semen is forcefully expelled through the penis and out of the body. Each ejaculation contains between 3 and 3.5 milliliters of semen, which contain between 200 million and 400 million sperm. Sperm production begins during puberty and continues over the course of the life span. As long as a man remains healthy, he will never stop producing, or "run out," of sperm, though the number of sperm produced may decline with age.

Before ejaculation, the Cowper's glands release pre-ejaculatory fluid, which neutralizes the urethra, making the path out of the penis more hospitable to sperm. This pre-ejacula-

tory fluid does not contain sperm, but could contain bacteria or viruses that could infect a partner. However, if a man becomes aroused again shortly after ejaculation, the new pre-ejaculatory fluid may contain residual sperm that was left in the urethra during the first ejaculation. This may put those who engage in subsequent sexual activity with him at risk for pregnancy and transmission of HIV and other STIs.

Shortly after ejaculation, blood flows out of the penis and the erection subsides. A man will not be able to achieve another erection for a certain length of time, known as the *refractory period*. This length of time varies by age and may be range from a few minutes to many days.

Men may experience erection without orgasm. There is no harm to a man if he engages in sexual activity that does not result in orgasm and ejaculation. Some men may experience a slight pain in the testes or groin if they engage in sexual activity without orgasm, but this pain—which is sometimes referred to as “blue balls”—subsides on its own or can be relieved through masturbation to achieve orgasm. If a man does not ejaculate for a long time, the sperm either are expelled through ejaculations during sleep or are simply reabsorbed by the body.

Common Client Concerns about Anatomy and Physiology

Sometimes men pose challenging questions about their anatomy or physiology to health care workers. Here are some suggestions on how to address their concerns.

Concern: “Is my penis big enough?”

Possible response: “Many men are concerned about the size of their penis. Some men wonder if their penis is as big as other men’s. While penises may vary in size when they are flaccid or not erect, most men’s penises are close in size when they are erect. However, if you are concerned about the size of your penis, we will be able to determine whether it is abnormally small.”

Concern: “Why does one of my testes hang lower than the other?”

Possible response: “It is perfectly normal for one testicle to hang lower than the other and for each of the testes to have a slightly different size or shape.”

Concern: “I could not get an erection the last time I had sex.”

Possible response: “Most men experience that at some point in their life. This may have happened to you for a variety of different reasons. It could simply have been stress or anxiety about a sexual encounter, or it could have been a sign of a physiological cause. The good news is that people here can help you.”

Concern: “I wish I could last longer when I have sex.”

Possible response: “Many men wish for the same thing. Any ejaculation that happens before you want it to may be due to overeagerness or ‘performance anxiety.’ You can do several things to last longer, if you wish, including wearing a condom to reduce sensitivity. A service provider here can tell you more.”

Concern: “My penis looks different from other men’s penises.”

Possible response: “Some penises look different from others because some men are circumcised and some men are not. Some men’s penises look very different when they are flaccid, or not erect. The width and length of a flaccid penis may vary, but the look and size of a man’s penis have nothing to do with how much of a man or how good a lover or sexual performer he is. However, if you are concerned about the appearance of your penis, see a service provider, who will be able to determine whether there is anything abnormal about it.”

Concern: “Is there something wrong with me if I wake up with an erection?”

Possible response: “Many men wake up with erections. Every night while a man sleeps, he may get four to five erections in his sleep. Sometimes he may wake up with an erection, regardless of whether he was having a sexual dream or sexual thoughts upon awakening.”

Concern: “Is there something wrong with me if I ejaculate in my sleep?”

Possible response: “There is nothing wrong with you. It is perfectly normal to ejaculate while you sleep. Sometimes such ejaculations are called nocturnal emissions, or ‘wet dreams.’ They are not harmful in any way, and many men may not even realize they have had one.”

Concern: “If I have sex too much, will I run out of sperm?”

Possible response: “No, men do not run out of sperm, regardless of how many times they have sex. Men are always producing sperm. While the amount of sperm produced may decrease as a man gets older, a healthy man will continue to produce sperm that is capable of resulting in pregnancy into older age.”

Concern: “I am afraid I might urinate inside my partner during sex.”

Possible response: “A lot of men wonder about that. Fortunately, a small muscle inside the prostate gland prevents urine from coming out of the bladder during sexual activity. A service provider here can explain more about that to you.”

Concern: “Sometimes I have sex and cannot achieve an orgasm. Is something wrong with me?”

Possible response: “That sounds frustrating. Other men have raised concerns about the same thing. Fortunately, you can talk to people here about this.”

Anatomy and Physiology Myths and Facts

Clients and health care workers may believe or want more information about the following statements about male sexual and reproductive anatomy and physiology. Some of the statements are true and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. It is normal for a man to sometimes be unable to achieve or maintain an erection. (FACT)

Sometimes a man may have difficulty achieving or maintaining an erection. This can result from such conditions as fatigue, illness, and nervousness, or it can be a side effect of certain medications. This does not necessarily mean that something is physically or emotionally wrong with him. He will most likely be able to achieve and maintain an erection at another time.

2. A man can urinate and ejaculate at the same time. (MYTH)

Although urine and semen are both expelled through the penis, a special muscle controls the flow of urine and semen. The body can expel only one or the other at a time.

3. Morning erections can be the result of waking up from a deep sleep. (FACT)

The penis may become erect when a man is in a state of deep sleep. This happens regardless of whether or not he is dreaming or having a dream that is sexual in nature. In fact, a man can achieve an erection at many times during the night. Sometimes men wake up in the morning from a dream and have an erection. This has nothing to do with the content of the man's dream or his current sexual desire.

4. A longer penis is more likely to satisfy a woman than a shorter one. (MYTH)

A woman's vagina is most sensitive in the first third of its length. Therefore, many women report that the length of the penis does not affect their sexual stimulation or satisfaction during vaginal penetration.

5. Men are usually capable of holding back their ejaculations as long as they want. (MYTH)

There comes a point during a man's sexual response cycle where he is unable to hold back an ejaculation. This can sometimes be challenging to a couple who are relying on withdrawal as a method of family planning. But this does not mean that a man cannot control his sexual desires or urges or that he cannot stop sexual activity once he is sexually aroused.

6. Even as men get older, they still can have erections. (FACT)

It may take longer for an older man to achieve an erection, but most older men can still achieve and maintain erections.

7. A man always knows whether his female partner has had an orgasm. (MYTH)

Although some women ejaculate fluid during orgasm, most women experience muscular contractions without ejaculation. As a result, it may be difficult for a woman's partner to know whether or not she has had an orgasm.

- 8. Just like women, most men are capable of having multiple orgasms. (MYTH)**

Most men can have only one orgasm during an act of sex and must wait through a period of time after ejaculation before they can have another orgasm.
- 9. Having sex too frequently can be harmful to a man. (MYTH)**

As long as a man is protected against STIs, engaging in sex frequently is not harmful.
- 10. A man can still reproduce into older age. (FACT)**

While women stop releasing eggs after menopause, many men produce sperm and can reproduce throughout their entire lives. However, a man's hormone levels and the amount of ejaculate he produces may decline as he gets older.
- 11. In men, ejaculation and orgasm are the same process. (MYTH)**

In men, orgasm is the muscular contraction of the pelvic muscles right before ejaculation, while ejaculation is the expulsion of semen through the penis. While these two processes usually occur in tandem, they are indeed separate processes. It is possible for a man to have an orgasm without ejaculating, as well as for a man to ejaculate without having an orgasm.
- 12. Once a man gets an erection, it is physically harmful to him if he does not ejaculate. (MYTH)**

While some men may claim this is true, achieving an erection or engaging in sexual activity without ejaculating is not harmful in any way.
- 13. A man cannot impregnate a woman while she is menstruating (has her period). (MYTH)**

Even when a woman is menstruating, it is possible for her to ovulate (release an egg) and become pregnant. However, a woman is most likely to become pregnant right after ovulation, which usually occurs in the middle of her menstrual cycle—not when she is menstruating.
- 14. You can tell how long a man's penis is by looking at the size of his hands, feet, or nose. (MYTH)**

The size of a man's hands, feet, or nose or any other body part bears no relation to the length of his penis.
- 15. The penis is a muscle. (MYTH)**

Although the penis is sometimes referred to as a muscle, it is more like a “sponge” that fills with blood.
- 16. A man's penis grows longer with frequent use. (MYTH)**

Use has nothing to do with how long a penis may or may not become.

3

Sexuality and Gender

This chapter provides an introduction to sexuality, including gender roles, sexual orientation, sexual development, sensuality, sexual behaviors, and the connection between sexuality and reproductive health. Its purpose is to increase your comfort with and understanding of these topics in order to provide appropriate and quality services to male clients.

Defining Sexuality

Sexuality is an expression of who we are as human beings—a total sensory experience involving the mind and body. Sexuality includes all of the feelings, thoughts, and behaviors of being male or female, being attractive and being in love, as well as being in relationships that include intimacy and physical sexual activity.

Sexuality begins before birth and lasts throughout the course of the life span. A person's sexuality is shaped by his or her values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, spiritual selves, and all of the ways in which he or she has been socialized. Consequently, the ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural, and moral factors.

Sexuality Is More Than Sex

Often, people confuse the terms *sex* and *sexuality*. While sex is part of sexuality, sex and sexuality are not the same. **Sex** refers to one's biological characteristics—anatomical (breasts, vagina; penis, testes), physiological (menstrual cycle; spermatogenesis), and genetic (XX; XY)—as a male or female. *Sex* is also a synonym for *sexual intercourse*, which includes penile-vaginal sex, oral sex, and anal sex.

Different Aspects of Sexuality

Sexuality involves many aspects of being human, including:

Sensuality

This is how our bodies derive pleasure. It is the part of our body that deals with the five senses: touch, sight, hearing, smell, and taste. When enjoyed, any of these senses can be sensual. The sexual response cycle, which is the mechanism that enables us to enjoy and respond to sexual pleasure, is also part of our sensuality.

Our body image is part of our sensuality. Whether or not we feel attractive and proud of our bodies influences many aspects of our lives. Our sensuality also involves our need to be touched and held by others in loving and caring ways; this is sometimes referred to as “skin hunger.” Adolescents typically are touched less by family members than are young children. Therefore, many teens satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from a teen's need to be held, rather than from sexual desire.

Fantasy is also part of sensuality. Our brain gives us the capacity to fantasize about sexual behaviors and experiences without having to act upon them.

Intimacy and relationships

This is the part of sexuality that deals with relationships. Our ability to love, trust, and care for others is based on our levels of intimacy. We learn about intimacy from the relationships around us, particularly those within our families.

Emotional risk-taking is part of intimacy. In order to have true intimacy with others, a person must open up and share feelings and personal information. We take a risk when we do this, but intimacy is not possible otherwise.

Sexual identity

Every individual has his or her own personal sexual identity. This can be divided into four main elements:

1. *Biological sex* is based on our physical status of being either male or female.
2. *Gender identity* is how we feel about being male or female. Gender identity starts to form at around age 2, when a little boy or girl realizes that he or she is different from the opposite sex. If a person identifies with the opposite biological sex, he or she often considers himself or herself to be transgendered. In some cases, transgendered persons have an operation to change their biological sex so that it corresponds with their gender identity.
3. *Gender roles* are norms established by society that tell individuals how to behave based on their biological sex. (More information about gender roles is provided later in this chapter, on pages 3.5–3.6.)
4. *Sexual orientation* refers to the biological sex to which we are attracted romantically. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). (More information about sexual orientation is provided later in this chapter, on pages 3.7–3.8.)

Sexual health

Sexual health involves our behavior related to producing children, enjoying sexual behaviors, and maintaining our sexual and reproductive organs. Issues such as sexual intercourse, pregnancy, and sexually transmitted infections (STIs) are part of our sexual health.

Using sexuality to control others

This element is not a healthy one. Unfortunately, many people use sexuality to violate someone else or get something from another person. Rape is a clear example of using sex to control somebody else; sexual abuse and commercial sex work are others. Even advertising often sends messages of sex in order to get people to buy products.

The Connection between Sexuality and Reproductive Health

Sexuality is an essential part of reproductive health. For example:

- Individuals make decisions about their sex lives and reproduction within the context of sexuality, gender inequities, and economic and social power.

- Individuals' attitudes about sexuality influence their choice of contraceptive method, how effectively the method is used, and their satisfaction with the method. They may be reluctant to use or may stop using a certain contraceptive method if they believe that it interferes with their sexual behaviors, decreases their sexual pleasure, or affects their sexual response.
- It is difficult for service providers to discuss STI prevention with their clients without addressing the specific sexual behaviors that put the client at risk for STIs, as well as behaviors that can help reduce that risk.
- Helping women and men develop a better understanding of their sexuality, the context of their sexual relationships, and the motivations behind their sexual behavior is an important step toward helping clients achieve sexual and reproductive health.
- By making assumptions about clients' sexual behaviors, health care workers may provide inappropriate services. For example, a service provider may suggest that a client use family planning because the provider incorrectly assumes that the client is having sex with members of the opposite sex. Also, a service provider may fail to give a client sufficient information about her risk for STIs or may misdiagnose a vaginal infection because the service provider incorrectly assumes that the client engages in only penile-vaginal, and not anal, sex.
- Being aware that clients may hesitate to express sexual concerns makes service providers better able to offer effective client counseling.
- A client's needs may be related to sexual abuse, sexual coercion, rape, or incest—issues that must be addressed to provide effective services.
- Offering counseling about sexuality may help attract clients to the facility and improve client satisfaction.

Defining Sex and Gender

Sex refers to *physiological* attributes that identify a person as male or female. **Gender** refers to widely shared *ideas and expectations* concerning women and men. These include ideas about typically feminine/female and masculine/male characteristics, as well as abilities and commonly shared expectations about how women and men should behave in various situations.⁵

Feeling locked into a gender role can limit our ability to express ourselves, and those who do not conform to their designated role may be subjected to criticism and attack. However, gender roles are not fixed—they can change over time as society changes and as many individuals reject traditional roles. For example, the rejection of gender roles in some societies has resulted in:

- Girls and women having access to athletic, educational, and economic opportunities previously considered to be “male”
- Men taking a more active role in parenting and household work
- Men being more willing to express their feelings (such as affection, grief, and fear)

Socially Constructed Expectations of Male Behavior

Society places many expectations on men based on traditional gender roles. Many of these expectations can lead to harmful consequences. For example, some of these harmful expectations are that men will:

- Be tough
- Not cry
- Not ask for help
- Not be afraid
- Take risks
- Find violence acceptable
- Have sex with many women
- Have many girlfriends
- Drink, take drugs, or smoke

How Male Socialization Can Negatively Affect Reproductive Health

- Men are expected to be knowledgeable about sexuality, even if they have never had sex or had access to any reliable sources of information about sexuality.
- Men feel pressured to have sex with many women to prove their manhood.
- Men are expected to take risks, which may include having sex with commercial sex workers or not using a condom.

⁵ Bruyn, M., and France, N. 2001. *Gender or sex: who cares?* Chapel Hill, NC: Ipas.

- Men are likely to engage in substance abuse, which may lead to high-risk sexual behavior.
- Men may use physical or sexual violence against women to gain power and control.
- Men are not accustomed to seeking reproductive health care and are often uncomfortable accessing reproductive health services. This may be because they have been socially conditioned to believe that an important part of being a man is to be “strong” and not to ask for help.

Sexual Orientation

As stated earlier, **sexual orientation** refers to the biological sex to which we are attracted romantically. Our orientation can be:

- Heterosexual (attracted to the opposite sex)
- Bisexual (attracted to both sexes)
- Homosexual (attracted to the same sex)

The range of sexual orientation, from heterosexuality to homosexuality, is a continuum. Most individuals' sexual orientation falls somewhere along that continuum. While scientific studies have shown that individuals cannot change their sexual orientation at will, sexual orientation may change over time. Scientific research has also shown that individuals who have sex with members of their own sex can be just as emotionally healthy as those who have sex exclusively with members of the opposite sex.

People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. Actually, however, the man and woman are expressing different gender roles. Their feminine or masculine behavior, respectively, has nothing to do with their sexual orientation. A homosexual man may be very feminine, very masculine, or neither. The same applies to heterosexual men.

Sexual Orientation Is an Important Issue to Address

Health care workers must create a safe and confidential atmosphere at the health care facility to help ensure that all clients can discuss their sexual behaviors openly without fear of criticism, punishment, or disclosure. This is especially important because many sexual behaviors can put clients at risk for transmitting and contracting HIV infection and other STIs. But this may be difficult for many health care workers to achieve, especially when they have strong views about sexual behaviors that may differ from their own and the individuals who engage in them. Therefore, understanding your own values and feelings about individuals who engage in various sexual behaviors is the first step toward being able to provide all clients with appropriate health care services.

Same-Sex Sexual Activity

Feelings of sexual attraction emerge in childhood. In cultures where attraction to members of one's own sex is considered socially unacceptable, a young person who has such feelings may hide or suppress them. Some individuals may continue to hide or suppress these feelings throughout their lives and may marry and have children with a person of the opposite sex. They may—or may not—ever act on their feelings and engage in sexual activity with members of their own sex.

Attitudes toward different sexual behaviors, and how sexual orientation is defined, can vary across or within cultures. Not all individuals who have had one or more sexual contacts with members of their own sex define themselves as homosexual or are considered to be homosexual by society. For example, some adolescent boys who experiment sexually with other boys (for example, by masturbating in a group) and some men who have sex with men

in isolated settings, such as prisons, do not consider themselves and are not considered by others to be homosexual. In addition, individuals who engage in same-sex sexual activity may not be attracted exclusively to members of their own sex and may not wish to engage in sex only with members of their own sex. Indeed, some married persons engage in same-sex sexual activity outside of marriage and still consider themselves to be heterosexual. Persons who have sex with both men and women may consider themselves to be bisexual, homosexual, or heterosexual.

With few exceptions, sexual attraction and sexual activity between individuals of the same sex are opposed by most cultures and are often the source of fear, hatred, and misunderstanding. As a result, many individuals who engage in same-sex sexual activity—whether regularly, on occasion, or just one time—may not fully disclose these behaviors to a health care provider.

Focus on Sexual Behaviors, Not Sexual Orientation

When addressing a client's concerns, giving a client health education or information, or providing services, health care workers must focus on the client's sexual *behaviors*, not the client's sexual orientation. This is because it is the behaviors—not the orientation—that put individuals at risk for transmitting and contracting HIV infection and other STIs.

It is also important to refrain from making assumptions about an individual's behaviors or lifestyle based on stereotypes. Homosexual, bisexual, and heterosexual individuals may abstain from sex, may build loving and lasting relationships with one partner, and may have multiple partners and/or engage in a variety of sexual behaviors or risky sexual activity.

Sexual and Social Development

Many milestones in sexual and social development are reached at generally the same age worldwide, though they may follow patterns that may vary from culture to culture.

When you review this information, it is important to remember that some of these milestones are indications of normal physical development, some are common behavioral reactions to physiological development, and some are culturally determined norms. In every culture, a great many individuals have experiences that do not conform to social norms and mores. In your dealings with clients, be careful not to assume that all clients' behaviors will adhere to the societal norm.

Milestones in Male and Female Sexual and Social Development

- **Begins to have sexual responses.** Occurs before birth. A male fetus achieves genital erections in utero; some males are even born with erections. Sexual responses in females are also intact before birth.
- **Explores one's own genitals (masturbates) for the first time.** Occurs between ages 6 months and 1 year. As soon as babies can touch their genitals, they begin to explore their bodies.
- **Shows an understanding of sexual identity.** Occurs by age 2. Children are aware of their biological sex.
- **Shows an understanding of gender roles.** Occurs between ages 3 and 5. Children begin to conform to society's messages about how males and females should act.
- **Asks questions about where babies come from.** Occurs between ages 3 and 5.
- **Begins to show romantic interest.** Occurs by ages 5 to 12, though may vary by culture. At this stage, children show the first signs of sexual orientation (sexual preference toward males or females).
- **Shows the first physical signs of puberty (the transition from childhood to maturation).** Occurs by ages 8 to 12. This usually occurs slightly earlier for girls than boys.
- **Begins to produce sperm (boys).** Occurs between ages 11 and 18. This milestone depends in part on the child's nutrition and may be delayed where nutrition is severely compromised.
- **Begins to menstruate (girls).** Occurs between ages 9 and 16. This milestone depends in part on the child's nutrition and may be delayed where nutrition is severely compromised.
- **Begins to engage in romantic activity.** Occurs by ages 10 to 15. This milestone depends heavily on cultural factors.
- **Has sex for the first time.** This varies greatly by culture, but fairly often it occurs during mid- to late adolescence across cultures. Many societies have cultural taboos against sexual experience outside of a traditional heterosexual marriage; in other cultures, a couple is expected to have sex—or even conceive a first child—before marriage; and in other cultures still, same-sex sexual experiences are common. An individual's first sexual experience may not be consistent with what society condones. For example, in

many societies girls would be disgraced by having premarital or casual sex, whereas young men in the same culture may be expected or encouraged to have sex before marriage. This does not mean that some—or even many—girls in these cultures do not have premarital sex, but that they may be afraid to disclose any sexual experience they have had to health care workers or others.

- **Gets married.** This varies greatly by culture. In some cultures, girls and boys are married very young; in others, young girls are married to older men. In some parts of the world, common-law unions are the predominant pattern. However, these relationships, like marriage, are a proxy for age at initiation of sexual activity.
- **Begins to bear children.** Many factors determine when and if a person has a first child. First childbirth also varies by community and individual. In some communities, the first child is expected to be born before marriage (thus proving fertility) or without marriage. In other cultures, first childbirth is expected to occur after marriage, while in others still, pregnancy may lead people to marry. Increasingly in some cultures, couples are choosing to delay having children or to have no children at all, a change made possible in part by the availability of effective contraception.
- **Experiences menopause/male climacteric (decreased male hormone levels).** Menopause occurs in women at around age 50 (it can start in the late 30s or early 40s as well), when the woman goes through a process of physiological changes characterized by the end of ovulation, menstruation, and the capacity to reproduce. Male climacteric occurs between ages 45 and 65 and is characterized by a decrease in testosterone production. For both sexes, this midlife process of transition results in changes in a person's physical structure, hormonal profile, and sexual functioning.
- **Experiences sexuality in later life.** Older adults (those aged 50 to 60 or beyond) can remain sexually active to the end of their lives. Though some age-related changes in sexuality take place, the total loss of sexual functioning is not a part of the normal aging process. Biological changes, illnesses, the therapies for those illnesses, and psychological and social factors can affect sexuality and sexual functioning.

Common Sexual Behaviors

While people may engage in a variety of behaviors for sexual gratification, the following are the most common sexual behaviors—the ones that clients will most commonly discuss with health care providers.

Masturbation

Masturbation is the stimulation of the genitals by manual contact—contact with fingers, hands, or objects. To increase sexual arousal, during masturbation individuals may also stimulate their nipples, anus, rectum, or any other part of the body. Masturbation is often an individual's first sexual experience and is performed by people in all cultures around the world. *Mutual masturbation* refers to two partners manually stimulating either each other's genitals or their own genitals in the other's presence. *Group masturbation* refers to the practice of masturbation among several individuals.

Masturbation is a pleasurable activity that can relieve stress, give individuals a sense of well-being, and improve sleep and mood. Masturbation can also help relieve sexual tension at times when a sexual partner is not available, interested, or desired. While many people believe that masturbation results in negative health consequences, no ill effects from masturbation are known.

Self-stimulation involves almost no risk for pregnancy or transmission or contraction of STIs. However, people should avoid contact with parts of the body that have skin lesions, sores, or abnormal discharge because this involves a risk for spreading infections to other parts of the body, such as the eyes or fingers. In addition, if a person touches another person's genitals during mutual or group masturbation, there is a small possibility of:

- Transmitting infections if one partner has another partner's infected secretions or semen on his or her hand and then touches his or her own or a partner's genitals
- Pregnancy if one partner has semen on his or her hand and then puts his or her hand in a partner's vagina (or if she is a woman, in her own vagina)

To maintain general hygiene and cleanliness, individuals should wash their hands before and after masturbating themselves or another person.

Penile-Vaginal Sex

Penile-vaginal sex involves placing a man's erect penis into a woman's vagina and, through friction, stimulating the nerves in the man's penis and in the woman's clitoris and vagina. This activity is commonly known as *sexual intercourse*. However, this text will use the term *penile-vaginal sex* to distinguish this sexual behavior from oral and anal sex, which are also sometimes known as *sexual intercourse*.

Penile-vaginal sex is a pleasurable activity that can relieve sexual tension and stress and give individuals a sense of well-being. Like other sexual activities, it can improve sleep and mood. Because sperm and other body fluids are transferred between partners, unprotected penile-vaginal sex can result in pregnancy or, if one partner is infected, the transmission of STIs. To avoid pregnancy, an individual can use an effective contraceptive; to avoid STIs, a person can use a condom. (See Chapter 4: Family Planning and Chapter 5: Sexually Transmitted Infections for more information.)

Oral Sex

The genitals can be stimulated by rubbing, touching, sucking, or licking with the lips, mouth, and tongue. In men, this activity involves stimulating the penis, scrotum, and testes; in women, it involves stimulating the vulva, clitoris, and vagina. This form of stimulation, known as oral sex, may also be called *fellatio* when performed on a man and *cunnilingus* when performed on a woman.

Oral sex involves no risk for pregnancy. However, the transmission of STIs is possible because body fluids and infections can be transmitted by contact between the mouth and genitals. Use of a dental dam can minimize the risk of STI transmission during oral sex.

Anal Sex/Anal, Rectal, and Prostate Stimulation

Anal and rectal skin contain sensitive nerve endings, and some men and women may find anal stimulation with fingers, objects, a penis, lips, a mouth, or a tongue pleasurable. In men, the prostate gland is palpable through the front wall of the rectum within 6 cm (2.4 inches) of the anal opening. Stimulation of the prostate gland through the rectum or by firm, external pressure on the tissue between the scrotum and the anus can cause pleasurable sensations.

Anal or rectal contact can transmit STIs. Anal sex is especially risky for the transmission of STIs, such as HIV because inserting and thrusting the penis or other objects into the anus can cause tears and bleeding in the rectum, facilitating transfer of bloodborne germs. Intestinal infections and diarrheal diseases can also be transmitted by anal and rectal contact. (See Chapter 5: Sexually Transmitted Infections for more information about ways to reduce the risk for STIs during anal sex.)

The Importance of Mutual Consent during Sexual Activity

When you think about common sexual behaviors and their health implications, it is important to understand that mutual consent is the basis for discussion of healthy sexual activity or relationships. For any sexual behavior, it is assumed that both of the partners are consenting, with neither person being forced or coerced to engage in the behavior. Sexual assault, rape, forced prostitution, coerced sexual activity, and forced sex in marriage are worldwide problems. In most cultures, any sexual activity with children, even if voluntary on the part of the children, is viewed as coercive and is referred to as child sexual abuse.

The psychological consequences of forced or coerced sexual activity can cause lifelong damage, even if no long-lasting health consequences result. Men are more often the perpetrators in these situations, and women are more often the survivors. However, it is important to recognize that men—and particularly boys—can also be survivors of forced and coerced sexual activity. Being a survivor of past childhood sexual abuse is common among sex offenders.

Health Considerations of Sexual Behaviors

Although a variety of sexually arousing behaviors may be enjoyable, engaging in some of them can have serious health consequences. Health care workers need to be able to distinguish those behaviors that put individuals at risk for transmitting and contracting STIs or are potentially harmful in other ways from those that are harmless. This will enable health care workers to advise clients who engage in those behaviors about the risks involved. Even if your job does not involve direct client counseling, knowing more about the health consequences of sexual behaviors may help you be more understanding and supportive of clients and the staff who work with them.

Safer Sex: Protecting against STIs

Some sexual behaviors carry a high risk for transmitting and contracting STIs, while others carry little or no risk.

A person can reduce his or her risk for sexual transmission of STIs in three ways:

1. Abstaining from sex
2. Engaging in sexual relationships only with partners whom he or she is sure are not infected with an STI
3. Practicing “safer sex”

Since this text does not cover all sexual behaviors, it is important to understand the concepts of safer sex so that you will be better able to determine whether an unfamiliar sexual behavior is physically harmless or dangerous to your client. Any unprotected sexual contact with an infected partner that causes bleeding or involves contact with semen, vaginal fluids, lesions, or sores on the body can transmit STIs. Understanding which sexual behaviors are common in the communities you serve will help you explain to individuals who engage in those behaviors ways to reduce their risk. Equally important, however, is providing reassurance to clients who express concern about behaviors that are harmless.

Ways to reduce the risk for STI transmission are provided on pages **5.9–5.12** in Chapter 5: Sexually Transmitted Infections.

Other Health Consequences of Sexual Behaviors

Certain behaviors used to enhance the sexual experience may be potentially harmful or dangerous in ways other than increasing the risk for transmitting and contracting STIs.

Sexual behaviors that may be harmful include:

- **Placing objects in the rectum.** This may be harmful, depending on the objects and how they are used. Objects should be clean, unbreakable, and manipulated gently, and should have no sharp edges. In addition, the objects should not be inserted too deep or left in for extended periods of time, and they should not be shared with others unless they are first disinfected or covered with a new condom.

- **Placing objects in the vagina.** This is generally harmless if the objects are clean, unbreakable, and manipulated gently, and if they have no sharp edges. In addition, the objects should not be left in for extended periods of time, and they should not be shared with others or inserted in the vagina after being inserted in the rectum unless they are first disinfected or covered with a new condom.
- **Using devices to constrict and prevent blood flow out of the penis.** This can enhance sexual pleasure and maintain a longer erection. A ring or any other object that may be difficult to remove—such as a cord, string, or ordinary rubber band—should never be used on the penis. The constriction may make it impossible for blood to flow out of the penis after an orgasm, possibly causing irreversible tissue damage. A band with a snap or Velcro release tape is a safer alternative.
- **“Dry sex.”** This behavior—which involves putting twigs, herbs, dirt, tree bark, detergents, or other substances in the vagina or taking other measures to dry out the vagina in order to cause friction—is painful and harmful to both women and men. Dry sex can increase the chances of causing tears, scrapes, or other damage to the vagina and penis. This behavior also suppresses the natural bacteria present in the vagina, thereby increasing the risk for transmitting and contracting HIV or other STIs. It is also believed, though not proven, that the extra friction may cause condoms to tear more easily, increasing the woman’s chances of becoming pregnant and both partners’ chances of transmitting and contracting STIs.
- **Partially suffocating yourself or someone else before or during orgasm.** This can be very dangerous, possibly leading to accidental injury or death, especially if communication between the partners fails.

Sexuality Myths and Facts

Clients and health care workers may believe or want more information about the following statements about sexuality. Some of the statements are true and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. A man’s nipples are sensitive to sexual arousal. (FACT)

Although men’s breasts and nipples are not often considered sexual, they are, in fact, sensitive to touch and sexual arousal. There is variation in nipple sensitivity among men, and nipple stimulation may or may not be perceived as enjoyable by a particular individual.

2. A lesbian (a homosexual woman) can be “cured” by having sex with a “real” man. (MYTH)

Being sexually attracted to someone of the same sex is not something that needs to be “cured.” In addition, having sex with someone of either the same sex or the opposite sex will not necessarily have any effect on whether a man or woman is attracted to or chooses to engage in sexual activity with someone of the same or the opposite sex.

3. A man who has had sex with a man is a homosexual. (MYTH)

Having a same-sex sexual experience does not mean a person is homosexual. Many people have sex with members of their own sex as a way of exploring their sexuality. What determines whether or not a man is homosexual are his feelings, not his sexual behaviors. Homosexual men feel primarily attracted to men. Therefore, even if a man does engage in sexual activity with another man, that does not necessarily make him a homosexual or mean that he is necessarily or exclusively attracted to men.

4. A man can sexually assault his wife. (FACT)

Any time a man engages in sexual contact with his wife without her consent should be considered a sexual assault.

5. Having sex too frequently can be harmful to a man. (MYTH)

As long as a man is protected against STIs, engaging in sex frequently is not harmful.

6. Only men masturbate. (MYTH)

Both men and women masturbate.

7. Masturbation is harmless. (FACT)

Masturbation does not cause harm to anyone of any age, unless an object is inserted into the vagina or anus in a harmful way (see page 3.X for more information).

8. A man’s sex drive (need to have sex) is stronger than a woman’s. (MYTH)

Although it is often believed that men have a stronger sex drive than women, this is not the case. Sex drive varies from person to person, and both men and women can experience different levels of sex drive at different times.

9. Men need to have sex in order to maintain good health. (MYTH)

It is normal and healthy for both men and women to have sexual feelings and a desire to express them, but neither men nor women need to have sex in order to be healthy.

10. Alcohol makes it easier for men to become aroused. (MYTH)

Actually, alcohol has the opposite effect. Alcohol is a depressant. It decreases the flow of blood to the genital area, making it more difficult to have an erection and experience orgasm.

11. In a same-sex sexual relationship, one person usually takes the male role and the other takes the female role. (MYTH)

In a same-sex sexual relationship, just as in an opposite-sex sexual relationship, both partners have the freedom to choose their gender roles and the roles they may play during sexual activity. There is no need for one person to always take the male role and the other to always take the female role.

4 Family Planning

This chapter introduces male contraceptive methods and examines men's roles in family planning. Specifically, the chapter focuses on methods that require men's active participation (condoms, withdrawal, vasectomy, and fertility awareness methods), including how they work, their effectiveness, and their advantages and disadvantages. Methods for women are also described briefly, primarily to provide information on how men can support their female partners in the use of these methods.

An Overview of Contraceptive Methods

Contraception is the prevention of pregnancy. Broadly speaking, any behavior, technique, drug, or medical device that achieves this end can be defined as a means of contraception.

Types of Methods

A wide variety of contraceptive methods are available, and they are intended to be used for variable lengths of time, from protection from a single act (e.g., condom, diaphragm, withdrawal) all of the way to lifetime protection (e.g., female sterilization, vasectomy), depending upon an individual's reproductive intentions. Often family planning professionals speak in terms of “delayers” (those wishing to delay a first birth), “spacers” (those individuals and couples desiring to prevent a birth for two to three years), and “limiters” (those individuals and couples who wish no more children). Vasectomy and female sterilization (tubal occlusion) are the only methods intended to prevent pregnancy permanently; all other methods are “temporary.”

Regardless of whether the method is one in which the male partner participates most actively in its use (such as the condom) or whether the female partner participates most actively in its use (such as injectables, oral contraceptives, or the IUD), men can play an important role in a method's use and effectiveness. This chapter focuses on methods in which men participate most actively—condoms, vasectomy, and withdrawal—as well as on fertility awareness methods, which require both partners' active participation.

How Contraceptives Work

Contraceptive methods work in a variety of ways. In simple terms, five events must happen for a normal pregnancy to occur:

1. Sperm must enter the vagina.
2. Sperm must travel through the cervix and uterus and enter the fallopian tubes.
3. An egg must be present in the fallopian tubes within 48 hours of the introduction of sperm.
4. Sperm must fertilize the egg.
5. The fertilized egg must implant into the lining of the uterus.

All methods of contraception are designed to prevent one or more of these events from occurring.

Effectiveness Rates

While all contraceptive methods are effective to some degree, some methods are more effective than others.

Effectiveness may be described in terms of “perfect” use and typical use:

- **Perfect use** reflects correct and consistent use of the method with every sex act.
- **Typical use** reflects our general experience with how effective the method is likely to be, given that most couples do not use contraceptive methods correctly or consistently with every sex act.

Both correct use and consistent use of methods vary greatly with such characteristics as age, income, users’ desire to prevent or delay pregnancy, and culture. Methods that depend on correct and consistent use by clients have a wide range of efficacy. Most men and women tend to be more effective users as they become more experienced with a method.

Additionally, for provider-dependent methods (e.g., the IUD, Norplant implants, or male or female sterilization), effectiveness is determined by the provider’s skill. (In other words, there could be a failure, even when the client used the method correctly, if the procedure was inadequately carried out or the client was not properly screened—for example, if the insertion or procedure was done while a woman was pregnant.)

This book provides both perfect and typical-use effectiveness rates. If the effectiveness rate is 95%, this means that five out of 100 women would get pregnant in one year of correct use; an 80% rate means 20 out of a 100 women would get pregnant in one year of correct use.

Table 4.1 (page 4.3) indicates perfect-use and typical-use rates.

Table 4-1. Effectiveness of family planning methods*

Method	Typical-Use One-Year Failure Rate
Norplant implants	0.1
Vasectomy	0.2
Combined injectables†	0.3
Progestin-only injectables (DMPA and NET-EN)	0.3
Female sterilization	0.5
IUD (TCu-380A)	0.8
Progestin-only oral contraceptives (during breastfeeding)	1.0
Lactational amenorrhoea method (LAM)	2.0
Combined oral contraceptives	6–8
Progestin-only oral contraceptives (not during breastfeeding)	‡
Male condoms	14
Coitus interruptus§	19
Diaphragm with spermicide	20
Fertility awareness–based methods	20
Cervical cap (nulliparous women)	20
Female condoms	21
Spermicides	26
Cervical cap (parous women)	40
No method	85

Notes:

* Adapted from: Hatcher, R. A. et al. 1997. *The essentials of contraceptive technology*. Baltimore, MD: Johns Hopkins University School of Public Health, Population Information Program.

† Special Programme of Research, Development, and Research Training in Human Reproduction. 1993. Facts about once-a-month injectable contraceptives: Memorandum from a WHO meeting, *Bulletin of the World Health Organization* 70(6):677–689.

‡ Outside the context of breastfeeding, progestin-only contraceptives are somewhat less effective than combined oral contraceptives. See Hatcher, R. A., et al. 1998. *Contraceptive technology*, 17th revised ed. New York: Ardent Media, Inc.

§ Data source: Hatcher, R. A., et al. 1998. *Contraceptive technology*, 17th revised ed. New York: Ardent Media, Inc.

Dual Protection⁶

What Is Dual Protection?

Dual protection can be defined as a strategy for preventing two unwanted conditions: transmission of HIV or another STI, and unintended pregnancy. Dual protection can include:

1. The use of condoms alone:

- The use of a condom (male or female) alone for both purposes

2. The use of condoms and some other method together:

- The use of a contraceptive method to prevent pregnancy, plus the use of a condom to prevent disease transmission
- The use of a condom plus emergency contraception, should the condom fail
- Selective condom use plus use of another family planning method (for example, use of the pill with a primary partner, but use of the pill plus condoms with secondary partners)

3. The avoidance of unsafe sex

- Abstinence
- Avoidance of all types of penetrative sex
- Mutual monogamy between uninfected partners, combined with a contraceptive method for those wishing to avoid pregnancy
- Delay of sexual debut (for young people)

What Does The Client Want?

Any recommendation or guidance about dual protection requires counseling to determine the individual's or couple's sexual and reproductive goals or intentions and determine the individual's or couple's risk for HIV/STIs and pregnancy.

Why Is Condom Promotion Important for Dual Protection?

The male latex condom and the female condom, when used correctly and consistently, are the only technologies that have been proven to be effective in preventing pregnancy and the sexual transmission of HIV at the same time (i.e., there is no other method that provides both pregnancy and disease protection at the same time).

Condoms and those who use them are often stigmatized because condoms are now so closely associated with only HIV/STI prevention, and their use implies that partners may have other sexual partners. This stigma from associating condom use and sex work or sexual promiscuity can be addressed by promoting condoms for both pregnancy and disease prevention, when they are used correctly and consistently, or as a method to be used in conjunction with another contraceptive.

⁶ Adapted from: Spieler, J., Karra, M., & Bogelsong, K. No date. *Condom promotion and dual protection*, USAID/G/PHN/POP/R; PRIME II Slide Show; and EngenderHealth. 2002. New York.

Why Is Dual Protection Counseling So Important in Family Planning Services?

- Many family planning clients may be at risk for infection with HIV/STIs, as well as unintended pregnancy. Many women are at risk for HIV/STIs mostly as a result of their partners' behaviors. Dual protection counseling can help clients perceive their own risk for infection and unintended pregnancy and to develop strategies to protect themselves.
- Meeting clients' needs for dual protection improves the quality of sexual and reproductive health services by addressing clients' multiple concerns.

How Does Dual Protection Counseling Relate to the Concept of Informed Choice?

- Dual protection counseling upholds the concept of informed choice by making sure that clients are knowledgeable about and aware of their risks for HIV/STI prevention and unintended pregnancy while making family planning decisions.
- Clients are not making truly informed choices about family planning unless they are:
 - Informed about the effectiveness (perfect use and typical use) of methods to prevent pregnancy
 - Aware of their risks for HIV/STIs
 - Knowledgeable about prevention of HIV/STIs
 - Understand the relative effectiveness of family planning methods in preventing HIV

What Are Some Key Strategies for Dual Protection in a Family Planning Setting?

Strategies useful in encouraging the adoption of dual protection in family planning settings include:

- Working with clients on partner communication and condom negotiation skills
- Helping women consider the ramifications of their decisions—both positive and negative—and recognizing the limitations that many women may have in negotiating condom use (i.e., insisting on condom use may lead to violence, abandonment, etc.)
- Involving men in counseling and education and addressing their concerns about condoms
- Destigmatizing condom use and making it acceptable to both partners
- Promoting the female condom as a viable method (where it is available)
- Discussing abstinence where it is appropriate

Male Condom, Withdrawals, Vasectomy, and Fertility Awareness Methods

Male Condoms

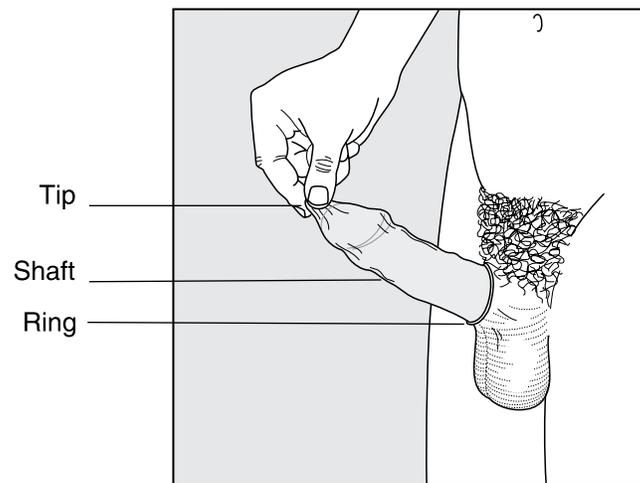
A male condom is a thin sheath that is placed over the erect penis just before sexual activity. It acts as a barrier, preventing pregnancy by keeping semen from entering the vagina. Condoms also prevent contact with semen and other secretions that transmit STIs; thus, they are used to protect against STIs.

Typical Features of Condoms

Though male condoms vary in terms of length, diameter, shape, contour, texture, color, flavor, and fragrance, they share some basic characteristics. All condoms consist of:

- A **tip**, which provides a reservoir for semen, reducing the chance that the condom will break during ejaculation
- A **shaft**, which covers the penis and provides the barrier
- A **ring** at the base, which helps hold the condom in place

Figure 4-1. Typical features of the male condom



Many condoms are lubricated with either a silicone or a water-soluble, jelly-like lubricant.

Condom Material

Condoms may be made of latex, natural rubber, polyurethane, or lambskin. While all condoms prevent the passage of sperm, latex and polyurethane condoms also prevent the transmission of STIs. Lambskin condoms are not recommended for protection against STIs because their small pores (openings) can permit passage of some viruses, such as hepatitis B, herpes, and HIV.

Latex condoms are used mostly because they are inexpensive, are widely available, and prevent the transmission of STIs. However, some individuals are allergic to latex. If one or both members of a couple are allergic to latex, the couple should use a polyurethane condom, if available, to prevent the transmission of STIs.

Effectiveness

Pregnancies reported with condom use are due primarily to inconsistent and incorrect use, not to defective condoms. When used correctly and consistently, condoms have a pregnancy rate of three pregnancies for 100 women in the first year of use. However, typical use of condoms has resulted in pregnancy rates of 14 per 100 women in the first year of use.

Advantages and Disadvantages

Advantages	Disadvantages
<ul style="list-style-type: none"> • Protect against pregnancy and STIs when used correctly with every act of sexual intercourse • Are widely available and low-cost • Help maintain an erection longer and prevent premature ejaculation 	<ul style="list-style-type: none"> • Reduce sensitivity • Can break • Occasionally interfere with achieving or maintaining an erection • Can cause a loss of spontaneity • Not as effective in preventing pregnancy as some other contraceptive methods

Some advantages of condoms are that they:

- Are safe
- Are easily available in most places
- Prevent both pregnancy and HIV/STIs (when used correctly with every act of sexual intercourse)
- Help protect against conditions caused by STIs (pelvic inflammatory disease, chronic pain, and possibly cervical cancer, as well as infertility in both men and women)
- Are easy to initiate and discontinue, and are effective immediately
- Require no prescription or medical assessment
- Allow immediate return to fertility
- Have almost no side effects (except rare allergy to latex or lubricant)
- Enable a man to take responsibility for preventing pregnancy and disease (male condom only)
- Often help prevent premature ejaculation (help the man last longer during sex)

Some disadvantages of condoms are that they:

- Require motivation to use consistently and correctly
- Require the partner's cooperation
- Need a ready supply, even if the woman or man is not expecting to have sex
- May interrupt sexual activity or reduce sexual pleasure
- Require proper storage and resupply
- Have a poor reputation (relating their use to immoral sex, sex outside marriage, or sex with sex workers)
- May embarrass some people to buy, ask a partner to use, put on, take off, or throw away
- Are not as effective as other methods in preventing pregnancy with typical use

Tips for Clients on Effective Use of Condoms

- Put on the condom before your penis comes into contact with your partner. This will reduce the risk for transmitting STIs.
- Use a condom only once; do not wash or reuse it.
- Always store condoms in a cool, dry place, and use them before the expiration date on the package.
- Do **not** use a condom if:
 - The package is broken.
 - The condom is brittle or dried out.
 - The color is uneven or has changed.
 - The condom is unusually sticky.
- If the condom tears or slips during sex, stop and replace it before continuing.
- If, after ejaculation, you realize that the condom has broken or slipped off, immediately wash your penis with soap and water to minimize the risk for infection. If the condom is being used for contraception, immediately inform your partner, tell your partner to insert a spermicidal foam or gel in her vagina, and discuss with her the use of emergency contraception to reduce the risk for pregnancy.
- Condoms may be used for contraception and/or protection against STIs. When using a condom to protect against STIs, wear either a lubricated or an unlubricated condom, as follows:
 - For penile-vaginal sex, you can use either a lubricated or unlubricated condom.
 - For oral sex, unlubricated condoms are generally preferred.
 - For anal sex, lubricated condoms are best because the anus does not have natural lubrication of its own.

- Do **not** use grease, oils, lotions, petroleum jelly (Vaseline), or other oil-based lubricants to make the condom slippery. These substances can cause the condom to break—a common reason for condom failure. Use only creams, gels, and foams that do not have oil in them. Since vaginal medications are commonly oil-based, do not use a condom if your partner is using a vaginal cream medication. The chart below shows lubricants that are safe and unsafe for use with condoms.

Lubricants That Are Safe and Unsafe for Use with Condoms

Safe for use with condoms	Unsafe for use with condoms
<ul style="list-style-type: none"> • Contraceptive foams, creams, and jellies • Egg whites • Water • Saliva • Glycerin • Silicone-based lubricants • Water-based lubricants 	<ul style="list-style-type: none"> • Baby oils • Massage oils • Hand or body lotions • Cooking oils (coconut, olive, peanut, corn, sunflower, butter, margarine) • Fish oils • Hemorrhoid ointments • Insect repellents • Vaginal cream medications • Palm oil • Suntan oil • Petroleum jelly (Vaseline) • Mineral oil • Burn ointments

Source: Adapted from: Hatcher, R. A., et al. 1998. *Contraceptive technology*, 17th revised ed. New York: Ardent Media, Inc.

Note: Many of the materials listed in this chart are not used intentionally as lubricants. However, clients should be aware of circumstances in which a condom might be accidentally exposed to one or more unsafe lubricants. For example, if a man has suntan lotion on his hands and then puts on a condom, he may expose the condom to the oils in the lotion, which can then degrade the condom and make it unsafe for contraception or protection against STIs. Similarly, if a woman is using an oil-based cream and the condom touches it before sex, the condom could become damaged.

Withdrawal

Withdrawal is a method in which the man pulls his penis out of his partner’s vagina before he ejaculates. This method prevents pregnancy by keeping sperm from entering the vagina.

While some fluid does leak from the penis before ejaculation, this pre-ejaculatory fluid usually contains no sperm. (It may, however, contain some sperm from a recent, previous ejaculation, which can lead to fertilization.) However, the pre-ejaculate can contain bacteria and viruses that cause STIs.

The Effective Use of Withdrawal

Withdrawal may not be a good method for men who have difficulty predicting when they will ejaculate or who tend to have repeat orgasms. In general, this method is more effective for couples who are familiar with each other's sexual responses than for new sexual partners.

To practice withdrawal effectively:

- Before penile-vaginal sex, urinate (to clean any sperm from a previous ejaculation) and wipe the tip of your penis.
- When you feel you are about to ejaculate, remove your penis from your partner's vagina. Ejaculate away from the entrance to her vagina.

Sometimes when a couple is practicing withdrawal, the man will not be able to withdraw his penis in time and will ejaculate inside his partner. When this occurs, the male partner has an important responsibility to inform his partner that he ejaculated inside her because a woman may not always be able to tell whether she has semen inside her vagina.

If a man ejaculates into his partner's vagina before withdrawal, she can reduce her risk for pregnancy by:

- Immediately inserting a spermicide into her vagina
- And/or using emergency contraception within 72 hours (Information about emergency contraception is provided on page 4.24.)

Effectiveness

Withdrawal is somewhat effective for preventing pregnancies as commonly used—19 pregnancies per 100 women in the first year of use (approximately one in every five). How effective the method would be if used consistently and correctly is highly uncertain; however, experts estimate that when used properly during every act of penile-vaginal sex, withdrawal has a pregnancy rate of four pregnancies per 100 women in the first year of use.

Advantages and Disadvantages

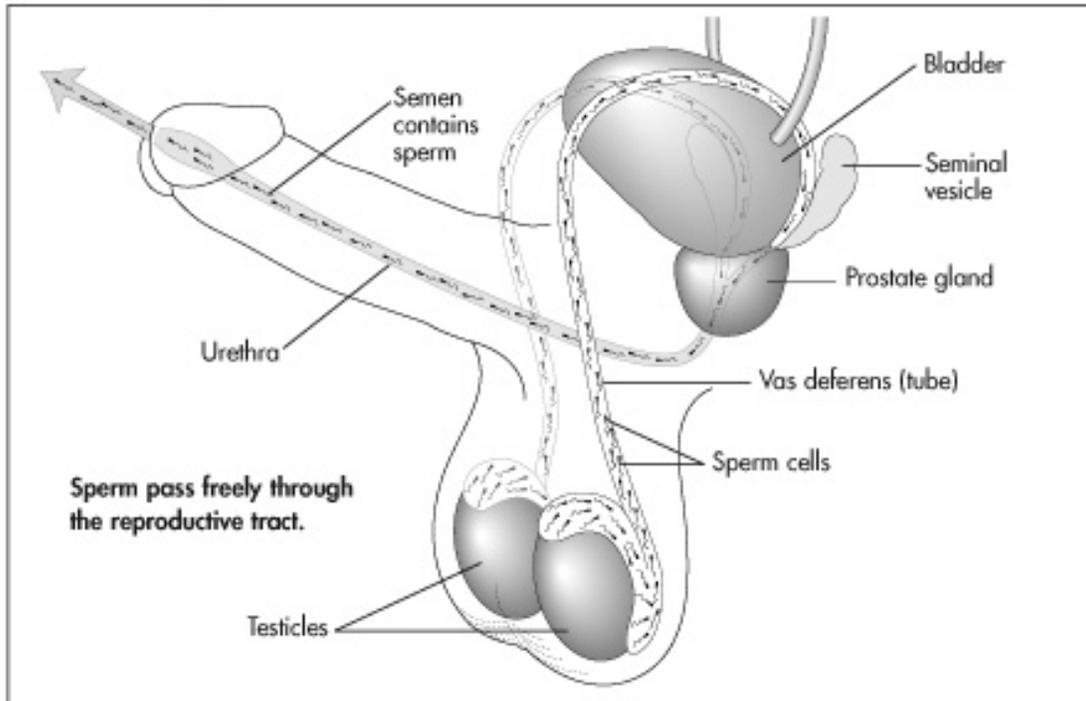
Advantages	Disadvantages
<ul style="list-style-type: none">• No cost• No devices required• Is always available• Does not require a visit to a health care provider• Is a backup method that is always available• Is better than no method at all	<ul style="list-style-type: none">• May interrupt the sexual pleasure of both partners• Requires a high level of self-control and may increase anxiety in both partners before impending ejaculation• May be difficult to accomplish in certain positions• May require a level of comfort for the man to communicate with his partner that he is about to ejaculate• Offers no protection against STIs, including HIV/AIDS• Is not as effective at preventing pregnancy as some other methods

Vasectomy

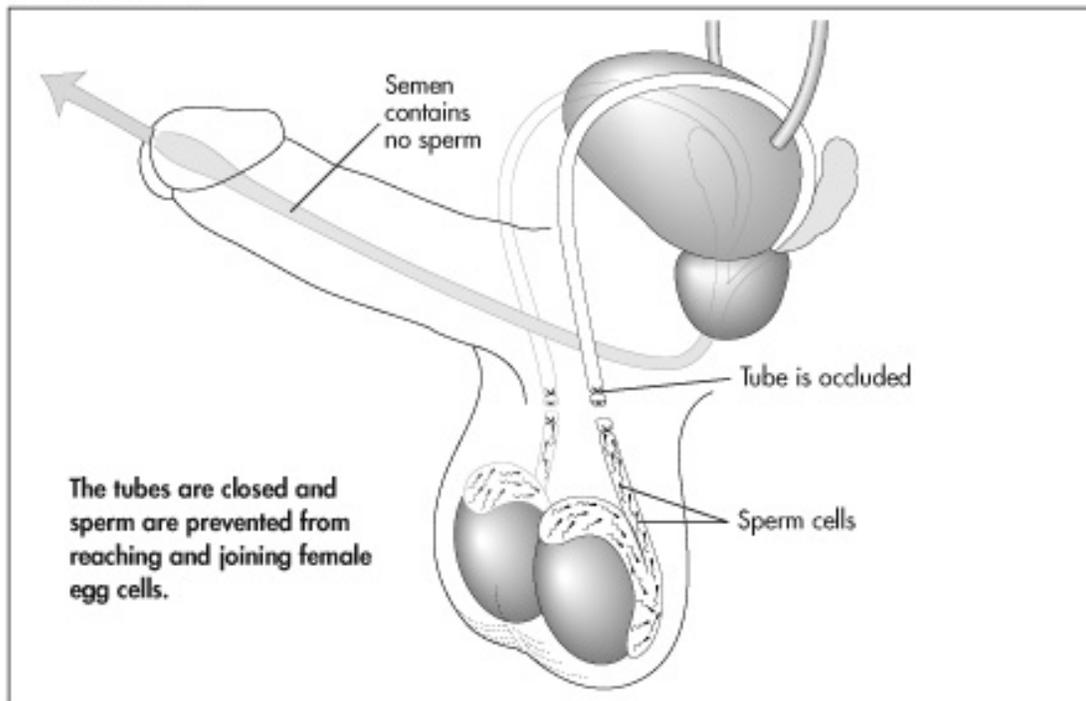
Vasectomy is a male sterilization procedure that prevents the passage of sperm into the ejaculate by blocking the spermatic cords (vasa deferentia).

Figure 4-3: Effects of Vasectomy on Male Anatomy

A. Before vasectomy



B. After vasectomy



Vasectomy is simpler, safer, and less expensive than female sterilization. Vasectomy is a minor operation that can generally be performed in a doctor's office or at a clinic and usually takes no more than 20 minutes.

While there are many ways to occlude the vas (e.g., ligation with sutures, division, cautery, clips, fascial interposition, and combinations of these), there are two basic approaches for scrotal entry—conventional (or incisional) vasectomy and no-scalpel vasectomy (NSV).

- **Incisional vasectomy.** The service provider wipes the scrotum with an antiseptic, then injects a local anesthetic into the skin of the scrotum to numb it. Next, he or she makes one or two small cuts in the skin of the scrotum through which he or she gently lifts out the tubes. The service provider cuts the tubes and may remove a small piece of each. He or she either ties the cut ends with a suture, clips them, or seals them with electric current, then closes the openings in the scrotum with small stitches. After a short rest (usually half an hour), the client can go home.
- **No-scalpel vasectomy (NSV).** As its name implies, this method does not use a scalpel to cut the skin. The NSV technique uses a vasal nerve block and two specialized instruments—a ringed clamp and dissecting forceps—to isolate and deliver the vas. The service provider pierces the skin of the scrotum with the forceps, then gently stretches the opening so that the tubes can be reached and blocked. Because the scrotal skin puncture is so small, very little bleeding occurs, and no stitches are needed to close the tiny wound. Developed and performed in China in 1974 by Dr. Li Shunqiang, this procedure has since gained acceptance worldwide.

Advantages

Advantages of NSV over incisional vasectomy include:

- Reduced risk for bleeding and other surgical complications
- Reduced swelling at injection and puncture site
- Reduced time required for procedure
- Less damage to tissue
- No need for stitches
- No need to make a return visit for removal of stitches
- Potential decrease in men's fear of vasectomy (since no scrotal incision is made)

After a vasectomy, a man can still achieve erections and orgasms. The amount of fluid in his ejaculations is no different than usual, and the fluid looks and smells the same. A man's hormones, beard, and voice do not change, nor do his sex drive and ability to have sex. The only difference is that the man has no sperm in his semen, so he cannot make a woman pregnant.

Complications

Like all surgery, vasectomy involves some risk, but the chance of serious problems is small. The most common complications of vasectomy are infection, inflammation, and blood clots in the area of the incision. However, these problems do not happen often and usually disappear with simple treatment.

Effectiveness

Overall, vasectomy is very effective and is one of the most reliable contraceptive methods available. Pregnancy rates following vasectomy are commonly quoted as less than one per 100 women in the first year following the procedure. Vasectomy failure may be related to user failure or to failure of the technique itself.

User failure occurs because the contraceptive effects of vasectomy are not immediate (since preexisting viable sperm must be cleared from the vas). User failure occurs when an alternative contraceptive method is not used during this period. Thus, the vasectomy user and his partner should practice alternative methods of contraception for at least 12 weeks after the procedure or until semen analysis shows that the semen is free of sperm.

The most common cause of failure of the vasectomy technique itself is spontaneous recanalization of the vas, which occurs when the two cut ends of the vas rejoin, creating passageways for sperm. Recanalization can occur at any time after vasectomy, from a few months to several years.

Because vasectomy is intended to be a permanent procedure, the client should be counseled and well informed before making a decision.

Advantages and Disadvantages of Vasectomy

Advantages	Disadvantages
<ul style="list-style-type: none">• Highly effective• Permanent• Very little time is required for the procedure• Client is able to return to work quickly	<ul style="list-style-type: none">• Risks associated with a surgical procedure• Reversal of the procedure is expensive and fertility cannot be guaranteed• Not available everywhere• Not effective immediately• No protection against STIs, including HIV/AIDS

Fertility Awareness Methods

Most women have an egg available for fertilization for only a few days out of their monthly menstrual cycle. Therefore, there is a time each month when a woman can get pregnant and a time when she cannot. Fertility awareness methods are designed to help couples identify the days of the month when the female partner is most likely to get pregnant, so they can avoid penile-vaginal sex on those days.

Couples can use a number of different strategies (or combinations of them) to determine when the female partner can get pregnant—that is, when she is likely to have an egg ready to be fertilized. The most common strategies are as follows:

- **Calendar (rhythm) method.** This method is based on the typical length of a woman’s menstrual cycle. Women whose periods occur on a regular schedule can estimate the day of the month when they will ovulate and can avoid vaginal sex for several days before and after that day.

- **Standard-days method.** This method identifies a fixed set of days in each menstrual cycle as the days when a woman can get pregnant if she has unprotected intercourse. For women who have menstrual cycles of between 26 and 32 days in length, they and their partners should avoid unprotected intercourse on days 8 through 19 of the cycle if they do not want to get pregnant.
- **Basal body temperature method (BBT).** This method is used to identify the small rise in body temperature that typically occurs with ovulation. However, because it indicates when ovulation has already occurred, it is difficult to determine the beginning of the fertile period. The safest way to use BBT is to avoid vaginal sex or use a barrier method during at least the first half of the cycle until three days after the temperature has risen.
- **Cervical mucus method.** Over the course of a woman’s menstrual cycle, the color, consistency, and amount of her cervical mucus change. These changes are a normal part of a woman’s cycle. Being “wet” does not necessarily mean that a woman has been sexually active. To avoid pregnancy using this method, a woman should not have penile-vaginal sex:
 - On any day when she can feel or see mucus on her fingers, toilet tissue, or under-pants
 - If she is unsure about whether there is mucus
 - Until the fourth day after the “peak symptom day,” the last day of the wettest mucus
 - During her menstrual period

Effectiveness

While each fertility awareness method is effective when used correctly and consistently with every sex act (one to nine pregnancies per 100 women in the first 12 months of use), fertility awareness methods are only somewhat effective as commonly used—20 pregnancies per 100 women in the first year of use (one in every five).

Note: If the female partner is not free to refuse sexual activity, fertility awareness methods are probably not appropriate for the couple.

Advantages and Disadvantages

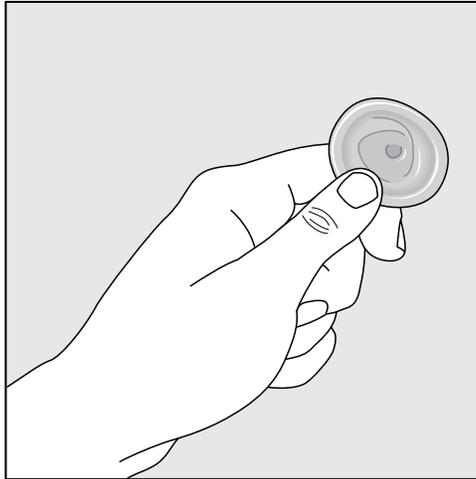
Advantages	Disadvantages
<ul style="list-style-type: none"> • Low or no cost • Are always available • Have no physical side effects • Are permitted by some religions and cultures that do not permit other methods of contraception • Do not cause a loss of spontaneity after sexual activity has begun • Are immediately reversible 	<ul style="list-style-type: none"> • Require planning and discipline • Do not protect against STIs, including HIV infection • Take time to learn • Couple may find it hard to know when the safe time is • Couple cannot have penile-vaginal sex, or must use another method, during the female partner’s fertile times

Condom Instructions

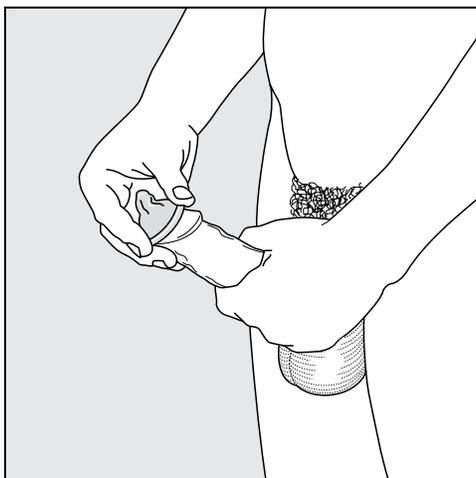
All clients considering the use of condoms should be provided with instructions and practice on their correct use. Although providers often mistakenly assume that all men know how to correctly use condoms, incorrect use is common and is a major cause of condom failure. Consequently, it is important for providers to have experience at demonstrating the use of condoms, so they can effectively explain condom use to clients.

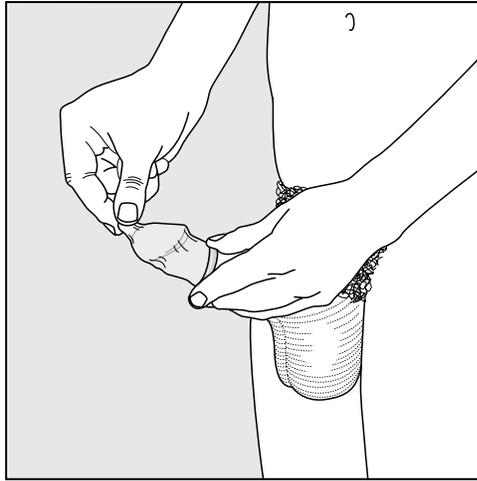
Figure 4-2. Instructions for Condom Use

A. Before penile-vaginal sex

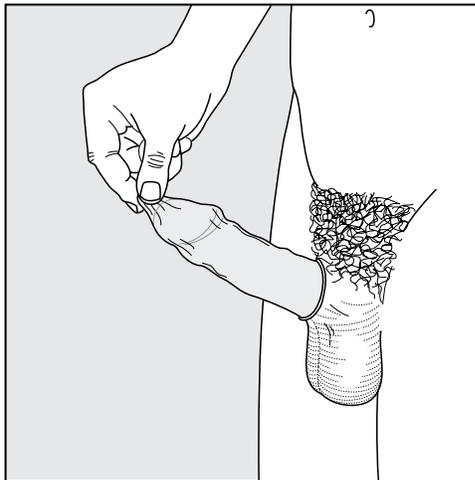


1. Carefully open the package so that the condom does not tear. Do not use scissors, teeth, or sharp objects to open the package. Look at the way the condom is rolled, so that when you start to put it on, you will place it correctly on the penis. The reservoir tip should be facing up. Do not unroll the condom before putting it on. If the condom looks dry or brittle, it may be old and more likely to break. Use a different one.
2. If you are not circumcised, pull back the foreskin. Put the condom on the end of the erect penis, leaving space at the tip. (*Note: If you initially placed the condom backwards on the penis, do not turn the condom around. Throw it away and start with a new one.*)



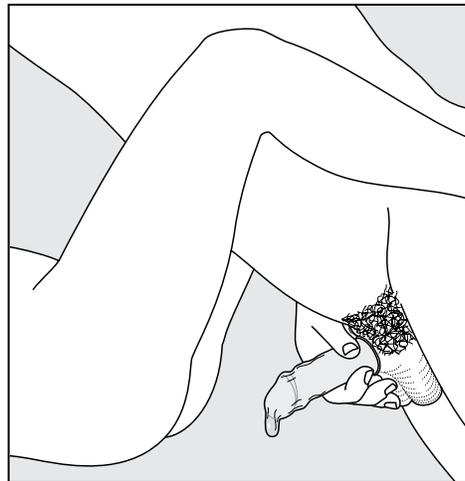


3. Pinching the tip of the condom to squeeze out the air, unroll the condom smoothly onto the penis to its base, using the soft part of your fingers, not the fingernails. Try to avoid leaving air bubbles under the condom, but if small bubbles are present, do not try to break them; this will damage the condom. The rolled rim should always remain on the outside of the condom.

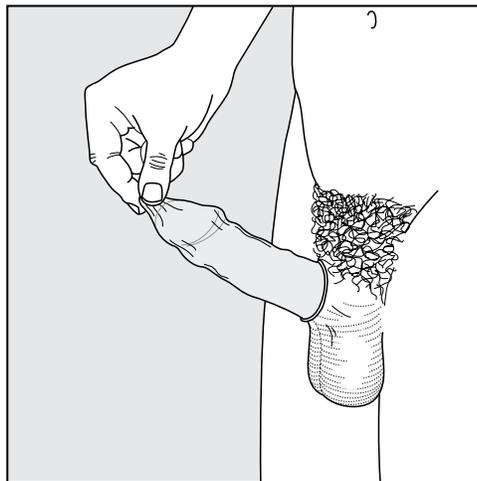


4. Check to make sure that there is a little empty space at the tip of the condom to catch the semen and that the condom is not broken. With the condom on, insert the penis for intercourse.

B. After penile-vaginal sex



1. After ejaculation, hold onto the condom at the base of the penis. Keeping the condom on, pull the penis out before it gets soft.



2. Slide the condom off without spilling the liquid (semen) inside. Dispose of the used condom.

Female Contraceptive Methods

The following chart provides some key information about female contraceptive methods (such as Norplant implants, combined injectables, progestin-only injectables, female sterilization, the IUD, the lactational amenorrhea method, oral contraceptives, diaphragms, cervical caps, female condoms, and spermicides). Detailed information about these methods is beyond the scope of this text. For more information about these methods, consult a reproductive health or medical textbook.

Method	Effectiveness as commonly used in first year	Advantages	Side effects/ considerations
Implant (e.g., Norplant, Jadelle, Implanon)	Very effective— one pregnancy per 1,000 women	<ul style="list-style-type: none"> • Is most effective contraceptive available • Offers long-term pregnancy prevention but is reversible • Does not interrupt or prevent sexual activity 	<ul style="list-style-type: none"> • Must be inserted and removed by specially trained health provider • May cause irregular bleeding • Does not protect against STIs
Combined injectable	Very effective— one pregnancy per 333 women	<ul style="list-style-type: none"> • Is easy to use (no daily routine) • Does not interrupt or prevent sexual activity 	<ul style="list-style-type: none"> • May cause irregular bleeding • Does not protect against STIs
Progestin-only Injectable (e.g. Depo-Provera, NET EN)	Very effective— one pregnancy per 333 women	<ul style="list-style-type: none"> • Provides long-term pregnancy prevention, but is reversible • May help prevent ovarian and endometrial cancer • Helps prevent ectopic pregnancy • Does not interrupt or prevent sexual activity 	<ul style="list-style-type: none"> • Causes delay in return of fertility (6–10 months) • May cause irregular bleeding • Does not protect against STIs
Female sterilization (tubal occlusion)	Very effective— one pregnancy per 200 women	<ul style="list-style-type: none"> • Is permanent • Helps protect against ovarian cancer 	<ul style="list-style-type: none"> • Requires a surgical procedure • Carries risk for possible postoperative infection or bleeding • Does not protect against STIs

Method	Effectiveness as commonly used in first year	Advantages	Side effects/ considerations
IUD	Very effective— one pregnancy per 125 to 170 women	<ul style="list-style-type: none"> • Provides long-term pregnancy prevention, but is reversible • Can reduce menstrual bleeding and cramping • Helps prevent ectopic pregnancy • Does not interrupt or prevent sexual activity 	<ul style="list-style-type: none"> • Must be inserted and removed by a specially trained health provider • May cause irregular bleeding • Does not protect against STIs
Combined oral contraceptives (birth control pills)	Effective— one pregnancy per 12 to 17 women	<ul style="list-style-type: none"> • Prevent ovarian and endometrial cancer, anemia, and ectopic pregnancy • Do not interrupt or prevent sexual activity 	<ul style="list-style-type: none"> • Increase risk for thromboembolism, especially in women who are older than 35 and smoke, who are at risk for heart attack or stroke, or who have clotting disorders (Women with uncontrolled hypertension and vascular complications should avoid combination pills.) • Does not protect against STIs
LAM (for six months after childbirth)	Effective— one pregnancy per 50 women	<ul style="list-style-type: none"> • Is available at no cost • Benefits mother and child • Does not interrupt or prevent sexual activity 	<ul style="list-style-type: none"> • May be passed on to the baby through breast milk by mothers with HIV infection • Does not protect against STIs
Progestin-only oral contraceptives (during breastfeeding)	Very effective— one pregnancy per 100 women	<ul style="list-style-type: none"> • May help prevent benign breast disease, endometrial and ovarian cancer, and pelvic inflammatory disease 	<ul style="list-style-type: none"> • Do not prevent ectopic pregnancy • Do not protect against STIs
Cervical cap used with spermicide	Somewhat effective— one pregnancy per five women who have not had children; one pregnancy per two or three women who have had children	<ul style="list-style-type: none"> • Is used only when needed • Is nonhormonal • May help prevent some STIs and conditions caused by STIs (pelvic inflammatory disease, infertility) • Helps prevent ectopic pregnancy 	<ul style="list-style-type: none"> • Requires fitting by health provider • May be difficult to remove • Requires a source of clean water to wash it in • Requires client to be comfortable about touching her own body • May interrupt sexual activity

Method	Effectiveness as commonly used in first year	Advantages	Side effects/ considerations
Diaphragm used with spermicide	Somewhat effective— one pregnancy per five women	<ul style="list-style-type: none"> • Is used only when needed • Is nonhormonal • May help prevent some STIs and conditions caused by STIs (pelvic inflammatory disease, and infertility) • Helps prevent ectopic pregnancy 	<ul style="list-style-type: none"> • Requires fitting by health provider • May be difficult to remove • Requires a source of clean water to wash it in • Requires client to be comfortable about touching her own body • May interrupt sexual activity
Female condom	Somewhat effective— one pregnancy per five women	<ul style="list-style-type: none"> • Protects against STIs • Can be used with nonwater-based lubricants • Is made of polyurethane, so may be used by those allergic to latex 	<ul style="list-style-type: none"> • May reduce sensitivity • Requires client to be comfortable about touching her own body • Is more expensive than male condoms • Must be inserted properly to be effective • May interrupt sexual activity
Spermicides	Somewhat effective— one pregnancy per four women	<ul style="list-style-type: none"> • Are used only when needed • Are nonhormonal • May help prevent some STIs and conditions caused by STIs (pelvic inflammatory disease, and infertility) • Easily available in many places • May protect against cervical cancer 	<ul style="list-style-type: none"> • May cause irritation to woman or her partner • Require client to be comfortable about touching her own body • May interrupt sexual activity • Some women are allergic to spermicides, which can increase the risk for STIs.

Emergency Contraception

Emergency contraception is a method that a woman can use after having unprotected penile-vaginal sex, to reduce the chances of becoming pregnant. With emergency contraception, the female partner either takes certain birth control pills or has a copper IUD inserted after unprotected sex. The method should not be used as a routine method of contraception. An IUD can be inserted up to five days (120 hours) after unprotected intercourse. Oral contraceptives should be taken as soon as possible, but can be used up to five days after unprotected intercourse.

Emergency contraception is an important method of preventing pregnancy when a condom breaks or slips off during sex. Men who know about emergency contraception may be more likely to tell their partners that this has occurred, thus enabling their partners to reduce the risk for pregnancy.

Men's Role in Family Planning

Ideally, family planning is the joint responsibility of a male and a female partner, and the method they choose should reflect the needs and concerns of both partners. Yet, even when this is the case, the primary responsibility for actually *using* the contraceptive method often falls on one of the partners. When using a male method such as condoms, withdrawal, or vasectomy, the male partner has the primary responsibility. But even when the couple uses a female method, such as oral contraceptives or Norplant implants, the male partner can play an important role in the method's use and effectiveness.

Ways in Which Men Can Support Family Planning Use

In general, men's role in female methods is providing support. Men can give their partners:

- Financial support (e.g., by helping her pay for the method)
- Emotional support (e.g., by accompanying her to the clinic, discussing the reasons for choosing one method over another, and/or supporting her choice of method)
- Help with the method if she desires (e.g., by helping insert the spermicide, if needed, or reminding her when to use it)
- Support by using an alternative method (such as withdrawal or condoms) in case she forgets to use or has an unexpected problem with her chosen method

Ways in Which Men Can Hinder Family Planning Use

Unfortunately, men can also hinder women in using female methods of contraception. In addition to withholding the types of support described above, male partners may actively interfere with their partner's choice of method. For example, they may:

- Forbid her from using any method, thereby forcing her to use one secretly if she chooses
- Not allow her the time to use the method before penile-vaginal sex (e.g., inserting a spermicide, or preparing and inserting a diaphragm, female condom, or cervical cap)
- Complain about or criticize her for the inconvenience of her method of choice (e.g., the female condom)
- Pressure her to use a method that may be harmful to her health
- Pressure her to have penile-vaginal sex during her fertile periods (e.g., when using a fertility awareness method)

Male clients should be encouraged to be full partners in a couple's reproductive life. One way to do this is to have respect for their partners and their partners' contraceptive choices. In all cases, men should consider which method is most beneficial for their partners and for themselves.

Ways in Which Health Care Workers Can Help Increase Men's Participation in Family Planning

Service providers and other facility staff can take some simple steps to help men become constructively involved in family planning decisions and contraceptive use. These include:

- Making condoms readily available at the facility
- Having community health workers and volunteers distribute condoms to men in various community settings
- Educating men on family planning in various community settings
- Counseling men about contraception during STI testing, diagnosis, and treatment
- Offering couples counseling to male and female partners during female clients' family planning visits
- Discussing family planning with couples using antenatal care services
- Providing an atmosphere in the family planning clinic that is welcoming to men

Family Planning Myths and Facts

Clients and health care workers may believe or want more information about the following statements about family planning. Some of the statements are true and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

1. A man does not need to use contraception after a certain age because eventually he loses the ability to reproduce. (MYTH)

While women stop producing eggs after menopause, many men continue to produce sperm throughout their lives.

2. A man cannot impregnate a woman while she is menstruating. (MYTH)

Even when a woman is menstruating, it is possible for her to ovulate (release an egg) and become pregnant. However, a woman is most likely to become pregnant right after ovulation, which usually occurs in the middle of her menstrual cycle, when she is not menstruating.

3. Anal sex is a risk-free way for women to avoid pregnancy. (MYTH)

Anal sex carries risks for both STI transmission and pregnancy. Anal sex is one of the easiest ways to spread HIV infection and some other STIs, and a woman can become pregnant from anal sex if semen from the man's ejaculation seeps out of her anus and enters the opening of her vagina.

4. Abstaining from sex is the only method of contraception that is 100% effective. (FACT)

Avoiding penile-vaginal sex and avoiding any genital or anal contact with semen are the only ways to absolutely avoid pregnancy.

5. The best way to use a condom is to pull it on tight. (MYTH)

The best way to use a condom is to leave some space at the tip to hold the semen after ejaculation. Some condoms have reservoir tips for this purpose; however, even if such a tip exists, some space should be left when putting on the condom.

6. Condoms, when used consistently and correctly, provide effective protection against pregnancy. (FACT)

Condoms provide very good protection against pregnancy when used correctly. However, many people use condoms incorrectly, thereby causing a typical-use effectiveness rate of 86%.

7. A woman is protected against pregnancy the day she begins taking the pill. (MYTH)

Most doctors recommend that women either abstain from penile-vaginal sex or use another method of contraception for seven days after a woman starts taking the pill. After this time, a woman is protected from pregnancy every day, including during her period.

8. Condoms are an effective means of contraception because they do not break easily or leak. (FACT)

Condoms are effective, depending on how carefully they are used. Condoms are inspected before being sold, and safety regulations require that condoms be able to hold a large amount of air without breaking. Condoms should not be exposed to heat or oil-based lubricants because both can cause the rubber to deteriorate. This, in turn, can increase a condom's chances of breaking.

9. Aside from abstinence, male and female condoms are the only contraceptive methods that can protect against STIs. (FACT)

Male and female condoms made of latex or polyurethane are the only contraceptive methods that protect against all STIs; no other methods offer such protection. Lambskin condoms do not protect against all STIs. A couple should always use condoms made of latex or polyurethane during sex if the partners are at risk for STIs.

10. There is a birth control pill that men can take to prevent pregnancy. (MYTH)

Scientists are currently developing a hormonal method of contraception for men that may be taken in the form of an injection or pill. However, the method is not currently available.

11. Vasectomy involves removing a man's testes so that he can no longer produce sperm. (MYTH)

Vasectomy is a simple operation that blocks the vasa deferentia so that sperm cannot pass from the testes to the urethra. The testes remain completely intact after vasectomy.

12. Vasectomy is a simpler operation than female sterilization (tubal occlusion). (FACT)

Vasectomy is a much simpler and shorter procedure than any female sterilization procedure. A vasectomy also requires much less recovery time than female sterilization.

13. A woman can take emergency contraception pills to reduce the risk for pregnancy after having unprotected sex. (FACT)

Emergency contraception is an effective mechanism for reducing the risk for pregnancy when contraception fails or is not used. Emergency contraception should be used when contraception fails (e.g., a condom breaks, a diaphragm becomes dislodged, or an IUD is expelled) or when a couple forgets to use contraception (e.g., a woman forgets to take her pills).

14. Withdrawal is an effective method of preventing pregnancy for a man who has never had sex before. (MYTH)

The effective use of withdrawal requires a man to have a high level of self-control during ejaculation. A man who is inexperienced in penile-vaginal sex will likely have difficulty removing his penis from the vagina in sufficient time before ejaculating.

15. Condoms have the highest typical-use effectiveness rate. (MYTH)

Although condoms can be effective in preventing pregnancy, many other contraceptive methods are more effective in typical use, including sterilization, IUDs, oral contraceptives, Depo-Provera, and Norplant implants.

5

Sexually Transmitted Infections

This chapter provides an introduction to **sexually transmitted infections (STIs)**. Its purpose is to increase your knowledge of common STIs, including ways to avoid contracting and transmitting STIs.

An Overview of STIs

STIs are infections that can be passed from one person to another person by sexual contact, although some STIs can be transmitted by other means as well. For example, a woman can transmit an STI to her fetus through the placenta or at the time of delivery as the baby passes through the birth canal. STIs can be transmitted between any two people—regardless of their sex or age—by penile-vaginal, oral, or anal sex and by skin-to-skin contact during sex.

In many places in the world, STIs are referred to as *sexually transmitted diseases (STDs)*. This training course uses the term “STIs” since it is the most commonly used and universally understood term.

STIs are part of a broader group of infections known as **reproductive tract infections (RTIs)**. In addition to STIs, RTIs include other infections of the reproductive system that are not caused by sexual contact. Some of these infections result from an imbalance of the microorganisms normally found in the reproductive tract (such as bacterial vaginosis or yeast infections); still other RTIs are incurred during medical procedures.

The symptoms associated with STIs and other RTIs vary from none to severe. You cannot always tell if a person has an STI, and people without symptoms often transmit the infection to others unknowingly.

The Importance of Learning about STIs

STIs are a global problem. In 1999, according to the World Health Organization (WHO), there were an estimated 340 million new cases of STIs.⁷ Although the impact of STIs is serious in both developed and developing countries, it is most profound in the developing world. In 2003, an estimated 4.8 million people became newly infected with HIV, and approximately 37.8 million people were living with HIV; in the same year, almost three million were killed by AIDS.⁸

Today, STIs are one of the most common problems for which people in the developing world seek health care services. As described on the next page, curable STIs, if left untreated, can result in serious health consequences.

7 WHO. 2001. *Global prevalence and incidence of selected curable sexually transmitted infections*. Geneva.

8 UNAIDS. 2004. *2004 report on the global HIV/AIDS epidemic: 4th global report*. Geneva.

Common STIs

STIs can be divided into two broad categories—curable STIs and incurable STIs (see table, below):

- **Curable STIs** can be treated with antimicrobial drugs. However, if these STIs are not diagnosed and treated in time, some of these diseases can cause irreversible damage, such as infertility, pelvic inflammatory disease (PID), premature labor and delivery, increased risk for cervical cancer, ectopic pregnancy, inflammation of the testes, pneumonia and other infections in infants, and, in extreme cases, death.
- **Incurable STIs** are caused by viruses. Although these infections cannot be cured, in some settings they can be managed by relieving or reducing their symptoms.

Signs and Symptoms of Common STIs

STI	Signs and symptoms	Curable or incurable
Chlamydia	<p>In men:</p> <ul style="list-style-type: none"> • Burning or pain during urination • Urethral discharge • Urethral itching • Swollen and/or painful testes • Some men have no symptoms. <p>In women:</p> <ul style="list-style-type: none"> • Burning or pain during urination • Unusual vaginal discharge • Abnormal and/or heavy vaginal bleeding (Note: This symptom is often caused by factors other than STIs.) • Bleeding after intercourse • Lower abdominal pain (pain below the belly button; pelvic pain) • Often, women have no symptoms. 	Curable
Genital warts (human papillomavirus, or HPV)	<ul style="list-style-type: none"> • Warts or bumps on the genitals, anus, or surrounding areas • In about half of all cases, clients have no perceivable warts. 	Incurable
Gonorrhea	<p>In men:</p> <ul style="list-style-type: none"> • Burning or pain during urination • Urethral discharge • Urethral itching • Swollen and/or painful testes <p>In women:</p> <ul style="list-style-type: none"> • Burning or pain during urination • Unusual vaginal discharge • Abnormal and/or heavy vaginal bleeding (Note: This symptom is often caused by factors other than STIs.) • Often, women have no symptoms. 	Curable

STI	Signs and symptoms	Curable or incurable
Herpes (herpes simplex)	<ul style="list-style-type: none"> • Burning or pain during urination • Blisters and ulcers (sores) on the mouth, lips, genitals, anus, or surrounding areas • Itching or tingling in the genital area 	Incurable
HIV/AIDS	<ul style="list-style-type: none"> • May include various symptoms and opportunistic infections due to lack of immune system function 	Incurable
Nongonococcal urethritis (NGU)*	<ul style="list-style-type: none"> • Pain during urination • Penile discharge 	Curable
Pubic lice	<ul style="list-style-type: none"> • Itching in the genital area or on the thighs, eyelashes, or eyebrows 	Curable
Scabies	<ul style="list-style-type: none"> • Lesions on the skin that itch, especially between the fingers and toes, in the armpits, and on the elbows, penis, and scrotum (and rarely on the back, face, and scalp) 	Curable
Syphilis	<ul style="list-style-type: none"> • Blisters and ulcers (sores) on the mouth, lips, genitals, or surrounding areas • Blister-like lesions • Enlarged lymph nodes in the groin area 	Curable
Viral hepatitis (hepatitis B or hepatitis C)	<ul style="list-style-type: none"> • Jaundice (yellowing of the eyes and skin) • Fever • Headache • Muscle ache • Dark urine 	Incurable

*This term is used to describe urethritis in men that is not caused by gonorrhea.

Gender, Sex, and STIs

Women’s and Men’s Vulnerability to STIs

Being male or female can affect an individual’s risk for contracting STIs, the seriousness of an STI’s complications, his or her ability to receive adequate treatment for an STI, and his or her experience of having an STI. These differences are explained below.

Biological Differences between Women and Men

- Women are more likely than men to acquire an STI from any single act of unprotected penile-vaginal sex because the semen remains in the vagina for an extended amount of time after sex. This increases the opportunity for infection. In addition, the interior wall of the vagina is more vulnerable to cuts or tears that could easily transmit STIs than the penis, which is less vulnerable because it is protected by skin.
- Many STIs produce no symptoms in women, produce symptoms (such as discharge) that may not be identified as being related to an STI, or produce symptoms that are not easily seen because they appear inside a woman’s body. As a result, women often do not seek treatment for STIs and may suffer greater long-term and permanent physical effects from STIs than men.
- If left untreated, STIs are more likely to cause serious complications in women than men. PID resulting from an untreated STI in women can lead to infertility, ectopic pregnancy, and chronic pelvic pain. Cervical cancer is also the result of an untreated STI.
- Women can pass STIs to a fetus, which may result in miscarriage, stillbirths, and infections in newborns. These infections, in turn, can cause blindness, pneumonia, other illnesses, or death.

Socially Constructed Expectations of Male Behavior

- Often, social expectations about men’s sexual behavior can result in men’s engaging in risky behaviors, such as having unprotected sex and sex with multiple partners. This behavior can contribute to men’s transmitting STIs to their partners.
- Many men have concerns about how to tell their wives that they have an STI. Men may fear that their wives will ask where the STI came from, which may put men in an uncomfortable situation if they have other partners whom they have not mentioned to their wives.
- Men are not accustomed to seeking reproductive health care and are often uncomfortable accessing reproductive health services. This may be because they view the services as being for women only or because they have been socially conditioned to believe that an important part of being a man is to be “strong” and not ask for assistance.

Power Imbalances between Men and Women

- Power imbalances and social expectations of how women should behave may make it difficult for women to discuss sex with or mention reproductive health concerns to their partners. As a result, women may not ask their partners to use condoms and may not be allowed to refuse sex, even when they know that it will put them at risk for pregnancy or STIs. In general, women may yield to their partner's wishes about sex-related issues to avoid being yelled at, divorced, beaten, or killed.
- Women are often afraid to tell their husbands or partners that they have an STI, even when their husband or partner transmitted it to them. If they do so, many women may experience physical, mental, or emotional abuse or divorce.
- Men may restrict women's access to services by limiting their financial resources, mobility, and access to information about services.

Risk Factors for Transmitting and Contracting STIs

Abstinence is the only way to be 100% sure of not transmitting and contracting STIs through sexual means. During unprotected sexual activity, persons are at the lowest risk for transmitting and contracting STIs by having sex *only* with partners:

- Whom they are sure are not infected with an STI
- Who have no other sexual partners

In all other instances, engaging in the following behaviors can put a person, his or her partner(s), and his or her child(ren) at higher risk for transmitting and contracting STIs:

- Having penile-vaginal, oral, or anal sex or oral-anal contact with a person who has signs or symptoms of an STI
- Having penile-vaginal, oral, or anal sex or oral-anal contact without using a barrier, such as a male condom, female condom, or dental dam^{9*}
- Having sex with multiple partners
- Having sex with a person who has other partners
- Having sex with a person whose behavior puts him or her at high risk for contracting STIs, such as commercial sex workers and injection drug users
- Sharing needles, syringes, or other drug paraphernalia during injection drug use
- Having sex while using drugs or alcohol or having sex with a person who does so
- Having penile-vaginal sex with or performing oral sex on a woman who is menstruating
- Having semen in the mouth
- Sharing sexual aids (“sex toys”) without first disinfecting them
- Sharing douching equipment without first disinfecting it
- Engaging in any sexual practice that causes tissue damage or bleeding (e.g., dry sex, anal sex)

Levels of Risk

Different sexual behaviors carry different levels of risk for transmitting and contracting STIs. If an individual is not sure whether his or her partner is infected with an STI, explain that the sexual behaviors in the chart on page 5.8 indicate various levels of risk.

Note: The risk between categories in the chart is not to scale, and the order of activities within a bar is not necessarily representative of any order in the risk of activities. Risks may vary somewhat from one type of infection to another; for example, condoms protect against gonorrhea but do not protect against syphilis, herpes, or genital ulcers unless the condom is covering the lesions. Risk levels also vary, based on context and different experts’ opinions. The following examples are provided simply as a framework.

⁹ *A dental dam is a square piece of thin latex that can be used to prevent the transmission of STIs while performing oral and oral-anal sex on a woman. If a dental dam is not available, a thin piece of plastic wrap or a male condom, cut lengthwise, can be used.

Levels of Risk

<ul style="list-style-type: none"> • Abstinence • Hugging • Massage • Masturbation • Fantasy • Phone sex • Cyber sex • Dry kissing • Not sharing sex toys • Sex with a monogamous, uninfected partner 	<ul style="list-style-type: none"> • Sexually stimulating another's genitals using hands • Giving a man oral sex without putting the head of the penis in mouth • Giving or receiving oral sex with a condom, dental dam, or plastic wrap • Receiving oral sex without a barrier • Sharing sex toys after disinfecting them or using a new condom • Tongue kissing 	<ul style="list-style-type: none"> • Engaging in insertive or receptive vaginal sex while wearing a condom • Engaging in insertive anal sex while wearing a condom 	<ul style="list-style-type: none"> • Engaging in receptive anal sex while using a condom • Performing oral sex without using a condom, dental dam, or plastic wrap (safer if no ejaculation in the mouth) • Sharing sex toys without disinfecting them or using a new condom • Sexually stimulating another's genitals using hands with cuts or broken skin (safer if making no contact with secretions, semen, or menstrual blood) 	<ul style="list-style-type: none"> • Engaging in insertive anal sex without wearing a condom • Engaging in insertive vaginal sex without wearing a condom 	<ul style="list-style-type: none"> • Engaging in receptive anal sex without using a condom • Engaging in receptive vaginal sex without using a condom
<p>No risk</p>	<p>Very low risk</p>	<p>Low risk</p>	<p>Medium risk</p>	<p>High risk</p>	<p>Very high risk</p>

Reducing Risk

Sexual behaviors occur along a continuum of risk, ranging from no risk to very high risk. This applies to different sexual behaviors, as well as to the various ways in which a person can perform any sexual behavior.

Harm Reduction

Harm reduction is an approach individuals can use to reduce their risk for contracting STIs. When using this approach, individuals take whatever steps they can to reduce the potential risk of a sexual behavior if they cannot or will not abstain from the behavior or if they cannot or will not have sex only with a mutually monogamous partner whom they are sure is not infected with an STI.

A harm-reduction approach:

- Focuses on changing behavior in order to reduce risk rather than attempting to completely eliminate the behavior or engage only in the safest sex practices
- Recognizes that people are willing to accept different levels of risk in their lives, and that the safest way of having sex may not be acceptable to everyone
- Acknowledges that some ways of having sex are clearly safer than others. For example, while abstaining from performing oral sex on a man is safest, using a condom during oral sex is the next safest alternative. But an individual has several ways to reduce the risk if these practices are not acceptable. For example, having oral sex *without* ejaculate in the mouth is safer than having oral sex *with* ejaculate in the mouth.
- Requires that people are given the information necessary to make informed decisions on their own

People accept different levels of risk to satisfy personal needs. While not everyone will follow every safer-sex recommendation, having adequate knowledge about the risks enables each person to make his or her own informed choices about reducing sexual risks.

Safer Sex

Safer sex includes practices that reduce the risk for contracting STIs, including HIV. These practices reduce contact with the partner's body fluids, including ejaculate from a man's penis (semen), vaginal fluids, blood, and other types of discharge from lesions or open sores.

As stated earlier, during unprotected sexual activity, individuals are at the lowest risk for contracting STIs by having sex *only* with partners whom they are sure are not infected with an STI and who have no other sexual partners.

With all other partners, safer-sex practices include:

- Using a barrier to cover the penis, vagina, hands, or any objects that are inserted into or come in contact with the vagina, anus, or rectum during every act of penile-vaginal, oral, or anal sex or oral-anal contact

- Avoiding sex with partners who have sores on their genitals or abnormal discharge from their genitals
- Avoiding oral sex with partners who have sores in their mouths
- Avoiding inserting fingers into the vagina or rectum if open sores are present on the hands or fingers
- Reducing the number of sex partners
- Avoiding sex with individuals who have multiple partners
- Avoiding sex with individuals whose behavior puts them at high risk for contracting STIs, such as commercial sex workers and injection-drug users
- Avoiding sharing needles, syringes, or other drug paraphernalia during injection-drug use
- Avoiding sex while using drugs or alcohol or with persons who do so
- Avoiding having penile-vaginal sex or performing oral sex on a woman who is menstruating
- Avoiding having semen in the mouth
- Avoiding sharing sexual aids (“sex toys”) or douching equipment without disinfecting them between uses
- Avoiding any sexual practice that causes tissue damage or bleeding

Barriers to cover the penis, vagina, hands, or objects used during sexual activity include a male condom, a female condom, a dental dam, a thin piece of plastic wrap, or a cut-open male condom.

Dual Protection

Many service providers are promoting the concept of **dual protection** to prevent against the transmission of STIs, including HIV infection. Dual protection is a strategy that prevents both STI/HIV transmission and unintended pregnancy through the use of condoms alone, the use of condoms combined with other methods (dual-method use), or the avoidance of risky sex.¹⁰ More specifically, dual protection can include:

- The use of condoms (male or female) alone for both purposes
- Dual-method use:
 - o The use of a condom plus another contraceptive method for extra protection against pregnancy
 - o The use of a condom plus emergency contraception if the condom breaks
 - o Selective condom use (choosing to use condoms with some partners and not others, depending either on the perception of the level of risk or on the context of the sexual activity and access to condoms) plus another contraceptive method (for example, using only the pill with a primary partner and using the pill plus condoms with secondary partners)

¹⁰ Spieler, J., Karra, M., & Bogelson, K. 2000. *Condom promotion and dual protection*, USAID/G/PHN/POP/R; PRIME II Slide Show; and EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York.

- The avoidance of risky sexual activity:
 - o Abstinence
 - o Avoidance of all types of penetrative sex
 - o Mutual monogamy between uninfected partners combined with the use of a contraceptive method for those who want to avoid pregnancy
 - o Delaying sexual debut (for young people)

Condom promotion is important for dual protection for the following reasons:

- The male latex condom, when used consistently and correctly, is the only technology that has been proven to be highly effective in preventing STI/HIV transmission and pregnancy at the same time.
- The female condom may be as effective as the male condom, but there are not enough data to support this claim at this time.

Legitimizing the condom as an effective contraceptive method is important for the following reasons:

- In some cases, pregnancy prevention can be a greater motivator for condom use than STI/HIV prevention.
- If family planning programs promoted condoms as an effective method of pregnancy prevention, this approach would reduce the stigma associated with the condom as a method of STI/HIV prevention.
- In general, many service providers who offer family planning services believe that condoms are not effective for pregnancy prevention, but that they are effective for STI/HIV prevention. In part, this bias exists because other family planning methods—such as sterilization, intrauterine devices (IUDs), injectables, and implants—are more effective than condoms in both perfect use and typical use. But when condoms are used consistently and correctly, they are highly effective against pregnancy. This fact needs to be communicated to service providers and clients alike.
- Data show that from a single act of unprotected penile-vaginal sex, the probability of acquiring various STIs is much greater than the probability of becoming pregnant. So if condoms are used consistently and correctly to prevent STIs, they must be even more effective against pregnancy.
- Condoms (and those who use them) are stigmatized because they are currently associated with STI/HIV prevention and their use implies that partners may have other sexual partners. The stigma from associating condom use and sex work or sexual promiscuity can be addressed by promoting condoms as effective methods for both pregnancy and STI/HIV prevention.

Dual-protection counseling is important in family planning services for the following reasons:

- Many family planning clients may be at risk for STI/HIV infection as well as unintended pregnancy. Many women are at risk for HIV and other STIs mostly as a result of their partners' risky sexual activities. Dual-protection counseling can help clients perceive their own risk for HIV and other STIs and unintended pregnancy and develop strategies to protect themselves.

- Meeting clients' needs for dual protection improves the quality of sexual and reproductive health services by addressing clients' multiple concerns.
- Pregnancy and STI/HIV prevention needs are inseparable and should be addressed together.

Dual-protection counseling relates to the concept of informed choice:

- Dual-protection counseling upholds the concept of informed choice by making sure that clients are knowledgeable about and aware of their risks for HIV and other STIs and unintended pregnancy while making family planning decisions.
- Clients are not making truly informed choices about family planning unless they are aware of their risks for HIV and other STIs and are knowledgeable about how effective the various family planning methods are in STI/HIV prevention. Dual-protection counseling ensures that clients are aware, knowledgeable, and informed.

Key strategies for dual-protection counseling in a family planning setting include:

- Working with clients on partner communication and condom negotiation skills
- Involving men in counseling and education and addressing their concerns about condoms
- Eroticizing condom use and making it appealing to both partners
- Helping women consider the ramifications of their decisions—both positive and negative—and recognizing the limitations that many women may have in negotiating condom use (for example, insisting on condom use may lead to violence and/or abandonment)
- Promoting the female condom as a viable contraceptive method (where it is available)

STI Myths and Facts

Clients and health care workers may believe or want more information about the following statements about STIs. Some of the statements are true and some are false. Each statement is followed by the term *myth* or *fact*, depending on whether it is false or true, and a brief explanation.

- 1. A man cannot transmit an STI if he withdraws before ejaculation. (MYTH)**
Withdrawal does not eliminate the risk for transmitting STIs. Pre-ejaculatory fluid from the penis can contain infectious organisms, and organisms on the skin of a man's genitals can be transmitted to another person.
- 2. A man can be cured of an STI by having sex with a girl who is a virgin. (MYTH)**
Proper treatment is the only way to cure or manage the symptoms of STIs. STIs cannot be cured by transmitting them to others. Having sex with a virgin or anyone else only increases that person's risk for infection.
- 3. It is possible to get an STI from having oral sex. (FACT)**
The person performing and the person receiving oral sex are at different levels of risk. The person *receiving* oral sex is at risk only if his or her partner has an open sore or ulcer in the mouth or on the face or has an STI in the throat. The person *performing* oral sex is at high risk if he or she has an open sore or ulcer on the lips or face or has ejaculate or vaginal fluids in the mouth. To protect against STIs, an individual should always use a latex or plastic barrier, such as a male condom, female condom, or dental dam, when having oral sex.
- 4. A monogamous person cannot contract an STI. (MYTH)**
Individuals who are faithful to their partner may still be at risk for contracting STIs if their partner engages in sexual activity with other people. In addition, individuals who are currently monogamous with their partner may have contracted an STI from someone else in the past; therefore, they may have an STI without knowing it and/or without telling their current partner.
- 5. If you have an STI once, you become immune to it and cannot get it again. (MYTH)**
Contracting an STI does not make a person immune to future infections. If a person is treated and cured but his or her partner(s) is not treated, the cured person can get the infection again. The cured person can also get the infection from another partner. Repeat infections can put people at risk for damage to the genital tract (e.g., scarred fallopian tubes) or chronic infection (e.g., chronic pelvic inflammatory disease).
- 6. You can become infected with more than one STI at a time. (FACT)**
A person can have more than one STI at the same time. For example, more and more people are now contracting chlamydia and gonorrhea together.

7. You cannot contract AIDS by living in the same house as someone who has the disease. (FACT)

HIV, the infection that causes AIDS, is transmitted through exposure to infected blood and other infected body secretions. Living in the same house with someone who is HIV-infected does not put those in contact with him or her at risk unless they share items that have been exposed to the infected person's blood or genital secretions (e.g., through the use of shared toothbrushes, razors, or douching equipment).

8. You can always tell if someone has an STI by his or her appearance. (MYTH)

Sometimes, STIs produce no symptoms or no visible symptoms. In fact, many people carry STIs for long periods of time without knowing that they are infected. In addition, STIs affect all people; no type of person is immune from STIs. People of different races, sexes, religions, socioeconomic classes, and sexual orientations all contract STIs.

9. Condoms reduce the risk for contracting STIs, including HIV. (FACT)

After abstinence, latex condoms are the most effective way to prevent STIs, including HIV. However, latex condoms are not 100% effective. Some groups have reported inaccurate research that suggests that HIV can pass through latex condoms, but this is not true. In fact, laboratory tests show that no STI, including HIV, can penetrate latex condoms.¹¹

10. A person infected with an STI has a higher risk for transmitting and contracting HIV. (FACT)

Both ulcerative STIs (those that cause sores) and nonulcerative STIs increase the risk for transmitting and contracting HIV. Ulcerative STIs increase the risk for HIV infection because the ulcers provide easy entry into the body for HIV. Nonulcerative STIs may enhance HIV transmission for two reasons: They increase the number of white blood cells in the genital tract, and genital inflammation may cause microscopic cuts that can allow HIV to enter the body.

11. STIs are a new medical problem. (MYTH)

STIs have existed since the beginning of recorded history. Evidence of medical damage caused by STIs appears in ancient writings, art, and skeletal remains.

12. Herbal treatments are effective in curing STIs. (MYTH)

Antibiotics are the only proven effective treatment for bacterial STIs, which include chlamydia, gonorrhea, and syphilis. Currently, there is no cure for viral STIs, which include genital warts, hepatitis, herpes, and HIV. Often, clients who receive STI care from nonmedical personnel believe that their STI has been treated, but this is not so. This misconception prevents them from getting adequate treatment, which puts their health and the health of their partner(s) at great risk.

¹¹ Gardner, R., Blackburn, R. D., and Upadhyay, U. D. 1999. Closing the condom gap. *Population Reports*, series H, no. 9. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

13. People usually know that they have an STI within two to five days of being infected. (MYTH)

Many people never have symptoms, and others may not have symptoms for weeks or years after being infected.

14. Abstinence is the only 100% effective safeguard against the spread of STIs. (FACT)

Abstinence from sex is the best way to prevent the spread of STIs. However, latex condoms are the next best option. When used consistently and correctly, these condoms are very effective at preventing the transmission of STIs.

15. It is possible to get some STIs from kissing. (FACT)

It is rare but possible to get syphilis through kissing if the infected person has chancres (small sores) in or around the mouth. Kissing can also spread the herpes virus.

16. Youth are particularly vulnerable to STIs. (FACT)

STIs are disproportionately higher among young people than adults for both biological and behavioral reasons. The highest reported cases of STIs are among young people (ages 15 to 24). In developed countries, two-thirds of all reported cases of STIs occur among those under age 25.¹²

17. Anal sex is the riskiest form of sexual contact. (FACT)

Anal sex carries a higher risk for HIV transmission than other types of sexual contact. During anal sex, the penis can tear the mucous membrane of the anus, which provides the virus with an entry point into the bloodstream.

18. Special medicines can cure HIV infection. (MYTH)

Currently, there is no cure or vaccine for HIV infection. Some drugs can slow down the production of the virus in an infected person.

19. HIV is a disease that affects only sex workers and homosexuals. (MYTH)

Anyone can become infected with HIV. A person's risk for HIV is not related to the type of person he or she is, but rather to the behavior he or she engages in.

20. HIV can be transmitted from one person to another when they share needles for drugs. (FACT)

Sharing needles during injection drug use carries a very high risk for HIV transmission. Infected blood is easily passed from one person to another via an infected needle or other equipment used to prepare or inject drugs.

¹² Senderowitz, J. 1997. *Young people and STDs/HIV/AIDS Part I: Dimensions of the problem*. Washington, DC: Pathfinder International.

6

Men and HIV and AIDS

This chapter provides basic information on understanding the transmission and prevention of HIV and AIDS, the levels of HIV risk, and the constructive roles that men can play to address HIV and AIDS.

Basic Facts about HIV and AIDS

What Is HIV?

HIV stands for *human immunodeficiency virus*. This virus attacks the body's immune system, which protects the body against illness. HIV infects only humans.

What Is AIDS?

AIDS stands for *acquired immune deficiency syndrome*. Becoming infected with HIV leads to a weakened immune system. This makes a person who has HIV vulnerable to a group of illnesses that a healthy person who does not have HIV probably would not get.

What Is the Difference between HIV and AIDS?

A person infected with HIV may remain healthy for several years with no physical signs or symptoms of infection. A person with the virus but with no symptoms is known as “HIV-infected” or “HIV-positive.” After a person has been infected with HIV for a period of time (often many years), symptoms caused by the virus begin to develop. At this stage, people with HIV are likely to contract opportunistic infections. When an HIV-positive person gets one or more specific infections (including tuberculosis, rare cancers, and eye, skin, and nervous system conditions), he or she is defined as having “AIDS.”

Where Does HIV Come from?

It is now generally accepted that HIV is a descendant of a simian immunodeficiency virus because certain strains of that virus bear a very close resemblance to HIV-1 and HIV-2, the two types of HIV (<http://www.avert.org/hivtypes.htm>). While we now have a much better understanding of how the virus works, there is still no cure or vaccine for it. When AIDS first appeared in each country, people blamed AIDS on certain groups. Often, people think the fault lies with people from “other places” or with those who look and behave “differently.” This leads to problems of blame and prejudice. It also means that many people believe that only people in those groups are at risk for HIV infection. They think that “it cannot happen to me.” Confusion about where AIDS comes from and who it affects also

makes many people willing to deny that it even exists.

How Is HIV Transmitted?

HIV is found in an infected person's blood (including menstrual blood), breast milk, semen, and vaginal fluids. HIV can be transmitted in the following ways:

- During unprotected vaginal, oral, or anal sex. HIV can pass from someone's infected blood, semen, or vaginal fluids directly into another person's bloodstream, through the thin skin lining the inside of the vagina, mouth, or backside.
- *By HIV-infected blood transfusions or contaminated injecting equipment or cutting instruments.*
- *To a baby during pregnancy, delivery, or breastfeeding.*¹³ An estimated 600,000 HIV-infected infants—at least 1,600 every day—are born in resource-constrained countries. Among women who do not breastfeed, an estimated 65% of perinatal HIV infections occur late in pregnancy and during labor and delivery (Family Health International. No date. HIV counseling and testing. Available at: www.fhi.org/en/Topics/Voluntary+Counseling+and+Testing+topic+page.htm/).

¹³ *Note:* A breastfeeding mother who has HIV can pass the virus to her baby through her breast milk. Studies show that one-third of babies who are breastfed by HIV-infected mothers will also become infected with HIV. However, breastfeeding is known to be good for the overall health of the baby, because the mother's milk is nutritious and protects the baby from disease. The alternative to breastfeeding for HIV-infected women is formula-feeding. However, for some women, formula can be too expensive. Even when formula is affordable, clean water is needed to mix with the formula and to wash the bottles used to feed the baby. Dirty water can give a baby diarrhea, which often leads to death. Clean water is a problem in some communities, and sometimes families do not have the means to boil the water to purify it. If formula and clean water are not available, it is probably better for HIV-infected mothers to breastfeed. In these cases, the health benefits of breast milk probably outweigh the risk of HIV transmission to the baby. It is also recommended that if an HIV-positive mother is breastfeeding, she should do so exclusively (e.g., she should not use formula sometimes and breastfeed sometimes).

Myths and Facts about HIV and AIDS

You can become infected with HIV from mosquito bites. FALSE. It has been extensively researched and proven that HIV cannot be transmitted in this way. In Africa, where malaria is common (and spread from mosquito bites), the only people infected with HIV are sexually active men and women and babies born to HIV-infected mothers, and people who became infected due to blood transfusions or sharing needles.

Anal sex is the riskiest form of sexual contact. TRUE. Anal sex carries a higher risk of HIV transmission than other types of sexual contact. During anal sex, the penis can tear the mucous membrane of the anus, which provides the virus with an entry point into the bloodstream. Dry vaginal sex also causes tearing of the mucous membrane and therefore is a high-risk behavior for HIV transmission as well.

People can become infected with HIV if they perform oral sex on a man. TRUE. HIV is present in the semen of infected men. Therefore, HIV may be transmitted if semen enters the person's mouth. A man can reduce the risk of transmitting HIV by wearing a condom and ensuring that no semen enters his partner's mouth.

When used correctly, condoms can protect men and women from becoming infected with HIV. TRUE. Latex condoms are not 100% effective, but after abstinence, they are the most effective way of preventing sexually transmitted infections (STIs), including HIV infection. Some groups have reported inaccurate research suggesting that HIV can pass through latex condoms, but this is not true. In fact, standard tests show that water molecules, which are one-fifth the size of HIV, cannot pass through latex condoms.

Circumcised men do not need to use condoms. FALSE. Male circumcision does not provide 100% protection against HIV infection. Three recent studies provide evidence of a 50–60% reduction in heterosexual HIV transmission among circumcised men. But circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners. Male circumcision should never replace other effective prevention methods. Circumcised men still need to use condoms correctly each and every time they have intercourse.¹⁴

HIV is a disease that affects only poor people. FALSE. Anyone can become infected with HIV. A person's risk for HIV is not related to the type of person he or she is (e.g., how much money they have), but rather the behavior in which he or she engages.

If you stay with only one partner, you cannot become infected with HIV. FALSE. Individuals who are faithful to their partner may still be at risk for HIV if their partner has sex with other people. In addition, individuals who only have sex with their partner now may have been infected with HIV from someone else in the past. Therefore, they may have the disease without knowing it and/or without telling their current partner. Only a long-term, faithful relationship with someone who has not been previously infected can be considered "safe."

14 Bailey, R. C., et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *Lancet* 369(9562):643–656; and Gray, R. H., et al. 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *Lancet* 369(9562):657–666.

People with STIs are at higher risk for becoming HIV-infected than are people who do not have STIs. TRUE. Infections in the genital area provide HIV with an easy way to enter the bloodstream.

A man can transmit HIV to his partner during sex, even if he withdraws before ejaculation. TRUE. Withdrawal does not eliminate the risk of HIV. Preejaculatory fluid from the penis can contain the virus and can transmit HIV to another person. However, withdrawing is better than ejaculating inside the sexual partner, since it reduces the amount of exposure to semen.

A man can be cured of HIV by having sex with a virgin. FALSE. Some people believe this misconception, but it is not true. Virgins do not have any power to heal HIV-infected individuals. There is no way to cure HIV once a person is infected.

HIV is transmitted more easily during dry sex than during wet sex. TRUE. HIV can be transmitted more easily during dry sex because the lack of lubrication causes cuts and tearing on the skin and mucous membranes of the genitals of both men and women. These cuts provide the virus with an easy way to enter the bloodstream.

You cannot contract AIDS simply by living in the same house as someone who has the disease. TRUE. HIV is transmitted through exposure to infected blood and other infected bodily secretions. Living in the same house with someone who is infected with HIV does not put those in contact with him or her at risk unless they share items that have been exposed to the infected person's blood or genital secretions (e.g., through the use of shared toothbrushes, razors, or douching equipment).

You can always tell if a person has HIV by his or her appearance. FALSE. Most people who become infected with HIV do not show any signs of illness for years. However, the virus remains in their body and can be passed on to other people. People with HIV look ill only during the later stages of HIV disease.

Traditional healers can cure HIV. FALSE. Over the years, many indigenous healers have claimed to be able to cure AIDS. To this day, no treatments done by traditional healers have been proven to cure HIV infection. We often hear of other people who say they have developed a cure for AIDS. People with HIV are a very vulnerable group, because they desperately want to get rid of their life-threatening illness and often will pay large amounts for even a small chance of a cure. Many people see them as a source of easy money and try to exploit them. People with AIDS often feel better and seem to recover a little after taking useless treatments just because they have the hope of a longer life. Unfortunately, there is no cure for HIV infection.

HIV can be transmitted from one person to another when they share needles while using drugs. TRUE. Sharing needles during injection drug use carries a very high risk of HIV transmission. Infected blood is easily passed from one person to another via an infected needle or other equipment used to prepare or inject drugs.

Levels of HIV Risk

The following are the different levels of HIV risk:

No risk = no contact with infected body fluids

HIV is transmitted by means of body fluids. If an uninfected person has no contact with such fluids, there is no risk of HIV's being passed from the infected person to the uninfected person. Behaviors that involve no risk of HIV transmission include:

- Abstaining
- Masturbating
- Hugging a person who has AIDS
- Kissing
- Fantasizing
- Giving/receiving massage

Lower risk = the possibility of contact with HIV because of the failure of protection

Using a condom still carries some risk, because no protective method is 100% effective. Behaviors that involve a lower risk of HIV transmission include:

- Having vaginal sex while using a condom
- Having anal sex while using a condom (Because the risk of condom breakage is greater during anal sex than during vaginal sex, this behavior could also be considered medium risk.)
- Performing oral sex on a man using a condom
- Performing oral sex on a woman using protection

Medium risk = high possibility of HIV transmission

This can be because of a lack of protection in situations where there is some chance of HIV-infected fluids entering another person's body (performing oral sex while not using a condom). Or it may be because protection is used, but in situations where there is a very strong chance that HIV-infected fluids will enter another person's body (anal sex while using a condom). Behaviors that involve a medium risk of HIV transmission include:

- Performing oral sex on a man while not using a condom
- Performing oral sex on a woman while not using protection
- Breastfeeding an infant (by an HIV-infected mother)

Higher risk = high probability of HIV transmission

This is in situations where no protection is used and where there is a very strong chance that HIV-infected fluids will enter another person's body. Behaviors that involve a higher risk of HIV transmission include:

- Having vaginal sex while not using a condom
- Having anal sex while not using a condom
- Having dry sex while not using a condom

Many factors affect these levels of risk.

The level of risk for many of these behaviors varies based on a range of factors. These include:

- How much HIV the infected person has in his or her body
- Whether the person is the “giver” or “receiver” of the sexual behavior
- How weak the person’s immune system is
- The presence of cuts or openings of the skin where contact with HIV is likely (for example, as a result of STIs)
- Whether the person has mouth sores or bloody gums (during oral sex)
- How well condoms and other protections are used

Voluntary Counseling and Testing for HIV

The Joint United Nations Programme on AIDS (UNAIDS) and the World Health Organization (WHO) recommend that the following four types of HIV counseling and testing services be clearly distinguished:

1. **Voluntary counseling and testing:** Client-initiated HIV testing and counseling to learn HIV status provided through HIV testing and counseling services
2. **Diagnostic HIV testing and counseling:** Provider-initiated HIV testing and counseling for individuals showing signs or symptoms that are consistent with HIV-related disease or AIDS, to assist clinical diagnosis and management
3. **Routine HIV testing and counseling:** Provider-initiated HIV counseling and testing for individuals being seen in such health care contexts as sexually transmitted infection (STI) clinics, antenatal care (ANC) clinics, and clinical or community-based health service settings—all where HIV is prevalent and antiretroviral (ARV) treatment is available
4. **Mandatory HIV screening:** HIV testing and counseling of all blood that is destined for transfusion or for manufacture of blood products

In many low- and middle-income countries, the primary model for HIV counseling and testing has been and continues to be the provision of client-initiated voluntary counseling and testing (VCT) services. Increasingly, provider-initiated approaches in clinical settings are being promoted (i.e., health care providers are routinely initiating an offer of HIV counseling and testing in a context in which the provision of, or referral to, effective prevention and treatment services is assured).

VCT is an effective and important strategy for HIV prevention and care, since it can be used as an entry point to facilitate behavior change, to offer access to other HIV and AIDS services, and to help provide care and support for those who test positive for HIV.

Pretest Counseling

Counseling is essential before anyone consents to be tested for HIV. If a person wants to get tested, a service provider should:

- Describe the test and how it is done
- Explain HIV and AIDS
- Discuss ways to prevent the spread of HIV
- Discuss the meaning of possible test results
- Ask what impact the test result, whether negative or positive, will have on the person being tested and any partner(s) he or she might have
- Address the matter of whom to tell about your test result
- Discuss the importance of discussing the results of your test with any of your partner(s)
- Discuss any other questions the client might have

Testing

Depending on the test being used, a small amount of blood will be drawn from the client's finger or arm or a swab will be used to scrape cells from the inside of the cheek for an oral test. The time to get the results will vary by the type of test and the geographic area one lives in.

The enzyme-linked immunosorbent assay (known as ELISA) has been the main screening test since HIV antibody testing became available in 1985. If there is a reactive result (a so-called "positive"), the test is repeated to check it. If an ELISA produces two reactive results, a second test, such as the Western blot, is used to confirm the results. The Western blot is more specific and takes longer to perform than the ELISA. Used together, the two tests are 99.9% accurate.

A rapid test for detecting antibodies to HIV produces very quick results, usually in 10 minutes, much faster than the standard HIV tests that are not available for 1–2 weeks. These rapid tests are increasingly being used because of the faster turnaround time. The availability of rapid HIV tests may differ from one place to another.

The rapid HIV test is an ELISA test. But instead of being analyzed in large batches along with other individual tests, the rapid test is analyzed alone. The slightly higher cost is outweighed by a fast result, which reduces the number of people who never return to find out their results. If the rapid test is positive, other confirmatory tests, including the Western blot, will be used to confirm the results.

Window Period

When a person is infected with HIV, his or her body generally does not produce detectable levels of antibodies until about three months (and sometimes up to six months) after infection. (Ninety-six percent of infected individuals develop antibodies within 12 weeks.) During this period of time, called the window period, a person will not test positive for HIV, even if he or she is infected with the virus.

Negative Result

A negative result means that no HIV antibodies were found in the blood or saliva (depending on which test is used). This condition is called seronegative and means the client is not infected with HIV—although it does not mean he or she is immune to HIV. HIV-negative clients should be encouraged to practice safer sex and other behaviors that will protect against HIV infection.

Indeterminate Result

Sometimes test results are unclear. The lab cannot tell whether a client is positive or negative, even if the test has been performed correctly. If this happens, the service provider should discuss the situation with the client and, if appropriate, test the client again.

Positive Result

A positive test result means that antibodies to HIV were found in the blood or saliva. This means that the client is infected with HIV. This condition is called being HIV-positive or seropositive. It is likely the client will develop AIDS, but no one can say for sure when that will happen. About half of untreated people with HIV develop AIDS within 10 years after infection. But prompt medical care can delay the onset of AIDS and prevent related life-threatening conditions.

Note: This information was adapted from: U.S. Centers for Disease Control and Prevention. No date. *Voluntary HIV counseling and testing: Facts, issues and answers*. Atlanta; and from: Family Health International. No date. HIV counseling and testing. Available at: www.fhi.org/en/Topics/Voluntary+Counseling+and+Testing+topic+page.htm/.

Prevention of HIV Transmission to Infants and Young Children

A comprehensive approach to preventing HIV infection in infants and young children includes the following:

1. Primary Prevention of HIV Infection

- Avoiding infection in all women and their partners
- Addressing the needs of pregnant and lactating women, especially in high-prevalence areas (since primary HIV infection during pregnancy and breastfeeding increase the threat of mother-to-child transmission of HIV)

2. Prevention of Unintended Pregnancies among HIV-Infected Women

- Ensuring that women and their partners are aware of their HIV status
- Making family planning available so that women and men can prevent unintended pregnancies

3. Prevention of HIV Transmission from HIV-Infected Women to Their Infants

- There are three different times when a woman can pass HIV on to her child:
 - Antenatally, when the baby is still growing in the uterus
 - During labor and delivery
 - During breastfeeding

Without intervention, the probability that an infected woman's child will become infected is about 15–30% without breastfeeding and can reach from 30–45% with prolonged breastfeeding.

A variety of interventions and precautions can be taken during each of these periods—antenatal, labor and delivery, postpartum, and during breastfeeding—to reduce the risk for infection. These practices are not absolute, but they do reduce the risk for transmission considerably.

Antenatal Period

During the antenatal period, a woman can be tested voluntarily to determine whether she is HIV-positive. Testing during this period offers several advantages. If a woman is HIV-negative, she and her partner can be counseled on risk reduction and condom use. This may be particularly important in areas where taboos on sexual activity during pregnancy or postpartum might cause a man to seek other partners, thereby placing a woman at risk when she resumes sexual activity with her partner. If a woman is HIV-positive, she can receive early counseling on the prevention of mother-to-child transmission of HIV (PMTCT) and on maintaining her health; she can make decisions about future fertility and about pregnancy termination (if that is a safe and legal option); and she can take steps to prevent exposing partners. Finally, she can be referred to care and treatment services for herself and her infant and partner. If a woman is HIV-positive, she can also receive support to maintain her health, including proper nutrition, treatment of sexually transmitted infections (STIs), and care for other infections, such as tuberculosis (TB) or malaria.

If a woman is HIV-positive and if antiretroviral drugs (ARVs) are available, she might receive treatment during the antenatal period, to reduce the risk of mother-to-child transmission of HIV (MTCT).

Labor and Delivery

Elective caesarean section can help to reduce the risk of MTCT. This may or may not be appropriate in resource-constrained settings, because of limited availability or the risk of complications.

Additionally, the risk of transmission can be reduced through avoidance of invasive procedures. Providers should avoid fetal scalp pH, artificial rupture of the membranes, and routine episiotomy. They should minimize instrumental delivery and lacerations and should make efforts to prevent postpartum hemorrhage. Of course, as always, providers should adhere strictly to infection prevention precautions.

Finally, and most promising, is the administration of nevirapine to reduce the risk of MTCT. A single dose of nevirapine to the mother during labor and a dose to the child within 48 hours have been found to reduce the risk of transmission by 50%, at a very low cost. An additional benefit is that nevirapine can be administered even in the absence of antenatal care.

Postpartum Period

The risk of MTCT can be reduced during the postpartum period through interventions related to breastfeeding. Breastfeeding can add to the risk of HIV transmission by 10–20%. However, decisions about whether and how to breastfeed can be complicated. While replacement feeding with formula would eliminate the risk of transmitting HIV through breast milk, this decision must be weighed against the risk of infant morbidity and mortality that occurs when formula feeding is done in countries where clean water is not readily available or where formula is not available or affordable. Additionally, in cultures where breastfeeding is the norm, avoiding it can stigmatize a woman as being HIV-positive.

It is currently recommended that when replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. In the absence of a safe alternative to breast milk, exclusive breastfeeding is recommended during the first six months of life. Mixed feeding with both breast milk and other feeds has been associated with a higher risk of HIV infection for the infant than is exclusive breastfeeding, and therefore it **should be avoided**, because it increases the risks of both HIV infection and the risks of diarrhea and other infectious diseases.

4. Provision of Care and Support to HIV-Infected Women, Their Infants and Family

- Services for HIV-infected women, their infants, and their families can include the prevention and treatment of opportunistic infections, the use of ARVs, psychosocial and nutritional support, and reproductive health care, including family planning. Children will benefit with improvements in the mother's survival and quality of life.
- Access to HIV-related care and support services also increases community support for programs to prevent mother-to-child transmission of HIV and the uptake of critical interventions, such as HIV testing.

In sum, a variety of interventions and precautions can be taken during the antenatal period, during labor and delivery, and during the postpartum period to reduce the risk of MTCT. It is important to remember, however, that the most effective way to prevent such transmission is to prevent a woman from becoming infected in the first place and to provide access to family planning to HIV-positive women who want to prevent pregnancy.

Note: This information was adapted from: U.S. Centers for Disease Control and Prevention. No date. *Voluntary HIV counseling and testing: Facts, issues and answers*. Atlanta; and from: Family Health International. No date. HIV counseling and testing. Available at: www.fhi.org/en/Topics/Voluntary+Counseling+and+Testing+topic+page.htm/.

HIV and Male Circumcision

The World Health Organization and the United Nations Joint Programme on HIV/AIDS (UNAIDS) have recommended male circumcision as an additional important tool to reduce the risk of heterosexually acquired HIV infection in men. There is now strong evidence from three randomized controlled trials undertaken in Kisumu, Kenya¹⁵; Rakai District, Uganda¹⁶ (funded by the U.S. National Institutes of Health); and Orange Farm, South Africa (funded by the French National Agency for Research on AIDS)¹⁷ that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Currently, 665 million men, or 30% of men worldwide, are estimated to be circumcised.

Male circumcision does not provide 100% protection against HIV infection.

- Three recent studies provide evidence of a 50–60% reduction in heterosexual HIV transmission among men.
- Circumcised men can still become infected with the virus and, if HIV-positive, can infect their sexual partners.
- Male circumcision should never replace other effective prevention methods.

Male circumcision should be a part of a comprehensive prevention package, which includes HIV testing and counseling services; treatment for sexually transmitted infections; the promotion of safer sex practices; and the provision of male and female condoms and promotion of their correct and consistent use.

- Counseling will be especially important to prevent men from developing a false sense of security and engaging in high-risk behaviors that could undermine the partial protection of male circumcision.

Male circumcision must be performed by well-trained practitioners in hygienic settings with free and informed consent, confidentiality, and risk-reduction counseling.

Individual human rights must be respected.

- HIV testing should be recommended for all men seeking male circumcision, but should not be mandatory.
- Where male circumcision is provided for minors (young boys and adolescents), the child should be involved in the decision making and should be given the opportunity to provide assent or consent, according to his evolving capacity.

15 Bailey, R. C., et al. 2007. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. *Lancet* 369(9562):643–656.

16 Gray, R. H., et al. 2007. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. *Lancet* 369(9562):657–666.

17 Auvert, B., Taljaard, D., Lagarde, E., et al. 2005. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 Trial. *PLoS Medicine* 2(11):e298.

Male circumcision is a marker for tribal and religious identity in many parts of the world.

- It is often a rite performed at a specific point in the male life cycle.
- In the studies that have taken place, education about the possibility that male circumcision could reduce the risk of HIV infection appears to have been well received at the community level, regardless of cultural or traditional attitudes in the surrounding area.

Promoting circumcision for HIV-positive men is not recommended.

- Based on the current available evidence, male circumcision is not recommended for HIV-positive men as an intervention to reduce HIV transmission to women.
- If male circumcision is requested by HIV-positive men following in-depth counseling on the known risks and benefits, it should not be withheld unless it is medically contraindicated.

There are no randomized clinical trial data on the impact of male circumcision among men who have sex with men.

Male circumcision provides a unique opportunity to address the health needs of men and their partners.

- When accessing circumcision services, men should learn about how to prevent HIV and other sexually transmitted infections, gender-based violence, and their important role in ensuring the health of their families and communities.

In addition, in some communities in Africa, male circumcision is a part of a manhood ritual. It is often done outside a clinical setting, in conjunction with a period of time when boys are becoming men, and in the midst of the nature (as their ancestors have done for some time). In some of these communities, if a man is not circumcised as a part of this ritual, he will never be considered a “man.”

Gender and HIV

Gender norms and roles and inequalities in power have a huge impact on the HIV risks that women and men face and take. However, other factors are important too, such as age, wealth and poverty, and location (village/town). All of these can have a sizable influence on the HIV risks that people take and face.

Key points include the following:

- ✓ Women face a greater risk of HIV infection than men for physiological reasons. Semen remains in the vagina for a long time after penetrative sex, which increases women's chances of infection from any single sex act. There are also more viruses in men's semen than in women's vaginal fluid. The tissue inside of the vagina is thin, making it more vulnerable than skin to cuts or tears that can easily allow HIV to enter the body. The penis is less vulnerable because it is protected by skin. Forced sex also increases the chance that the vagina will tear or cut. Very young women are particularly vulnerable, because their vagina lining has not fully developed. Women infected with a sexually transmitted infection (STI) are at least four times more vulnerable to infection than are those with no such infection. Women often do not know that they have an STI, as they often show no signs of the disease.
- ✓ Women face greater risks of HIV than men because they lack power and control in their sexual lives. Women are not expected to discuss or make decisions about sexuality. An imbalance in power between men and women means that women cannot ask for or insist on using a condom or any other forms of protection. Poor women may rely on a male partner for their livelihood, which can also leave them unable to ask their partner or husband to use condoms. This also makes it difficult for them to refuse sex, even when they know that they risk becoming pregnant or infected with an STI, including HIV.
- ✓ Many women face a greater risk of HIV infection than men because they have to trade sex for money or other kinds of support. This includes women who work as sex workers, but it also includes women and girls who exchange sex for payment of school fees, rent, food, or other forms of status and protection.
- ✓ Violence against women increases their risk of HIV infection. The crime of rape is linked to men's power over women. Forced sex increases the risk of HIV transmission because of the bruising and cuts it may produce. Other kinds of physical and emotional violence also increase women's risk. Many women will not ask their male partners to use condoms for fear of men's violent reaction. Women who must tell their partners about being infected with HIV or some other STI may experience physical, mental, or emotional abuse or even divorce. Violence is a primary way in which men maintain control over women and take away their power.

- ✓ Men take more risks with HIV because of the way in which they have been raised. Men are encouraged to begin having sex early to prove themselves as men. A sign of manhood and success is to have as many female partners as possible. For married and unmarried men, multiple partners are culturally accepted. Men may be ridiculed if they do not show that they will take advantage of any and all sexual opportunities.
- ✓ Competition also plays a role in HIV risk. Competition is another feature of living as a man. This includes the area of sexuality. Men compete with other men to demonstrate who will be seen to be the bigger and better man. Another sign of manhood is to be sexually daring. This may mean that you do not protect yourself with a condom, as this would be a sign of vulnerability and weakness. Many men believe that condoms lead to a lack of pleasure or are a sign of unfaithfulness. Using condoms also goes against one of the most important indicators of manhood, which is having as many children as possible.
- ✓ Men seek younger partners in order to avoid infection. This behavior is based on the belief that sex with a virgin cures AIDS and other diseases. On the other hand, women are expected to have sexual relations with or marry older men, who are more likely to be infected.

Engaging Men in HIV and AIDS

Men can use their privilege and power in several ways to address HIV and AIDS. The most immediate role that men have in HIV and AIDS is in their own sexual lives. Men are privileged because their gender roles give them power over women in sexual decision making. With power comes responsibility: Men can use this responsibility to protect themselves and their sexual partners from HIV transmission. This can be done through healthy preventive behaviors and good communication. Knowing one's HIV status is another key strategy. But men also have power in the family, the community, and the workplace. They can use this power to promote HIV prevention and encourage other men to support and become actively engaged in community responses to the HIV epidemic.

Promoting gender equality must be central to men's roles in HIV prevention. Across their different roles in the family and community, one of the biggest contributions that men can make to HIV prevention is to promote gender equality. Women's lower levels of social, economic, and political power are the basis of their greater vulnerability to HIV. Increasingly, HIV and AIDS are becoming a women's disease in Africa. In taking action on HIV, men need to listen to women, act as allies rather than as protectors, and challenge sexist attitudes, behaviors, and policies.

7 Men and Maternal Health

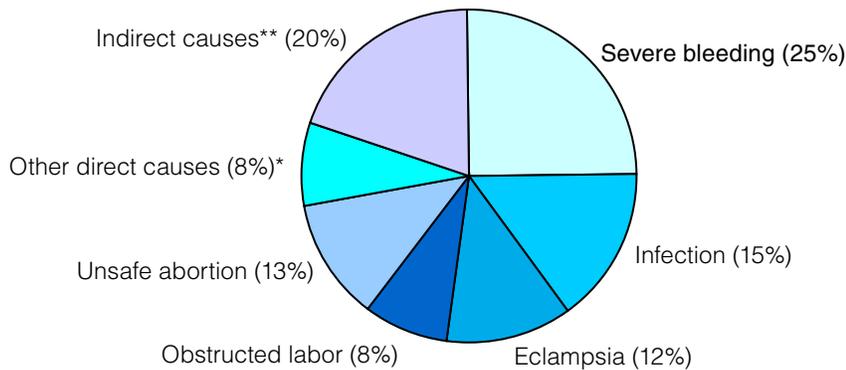
This chapter describes the causes of maternal mortality and morbidity and the constructive roles that men can play in preventing these outcomes.

Maternal Mortality and Morbidity

Complications of pregnancy and childbirth are the leading causes of death among women of reproductive age in many developing countries, accounting for an estimated 529,000 maternal deaths each year.¹⁸ Figure 7-1 shows the various causes of maternal mortality.

About half of the nearly 120 million women who give birth each year experience some kind of complication during their pregnancies, and between 15 million and 20 million develop disabilities such as severe anemia, incontinence, damage to the reproductive organs or nervous system, chronic pain, and infertility.¹⁹

Figure 7-1. Causes of maternal mortality



* Other direct causes include causes related to ectopic pregnancy, embolism, and anesthesia.

** Indirect causes include causes related to anemia, malaria, and heart disease.

Source: WHO. 1997. *Coverage of maternal care: A listing of available information*, 4th ed. Geneva.

18 UNFPA. 2004. *Maternal mortality update 2004: Delivering into good hands*. New York. Accessible at: <http://www.unfpa.org/publications/detail.cfm?ID=222>.

19 Ashford, L. 2004. *Hidden suffering: Disabilities from pregnancy and childbirth in less developed countries*. Washington, DC: Population Reference Bureau. Accessible at: <http://www.prb.org/pdf/HiddenSufferingEng.pdf>.

Preventing Maternal Mortality

Safe motherhood can be achieved by providing quality maternal health services to all women. Services to help make motherhood safer include²⁰:

- Care by skilled health personnel before, during, and after childbirth
- Emergency care for life-threatening obstetric complications
- Services to prevent and manage the complications of unsafe abortion
- Family planning, to enable women to plan their pregnancies and prevent unintended pregnancies
- Health education and services for adolescents
- Community education for women, their families, and decision makers

Efforts to reduce maternal death and disability must, therefore, address these issues.

²⁰ Family Care International (FCI). 1998. *Fact sheet on safe motherhood*. New York.

Men's Role in Maternal Health

Two factors that contribute to maternal mortality and morbidity are:

1. Delay in recognizing when a sign or symptom is serious enough to require medical attention
2. Delay in seeking treatment for complications, including contacting medical personnel and arranging transport to a medical facility if necessary

Men can play a key role in preventing these two delays to accessing services. While men often are the ones who decide when a woman's condition is serious enough to seek medical attention, few men have been educated to understand the risks of pregnancy and to assess when a symptom requires urgent attention. By learning the danger signs and being prepared for emergency situations, men can help save women's lives and help protect families from the tragic consequences of maternal death.

The following are examples of what men can do to help prevent maternal mortality and morbidity.

Men's Role in Accessing Medical Care during Emergencies

- Reduce the delay in getting treatment by learning to recognize complications of pregnancy and delivery and the ways to respond to them.
- Decide that the woman should be transported to a clinic.
- Pay for her transport.
- Allocate family and community resources for transportation and delivery.

Men's Role in Antenatal Care

- Help ensure that the woman gets proper antenatal care, including good nutrition and plenty of rest.
- Assist with household or other tasks.
- Provide transportation or money for clinic visits.
- Learn the danger signs of pregnancy.
- Arrange for a trained attendant and necessary supplies to be available during the delivery.

Men's Role in Family Planning and Birth Spacing

- Help prevent unintended pregnancy and unsafe abortion, which can lead to maternal death, by using family planning.
- Play a supportive role in family planning decision making and the effective use of contraceptive methods.

Men's Role in a Community Response to Maternal Mortality

- Be involved in community-wide decisions to ensure that resources and systems for medical assistance and transport are in place and available to women who need them.

Men's Role in Addressing Gender Inequality

- Help address gender inequality—women's low status in society, lack of education, and poverty—which perpetuates poor health outcomes in women.

Danger Signs That Men Can Identify

The following are danger signs for women and newborns, Men should seek immediate medical attention when a woman or newborn presents these signs.²¹

Danger Signs for the Mother during Pregnancy, Childbirth, and the Postpartum Period:

- Bleeding
- Fever
- Convulsions, headache, and sweating
- Labor that lasts more than 12 hours
- Presentation of the hand or foot during labor
- Placenta that is not delivered within 30 minutes of childbirth

Danger Signs for the Newborn:

- Difficulty breathing
- Not feeding well
- Convulsions
- Fever or very low temperature
- Jaundice or bleeding
- Vomiting
- No stool
- Swollen abdomen

²¹ WHO. 2000. *Managing complications in pregnancy and childbirth: A guide for midwives and doctors* (WHO/RHR/00.7) Geneva.

8

Provision of Men's Reproductive Health Services

This chapter introduces and explores the management and implementation issues affecting the delivery of men's reproductive health services.

Management Issues

Managing a men's reproductive health program is similar to managing any other program in a health care facility: It requires establishing a clear direction for the facility, finding ways to motivate staff to do their best, and managing the program's finances. The following case studies present issues that managers may face when initiating or expanding men's reproductive health services. These case studies provide an opportunity to reflect on the potential challenges that the programs may face.

Management Case Studies

Case Study 1: Sex of the Staff

An urban family planning facility was starting to offer reproductive health services to men. The managers assumed that male clients would want to see male service providers only, but the managers had difficulty finding and recruiting male providers to staff the men's clinic. As a result, the men's clinic was offered only once every other week.

Case Study 2: Staff Resistance to Men's Services

The doctor at a family planning clinic obtained permission to train her female paramedics to examine and treat men for sexually transmitted infections (STIs). The paramedics, who were experienced in diagnosing and treating STIs in women, had never treated men but were interested in doing so. They received the training, and 12 male clients were scheduled to attend the first men's clinic, which was planned for a time when the physician would be away.

The first client's visit was uneventful, but when the second client went into the examination room, the paramedic assigned to his case refused to see him. She walked out, telling the clinic assistant that she was unprepared to treat a man—she did not feel she had had adequate training or that she had gone through all of her training in women's health to treat men. One of the clinic assistants then said that she, too, felt the male clinic experiment was a mistake.

Case Study 3: Condom Variety

A private, multiclinic facility that provides family planning and STI services in diverse communities was facing a financial crisis. Services for low-income women were being subsidized by government funding, but men's services were not being subsidized. As a result, many men were treated on a sliding-scale basis, paying whatever they could afford. The facility purchased one brand of latex condoms for all of its clinics at low cost through

a central purchasing program, and the clinics provided condoms for free to male and female clients. However, the clients complained that the condoms broke, had an unpleasant smell, and interfered with sex.

Case Study 4: Outreach Strategies

A rural family planning facility that was starting a men's reproductive health program wanted to train village health workers to engage in outreach activities to educate men and encourage them to attend the men's clinic. Two new outreach workers were trained: a dynamic young man in his late 20s who had completed high school (a high level of education for the district) and was outspoken about the need to extend health care for all; and a married woman in her mid-40s who had several children and had worked as a clinic assistant before she was married. The health workers were sent into the community to educate men individually and in small groups. After three months, the manager overseeing the outreach program reviewed the numbers of male clients who had used the services and found that, between them, the health workers had drawn in only five clients. The program manager was asked to make a recommendation about whether to continue the program or close the clinic.

Management Issues to Consider

When planning a men's reproductive health services program, consider the following issues to help ensure that clients receive the kinds of services they want and need and that staff are supportive of the program:

Sex of the staff

- The sex of the service provider and other staff may not be as important as the flexibility in schedule that the clients may need.
- Some female providers would like to provide services to male clients, and many men appreciate seeing female providers. Therefore, managers should consider staffing “male clinics” with both men and women, if appropriate.
- Feedback from the target audience of a program (in this case, men) helps when making decisions about scheduling, staffing, and other aspects of services.

Staff resistance to men's services

- It is important to assess staff members' motivations toward working with men *before* training or assigning them to the men's clinic. Consider assigning to the men's clinic only staff who have positive attitudes toward working with men.
- Staff values around providing services to men must be clarified—that is, staff must be allowed to voice fears, concerns, and doubts *before* initiating services.
- A strategic plan must be prepared for incorporating men's reproductive health services into the facility's other services.
- Broad-based support must be built at all levels, including frontline staff, service providers, and management.

Payment for services

- Men appreciate variety in choosing services.

- Charging a fee for services increases the perceived value and quality of the service.
- Men may be likely to pay for services that they feel are of higher quality.
- Condom sales are one way of making men's services sustainable and self-sufficient.

Serving special populations

- The rapid use of services by a particular group within the population may indicate that the group has a high need for the services or that promotional efforts are particularly effective with that group.
- An unexpected demand for a particular service may indicate an opportunity for the facility or another facility in the community.
- A facility that uses a men's services program primarily to help women, or that is oriented strongly toward particular segments of the male population, may have difficulty accepting male clients as individuals with their own needs.

Outreach strategies

- The purpose of outreach is to provide awareness, information, and choice. Outreach should not be used to aggressively motivate people toward a desired behavior, belief, or outcome.
- Outreach workers must be carefully selected and trained before being sent into the community. In addition, it is important to consider how outreach workers will be perceived in certain contexts.
- Interpersonal skills, such as listening and maintaining client confidentiality, are particularly important for outreach workers.
- In some cultures, it may be more appropriate or beneficial for men to speak with other men about services and health-related matters.
- Outreach may be done in a variety of settings; an outreach worker should be able to be flexible to take advantage of new opportunities.
- Potential male clients may be more receptive to services if they are involved in helping plan them rather than simply receiving information about them.

Cost Considerations

One of the more controversial issues surrounding the initiation or expansion of men's reproductive health services is that of limited resources and cost. Some reproductive health professionals believe that attempting to create and build services for men will take away scarce resources needed for women's services. Undoubtedly, start-up costs for initiating men's reproductive health services may prohibit or limit some facilities from serving men. However, there are many ways to incorporate men's services into current services that cost little or nothing at all.

The following is a list of services or activities that facilities may be able to initiate or incorporate into their existing services. Of course, many of the cost estimates will vary depending on the country and context. When reviewing the list, consider the broad range of ways that facilities might meet men's reproductive health needs without using significant financial and staff resources.

No-Cost Services

- Allowing men to participate in family planning counseling sessions with their partners
- Encouraging female clients to discuss family planning and reproductive health with their male partners
- Discussing male methods of contraception with men
- Encouraging male and female clients to bring their partners for STI testing
- With their partners' permission, allowing men to observe their partners' reproductive health visits and procedures, to generate awareness and encourage support
- Encouraging men to be supportive of their partners' efforts to obtain antenatal care, postpartum care, and safe-motherhood services
- Encouraging male community and religious leaders to promote the men's services offered at your facility
- Promoting men's services at community-education workshops

Low-Cost Services

- Generating a list of referral services for men
- Forming partnerships with male-oriented community groups
- Displaying male-related posters on the walls of the clinic
- Putting male-oriented magazines in the waiting rooms
- Putting male-related leaflets in the brochure racks
- Including "men's services" on facility signs
- Including "men's services" on leaflets advertising the services
- Conducting community-education workshops with men
- Conducting educational sessions with men within the clinic
- Conducting and teaching testicular self-exams
- Conducting prostate-cancer screening

- Providing parenting and fatherhood education at the clinic or in the community
- Developing medical-record forms that are suitable for male clients
- Forming a satisfied-clients panel to conduct education in the community

Moderate- to High-Cost Services

- Hiring male frontline staff
- Providing condoms free of charge to clients
- Designating a restroom for men only
- Scheduling clinic hours for times when men are likely to attend
- Designating special hours for male-only clinics
- Providing men with testing and treatment for STIs, including HIV testing and counseling
- Providing treatment for impotence or erectile dysfunction
- Providing infertility treatment for men
- Providing vasectomy services
- Training staff in male sexuality and working with male clients
- Training service providers in counseling men and conducting male examinations
- Creating a private space for counseling and examinations
- Advertising men's services in newspapers, on the radio, and via flyers
- Conducting a social-marketing campaign in the community to motivate men to use services
- Changing the name of the facility so that it is appropriate for men
- Designing the décor of the facility so that it is welcoming to men

High-Cost Services

- Hiring male service providers
- Designating a special section of the facility for men only
- Offering a male-only clinic

Creating a Male-Friendly Environment

As with any health care program, the success of a men's reproductive health services program depends on how well it meets the needs of its clients. Therefore, viewing the clients' needs as a key focal point in the design and implementation of services helps ensure the program's success.

When you consider a facility from a male client's perspective, it is important to think about what he sees, feels, and hears when he is at the facility or is considering seeking services there, as well as who he talks to and how he is treated there. This includes the facility's physical appearance, layout, and protocols and procedures, as well as the staff's tone of voice, body language, and other nonverbal cues.

Because reproductive health services traditionally have been aimed at women (or may be provided through hospital maternity wards), often the name or physical environment of a facility is geared toward women. For example, magazines in reception/waiting areas may be ones aimed at women, posters on the wall may show images of women with children, and the color or style of the furniture or surroundings may be ones that women generally favor. In addition, the staff may be mostly female or may be oriented toward serving women, which may cause men to feel uncomfortable or unwelcome.

Ways to Help Men Feel Comfortable at a Facility

- **Orienting and sensitizing staff to work with men.** Before services for men are initiated, all staff working at the facility should be aware of which services are available for men, as well as men's special needs.
- **Using a name for the program/facility that welcomes both men and women.** Avoid names that are women-specific or imply that men might not be welcome without a female partner. These include such names as "Women's Clinic" or "Obstetrics Clinic."
- **Using decorative materials and colors that appeal to both men and women.** When decorating the waiting areas and service areas, avoid colors and decorative items that are considered specific for women and infants. Changing wall colors, furniture, or décor may not be feasible if resources are limited. But even in these settings, the choice of wall posters or other low-cost items can send subtle messages that men are welcome.
- **Designating a male restroom, if possible, and clearly marking it "Men's Room."** Alternatively, if men and women will be sharing one restroom, use a neutral term, such as "restroom" or "toilet." In such cases, it should be possible to lock the door when the restroom is in use.
- **Including reading materials men favor in reception/waiting areas.** Such materials include magazines, newspapers, or other publications that are popular with men in the local area and are compatible with the facility's philosophy.
- **Making men's information, education, and communication (IEC) materials readily available.** Display client-education materials that address men's issues and posters about male anatomy and male genital self-examination in all examination rooms.

- **Making condoms readily available.** Display signs saying “Condoms Available” (for sale or free) at the reception desk or another area where men are likely to view them. Stocking more than one brand of condom, if possible, helps reinforce the idea that the staff take men’s contraceptive and disease-protection needs seriously.
- **Addressing men’s needs in scheduling services.** If possible, schedule men’s services during times suitable to men’s work and recreational schedules. In addition, staff and clients should be scheduled in such a way that a man who enters the reception/waiting area will see other men. This will prevent making him feel isolated at the facility.
- **Creating a medical record for each male client as an individual, rather than keeping his medical information in his female partner’s file.** To ensure the male client’s rights as a client on his own accord, it is important for the clinic to keep his medical information separately and not in relation to his partner’s.
- **Providing facility space or time for seeing couples, to enable men and women to receive counseling together if desired.** Sites should ensure that they are welcoming for clients who want to come and receive services together. Therefore, sites should ensure that time and space are offered, so that couples interested in receiving services as a couple are able to.
- **Creating an awareness of men’s reproductive health services in the community.** The availability of men’s reproductive health services should be clearly announced in all facility communications, including literature, signs and posters about services, and telephone answering messages. If possible, facility staff should arrange for outreach workers to spend part of their time at the facility.

Role of Frontline Staff

Frontline staff, such as doormen, guards, and receptionists, are often the first people at the facility with whom a potential client comes in contact. The behavior of such staff is one of the key elements in the success or failure of a men's reproductive health program. Frontline staff who are friendly, competent, courteous, and respectful set a favorable tone for the entire visit; frontline staff who are curt, rude, incompetent, or unwilling to offer guidance or assistance set an unfavorable tone for the visit.

When frontline staff have been left out of the process of planning the men's reproductive health services program, they may resent or feel anxious about the program or not be aware of its goals and features. This, in turn, may cause frontline staff to have unfavorable interactions with clients and hinder the program's objectives. Therefore, managers must incorporate training for frontline staff into their plans for implementing men's reproductive health services. (See Appendix B for more information on training frontline staff.)

The next few pages provide tips to guide frontline staff in working with male clients and determining priority situations. These pages may be copied (or adapted) and displayed in facility reception/waiting areas or other places where frontline staff are likely to see them.

Tips for Frontline Staff on Working with Male Clients

- **Help male clients feel comfortable when speaking with you about health-related matters.** You can accomplish this by using a calm and professional manner, giving the client your full attention, assuring him that anything he tells you will be kept confidential, listening to him until he is finished speaking, and not criticizing or judging what he tells you.
- **Be sensitive to the health care needs of all clients.** Address all clients in a neutral, professional manner, regardless of their age, background, or sexual orientation.
- **Maintain client confidentiality.** You must keep anything that clients tell you confidential; do not share it with anyone other than the appropriate staff. When working with both members of a couple, always try to think of how both of their needs can be served without violating confidentiality.
- **Be objective, especially when working with couples.** If you are used to working with female clients, you may have a tendency toward empathizing with the female partner when a couple has a problem. Remember: Men are clients in their own right. Working with couples requires objectivity and an ability not to get emotionally involved with their problems.
- **Learn to recognize and handle potential men’s reproductive health emergencies.** For a list of situations requiring immediate attention, see “Prioritizing Client Needs” on page 8.11–8.12. If a male client needs to see a service provider immediately, either fit him into the clinic schedule—even if it is not a men’s clinic or a scheduled time for male clients—or refer him to an appropriate facility.
- **Ask counselors or service providers for help if a situation is beyond your expertise.** If you are not sure whether a client presents with an emergency or how to handle any situation, ask an administrator or service provider for assistance.
- **Learn to distinguish between dangerous and nonthreatening situations.** If a man or group of men acts in a disruptive manner, do not necessarily assume that the behavior poses a serious risk to yourself or others at the facility. Doing so in error can drive away men who otherwise might become good clients. Learn how to respond constructively in difficult situations so you can help involve men in your program. Being aware of typical behavior patterns men exhibit when they enter the unfamiliar clinic environment will help you feel less resentful and anxious and will enable you to respond appropriately to male clients’ behaviors. This is especially useful when dealing with young men, who may find the environment and issues more threatening than older men do.
- **Learn how to handle angry clients.** Often, clients may express anger as a result of feeling uncomfortable, awkward, powerless, or unsure in a new situation. Reacting in an angry manner in return does not solve the problem; it only heightens tension and personalizes the situation. Before constructive discussion can take place, the client must be allowed to release his feelings. Only then can you attempt to address the problem and find solutions.

Prioritizing Client Needs

In each case, if your facility is not available to see clients within the recommended time frame or the clients are unwilling to wait, refer them to another facility.

Emergencies

The client must see a service provider **immediately** if he:

- Has an erection that has lasted more than an hour and will not go down
 - Has severe pain in the testes that has lasted more than 15 minutes, or has recurrent, shorter episodes of moderate or severe pain in the testes
 - Has any major injury to the scrotum, testes, or penis
 - Is unable to urinate, even though the bladder is full
 - Has a hernia (swelling in the groin and scrotum, particularly after straining) that does not go down and is painful
 - Has a foreskin (on the penis) that is retracted, tight, and swollen and cannot be pulled back down over the glans
-

Conditions Needing Prompt Assessment

Schedule an appointment for **within the next 12 hours** if the client has:

- Blood in the urine
 - Mumps accompanied by pain in the testes
 - High fever and chills
 - A penis or scrotum that is swollen, inflamed, or painful
-

Conditions Needing Assessment Soon

Schedule an appointment for **within the next 24 to 48 hours** if the client has:

- A burning pain when urinating
- Discharge from the urethra (may be yellowish, milky, or clear)
- Open sores or bumps on the penis or scrotum
- Lump(s) in the groin
- Itching (possibly with rash) in the genital area
- A sore throat (with a history of oral sex)
- Sores around or inside the mouth (with a history of oral sex)
- Anal pain, irritation, or rash (with a history of anal sex)
- Diarrhea (with a history of oral sex)
- Jaundice or abdominal pain
- A history of sexual contact with a person who has an STI
- A history of unprotected sex with a person who is infected with HIV, has AIDS, or uses drugs intravenously

(These are all signs and symptoms of STIs. Tell the client that he may have an STI—though only a medically trained person can actually make a diagnosis—and instruct him to abstain from sex until after he has been examined and treated. Tell him that if he does have sex, he must use a condom.)

Schedule an appointment for **within the next week** if the client has:

- Lumps (swollen lymph nodes) in the armpits or neck
- A lump in the testes, regardless of whether it is painful

Nonurgent Situations

Schedule an appointment for **the next convenient time** if the client has:

- A request for a routine examination
- A hernia (swelling in the groin and scrotum, particularly after straining) that is not painful and/or is intermittent
- Sexual problems
- Abnormality of the genitals
- Concerns about infertility

Potential Interactions between Clients and Frontline Staff

Each conversation and interaction that a frontline staff member has with a male client or potential male client is unique. However, the following scenarios describe typical situations that an individual working in a facility's reception/waiting area or answering the phone may encounter. Some possible responses are provided for each scenario.

Scenario 1: Reluctant Male Client

Visitor/Caller

- He thinks he has an STI because he has penile discharge, a burning pain when he urinates, and a sore on his genitals.
- He wants information and treatment, but he is embarrassed and reluctant to say what he wants, and generally acts evasive.
- He demands to speak with a man.

Receptionist

- She is a woman alone on duty.
- No one else is available to respond to the man.

Possible response

- Explain that you need to have a little bit of information to be able to schedule him properly. Ask if he has an urgent problem or thinks he may have a disease that he could have gotten from sexual contact.

- You may need to ask a few more questions, such as whether he has a burning pain when he urinates, discharge from his penis, or sores on his genitals. If so, schedule an appointment for him as if he has an STI. If not, schedule him for the next available (nonurgent) visit.

Scenario 2: Angry Wife

Visitor/Caller

- She suspects that her husband has been having an affair.
- She thinks her husband has come to the clinic to be tested and treated for an STI.
- She is worried that her husband may have infected her or may do so in the future. Since he does not use condoms with her, she knows that if he has an infection, she will have to convince him to use condoms or she risks becoming infected herself.
- She wants information about his situation.

Receptionist

- He knows that he cannot discuss a client's situation with anyone, even if it is her husband.

Possible response

- Explain that all client care is confidential, regardless of whether the client is male or female.
- Say you are sorry that you cannot give out any information about clients, but that she will have to talk with her husband herself.
- Tell her that if she likes, she may make an appointment to talk with a counselor about her concerns and how she may deal with her husband.
- Tell her that if her husband wants the staff to explain his condition to her, he will have to contact the clinic and give permission to do so.

Scenario 3: What Does He Want?

Visitor/Caller

- He is a man in his 40s who recently has had difficulty maintaining an erection.
- As a result, he has been avoiding having sex with his wife.
- He wants information and help, but he does not even know whether this is a problem with which he can be helped.
- He is embarrassed and reluctant to say what he wants.

Receptionist

- She has to stay at the reception desk.
- Other staff (service providers, counselors, and support staff) are available; she can call on them for help if she feels it is needed.

Possible response

- Sometimes men are not sure of what they want or what services are available, but they are reluctant to admit this.

- Ask if you can help him, offer information on services, and point out educational literature and condoms (if available).
- Ask if he has questions or would like to talk privately with a counselor.
- Do not be surprised if he leaves without asking for anything on this visit; he may come back at a later time when he is ready to ask for services.

Scenario 4: Young Men

Visitor/Caller

- Three to six young men enter the reception waiting area together in a group.
- They go together for mutual support and to see what the place is like—but as a group, they are noisy and comment freely and loudly on what they see around them.
- Some of them tease the staff or make inviting remarks to the female staff.
- Despite their behavior, they are interested in getting condoms and finding out about the services available at the clinic.

Receptionist

- He wants to keep the clinic moving along peacefully without disrupting the other clients in the reception/waiting area.
- Other staff are present at the clinic, but they do not often come into the reception waiting area, where he is.

Possible response

- Do not automatically assume that the young men will be disruptive; they may simply be expressing their need for the mutual support of other men by coming in a group. Ask them if they would like health-education pamphlets, condoms, or an appointment.
- Politely ask the young men either to be quieter so they will not disrupt the clinic or to leave the facility.
- If their behavior does not improve and you cannot leave your post in the reception/waiting area (do not leave the area unguarded), ask another staff member to get assistance, or call a supervisor to ask the men to leave.
- If the behavior seems threatening, call security, the police, or other appropriate help if necessary.
- If any of the young men are recognized as having been disruptive before, prohibit them from returning to the facility. If they return, call for assistance immediately.

Scenario 5: Angry Client

Visitor/Caller

- He came to the clinic three days ago to be examined for a possible STI and was told to return today for the test results. The results are not available.
- He is angry—angry about the possible STI, angry at the person who may have given it to him, and angry at the facility for not having the results available.
- He begins to scream at the receptionist.

Receptionist

- She does not know what happened to the test results.
- No one is around to help her find the test results right now.

Possible response

- Do not argue with an angry client. Address him in a factual, calm manner.
- It may not always be possible to correct the problem that bothers him, but providing information or options can often help.
- If you have the time and are comfortable doing so, calmly ask the man if he wants to tell you why he is angry. Listen patiently for a short time, asking a few questions if necessary to clarify events. Let him know you understand that his experience has made him feel angry and upset. Having his feelings acknowledged may help him calm down. In some cases, the man will have misinterpreted or misunderstood events, and an explanation may clarify matters for him. In other cases, you may be able to identify a reasonable compromise solution to his problem, such as a rescheduled appointment, a chance to talk with a service provider, a refund of his payment, or some free condoms.
- If you do not have the time or training to handle an angry client, tell him you are sorry but you will not be able to discuss this now. He can schedule another appointment if he wishes. If a particular person handles grievances, such as a clinic manager, you may refer the client to that individual.
- If necessary, call another staff member for assistance.
- If the angry client makes serious threats, call security or the police.

Scenario 6: Male Client Who Has Sex with Men

Visitor/Caller

- Because he performed oral sex on a man and has a sore throat, he tells the receptionist he would like to be checked for STIs and wants a throat examination.
- He becomes annoyed when she tells him that he does not need a throat examination and does not ask him whether he has had sex with men or wants to be tested for HIV.
- He tells her he is a homosexual and deserves the same treatment as anyone else.

Receptionist

- The clinic's usual routine for STI testing is to swab the urethra for gonorrhea and chlamydia and check for skin lesions. Her clinic does not perform throat examinations, which are considered part of general medicine.
- She does not know much about AIDS, which has not spread to her small, rural community. She thinks the only people in her country who have AIDS are the sex workers and homosexual tourists in the large city 80 km away.
- She is a conservative, religious person with traditional values. To her knowledge, she has never spoken with a homosexual before, and she wishes to end the encounter as quickly as possible.

Possible response

- Address the client in the same neutral, professional manner that you would any other client.
- Say you are sorry you upset him and will schedule an appointment with a service provider, who will determine the testing and care he needs.

Appendixes

Appendix A

Additional Tips for Serving Male Clients

1. **Situation:** A male client seems reluctant to receive counseling or health education.

Rationale/what to do:

- Many men are uncomfortable expressing their feelings and talking openly about their concerns. Therefore, ask the client why he came to the facility today, and see that that issue is dealt with directly and promptly so he can receive the appropriate attention for his needs.
- Men are usually socialized to act decisively and to be in control. Therefore, reaffirming that a man has acted appropriately by seeking care or addressing a problem may make him feel comfortable enough to proceed to ask for information or help.
- A man is likely to feel more comfortable and confident that his immediate needs have been met after he has spent some time talking with a staff member at a health care facility. It may be easier for him to respond positively to a staff member who says:
 - “Let me just point out a few tips to you...”
 - “I would like to be sure that you understand how you got that disease.”
 - “Even when we have dealt effectively with a problem, we sometimes have a few remaining doubts afterward. Is there anything more you would like to discuss with me?”
 - “You seem to have a general understanding about how to use condoms, but are there any points you would like to know a little more about?”
 - “As long as you are here today, are there any other things you would like to ask or tell me about?”
 - “How will you let the people you have had sex with know that they need to come in to be checked for this infection?”
 - “How do you plan to talk with your wife about this problem?” (Be sure that the client has privacy during this conversation.)
- A staff member may also ask a client, in a private location, to repeat back how a medication will be used or to demonstrate (on a model or raised fingers) how he will put on a condom. This will provide an opportunity for coaching to correct misinformation or errors in technique.
- It may be desirable to schedule another visit to address questions, couple issues, the consistency and correctness of ongoing contraceptive method use, etc.

2. *Situation:* A male client has an unexpected religious or ethnic background.

Rationale/what to do:

- In many parts of the world, the population is composed of several groups that differ by religion, ethnicity, race, and/or cultural practices. While men of some groups may more commonly seek services than others, do not assume that all men are the same.
- Address each client as an individual rather than as a member of a subgroup. If the client has decided to seek information or services, he has made his own decision, regardless of his group affiliation.
- Act professionally toward all clients. Do not gossip about or call attention to their religion, ethnicity, etc.

3. *Situation:* A male client has an unexpected age, physical status, or medical history.

Rationale/what to do:

- Occasionally, clients do not fit the usual profile, such as a 12-year-old asking for condoms or an elderly man concerned about a possible sexually transmitted infection (STI). Similarly, disabled individuals (e.g., those who are unable to walk, blind, or developmentally challenged) may present reproductive and sexual health needs.
- While it may happen infrequently, some men may complain of such problems as a penis that is too large, or they may wonder whether having sex many times a day may be contributing to an inability to conceive.
- Address all clients as individuals, without making assumptions about the validity of their need for information or services, their sexual behaviors, or their physical status.
- Ask clients for more information about their circumstances if it is necessary to perform your job tasks; refer them to a service provider or counselor, as appropriate, for further assessment and care.
- Even if a particular individual turns out not to be a candidate for reproductive health services, he may need such services in the future or may be willing to refer others to your facility if he feels he has been treated with kindness and respect.

Appendix B

Training Frontline Staff

This appendix is aimed at managers who will be training frontline staff. Frontline staff include all of the employees or volunteers at a facility who interact with clients other than clinicians and counselors, including doormen, guards, janitors, receptionists, clinical assistants, records staff, appointment clerks, accounts clerks, lab technicians, switchboard operators, interpreters, drivers, and maintenance workers.

Objectives of Training Frontline Staff

- Communicate the facility’s philosophy regarding men’s reproductive health services.
- Familiarize frontline staff with the men’s reproductive health services program and procedures.
- Provide frontline staff with the knowledge and skills needed to perform job responsibilities specific to men’s reproductive health services.
- Develop a cooperative team spirit among staff working in the men’s reproductive health services program.
- Encourage positive attitudes and alleviate fears about men’s reproductive health services.
- Increase awareness of gender-sensitivity issues among male and female staff in relation to each other and to clients.
- Orient new staff to the men’s reproductive health services provided at the facility.

When training frontline staff:

- Use participatory training techniques, such as role-play exercises, as much as possible to develop skills and positive attitudes.
- Reinforce the benefits of the men’s reproductive health program.
- Allow staff to identify and express their concerns about issues that may arise as a result of initiating a men’s reproductive health program and to develop ways to address them. This helps encourage a feeling of “ownership” of the program. For example, staff can display educational materials and signs, obtain feedback about the services from clients, or persuade existing male and female clients to refer men for men’s reproductive health services.
- Provide staff with an opportunity to practice using procedures and forms.
- Allow staff to discuss how they would like to be treated if they were a man coming to the facility for services or information.
- Review the information and materials listed below.

Information and Materials to Review with Frontline Staff

- Services provided as part of the men's reproductive health program, including what they are and for whom they are designed
- Schedules and information sheets
- A referral list
- Staffing, particularly whether a male service provider will be available (for men who request this) and/or staff with certain skills (such as a urologist or a sex counselor)
- Tip sheets for receptionists and switchboard operators
- The information needed to refer clients to other health care facilities or a health information hotline
- A reception/waiting area and telephone etiquette
- Steps to take when a client becomes unruly; how to get backup and call for help

Appendix C

Male Client Survey

Thank you for taking the time to fill out this short questionnaire after your visit here today. We will use this information to help provide you with the best services possible. Your participation is optional and anonymous, and all of your responses will be kept confidential; no one will know that you filled out the survey. Please answer all of the questions. Feel free to provide additional comments.

Place a check mark next to your answers to the following questions:

1. Have you ever visited this facility before?
 Yes No
2. Who accompanied you to the facility today?
 I came by myself.
 My wife/girlfriend/partner
 Male friend(s)
 Female friend(s)
 Relative(s)
3. Did you have an appointment today?
 Yes No
4. If you answered *yes* to the previous question, did you make the appointment yourself, or did someone else make the appointment for you?
 I made the appointment myself.
 Someone else made the appointment for me (check the appropriate response):
 My wife/girlfriend/partner
 A friend
 A relative
 Other

Place a check mark in the box that matches the way you feel about your visit today:

	Strongly agree	Agree	Neutral/ Do not know	Disagree	Strongly disagree
5. The staff made me feel welcome.					
6. The staff made me feel comfortable enough to ask questions during my visit.					
7. The reception/waiting area made it seem like only women should be here.					
8. I would have felt more comfortable if more men were working here.					
9. The staff seem to have a positive attitude toward male clients.					
10. This is a good place for men to get tested for sexually transmitted infections (STIs).					
11. The pamphlets/other materials I was given were helpful to me.					
12. I feel like all of my concerns were met during my visit.					
13. I would recommend this place to a male friend or relative.					
14. If needed, I would come back here in the future.					

15. Reason for your visit (Check all that apply.):

- STI testing/treatment
- HIV test
- Obtain condoms or other contraception
- Obtain information, education, or counseling
- Provide support to my wife/girlfriend/partner
- Other (please explain):

Do you have any suggestions about how we could improve our services to meet your needs? (Please fill in below.)

Appendix D

Developing and Managing Men's Reproductive Health Services

Men's Reproductive Health Services and the Health Care System

Men's reproductive health services should be well integrated into existing services and should make appropriate use of existing staff and facilities. In addition, systems for client referral and follow-up and linkages to other health services need to be established. Because men's reproductive health services are less complex than gynecological and obstetric services, they can be offered in a greater variety of settings by more types of staff than women's reproductive health services and can, thus, be provided at facilities where it would be difficult or inappropriate to provide services to women.

The Service Manager's Mandate

Managers of men's reproductive health services are responsible for making these services available to the largest number of potential users and for ensuring that the services are affordable and sustainable over the long term. To ensure that quality services are provided, managers must:

- Ensure that all clients make voluntary, fully informed, and well-considered decisions
- Ensure the medical appropriateness, safety, and effectiveness of all clinical and surgical procedures

To guarantee that these quality services are well utilized and successful, managers should also:

- Establish services that are responsive to the needs, preferences, and behavior of clients and the community
- Make services widely available and easily accessible to all potential clients
- Plan and manage services to ensure their efficiency and cost-effectiveness
- Strive for long-term viability and sustainability of services

General Programming Considerations

The information provided here is designed to describe some of the basic programming issues to be considered in developing and managing men's reproductive health services. It is not meant to be an exhaustive explanation.

Location of Services

With very little additional investment, men's reproductive health services can be offered on a continuous, year-round basis at nearly all permanent health care facilities, including hospitals, multipurpose health care centers and clinics, specialized family planning clinics, and the treatment rooms of private physicians.

Mobile Teams

Whole teams can be used successfully to offer men's reproductive health services to rural, remote, or underserved communities. While such teams may cost more and may require more resources than services provided continuously at permanent facilities, they offer a means of bringing services to men who would not otherwise have ready access to them. It may, however, be more difficult for mobile teams to maintain cleanliness and asepsis, to screen and counsel clients, and to provide follow-up of laboratory tests and treatment for sexually transmitted infections (STIs). In addition, working in mobile teams places an extra burden on personnel, who are at greater risk for mistakes as a result of their fatigue and additional work pressures.

Each country must study its own conditions and priorities to determine whether mobile teams are compatible with national health needs and objectives. The use of mobile teams should probably be viewed as a short-term solution while local capacity for delivering men's reproductive health services on a permanent basis is being developed.

Men's reproductive health services can be integrated into existing health services. For example, men's programs that are established in specialized family planning clinics often can sustain a high level of performance over an extended period of time; in such settings, the men's reproductive health services team becomes expert, and services can be offered efficiently and safely. However, men's services may have to compete for scarce financial and human resources with services for women and with more urgent curative and emergency services; as a result, unless there is an adequate caseload of male clients to justify the use of resources, having a specialized service may prove expensive.

Facilities

As discussed above, men's reproductive health services can be offered at a number of permanent and temporary locations. But regardless of where the services are offered, certain spaces must be provided to ensure that the services are quality and comprehensive services. They are:

- A comfortable waiting area for new arrivals and follow-up clients
- A private space for counseling
- An examination room for preoperative and follow-up examinations*
- A place for record storage and retrieval
- A place for laboratory investigations (e.g., blood, urine, and semen analysis)
- A clean room for surgery, isolated from the outside and from clinic traffic*
- Areas where staff can wash their hands
- Toilets and washing facilities for clients
- A rest area for clients after surgery*
- Facilities for sterilizing or high-level disinfecting surgical instruments and supplies*
- Waste-disposal facilities
- A laundry

* Applies more specifically to vasectomy and other surgical services.

Several of these functions may share a common space with other health services, such as those for women or a general medical practice, especially at facilities that are not very busy. However, as the caseload increases, a separate area may need to be assigned for each function. The accommodation should be planned to permit an orderly flow of clients through the facility, particularly as the number of clients increases. Some of the components listed above, such as laboratory tests, laundry, and sterilization/high-level disinfection, may be contracted out or, in multiple-site programs, handled by a central supply unit if they are not provided at the facility.

Who Can Provide Men's Reproductive Health Services?

In all cases, service providers must be carefully selected to ensure quality service delivery. Knowledge and technical skill are, of course, prerequisites; in the case of vasectomy, services may be performed by general practitioners, specialist surgeons, other physicians, nurse-practitioners, and paramedics. It is important that service providers be committed to providing men's reproductive health services. Specialists, including some urologists, may be too preoccupied with more complex surgery and medical problems to take an active interest in STI treatment, male contraception, or even vasectomy, an elective procedure that can become tedious and boring for the surgical expert. (Interestingly, obstetrician-gynecologists who are closely involved with and committed to family planning have organized and conducted some of the most successful vasectomy programs.)

Staffing

There is no simple formula for determining the personnel required to staff a men's reproductive health service; staffing requirements will depend on the services provided. Even at a facility that provides vasectomy and medical services, only a nurse and a physician may be needed since one person can handle several of these functions. For example, a well-trained surgical assistant may easily receive the client, take the preliminary medical history, counsel the client, handle the laboratory tests, assist a surgeon in the operating theater, and sterilize instruments. As the caseload increases, more personnel, each responsible for one area, may be needed.

When selecting personnel to work with men, managers should:

- **Assess staff motivations toward working with men.** Staff members have different motivations for serving men. At one end of the spectrum are staff who see men chiefly as part of the problem of STI transmission (and reinfection) of their female clients, and at the other end are staff who see men as clients with their own individual health needs. Those in the latter category tend to be more motivated and committed to providing services than those in the former. As a result, they may make more effort to conduct outreach and to meet their male clients' needs.
- Assign staff who have a positive attitude toward men. Selected staff should be positive about wanting to work in the men's reproductive health program and comfortable serving men. These criteria should be applied both to existing and to newly hired staff.
- **Consider both men and women.** In most settings, both male and female staff can participate; staff do not need to be exclusively male.
- **Make your staff familiar to male clients.** Consider cross-training so that they can provide both clinic and outreach activities, and give them responsibility for staffing both

types of services. Staff who are known in the community will be able to provide clients with a familiar, trusted face in the facility setting.

- **Utilize volunteers.** Medical, nursing, and public health students can be especially valuable volunteers.

Paramedical Personnel

A number of countries have successfully trained and used paramedical personnel to perform men's reproductive health services. In places where the use of paramedical personnel is legal and permitted by local regulations, doing so can free physicians to do other work. For example, medical assistants, medical students, nurses, and community health workers have performed the vasectomy procedure competently and safely, and medical students, nurses, and paramedics may perform physical examinations and diagnose and treat STIs. Paramedical staff may find the medical and surgical tasks challenging, interesting, and rewarding and, thus, may be motivated to remain involved with the program.

Reports from some programs have indicated that paramedical staff empathize closely with clients, and that this has led to better community and client acceptance of the programs. However, managers should consider the concerns of the community and other health care providers about the provision of services by paramedical staff. Paramedical personnel should work under the supervision of responsible physicians who can competently perform the procedure in question. In fact, a physician must be available and ready to intervene whenever paramedical personnel provide clinical services, in case they encounter problems. Clearly, paramedical personnel must be selected with great care for aptitude, skill, dexterity, interpersonal skills, and judgment. Their training must be more comprehensive than that of physicians. Paramedical personnel should be required to perform a larger number of training cases than physicians and to establish proficiency in performing surgical procedures, and they should receive instruction in relevant anatomy, physiology, and pharmacology.

Client Follow-Up and Medical Referrals

Follow-up is a crucial part of all services, especially surgical services and STI treatment. If mobile teams are used, local physicians or specially trained community health personnel may conduct follow-up examinations. Paramedical staff must be trained to identify problems and to refer clients to the nearest health care facility when they encounter serious complications. Also, clients must be instructed to seek assistance if they encounter postoperative problems.

Programs must always be prepared to refer clients to another department or to another sector of the health care system when appropriate. In the event of rare, life-threatening surgical complications, clients may need to be referred to another facility that is better equipped to handle the situation. If medical problems, such as the presence of an STI, are discovered during a prevasectomy examination, the vasectomy provider must be prepared to treat or refer the client. Occasionally, screening and counseling may identify psychological problems that require referral for further counseling or psychiatric treatment.

The widespread use of antibiotics has encouraged the development of antibiotic-resistant strains of a number of common STIs. A client who has received inadequate treatment may suffer long-term symptoms of STIs, and will continue to spread the infection to others.

Hernia Repair and Urological Surgery

Facilities that provide physical examinations for male clients are likely to identify men who need hernia repair or other types of urological surgery. Hernia repair may be performed by appropriately trained surgeons or other physicians. Urological surgery may be performed by urologists or, in some settings, general surgeons. A men's reproductive health program should identify suitable referral channels in the community if possible. Physicians and surgeons who agree to accept referrals from the facility may become active supporters of the men's reproductive health program and its staff.

Assessing the Receptiveness of the Local Community

Before introducing men's reproductive health services at a facility, managers must consider the environment or community in which the services are to be located. Managers must identify and take into account political, cultural, and religious attitudes, and must study local laws and regulations, guidelines for medical practices, and codes of ethics to determine how these will affect services. Managers must also obtain all necessary permits and licenses and should investigate the level of community knowledge and practice of family planning and the availability of other family planning and STI services. Existing data, group discussions, and community surveys can help identify common myths and misinformation about men's reproductive health issues that can be addressed with information and counseling. In addition, in this preliminary community survey, local medical and health professionals should be interviewed to determine their attitudes about providing men's reproductive health services and their willingness both to collaborate in the delivery of men's reproductive health services and to refer potential clients.

Estimating the Potential Caseload

To develop services that meet local needs, managers will have to estimate the potential demand for each type of service. This estimate will be important in determining the facilities, staffing, and other resources required. The actual number of clients who request services will be influenced by such variables as cultural acceptability, the design and accessibility of services, the existence of similar services in the community, and the community's level of information and education about men's reproductive health services. When services are first introduced in a community, the number of clients may be limited. However, the caseload can be expected to increase as the number of satisfied clients grows, as accurate information becomes more widespread, and as fears are allayed and misconceptions are corrected. Having some idea of the potential number of clients can assist managers in forecasting and planning for growth rather than being overcome by it.

Sustainability

To provide services efficiently and to ensure that they will be sustained, managers need to understand and use budgeting principles and other aspects of financial planning and management. Securing adequate financing of services can be a complex problem involving

multiple sources of funding. The most common sources of funds for men's reproductive health services are:

- **Government subsidies.** While subsidies may initially help make services available, subsidized services may be difficult to manage and sustain over the long term.
- **Grants from donor agencies.** Several international donor agencies provide grants for vasectomy and other men's reproductive health services during the first few years of operation. Most have policies to phase out support and encourage self-sufficiency.
- **Client fees for services.** Fees must be set at a level that covers costs but does not discourage use of the services. Accommodations must be made for clients who cannot afford even modest fees; no client should be denied services because of an inability to pay.
- **Insurance.** Private or government health insurance may cover the cost of men's reproductive health services.
- **Income-generating approaches.** Organizations sometimes help support the costs of services through special fundraising events or by using revenues from profitable services to support those that are not profitable.
- **Combined financing mechanisms.** Most often, financial support derives from a combination of sources, such as sliding-fee scales combined with profits from other services and grants from donor agencies.

Managers must learn and use financial management and accounting procedures. Effective accounting and auditing systems help managers keep costs under control, stay within budgets, and avoid or anticipate financial difficulties. Governmental and other donors often require particular accounting systems, but all services should maintain internal accounting systems that are designed to permit periodic internal and external audits.

Planning for Self-Sufficiency

Because new reproductive health services often rely on outside funding or on sources of income that may be unreliable over the long term, managers must continuously monitor and improve the efficiency, and thereby the sustainability, of these services. Services that rely on subsidies may find that they are continuously compensating for reductions in funding. To minimize this problem, nongovernmental organizations should diversify and balance their sources of funding so that the loss of any one source will not drastically affect their ability to provide services. In most for-profit enterprises, the sustainability mandate is clear: Costs must be transferred to clients or recovered from third parties (such as insurance companies or governments) as soon as possible, or the institution will be forced to close. Governments and donors may be willing to support for-profit organizations during their early stages, but will not usually provide funds indefinitely for recurring costs. Managers should consider the following strategies in working toward self-sufficiency:

- Keep costs to their absolute minimum without sacrificing quality.
- Review service options to deliver services as economically as possible.
- Achieve economies of scale so that costs are shared among more cases.
- Work toward cost recovery by gradually increasing reliance on fees and insurance.
- Adopt supplementary income-generating schemes.

In addition, managers must:

- **Provide ongoing training for different levels of staff.** This is to ensure that a technical skill is not lost if a professional leaves.
- **Be persistent in offering reproductive health services to men.** Service providers need to be patient with men. Many men do not know what to expect when accessing reproductive health services because they may have never been to a doctor, and, therefore, may be uncomfortable accessing services.
- **Integrate services into existing programs or make use of existing facilities.** Often, managers believe that a substantial amount of extra funding is needed to initiate male involvement activities. However, current programs or facilities can easily incorporate male involvement activities or services at low cost; for example, this can be done by having health educators talk about male involvement when they are doing group discussions or by having a clinic set aside a separate room in which male clients can be seen.
- **Ensure appropriate high-level support and supervision.** Garner the necessary political support.
- **Take a long-term perspective.** Since instituting men's reproductive health services may involve substantial social change, as well as the more readily defined logistics of setting up a service program, managers may need to put special effort into sustaining management and staff commitment for a number of years of slow growth before a program can be considered self-sufficient.

Characteristics of Successful Programs

The activities discussed so far are important to consider when organizing a men's reproductive health program. But they may not be sufficient for launching and managing a successful program that truly meets the needs of the community. Public health professionals have considered what makes the difference between a lackluster or unsuccessful program and one that is obviously dynamic and successful, and a few characteristics that successful programs seem to share are summarized below.

Client Satisfaction Is of Paramount Importance

An Emphasis on Quality and Client Satisfaction

Satisfied clients are an important source of referrals for a men's reproductive health services program; a men's program that has established a reputation for excellent service is likely to produce self-generating demand through word of mouth from clients and local health professionals. Because the way that staff treat clients will undoubtedly influence their satisfaction with and perceptions of the services, a program cannot afford to make mistakes in this regard, especially in the early stages. If staff are attentive and compassionate, even clients whose medical problems cannot be addressed by the program will be more likely to leave with a favorable impression and to share that impression with potential clients. On the other hand, neglecting clients or treating them inconsiderately to achieve higher volume is self-defeating in the long run, and will ultimately serve to turn clients away from the services.

Attention to the Special Needs of Men

Programs that specifically take into account the psychological characteristics of men and the dynamics of men's relationships with their partners are more likely to succeed. In some societies, this may mean that the men's reproductive health services program should be physically separate from women's services. In some cultures, it may be advisable for key facility staff to be men. Facility hours should be convenient for clients; evening, weekend, or holiday sessions may be suitable for men who find it inconvenient to leave their jobs on weekdays. Finally, educational materials and information programs should carefully address common misunderstandings about male and female sexuality and reproductive health issues.

Gender Concerns

Gender is a fundamental context for work with both men and women since it shapes all aspects of clients' lives. While sex is biologically determined, gender roles are culturally determined and dictate the balance of power in relationships. Gender issues, which are inevitably culture-specific, are a crucial consideration in program design. Managers should:

- Make sure that staff are gender-sensitive. Provide training that helps staff understand and overcome their own gender biases.
- Train staff to deal effectively with co-workers and clients of the opposite sex. At regular intervals, provide refresher training sessions to orient new staff and reinforce learning for older staff.
- Talk to clients, potential clients, service providers, opinion leaders, teachers, and others to learn what the pressing gender concerns are in the community. Address these concerns in program design.
- Recognize cultural constraints related to gender that affect information gathering and service delivery.
- Make sure that male clients understand women's reproductive physiology, using a three-dimensional model if necessary.
- Make sure that counselors acknowledge the role of important people in clients' lives other than their partners. Incorporate these important people into counseling and service provision as appropriate and as desired by the client.
- Use culturally and socially appropriate terms to discuss sensitive subjects, such as sexuality. Ensure that the institution has strong internal leaders and external policy support in winning over key allies.
- Form linkages with other services in the community, to ensure that the program is able to address such issues as gender-based violence.

Working with Multiple-Language and Multicultural Populations

In many countries, the community served by a facility includes people who speak a number of languages and have different cultural backgrounds. This has implications for the choice of staff at the facility; the types of information, education, and communication (IEC) materials made available to clients; and the use of translators. Managers should implement policies and encourage staff to:

- **Make important signs, directions, and phone messages in all major local languages.** All information that a potential client would need to have about the facility should be in the major local languages. In addition, if clients will need to bring a translator with them to the facility, the message should include that information.

- **Publicize multilingual services.** Being able to serve clients who speak various languages is a real benefit for a facility. The facility can publicize this in the literature about its services and can post a notice in the waiting room, outside the door, or at the reception desk saying which languages are spoken at the facility.
- **Make multilingual staff available to clients.** It is helpful to have staff who speak each of the major local languages available at all times that services are provided. If such staff work in another department, managers should make arrangements to “borrow” them to translate during a facility session if necessary. Translating can be time-consuming; therefore, managers should be respectful of staff translators’ need to perform their regular job, and should not penalize them for spending time translating. Staff from other departments who act as translators may need extra training in medical terminology, facility procedures, and client confidentiality, and may receive bonus pay for their additional responsibilities.
- **Be sensitive to gender issues.** If a woman is asked to act as a translator for a male client, she should be introduced as a trained person working in a professional role, with the usual expectation of confidentiality.
- **Assess the translator’s ability to ensure client confidentiality.** If a male client brings his own translator, or if a friend or family member is asked to translate, staff should tell the client that he may be asked to talk about private and personal matters, and that it is important for his care that he answer them completely and honestly, *before* starting a discussion of medical problems, symptoms, etc. The staff should then ask the client if he thinks he could do this with this translator or if he would rather reschedule the appointment for a time when someone else could translate. If the client feels he can use the translator, the staff should tell the translator that he or she is acting in a confidential role and is being trusted not to discuss personal matters with others in the family or in the community.
- **Avoid using other clients as translators.** The cautions discussed above apply to the use of passersby or other clients in the waiting room acting as translators—which should be avoided if at all possible.
- **Avoid stereotyping based on religious or cultural identification.** Staff should focus on the individual client’s needs and requests. Staff training on these topics may help bring out hidden biases and to set them into a more realistic context for individual client care.
- **Make information, education, and communication (IEC) materials available in different languages.** Print materials should be available in each of the major local languages if possible. If not, translations should be offered, if necessary.
- **Verify translations.** When translating medication instructions or other materials into another language, the materials should be checked to make sure that they will be understood correctly by speakers of that language. This can be achieved by having someone else “back-translate” them into the original language. Also, sensitivity should be shown to cultural differences that may require changes in how certain terms or concepts are presented—especially those dealing with sexuality.
- **Learn the acceptable and common sexual terminology in each language spoken.** Staff should show sensitivity to cultural differences that may require changes in how certain terms or concepts are discussed with clients.

- Use simple language. Staff should use simple language that can be read and understood by laypersons.

Working within the Community

A men's reproductive health service may be more acceptable and successful when it is located within the community it is intended to serve. (However, some men may prefer to travel long distances to facilities where they are unlikely to encounter anyone they know.) Some programs have had good results by employing staff who reside in the surrounding area. As much as possible, staff members should have the same socioeconomic, cultural, and ethnic characteristics as their clients. Finally, the facility should have good connections with other local institutions, such as social welfare organizations, local health facilities, community-based family planning programs, and local government councils or groups. In sum, the program should strive to be part of the local social fabric.

Developing Leadership

A successful men's reproductive health program is usually headed by a professional who has taken a personal interest in involving men in family planning and reproductive health and who is committed to the success of the project. When services are introduced in a locality for the first time, it is especially important for the leader to be patient, persistent, and committed and to be willing to be a pioneer.

Features of Successful Family Planning Programs

Men's reproductive health services can be operated within the context of a client-centered family planning program, general medical services, a hospital, or another type of facility and should be well integrated into existing services. The main features of successful family planning and reproductive health services have been identified as follows. They:

- Provide a wide choice of methods of contraception
- Place the concept of family planning and reproductive health within the broader context of each client's experience
- Ensure the accessibility of family planning methods through a variety of staff and delivery systems
- Support clients by providing full information and counseling and by providing reassurance when problems arise
- Enhance the quality of services by promoting the highest possible standards of care appropriate to the setting
- Respond to clients' needs and preferences for family planning methods and services
- Provide effective outreach and follow-up
- Encourage active client participation at all stages of service development and implementation
- Undertake research and evaluation to elicit clients' perceptions and preferences

These principles apply to contraceptive and other services to improve men's and women's reproductive and sexual health and knowledge.

Access to Reproductive Health Services

Access issues may be a particular concern in providing services that include men. For example, in many countries, there may be cultural biases against allowing men into areas designed for the provision of reproductive health services for women. In areas where men's and women's services can be integrated, it is essential that the inclusion of men's services not compromise resources for women. Managers should:

- Integrate men's services into existing female-oriented settings if appropriate
- Consider the feasibility of providing stand-alone services for men only
- Consider the feasibility of adolescent-oriented services
- Address the issue of hospital regulations restricting men's access to obstetrics and gynecology departments and other areas so that the modesty of female clients in the wards is not violated
- Set service hours that accommodate both men's and women's work schedules
- Offer services every day, and keep waiting times to a minimum. (This may be especially important to low-income men, and women, who work as day laborers and cannot afford to take much time off for medical appointments.)
- Consider providing services off-site: at workplaces, job-training centers, existing medical facilities (e.g., STI clinics), schools, prisons, and religious facilities, and through mobile vans
- Arrange transportation, if necessary, to take outreach workers, IEC materials, and even medical services to locations frequented by men
- Help service providers eliminate both facility and staff biases that may be an obstacle to providing services to men
- Help providers recognize the missed opportunities to reach men who are already in the facility for other purposes—for example, by addressing information and education to men in waiting rooms
- Design male-focused IEC activities to help improve men's knowledge about family planning and other aspects of reproductive health
- Consider offering special services to groups of men who are often overlooked, such as partners of postabortion clients
- Develop policies that encourage couples to seek services together. In a number of countries, this has been a key to greater male involvement in both adult and youth clinics
- Make sure that existing services are well linked, especially where resources are scarce (For example, some mosques have health-education facilities and a school, which can be important venues for education aimed at men.)
- Make sure that individuals are able to decline couple-centered services that they do not want

Integrating STI Services

Reproductive health services include much more than contraception and safe motherhood. They should also include such services as child survival, adolescent services, and treatment, diagnosis, and education related to HIV and other STIs.

Providing STI services may present special challenges. For example, in some cultures a great stigma is attached to STIs, and clients and providers may not be prepared to talk openly about them. To successfully integrate STI services, managers should bear in mind the following:

- Prevention is of the utmost importance. Programs should include the provision of condoms, as well as information about and demonstrations of condom use.
- Programs should provide training for providers to address concerns and biases related to STIs, including HIV/AIDS.
- Outreach workers, health educators, counselors, and service providers should all be prepared to counter common misconceptions about the causes and transmission of STIs (e.g., AIDS is caused by someone putting a curse on the person).
- All facility staff should have some knowledge about the signs and symptoms of STIs and have correct information (not myths) about their causes and transmission. The staff members may have opportunities to serve as informal health educators of their family members and friends, as well as sources of referral of individuals who need screening for STIs.
- The integration of STI diagnosis and services into existing programs may help alleviate the stigma attached to going to a facility or department that addresses STIs only.
- It may be useful to institute “syndromic” treatment of STIs, particularly if laboratory services are expensive or unavailable.
- All STI clients should refer their sexual contacts for screening and treatment.
- Support groups are a good way to involve everybody in the fight against HIV/AIDS.
- Education, counseling, and participation are important to help change behavior.
- Clients can be excellent community educators, thereby helping reduce STI-related stigma in their own communities.

Appendix E

Informing the Community and Attracting Clients

Introduction

This appendix outlines some of the key considerations for program developers who wish to institute informational and promotional activities for their men's reproductive health services. Information and promotion help the general public become aware of men's reproductive health services and enable prospective clients to be more knowledgeable about clinical and counseling procedures. Information, promotion, and counseling are also important in ensuring that clients are well informed and satisfied, and, thus, are more likely to share their positive experiences with others in their community.

Each program should determine the most appropriate ways of informing potential clients about the availability of services. While a program may rely exclusively on one or two methods or approaches, more typically a variety of channels will be developed. The specific ways chosen to develop a network for referring clients to the facility will depend on:

- The nature of the service-delivery system
- The location and setting of the service sites
- The sensitivity about reproductive and sexual health matters in the community and the openness with which they can be discussed
- Local regulations

Information, Promotion, and Counseling

Informing clients about reproductive and other sexual health matters is different from promoting services or counseling clients. While each of these activities has its own primary purpose, individual staff members are often responsible for more than one of them. For instance, a nurse-midwife in a family planning clinic may inform clients of their contraceptive options, a community worker may inform people in the community about the various contraceptive methods, and a counselor may counsel clients on specific methods. Whatever their individual responsibilities, staff members should understand the differences between these three activities, as follows:

- **Information:** To provide facts that the client can use in making decisions about family planning, reproductive health, and other sexual health matters
- **Promotion:** To encourage individuals to practice family planning, maintain good reproductive health, and protect themselves from sexually transmitted infections (STIs)
- **Counseling:** To assist the individual client in making an informed, voluntary, and well-considered decision about a variety of services and options, including family planning and diagnosis and treatment of HIV and other STIs

Information

Clients must be given complete, accurate, and unbiased information about a variety of issues, including available contraceptive methods, sexual functioning, STIs, domestic violence, and safe motherhood. Messages that are one-sided—for example, those that favor one method of contraception over another, address only the advantages of particular methods, stigmatize certain sexual practices, or fail to acknowledge the possibility of STI transmission—are misleading and compromise informed choice.

For information activities to be effective, a range of services must be available and accessible to the public, and these services must be provided in a noncoercive atmosphere. If a family planning service offers information about vasectomy but the procedure is either unavailable or inaccessible, potential clients will be disappointed and frustrated. In addition, the credibility of the family planning service will be damaged. If information is presented in a coercive atmosphere, clients are likely not to believe it and may resist taking action, whereas they may have considered change in a more open and supportive environment. If clients receiving reproductive health services feel pressured in any way, they are likely to regret the procedures afterward and to criticize both the services and the service provider.

Men's reproductive health providers must ensure that all personnel who give information about men's health are themselves well informed. Training programs for doctors, nurses, field workers, counselors, and other appropriate personnel should include facts about male contraceptive methods, including advantages, disadvantages, and side effects; STIs; and men's sexual functioning. Staff members should also be routinely supervised to ensure that they are providing clients with accurate and complete information.

Promotion

The major purpose of promotion is to encourage people to take action—for example, to practice family planning or safer-sex behaviors. It is acceptable to promote the benefits of small families and to encourage clients to use some method of family planning. However, urging healthy clients to use specific methods compromises voluntary choice.²² Similarly, it is acceptable to urge clients to protect themselves from STIs while enabling clients to decide whether they will do so by using condoms, abstaining from sex, or practicing mutual monogamy.

Family planning and reproductive health services have undertaken a variety of promotional activities. One of the most common is to use trained community workers to promote contraception. These individuals usually have other public health or family planning responsibilities, such as providing information about health services and contraceptive methods, distributing contraceptive or medical supplies, or accompanying clients to facilities. Similarly, STI-prevention campaigns have promoted condom use and testing for HIV infection. Some promotional activities—notably, the provision of incentives and disincentives—can pose serious threats to free and informed choice.

²² World Federation of Health Agencies for the Advancement of Voluntary Surgical Contraception. 1995. *Voluntary choice and surgical contraception*. New York: AVSC International.

When promoting to men, considering men’s socialization regarding health issues is important. Men may perceive seeking health care as a sign of weakness. As a result, men are often less likely than women to seek health care when needed, often opting to “tough it out” or hope that the problem goes away on its own. Therefore, promotional efforts aimed at men need to emphasize that visiting a health care facility does not detract from a man’s manhood or masculinity.

Counseling

In addition to providing information about contraceptive methods, HIV and other STIs, sexual functioning, and other clinical, social, and psychological conditions and issues, the counselor focuses on the client’s options and how decisions are made. When discussing sterilization, the counselor must stress that the method is intended to be permanent.

An effective counselor of men:

- May be a man or a woman
- Is knowledgeable about male reproductive health and male family planning methods
- Tailors counseling to men’s informational, psychological, and communication needs
- Is not embarrassed to discuss sexuality
- Is sensitive to and takes seriously men’s concerns
- Has a positive attitude toward male involvement in family planning
- Discusses male family planning methods with female clients

Considerations

Counteracting Misinformation

Misinformation about family planning methods, STIs, and sexual health matters is a major obstacle in some countries. These topics are often the subject of rumors and myths (for example, “Vasectomy makes a man impotent,” “Brand X condoms always break,” or “You can tell if a person has HIV or AIDS by his or her appearance”). Sometimes dissatisfied clients, opponents of family planning services, or even poorly informed service providers may circulate misinformation. Broad-based information activities that communicate in a simple, clear, and objective manner can be used to counteract rumors and myths. Service providers should aim to identify any such rumors and misinformation as soon as possible and to address them at the source; follow up with clients to ensure that they possess correct information; provide quality services that are trusted by the community; provide accurate information about contraceptives, including their advantages and disadvantages; and use words and symbols in information activities that promote understanding rather than confusion.

Public information and communication, referral systems, and facility-based information and communication activities are all necessary parts of an information program.

Public Information and Communication

Public information and communication approaches help stimulate interest in men’s reproductive health services and provide basic information. However, these approaches are impersonal and cannot cater to individual situations, needs, and questions. These approaches include:

- **Mass media.** Techniques can include posters, billboards, newspaper articles, advertisements on buses and trains and in periodicals, and radio and television announcements. Mass-media messages can reach a large audience, but they are impersonal, can be expensive, and, under most conditions, can deliver only simple messages.
- **Printed materials.** Consideration should be given to the development of some printed materials for every program. A brochure or question-and-answer sheet written in simple language and in local dialects can efficiently address common questions and concerns. Information should be presented in a straightforward, nontechnical, and noncondescending manner. In a number of programs, illustrated printed materials for low-literate/illiterate audiences have been developed. Comic books, for example, have been used in a number of places, including Mexico, the Philippines, and Thailand. Illustrated materials can be colorful; can contain interesting, attention-grabbing stories; and can convey essential facts about men's reproductive health using drawings and a minimum of words. In some countries, picture books using specially designed and pretested photographs or drawings have been developed to communicate with potential clients who are illiterate.
- **Social marketing.** Based on marketing principles developed by profit-making enterprises, social marketing promotes products, such as condoms, that are considered beneficial to society by defining and researching target audiences; planning, developing, and pretesting messages and materials; advertising extensively; and selling products or services, often at subsidized or reduced cost. Social marketing has considerable potential for use in men's reproductive health programs. Retail and pharmacy sales and community-based distribution (CBD) make condoms more available and can also lead to clinical referrals.

Referral Systems

Client-referral systems provide links for potential clients between the community and the facility. The primary purposes of referral systems are to guide interested clients to sources of more information and to assist them in getting a service. Thus, client-referral programs are most usefully directed toward those who have decided that they do not want children at this time or that they are at risk for HIV and other STIs and want protection or treatment. A number of referral systems are described below.

Word-of-Mouth from Satisfied Clients

Word-of-mouth from satisfied clients is perhaps the most potent advertisement for any program. In some settings, the men's reproductive health services program may have such a good reputation in the community that word-of-mouth communication alone ensures an adequate caseload. In addition, in some settings, informal oral communication may be one of the few ways available to spread information about services. The key ingredient to a successful word-of-mouth program is a quality and affordable service: Clients who are satisfied with their treatment are more likely to discuss the service and recommend it to friends and relatives. Make sure that services are efficient, professional, responsible, and of quality before creating interest in them so that word-of-mouth communications will be favorable.

Satisfied clients of an existing men's reproductive health program may be willing to do outreach to other men in the community. For example, some programs have formed clubs of men who have had vasectomies. In a typical arrangement, vasectomized men who accept the invitation to become club members receive additional information and materials to distribute to other people in their communities. These men may be given an identifying pin,

badge, or certificate that might elicit questions from friends and community members. Program managers may convene occasional meetings of club members in order to give further training in communication skills and provide a social environment where club members can exchange experiences.

Members of one such club in a Sub-Saharan African country formed their own outreach group. Together with their wives, the men visit throughout the community, sharing their experiences and talking with interested men and their partners to educate them about all kinds of family planning, including vasectomy. The vasectomy clients also have volunteered to be “posted” at facilities to talk informally with anyone who is interested in learning more about vasectomy as a contraceptive option.

Field Agents

In many countries, community development, health, and family planning programs employ field (outreach) workers who are closely and frequently in touch with the community. After brief training, these workers can give people accurate information about men’s reproductive health services and refer interested clients to service sites. Field workers can conduct focus groups or community surveys about the need for men’s reproductive health services and can provide program information at the end of the research interaction.

Many family planning and STI programs have their own special field workers. In addition, programs for CBD of temporary contraceptives employ community-level agents. These workers can also be trained to communicate about men’s reproductive health services. CBD workers, in particular, often know who among their customers are dissatisfied with their current contraceptives, want no more children, or appear to be at risk for STIs. The CBD workers can refer these clients to a site where men’s reproductive health services are offered.²³

Examples of community health workers who can serve as referral agents include traditional healers, birth attendants, health educators, pharmacists, and medical, nursing, and public health students. Also consider trying other communicators, such as retired teachers, sports figures, agricultural extension workers, taxi drivers, male elders, and peer, marriage, and school counselors. To reach men with lower incomes and educational levels and those from minority subgroups of the population, use outreach workers from similar backgrounds. To reach men who work during the day, do outreach at the worksite or provide care at a satellite location.

Religious leaders are also a potential resource for promoting men’s reproductive health services. In many societies, religious scholars can be involved in identifying relevant messages from religious documents and traditions that promote family well-being and its relationship to reproductive health and men’s responsibilities. These messages and traditions can then be used to inform congregations and disseminate information to other religious leaders. For example, many scholars of Islam from around the world have already provided contemporary interpretations of the *Koran* and *ahadith*, Islamic religious texts that support family planning and population issues. Men’s reproductive health information has been distributed through mosques, temples, and churches.

23 Mumford, S. D. 1983. The vasectomy decision-making process. *Studies in Family Planning* 14 (3):83–88.

Professional Referral Systems

The local medical community should be informed about the availability of men's reproductive health services. Service providers who do not themselves offer contraception, vasectomy, STI, or sexuality counseling services are often willing to refer their clients to a quality service. In particular, pediatricians, internists, gynecologists, urologists, and emergency-department physicians are likely to identify men whom they can refer for men's reproductive health care. Clinics that deal exclusively with STIs may refer men for other reproductive health and family planning needs. Similarly, local hospitals, family planning clinics, and medical societies should be informed about the program's services. In some programs, nonmedical community-service professionals have been used successfully as referral sources. Such groups may include social workers, religious leaders and clergy, and teachers. Ways of informing local professionals include seminars, letters, word of mouth, and announcements in professional journals and newsletters.

Groups and Organizations

Organizations in which men predominate are suitable sources of potential clients and often are an appropriate focus for organized educational activities. Some programs have seen effective cooperation with factories, unions, agricultural workers' organizations, taxi drivers' associations, police officers' and firefighters' organizations, schools, probation departments, communes, and community-service societies. Women's groups are also a good venue because women are often interested in learning about men's reproductive health services for their partners or husbands. Many organizations welcome outside speakers who can talk about subjects of potential interest to their members or employees. Large employers, commercial factories, military bases, and prisons may be good locations at which to establish satellite services. Consider asking well-known local groups to endorse messages and contribute to a policy of advocacy.

Community Advisory Boards

Members of a community advisory board, assembled for the purpose of assisting with the planning of a men's reproductive health program, can also serve to disseminate information about the program to the community. They may act as public speakers or as contacts with other organizations to which they belong, or they may simply provide word-of-mouth support. Keep board members informed about details of the program, and solicit their involvement in deciding how they can help promote the program to the community.

Journalists and the News Media

Well-placed, favorable news items are an excellent, low-cost means of raising public awareness. Provide training, information, and education to journalists. Designate a senior professional or a manager to be the primary facility contact for the news media. This person should be credible, judicious, and discreet. He or she should understand the workings of the news media, as well as their power to shape public opinion, and should interact well with journalists. The media contact should be afforded prompt access to the top policy makers at the facility, when necessary. He or she should also be quite knowledgeable about men's reproductive and sexual health matters and their impact on women, and should keep up to date on new developments, to provide accurate information to the media or at least to recognize when another, expert source is required. This person should also review any press releases before they are sent out and should be kept informed about public speaking engagements at which the men's reproductive health program will be discussed.

Policy Makers and Influentials

The support and endorsement of community leaders, politicians, policy makers, and professionals can be vital to the success of a men's reproductive health services program. Such individuals can directly and indirectly influence the legal and financial environment in which the program operates, as well as provide authoritative opinions. As a result, special outreach efforts should be directed to these influentials. Personal contact and targeted meetings with program managers and directors can be important elements in gaining their support.

Clinic-Based Information and Communication

Family planning and primary health clinics can be primary sources of information and communication about men's reproductive health services. Clients who come for other services easily can be given information about relevant men's reproductive health topics individually or in group sessions through lectures, discussion, and audiovisual presentations. Posters about men can also be displayed, and question-and-answer brochures about men's reproductive health topics can be made available. Ensure that all staff are well educated regarding the men's reproductive health services available so they can provide this information to the maximum number of clients.

Female family planning clients are often eager to refer their husbands or partners for care. In some cases, couples may come to a facility together when they are thinking about spacing or ceasing childbirth or when they have fertility or sexual concerns. For male clients who come to request services on the recommendation of their wives or partners, the facility should provide confidential client assessment and counseling. Men who are in coupled relationships may nevertheless have personal concerns that they do not share with their partners, and vice versa.

Consider offering special services to groups of men who are often overlooked, such as husbands or partners of postabortion clients, of pregnant and postpartum women, and of women who will soon have or have had major gynecological surgery or a mastectomy. Such men are likely to have specific counseling needs, as well as more general reproductive and sexual health needs. Their female partners are a natural referral source.

Developing Information Activities and Materials for Clients

Developing an effective information and education program about men's reproductive health services is not a hit-or-miss matter. Whether a program is advertised on television, on radio, on posters, or in brochures, program managers must follow a certain sequence of steps to transmit clear messages to a well-defined audience. Information and communication activities require careful planning and execution. Program managers should draw upon the expertise developed over many years in advertising, graphics, marketing, social marketing, and communications research.

Informed and voluntary choice is jeopardized when undue emphasis is placed on particular methods of contraception, to the exclusion of others. Information about condoms or vasectomy should be part of a broad communication program about family planning, and clients should, therefore, receive information about all of the available options before they make a choice.

As service providers plan and develop information activities and materials, they should seek assistance from two valuable sources: members of the target audience and professionals with experience in communication activities. Client participation will be essential if the program is to succeed. Through focus groups and interviews, clients can help develop the messages to be conveyed and can identify the appropriate information channels for these messages. Furthermore, clients can review sketches and drafts of materials being developed during the critical pretesting stage.

A variety of professionals have considerable experience with information activities, and program managers should ask these professionals to participate in planning and carrying out the program. Managers should draw upon the experience of personnel from such areas as health education, communications, graphic design, advertising, production of audiovisual materials, and communications research. These personnel's efforts can encourage better use of resources and can enhance the effectiveness of information materials and activities. Family planning managers who are not experienced in carrying out information programs and who are in countries where resources are scarce may have difficulty in obtaining appropriate professional assistance. Ministries of health, major hospitals, and family planning organizations often have communication departments that can help plan and develop information programs.

Major Steps in Developing an Information Program about Men's Reproductive Health Services

1. Analysis

- a. Research the proposed target audiences and their characteristics. This means: interview community leaders and clients, talk to experienced health care personnel who have worked in the community, consult reference materials, and conduct surveys and focus groups to find out what messages might motivate men to use the services. Talk with women in the community as well. If a particular group of men will be targeted as potential clients (e.g., adolescents, low-income men), answers should be obtained directly from such men. Focus groups, in particular, are often more effective when the participants share similar backgrounds or demographics. A major goal of all of these activities is to collect information about the proposed target audiences so that messages can be tailored to meet their needs and the most effective communication channels can be chosen to reach them.
- b. Determine which messages are circulating, which materials already exist, and which existing information sources are most trusted.
- c. Examine the institution's ability to carry out an information program, and consider whether additional resources are required.

2. Developing a plan

Determine the objectives, topics, and target audiences. Identify the resources required,

both inside and outside the institution. Identify staff members who will be involved, and spell out their responsibilities. Develop a schedule and a budget.

3. Developing messages, materials, and activities

Investigate the target audience's knowledge about men's reproductive health, HIV and other STIs, and family planning, and develop messages based on these results. Review these messages with staff. Select the most appropriate information channels to convey the messages. Design materials and activities, and review these with staff.

4. Pretesting and revising

Pretest the messages, materials, and activities on the target audiences. Revise as necessary, and review the revised materials and activities with staff. Repeat this stage as required.

5. Implementation

Train staff members to use the materials and to carry out the activities. Produce and distribute the materials. Implement the program.

6. Assessment

Assess the impact of the information activities on the target audiences. Revise the material and activities as required.

More details on each step follow.

Analysis

Careful analysis is the first step in any successful information program. During this stage, staff should talk to clients and other members of the local community and should examine the messages being circulated. Clients receive information about contraception (including vasectomy), HIV and other STIs, and male sexuality in many ways. Some of this information may be inaccurate or incomplete. Service managers should also examine the context in which communication takes place. They should seek to answer the following questions:

- Where do men usually get information about contraception, HIV/AIDS and other STIs, and sexual performance and dysfunction?
- What rumors and myths exist about condoms, vasectomy, withdrawal, and getting HIV/AIDS and other STIs?
- What forces are at work that might make clients resist or not believe information about male involvement in family planning, including condoms and vasectomy?
- Which sources of information does the community trust and rely upon?
- What information is being presented in newspapers, on television, and on the radio?
- Is family planning widely practiced in the community, or is it just beginning to be used?
- How prevalent is vasectomy?
- Where do men go for STI diagnosis and treatment services?
- Where are condoms obtained?
- Do any laws or local customs potentially restrict public discussion about family planning, vasectomy, HIV and other STIs, and male sexuality?
- What role do men play in making decisions about family planning?
- What role would women like men to play?

- Are other facilities already providing information about contraception (including vasectomy) and other men’s reproductive health services?
- Are men involved in supporting their partners through pregnancy, childbirth, and breastfeeding?

Part of the analysis should include *selection of the primary target audience*. Public health considerations should determine this audience: The group most affected by the severity and prevalence of identified health problems.

Staff members responsible for information activities should describe the target audience in writing, revise that description as the activities progress, and continually refer to it as a guide. Consider this, for example: “The primary target audience for this activity is rural, illiterate, married men between the ages of 30 and 45 with at least two children. The secondary target audiences are their wives and parents.”

In addition to the primary target audience, decide which other groups need to be informed about the men’s reproductive health program, such as female clients, policy makers, opinion leaders, and local health professionals. Messages and materials for the various target audiences should be coordinated in content, timing, and intent.

Part of the analysis should also include an *analysis of communication needs and preferences* of the selected target population and any secondary target audiences identified. The following questions should be considered:

- What languages do they speak and read?
- Are these potential clients literate, low-literate, or illiterate? What is their education level?
- What are their vocabulary and word preferences?
- Which images and sounds (music) have positive (or negative) connotations?
- In what settings do men want to receive information about men’s reproductive health issues?
- What communication channels appeal to these men in general? concerning men’s reproductive health issues? concerning men’s reproductive health issues in the settings they say they prefer? (See the section on communication channels, below.)
- Who and/or what influences these men’s decisions about men’s reproductive health issues? What figures or spokespeople would they trust?
- What is important to this audience? What would motivate the audience members to act? What factors are most important for the audiences when deciding both to seek and to continue to use men’s reproductive health services?
- What knowledge, concerns, problems, questions, and misconceptions about men’s reproductive health issues contribute to the behavior being promoted?

Developing a Plan

After careful analysis of the selected health problem, target audience(s), and available resources, the second step is to develop a plan. The plan should include the key behaviors

targeted for change and the key messages that promote the desired behavior; targets for changing the knowledge, attitudes, and practices that contribute to that behavior (and messages and information that address those factors); activities that will be used to deliver those messages; and the communication materials needed to support this work.

Developing Key Messages, Activities, and Support Materials

Once the target audience has been selected and its characteristics, needs, attitudes, and level of understanding have been assessed, key messages should be developed. These messages should address the main behavior identified during audience research. If staff have little or no experience with health communication, materials development, or marketing, the program would benefit from outside assistance, if possible.

While the messages are being determined, staff should also be researching the most appropriate information channels (see below) to convey these messages to this particular target population. Only then do the staff members begin designing actual support materials.

Regardless of the medium selected (print, audio, live performance/video), it is important to follow good health communication guidelines when developing messages. Specifically, the messages should:

- Be audience-specific.
- Be culturally sensitive.
- Use language that appeals to the audience.
- Include images that appeal to the audience (pretesting is essential).
- Be as simple as possible, with concepts the audience understands.
- Be realistic and feasible for the intended audience.
- Be positive (stressing what to do, instead of what not to do).
- Be action-oriented (what to do, not just what to know).
- Be “sex-positive” (portraying sex in a positive light, rather than giving punitive messages about engaging in sexual behaviors that put people at risk for STIs).

In addition, those creating the messages should be aware of specific issues dealing with men and reproductive health:

- Messages should not say or imply anything negative about men.
- Messages should respect men and women as equal partners and should not stereotype either sex.
- Men sometimes know less about reproduction, anatomy, and contraception than women. Men may also require more education than women, which should be delivered in ways that don’t highlight their ignorance.
- Men may have less interest in contraception and more interest in disease prevention than women; therefore, both issues should be addressed when discussing condom use.
- Even within the same cultural group, men may hold different misconceptions and myths about health than women.

Pretesting and Revising

Pretesting is a necessary step in program development, materials development, and marketing. Pretesting is essential since it helps ensure that information materials and activities are culturally appropriate, relevant to clients' concerns, and presented in familiar language and at an educational level that clients can understand.

Pretesting can be conducted in a variety of ways—for example, through focus groups; structured, in-depth interviews; or interviews with members of the target audience at a common gathering place, such as a facility waiting room, sporting event, barbershop, or bar. Managers should plan sufficient time for several rounds of pretesting. Elements that require pretesting include illustrations, text, layout, size, color, and sequence (for printed materials) and script, recorded voices, music, images, costumes, and any text (for live performances and slide programs, videos, films, radio or other audio productions). The comprehension (either spoken or written), vocabulary preferences, and cultural acceptability of messages should be assessed, as well.

Once pretest results have been collected, the messages, materials, and activities are revised as needed. If revisions are extensive, another round of pretesting may be required. In addition to pretesting with the target audience, service providers and appropriate gatekeepers should review the materials.

Implementation

Implementation may begin as soon as the information activities and materials have been revised and finalized. This phase involves such tasks as training staff, producing an adequate supply of materials for service sites, establishing an efficient reordering system, scheduling broadcasts and events in a cost-effective way and at times that are most convenient for the target audience, and providing audiovisual equipment and training to service sites. All activities should be monitored and supervised throughout this stage to ensure that the objectives are being achieved and the target audiences are being reached.

Assessment

The final step is to review the program and to use that assessment to decide on future activities. Information programs are cyclical in nature, so the steps presented above should be repeated in response to the changing needs of the audiences and the environment.

Information Channels

Clients acquire information by hearing or seeing it expressed in different ways at different times. They listen to friends, neighbors, health care workers, and community leaders. If they are literate, they may read pamphlets, magazines, and newspapers. If they are low-literate or illiterate, they may ask other people to read material to them. They may also watch television or listen to the radio, see poster and billboard displays, or attend information sessions at health care centers and in their communities. Because people obtain information from so many different sources and because they learn by hearing and reading messages over and over again, it generally is more effective to use a combination of information channels than to rely on only one.

Before one chooses the channels to be used, it is essential to define the target audience and to identify the objectives and messages of the information program. A particular channel should be selected because it is an effective and efficient way to reach the audience and accomplish the program's goals. Mass-media messages, for example, raise awareness but do not necessarily in themselves lead to behavior change. Such messages need to be reinforced through other channels, such as written materials and one-on-one communication with providers or peers.

Planners should also consider how to evaluate the effectiveness and costs of particular information channels. For example, a very inexpensive form of assessment may consist of asking each new male client how he heard about the men's reproductive health program. All information channels have costs associated with them—for example, salaries or time away from other tasks for staff involved, fees for outside experts, and costs for paper, ink, photography, videotape, or air time. The costs of using a particular channel must be weighed against its effectiveness in disseminating information to potential clients.

Marketing Concepts

Certain marketing concepts are useful to keep in mind when designing messages and materials to promote men's reproductive health services. For example:

- What is the **product** (service) you are offering? Consider not only the service itself, but also knowledge and self-awareness, health (of men, partners, children), better ability to provide for one's family, the chance of a more satisfying sexual relationship, and more "modern," smaller families.
- Who is the **person** to whom the service is being offered? What kind of person is he, and what are his life circumstances? Should certain people use or not use this service?
- What is the **place** where the message will be delivered? Where will the men receive messages (from what source, and through what channels—for example, at home, work, school, community centers, and religious, cultural, and social events). Location has implications for the form of the message (e.g., written, word of mouth, broadcast).
- What is the **price** to the client? How will he pay for it? Are special provisions made for low-income men?

Some additional tips for marketing your program include the following:

- Consistency is important: The name of the facility, its appearance, the services it offers, the way it operates, the ways it is promoted to the public, and the actual messages and materials used should all be consistent. Repetition and consistency may appear boring to those working within the facility, but they are very effective in establishing a clear image of the program in the public mind.
- Remember to include such basic information as the facility's location, hours, and telephone numbers, if any. If broadcast media coverage of a men's topic is anticipated, be sure that the broadcast station has relevant information for referral of those individuals who want more information or services.
- Use marketing techniques creatively to get attention without spending a lot of money on advertising. Examples include simple flyers or brochures to hand out or post on public bulletin boards and at bus stops, client-information cards listing services, placards on

vehicles, signboards, pamphlets that can be placed in waiting rooms of outside referring service providers, letters to newspaper or magazine columns, and the distribution of condoms and men's service information at barbershops, bars, sporting events, parades, fairs, and other public events.

- Seek information on successful ways that others have promoted men's services, and adapt their ideas to your own situation.
- Materials that encourage word-of-mouth communication (such as "Tell a friend...") provide added value.
- A well-publicized contest for the design of promotional materials (e.g., posters) with awards and publicity for the contest winner(s) can enlist the creative energies of local artists. Such a contest also can increase program awareness as contestants are being sought and gain publicity through media coverage of the contest results and award ceremony.
- Materials that are used and seen repeatedly can reinforce messages. Examples include client information cards (to be kept in a wallet); items of clothing, such as T-shirts, hats, and scarves; shopping bags; small magnets; and pencils, pens, and drinking mugs inscribed with facility information.
- Community-theater troupes and indigenous entertainers have successfully been involved in promoting men's reproductive health in a number of communities.
- Messages delivered by prominent persons or professionals carry authority and establish the legitimacy of a program. On the other hand, the message "Try this—it worked for me" is more effective when delivered by someone who resembles the message recipient closely in background and personal characteristics.
- Internet-based communication about men's reproductive health has the potential for delivering both authoritative and personally persuasive messages.