

**SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH:
FAMILY PLANNING PROGRAM**

**CLIENT EDUCATION &
PREGNANCY COUNSELING PROTOCOLS**

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California Family Health Council, Inc.
Title X Guidelines

FAMILY PLANNING PROGRAM
MATERNAL & CHILD HEALTH DIVISION
COMMUNITY HEALTH NETWORK
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
CITY AND COUNTY OF SAN FRANCISCO

NURSE MANAGERS' ACKNOWLEDGEMENT

The following Nurse Managers have acknowledged receipt and review of the Standardized Procedures which are contained herein:

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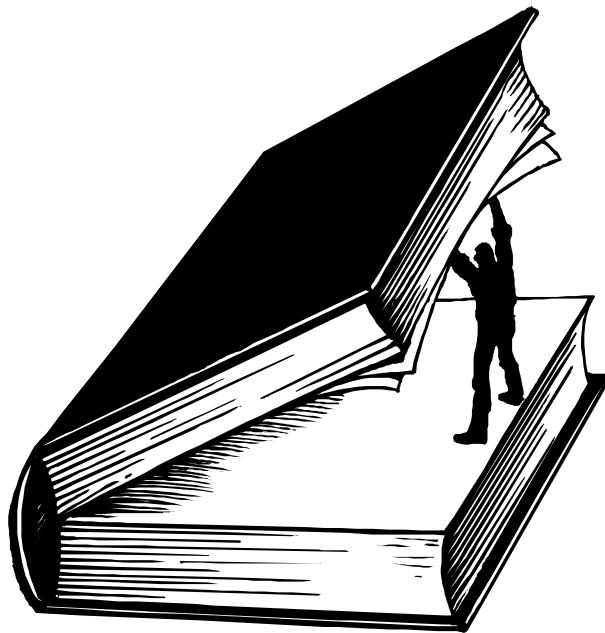
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I: INTRODUCTION



A. Guidelines for Using these Protocols

1. Who Should Read this Document

This document is designed to serve as a guideline for the training and evaluation of all family planning program staff involved in providing education and counseling services. The guidelines and protocols contained herein ensure that family planning staff members:

1. Are knowledgeable about the information that they are expected to provide to clients;
2. Have specific guidelines as to the process and content of client education.

2. How to Use this Document

Document Sections are divided between those that:

1. *Describe FamilyPACT and Title X Regulations* that should be reviewed by all staff members who are providing family planning services, regardless of past training or experience;
2. *Provide general guidelines for counseling and education processes* related to particular topics or client groups (e.g., counseling adolescents, discussing domestic violence, educating clients about sexual response). These “overviews” were written for staff members who have little or no experience working with clients in these specific areas. Please note, however, that they are not meant to serve as substitutes for training in these subjects.
3. *Provide information on and education/assessment/counseling guidelines and tools for non-family planning related topics that Title X requires delegate agencies to discuss with clients.* These should be reviewed whenever staff members have particular questions about or are unsure of how to proceed in a particular information area.
4. *Provide information and education/counseling guidelines* specific to contraception and STI testing and treatment. These guidelines conform to Title X regulations and Family Planning Medical protocols. Whenever these sections are updated, they should be reviewed by all staff members, regardless of training or experience.

3. Other notes

Although the words “her” and “she” are used for ease of the reader, information provided in the protocols also applies to male clients as relevant.

B. Training Requirements

DPH staff members who are providing family planning education and counseling services *must be prepared to discuss with clients all of the following topics within the context/boundaries of their job description* (please refer to individual topic areas in this protocol for detailed information):

1. Adults & Adolescents

- Description of services and clinic procedures
- Instructions for breast or testicular self-exam
- Reproductive anatomy and physiology,
- Contraceptive method options
- STI/HIV prevention
- Preventive health care (as per client interest), including drug and alcohol abuse, smoking cessation, nutrition, exercise
- Preconception health and pregnancy planning
- Psychosocial issues, including partner relationship and communication, asset recognition, risk-reduction and decision-making

2. Adolescents

- Abstinence
- Confidentiality & Ability to Consent to Treatment
- Parental Involvement
- Coercive Sex

3. Recommended Training

In order to be able to fulfilling this obligation, the following training is recommended for all staff members who are new to the family planning field as applicable to their job descriptions:

- Family PACT registration / eligibility / billing paperwork & customer service;
- Family Planning medical, education and counseling protocols and Family PACT / Title X regulations regarding the same;
- Pregnancy counseling and testing;
- Cultural competency;
- Adolescent development & youth service provision;
- Provision of counseling and education on the following topics: family planning / contraception, STIs, HIV, sexual and reproductive health
- Provision of the following medical services: family planning / contraception, STIs, HIV, sexual and reproductive health
- Provision of outreach services on the following topics: family planning / contraception, STIs, HIV, sexual and reproductive health
- Domestic violence / partner abuse screening and referral;
- Applicable clinic emergency management plans and procedures;
- Employee management issues.

**II. GENERAL TITLE X & FAMILY PACT
REGULATIONS REGARDING
CLIENT EDUCATION AND COUNSELING**

A. Goals of the Education Process

In accordance with California Department of Health Services Family P.A.C.T. (Planning, Access, Care & Treatment) Standards and Federal Title X Guidelines, the goals of the education process are to provide clients with the information needed to:

1. Make informed decisions about family planning;
2. Use specific methods of contraception and identify adverse effects;
3. Perform breast/testicular self-examinations;
4. Reduce risk of transmission of STIs and HIV;
5. Understand the range of services available and the purposes and sequence of clinic procedures;
6. Understand the importance of recommended screening tests and other procedures involved in the family planning visit

B. Required Education and Counseling Topics

I. Introduction

Title X Guidelines require that clients receive information and counseling on the topics below.

2. Adults & Adolescents

- Please see individual topics (listed in the table of contents) for detailed descriptions of each area:
- Description of services and clinic procedures
- Instructions for breast or testicular self-exam
- Reproductive anatomy and physiology,
- Contraceptive method options
- STI/HIV prevention
- Preventive health care (as per client interest), including drug and alcohol abuse, smoking cessation, nutrition, exercise
- Preconception health and pregnancy planning
- Psychosocial issues, including partner relationship and communication, asset recognition, risk-reduction and decision-making

3. Adolescents

- Title X requires that additional subjects be covered when working with adolescents. Please see *Section IV. Special Considerations when Working with Adolescent* for detailed instructions:
- Abstinence
- Confidentiality & Ability to Consent to Treatment
- Parental Involvement
- Coercive Sex

C. Confidentiality

1. Introduction

All family planning services must be provided in accordance with the SFDPH Notice of Privacy Practices, available online at <http://www.sfdph.org/InsideDPH/HIPAA/HIPAAsumNotice.htm>. This requires that all personal client information be treated as privileged communication and held confidential. It should not be divulged without the client's prior written consent, except as required by law.

2. Practical suggestions for ensuring confidentiality:

- a. **SIGN-IN:** If you must use a sign-in sheet, minimize others' ability to read the list, for instance by utilizing individual sign-in cards which a client can fill out and then give to the receptionist.
- b. **NAME:** When addressing a client in the waiting room, use only her first name. Never use titles like Miss, Mrs. or Senora.
- c. **SETTING:** Provide a private setting for interviewing and counseling clients.
- d. **VOICE:** Use a quiet, conversational tone of voice when speaking with or about your client.
- e. **RECORDING:** Record only that information which is necessary for the client's medical record.
- f. **CHARTS:** Secure charts and notes rather than placing them where others might read them. Consider files to be "off limits" unless involved in a specific filing task.
- g. **PRIVACY:** Keep information about clients to yourself. If approached by a client in public, be discreet about her visit to the clinic.
- h. **PARTNERS:** If a client is accompanied by a partner, call the client first and then ask her confidentially if she would like to include the other person in the education session. Even if she asks to include her partner, set aside some time during the session where you are working only with her.
- i. **COMMON SENSE:** When in doubt, use common sense and good manners.

3. Youth Confidentiality Issues

Please see Section IV: "Guidelines for Counseling & Educating Adolescents."

D. Informed Consent

1. Definition:

In the case of family planning services, informed consent is a client's agreement to any procedure or service after having been informed of all the benefits and risks involved, as well as all available alternatives. This requires that no client be in any way coerced to accept particular methods or procedures, or otherwise participate in family planning services.

2. Title X and FamilyPACT Requires that:

- a. Clients be informed/educated verbally in a language that they understand;
- b. Clients be informed/educated through an interactive process during which the client is encouraged to ask questions;
- c. This verbal process be supplemented with linguistically and educationally appropriate *written materials*;
- d. All written consents (required for primary contraceptive method) be maintained in the client's file and updated as needed.
- e. Clients be assured that they have the freedom to withdraw their consent at any time.

3. Informed Consent is Required for:

- a. The process of eligibility determination;
- b. Enrollment in Family PACT;
- c. Primary birth control method and all prescription contraceptive methods used by the client;
- d. All invasive procedures;
- e. All sterilization procedures (State and Federal Consent forms required – See *Addendum 1, Forms: Method Consents*)

4. Additional Requirements:

A copy of the California Department of Health Services *Family Planning Patient Rights* statement should either be provided to clients or posted prominently within the clinic wherever family planning services are provided (please see *Addendum 4, Forms: Consent and Confidentiality*.)

Consent is required *only from the individual client receiving family planning services*. This includes minors who have the legal right to self-consent for pregnancy related services.

E. Linguistic and Cultural Competency

1. General Guidelines (Title X)

- All services and materials must be provided in a culturally sensitive manner and communicated in a language understood by the client.
- Each Title X Delegate Agency should make available educational and counseling materials, including standard consent forms, in all primary languages spoken by a minimum of 10% or greater of the clinic's client base. (A wide range of reproductive health materials can be ordered from the MCH Family Planning Program in English, Spanish and Chinese.)
- All Title X Delegate Agencies are expected to provide oral translation services whenever possible if counseling services and written materials are not available in the client's preferred/primary language.

2. When Providing Services in a Language in Which Clients Aren't Fluent:

- Use visual aides as much as possible;
- Use simple vocabulary and sentence structure;
- Check repeatedly with the client to ensure their understanding;
- Do not give the client the impression that she is the problem for the difficulty in communicating.

3. Personal and Cultural Values and Reproductive Choice

Both cultures and families vary widely in the values and beliefs that affect their reproductive lives. Family Planning staff should learn about the personal and cultural values that influence their client's lives:

- What is the ideal family size?
- Who makes sexual decisions?
- What is a desirable marriage age?
- How is same-gender sexuality regarded and handled?
- How does the client understand the causes of illness?
- Who are the highly respected healers in her community (e.g., doctors, herbalists, midwives)?
- What is safe to tell the care-giver?
- Is the general communication style direct or indirect? Formal or informal?

F. Documentation

1. Family PACT Standards:

- Medical record documentation must reflect the scope of education and counseling services provided to clients, including but not limited to individual client assessment, topics discussed and name and title of counselor.
- Documentation must support services claimed for reimbursement.

2. The Medical Record as a Legal Document

Keep in mind that the medical record becomes a legal document when used in court as evidence. Thus, when charting, it is essential to follow guidelines established for recording information in the medical record.

3. General Guidelines

Legibility: All information written in the medical record should be neat and legible.

Brevity: All information recorded should be short and to the point. Avoid unnecessary words.

Accuracy: All recordings must be specific and complete. This is especially important for information required by OFP, Family Pact, and local guidelines and protocols. If significant information is omitted, the record will be inaccurate.

Correct Spelling: Two medications may have similar spellings but be quite different. If the medication given is incorrect, the record will be inaccurate. If you do not know how to spell a word, look it up.

Signature: The person making an entry in the chart must sign the chart with one initial, the legal last name and abbreviated title or position.

Erasures/Correcting Mistakes: DO NOT ERASE! Do not use white-out or try to cover the mistake by scratching it out. When correcting an error, draw a single line through the mistake. Write "ERROR" above the mistake and sign. Example:

ERROR, S. Michaels, M.D.

IUD inserted.

Return to clinic for IUD insertion during next menstrual period. S. Michaels, M.D.

If a paragraph needs to be corrected, draw a line across the entire paragraph, write "ERROR," and sign. If an entire page needs correction, place the page in the back, draw a line across the entire page, write "ERROR," and sign. Place the original page in the back of the chart, fill out a new page and get signatures exactly as they were on the original page with mistakes.

No Blank Lines: Leave no blank lines on the chart. Information must be recorded chronologically and on consecutive lines. If an entry does not use an entire line, a straight line should be made to the end of line. By doing this, information cannot be charted in blank spaces. The person signing is legally responsible for any information written between their own signature and the signature above theirs.

Use Ink: Always use ink when writing in a chart. Never use a pencil, as it does not provide a permanent record. Some clinics may also indicate a particular color of ink, particularly for photocopying & faxing purposes.

Write All Entries after Procedure: Write entries in the record ONLY after a procedure has been done, information covered, or decision has been made and not before. All entries should be written in past (or with directions present), not future tense.

New Pages: Always fill out headings completely for each new page added to a chart. Make sure that the client's name and chart number are on each new page. When you reach the bottom of a page, insert a new sheet.

Learn the Medical History Form: Familiarizing yourself with this form is the first step in obtaining a complete medical history. When you come across unfamiliar names or abbreviations, look up the terms in a medical glossary or ask a clinician its meaning. Then decide how best to translate the term for clients.

Terminology: Use correct medical terms and abbreviations. If you are not sure of the medical term or abbreviation, research it. Medical history forms use terms not normally used by a layperson. These terms may be medical words describing a condition or abbreviations of several words. During the interview, make sure that the client understands all of the medical terms used or her/his response may not be accurate.

Common Medical Abbreviations: Please see chart, Appendix 4, Page183.

III. GUIDELINES FOR EFFECTIVE COUNSELING AND EDUCATION

A. Principles of Effective Client Education

1. Maintain a warm and pleasant attitude to allay client anxieties and encourage sharing of questions and concerns.
2. Ask open-ended questions whenever possible (e.g., “How”, “What” -type questions encourage full responses rather than Yes/No questions).
3. Ask your client if she has any questions.
4. If you don’t know the answer to a question, be honest and try to find the answer.
5. Develop simple explanations for complex health information. (E.G., to explain theoretical vs. use effectiveness state, “98% theoretical effectiveness means that if 100 women use this method perfectly for a year, 2 will still get pregnant. 85% use effectiveness means that of 100 women using this method for a year, 15 actually get pregnant because people don’t all use the method perfectly.”)
6. In answering questions about clinic policy or procedures, explain the reason for the policy. If you aren’t sure of the reason, ask.
7. Be aware of your own values and biases and which clients tend to “push your buttons.” This can help you keep your personal values from interfering with your client’s needs.

B. Client-Centered Education & Counseling

Client Centered Education and Counseling seeks to help people evaluate the world and themselves from their own perspective by providing them with a nondirective environment and unconditional positive regard. In client-centered counseling, the focus is on the client's concerns and interests. Counseling techniques explore the personal meaning a client gives to issues discussed.

All staff involved in providing family planning services should approach interactions with clients through a client-centered approach that includes:

- Respect and empathy for the client
- Good communication skills
- Tolerance for values and beliefs different from one's own
- Unbiased attitudes toward all clients, regardless of circumstances or background
- Comfortable discussing human sexuality
- Unbiased attitudes towards all contraceptive methods
- Technical knowledge and skills

Following the model below will help to ensure a client-centered approach that supports informed consent and makes the best use of both the provider's and client's time:

1. Assess what the client wants to learn.

People only learn what has personal meaning for them. If your client's primary learning needs are not clear, ask her what she is interested in learning about first.

Example: "I'm glad you read the pamphlet on the different methods. Which are you most interested in?"

Example: "You seem fairly worried about AIDS. Is there a particular question or worry that you have?"

2. Assess what the client already knows.

Save both you and your client time by not giving her information she already has. Similarly, don't assume your client already knows basic information about her body or her method of birth control. Ask her what she knows about a particular topic you plan to discuss.

Example: "Can you tell me what danger signs to look for when you're on the pill, Shirley?"

Example: "Have you ever noticed that your vaginal discharge changes? How does it seem?"

3. Involve the client in her own learning process.

Allow her to explain how she'll use her method; ask her what experiences she has had with that method and what obstacles she anticipates in using such a method, etc. The more the client participates in the education process, the more she will retain.

Example: "What difficulties do you think you'll face in using this method?"

Example: "Would you prefer the pamphlet in English or Spanish?"

4. Use visual aids.

Many people learn best visually; others learn best audibly (by listening). Pelvic models, sample birth control kits, pamphlets, and diagrams should be routinely available for the initial education process. Posters, films, slide-tapes, and other audio-visuals further augment the learning process. Allowing the client to try out the demonstration model herself further enhances her learning.

Example: “Here, you try to slip the diaphragm in.”

Example: “You can see here where the IUD goes.”

5. Assess what the client has learned.

Give the client an opportunity to repeat or demonstrate what she has learned, either throughout or at the end of the education process. This not only helps you assess whether the client has learned the essential information, but also reinforces her new knowledge or skill.

Example: “So when would you say you ovulated in your last cycle?”

Example: “I want to make sure I’ve done my job. Can you tell me the danger signs for the pill?”

C. Clients with Special Needs

1. Introduction

In order to effectively educate ALL of our clients, we must be prepared to meet their special learning needs. Assessing the special needs of a client requires skill and candor (e.g., sometimes asking in a direct or nonjudgmental way about a client's circumstances or concerns).

Keep in mind that assessing special needs over the telephone may be tricky. For example, a client who asks you to repeat information several times or who seems to be distracted or on drugs may in fact have a learning disability and be attempting to act independently.

2. Clients with Limited English Speaking Ability...

- May need simplified explanations, an interpreter, written materials in their own language, and/or a referral to an agency where staff speak their language.
- Check repeatedly with the client for understanding.
- Do not give the client the impression that she is the problem for the difficulty in communicating.

3. Clients with Limited Reading Skills

Many clients have limited reading skills. However, few will inform a health care provider if reading presents them with problems due to the stigma attached to being a non-reader. Therefore it is doubly important for staff to be aware of and sensitive to this possibility. The following are tips for working with low or non-readers:

- Have on hand materials written at a variety of reading levels in various languages;
- Pay special attention to how a client responds to the written materials you provide. Add additional materials if those you first give seem to be too difficult for the client to read;
- Make extensive use of simple, realistic-looking diagrams and models;
- When discussing over-the-counter products (e.g., contraceptive creams) show clients sample boxes; many non-readers become experts at negotiating a reading world by memorizing the look of objects, etc.

4. Clients with Disabilities

When working with disabled clients, keep the following in mind:

1. Many cultures and societies try to “de-sex” people with disabilities, which can have a profound impact on disabled clients' ability to take care of their sexual health.
2. As with their non-disabled peers, experiences and attitudes will vary among clients who have disabilities.

Below are some brief tips for working with disabled clients. For more information about this topic, please refer to the Sex Education and Information Council of the U.S. (SEICUS) Annotated Bibliography on Sexuality and Disability at <http://www.siecus.org/pubs/biblio/bibs0009.html> or visit the Center for Women with Disabilities at <http://www.bcm.edu/crowd/index.htm>.

a. Learning Disabled

- Use very simple explanations;
- Repeat crucial information several times;
- Recognize that may have difficulty using certain methods (e.g., diaphragm);
- Remember that may not be able to read pamphlets or directions;

- It is important to have the client repeat back information.
- b. Hearing Disabled
- May need a sign language interpreter;
 - May need a private setting where you can speak very loudly without causing undue attention;
 - May need extensive written materials;
 - Use videos, slides, models and other visuals extensively.
- c. Visually disabled
- May need repeated verbal explanations
 - Need a chance to feel various models/instruments, etc.
 - Need materials in Braille
 - May need assistance getting onto exam table, through clinic, etc.
 - May need assistance filling out forms
- d. Physically disabled
- Need information about access to building when making appointment
 - Clients in wheelchairs will need access to a lavatory with a wide door and rails
 - May need two people to assist her onto exam table

**IV. GUIDELINES FOR
COUNSELING & EDUCATING ADOLESCENTS**

A. Working Effectively with Adolescents

1. Adolescent Development & Family Planning Concerns

Please Refer to Appendix 1, Page 180, for a complete Adolescent Development Chart.

- Changes in thinking patterns: Adolescence is a time of rapid emotional and mental, as well as physical growth. Young adolescents (age 11-13 or older) still have the abstract thinking capacity of children. Older adolescents (\geq age 16) are often thinking much like adults.
- Time constraints: You may have only minutes to ascertain whether a 14 year-old is thinking more like a child or an adult and to gear the counseling session accordingly.
- Mid-adolescence: Many adolescents become sexually active while they are still in mid-adolescence, generally between the ages of 13–15. Briefly, this stage is characterized by:
 - a. Concrete thinking, oriented to the “here and now;”
 - b. Intense peer involvement, particularly around issues such as sexuality;
 - c. Idealized and romanticized first-love relationships

2. Taking Young People’s Developmental Needs into Account

All methods of birth control require some ability to plan ahead, a skill that is usually only acquired in later adolescence. To successfully protect themselves from STIs and unintended pregnancy, young people will need to practice these skills with the educator/counselor.

- Concrete thinking: Be respectful of concrete thinking by asking questions like:
 - a. Exactly where would you keep your pills?
 - b. What do you do everyday that you can use to remind yourself to take your pills?
- Peer involvement: Use peer involvement:
 - a. Do you have any friends who take the pill? What do they say about them?
- Romanticized relationships: Help young people assess their relationships more realistically:
 - a. I know it’s hard to imagine that Mike might have an STD, but it happens.
 - b. I’d like to keep you safe. Love never protected anyone from infection

3. The HEADSSS Counseling Model

IN addition to the above guidelines, it is important to remember that youth are often at higher risk for health problems such as eating disorders, substance abuse, and depression, all of which can influence choices related to reproductive health. Asking questions using the HEEADSSS model, family planning staff can quickly cover all of the basics when counseling youth:

- H** = Home
- E** = Education/employment
- E** = Exercise/Eating
- A** = Activities
- D** = Drugs/Depression
- S** = Suicidality
- S** = Sexuality
- S** = Safety

B. Abstinence

1. Title X Requirements

Title X requires that all Family Planning providers discuss abstinence with their minor clients, regardless of whether or not these clients request information on this topic. Some providers fear that discussing abstinence may create mistrust. However, it is not uncommon for youth to attend a family planning clinic in order to get help deciding whether or not to become sexually active or to feel ambivalent about their sexually activity.

2. Beginning the Discussion

The following questions are designed to help to address abstinence in a trust-building manner:

1. Is the client already having sex?
2. Does she plan to have sex in advance or does it “just happen”?
3. What circumstances normally lead up to intercourse?
4. Does she like or enjoy sex when she has it?
5. Does she have friends who are choosing not to have sex?
6. What are the benefits and drawbacks of her having or not having intercourse?

3. If a Client Feels Ambivalent about Having Sex

If a client feels ambivalent about having sex, allow her to explore any conflicting feelings she may have about sexual activity. The following information may be helpful:

1. About half of all people decide not to have sex while they are still in high school.
2. Stress that she has the right to say no to sex whenever and with whomever she wishes, even with someone she has had sex with in the past.
3. Educate her about the sexual response cycle and explore her feelings about alternatives to intercourse (i.e., heavy petting, masturbation).
4. Discuss the importance of communication within a relationship; review & practice communication skills (please see *Addendum 11: Client Education Materials* for a sample handout).

5. Abstinence as a Contraceptive Method

Please refer to *Section IX. Birth Control Methods*.

C. Parental Involvement

1. Introduction

- Minor clients have the legal right in California to consent to reproductive health care without parental notification/involvement (see SFDPH Policy, “Consent for Dependent Minors (Ages 12 – 17): Urgent, Primary Care and Behavioral Health Services”).
- Title X guidelines state that “counselors should encourage family participation in the decision of minors to seek family planning services.”

2. When Discussing Parental Involvement, Remember:

- a. *Confidentiality* is extremely important for adolescents; studies show that teens will forgo or delay seeking reproductive health care if they think that their parents might be notified. (Please refer to Youth Confidentiality Handouts, Appendix 14 on page 197.)
- b. *Most youth (60-80%) communicate with parents/guardians* about sexual activity. Those youth who do not often avoid doing so due to well-founded fears of parental abuse or other severe consequences (i.e., being kicked out of their homes).
- c. *Parents and guardians play an important role* in their children’s lives. Teens who have close, warm relationships with their parents/guardians have lower rates of sexual activity and higher rates of protection from unplanned pregnancy and STIs

2. Questions for Encouraging Parent-Child Communication

Before beginning this discussion, emphasize that all family planning services are confidential.

- a. Does the teen’s parent(s) or guardian(s) know she is sexually active?
- b. Are her parent(s)’ feelings about it important to her?
- c. What would her parent(s) say/do if they knew she was sexually active?
- d. Would she like to explore ways to bring the subject up with her parent(s) / guardian(s)?
- e. If not, are there other adults with whom she can talk?
- f. If she became pregnant, would she rely on her parent(s) or guardian(s) for helping her carry out her decision regarding her pregnancy?

3. What to Do When a Parent is Present

Provide the client with a confidential space in which to discuss sensitive issues alone. Make this “separation” non-traumatic for both parent and child by following these steps:

- a. *Lay out the course of the visit and your clinic policy.* (Please refer to Youth Confidentiality Handouts, Appendix 14 on page 198.)
- b. For example, “We will spend some time together talking about your daughter’s health history and any concerns you may have, then I will meet with your daughter alone. At the end of the visit, we will all meet together again to wrap up the visit.”
 - Stress that the daughter has specific legal rights related to consent and confidentiality that you are required by law to uphold. (Please see Addendum 4, Forms: Consent and Confidentiality for a sample handout to give parents on this issue.)
 - Reinforce that this policy applies to ALL adolescents who come to the clinic for family planning services, and is not specific to that parent or guardian’s child.

- Validate the parent’s role in supporting her daughter’s health and well-being.
 - Address any questions or concerns that the parent or guardian might have.
 - Direct all questions and discussions to the youth during the “joint” portions of the visit.
- c. Separate the parent and child. Invite the parent to have a seat in the waiting area. Assure her that you will call her back prior to the end of the visit.
- d. Revisit with the client all issues covered in the initial portion of the visit:
- Consent and confidentiality, including when confidentiality must be breached.
 - Areas of parental concern - get the youth’s perspective.
 - Fill out the medical history form.
 - Review what will happen during the medical exam; ascertain whether or not the youth would like her parent/guardian present during the procedure.
 - At the end of the visit, clarify what information the youth is comfortable sharing with the parent
- e. Reunite the parent back to close the visit with both parent and youth.

D. Coercive Sexual Activity

Title X Guidelines (Section 8.7, Minor Services) require that all adolescent clients be counseled on resisting attempts to coerce them into engaging in sexual activities.

1. Definition

Creating a feeling, situation or atmosphere where emotional and/or physical control leads to:

- Sexual abuse or rape;
- The object feeling as though s/he has no choice but to submit to the “controlling” party.

2. Warning Signs of Possible Sexual Coercion

While these following may have many causes, screen for sexual coercion with youth who:

- Are reluctant, visibly uncomfortable or upset with discussions of sexual activity
- Appear despondent or depressed for no discernable reason
- Are overly anxious
- Avoid the physical/pelvic exam
- Are extraordinarily worried about confidentiality
- Are nervous about partner in the waiting room
- Do not seem to be able to consent to treatment or return for appointments

3. Assessing Potential Sexual Coercion

1. How did you and your partner meet? (If they met through high-risk activity like a drinking party, discuss other risk factors involved.)
2. Does your parent/guardian know you are seeing this person? What does your parent / guardian think of your partner? (These questions provides context for relationship.)
3. Do you feel they respect you for who you already are? Do you respect them?
4. What do you usually do together when you see your partner? If it’s mainly for sex, do you ever do anything else together? Do they show interest in more than one aspect of your life?
5. When you have sex, is it usually because: a) your partner wants to; b) you want to or: c) you both want to?
6. Have you ever had sex when you haven’t wanted to do so? What were the circumstances?

4. Helping Clients Avoid Sexually Coercive Situations

Young Women

- a. **Know your sexual intentions and limits.** Understanding what you want before finding yourself in a sexual situation will help you communicate your intentions clearly.
- b. **Know your rights!** You have the right to say NO to any unwanted sexual contact, to change your mind in the middle of a sexual encounter, and to refuse to have sex with someone you have previously had sex with.
- c. **Don't assume your partner can read your mind** or will “get the message” without your having to say what you are feeling.

- d. **Clearly communicate your wants and expectations.** Tell the person you are with how far you want to go, what you want and don't want to do, and when you want to stop. Say "NO" like you mean it. Avoid giving mixed messages by backing up your words with your body language. If you are uncertain about what you want, ask your partner to respect your feelings until you figure it out.
- e. **Be careful in "yellow light" situations.** Some people think that drinking heavily, wearing "sexy" clothes, or agreeing to be alone with them indicate a willingness to have sex. Strongly communicate your limits and intentions in such situations.
- f. **"Trust your gut!"** If you start to feel uncomfortable or unsafe in a situation, listen to your feelings and act on them; get out of the situation as soon as possible.
- g. **Don't be afraid to ask for help or make a scene!** If you feel threatened, let the other person know how you feel and get out of the situation, even if it's awkward and even if you embarrass or hurt the other person's feelings.
- h. **Be especially careful when drugs or alcohol are involved.** Substances can make you less aware of danger signs and less able to communicate clearly.
- i. **Go to parties or clubs with friends you can trust and agree to look out for each other.** Leave parties with people you know. Don't leave alone or with someone you don't know very well.
- j. **Get involved if you think someone else might be in trouble.** If you see someone who seems coercive or who might become a victim, help the person who might get hurt.
- k. **If coerced, remember, it is not your fault!**

Young Men

- a. **Know your sexual intentions and limits.** Waiting to have sex until you are ready to deal with emotional, contraceptive, and health needs (like STIs) will put you in greater control of your own life.
- b. **Be your own person.** Being true to yourself makes you more of a man, not less of one. Don't let friends, girlfriends/boyfriends or older relatives pressure you into having sex.
- c. **Talk honestly with your partners about sex, contraception, and STI prevention.** Taking as much responsibility as your partner does gives you more control.
- d. **Listen carefully to your partner.** If s/he says "NO," or their body language tells you s/he is unsure or unwilling, stop. If your partner was willing at first, but then doesn't want to go any further, stop. Doing otherwise may legally be considered rape.
- e. **Check in if you are getting a "mixed message."** If you are not sure what your partner wants, don't use threats or force. Stop and ask.
- f. **Don't assume you know what another person wants.** Just because someone gets drunk, wears "sexy" clothes, or agrees to be alone with you, doesn't mean that s/he wants to have sex. Don't assume that just because someone has had sex with you before, s/he is willing to have sex with you again. Don't assume that when a partner says "yes" to kissing or other touching, s/he is willing to have intercourse.

- g. **Be aware of situations where you may be committing rape or sexual assault!** You may be considered guilty of these crimes if you have sex with someone who is high or drunk, passed out, asleep, unable to say "no," or too "out of it" to know what's going on.
- h. **Resist peer pressure to do things you don't want to do.** Don't participate in violent or criminal acts or get involved in any activity that makes you feel uncomfortable. Don't ever "join in" or "go along" with people who are abusing another person.
- i. **"Get involved" if you think someone else might be in trouble.** If you see someone who seems coercive or who might become a victim, help the person who might get hurt.

Special Issues for Young Gay, Bisexual, Queer and Questioning (GBQQ) Men

- a. **Being gay, bi or queer** doesn't mean you must have sex and sex is not the only way to connect to the gay community;
- b. **Remember your rights & speak up!** You have the right to say "NO" to anything that feels uncomfortable, unsafe, or that you don't want to do. This won't make you less desirable or "less gay."
- c. **It's OK to not know what you're doing in sexual situations;** the myth is that "real men" are "born knowing about sex." But in reality, all of us – male or female, gay, straight or bi – have to learn about sex like we do about everything else.
- d. **Don't let a more experienced partner take away your control.** You may feel like you "don't have to know the ropes" with someone who is older or more experienced. But this doesn't mean that you shouldn't express your own wants, needs and concerns.
- e. **Don't trust an older partner** to put your interests over his own – you have the right to protect yourself emotionally, physically and health-wise.

4. Discussing "Date Rape" Drugs

a. What they are:

Certain drugs (e.g., Rohypnol, GHB, and Ketamine) are called "Rape Drugs" because they can put people at risk for sexual assault. When hidden in a drink or a cigarette, they may be undetectable. However, they are powerful and dangerous and may even result in death.

b. Suggestions for Protecting Oneself:

- Don't accept drinks or cigarettes offered by people you don't know.
- Don't drink beverages that you did not open yourself.
- Don't share or exchange drinks with anyone.
- Don't take a drink from a punch bowl or a container that is being passed around.
- If possible, bring your own drinks to parties.
- If someone offers you a drink from the bar at a club or party, accompany the person to the bar to order your drink, watch the drink being poured, and carry the drink yourself.
- Don't leave your drink unattended while talking, dancing, using the restroom, or making a phone call.
- If you realize your drink has been left unattended, discard it.
- Don't drink anything that looks or tastes strange (e.g., salty or with too much foam).

- Don't mix drugs and alcohol.
- c. Potential Signs of Having Been Drugged
 - Feeling more intoxicated than usual in response to the amount of alcohol consumed;
 - Waking up very hung over, feeling “fuzzy,” experiencing memory lapse, and being unable to account for a period of time;
 - Remembering taking a drink but being unable to recall what happened for a period of time after consuming the drink;
 - Feeling like you had sex, but being unable to remember part or all of the incident.

5. Reporting Coercive Sexual Activity

Please refer to the next section, “Reporting Physical Abuse/Neglect, Emotional Abuse and Sexual Abuse.”

E. Reporting Neglect, Abuse and Sexual Coercion

1. Reporting Requirements

As “mandated reporters,” all clinic staff members are legally required to report all cases of known and suspected child abuse to either Children’s Emergency Services (Department of Health Services) or law enforcement authorities. The physician-patient privilege and the psychotherapist-patient privilege DO NOT APPLY to the Child Abuse Reporting Law.

You do not have to prove abuse/neglect or know who did it.

2. Definitions

Physical Abuse: Any act, which results in a non-accidental injury, most often severe corporal punishment. This category also includes intentional, deliberate assault –burning, biting, cutting, poking, twisting limbs, or otherwise torturing a child.

- *Physical Indicators:* Accidents, unexplained injuries, injuries unusual for the person’s age group, burns with no evidence of withdrawal, bite marks, distinctively-shaped lacerations, multiple lacerations or abrasions, damage to internal organs.
- *Behavioral Indicators:* Statement from victim, excessive passivity, compliance and fearfulness or excessive aggression, attempts to hide injuries.

Physical Neglect: The negligent treatment or maltreatment of a child by a parent/caretaker under circumstances indicating harm or threatened harm to the child’s health or welfare. California law defines two categories: severe neglect (i.e., failure to thrive in infants) and general neglect. General neglect = negligent failure of a parent/caretaker to provide adequate food, clothing, shelter, medical care or supervision where no physical injury has occurred

Emotional Abuse: Mandated reporters may report suspected emotional abuse. However, they must report suspected cases of severe emotional abuse that would constitute willful cruelty or unjustifiable punishment. There is no universally accepted definition of emotional abuse. However, the following are widely recognized as such:

- Rejecting/denying emotional response (not acknowledging a physical presence, refusing to interact; failing to show affection)
- Degrading (insults, ridicule, name-calling, yelling, public humiliation)
- Terrorizing (inducing extreme fear, coercion by intimidation, threatening violence)
- Isolating (physical confinement, restricting normal contact with others)
- Corrupting/Exploiting (using a person for advantage or profit)

Sexual Abuse: Any act or sexual assault, including: rape, gang rape, incest, sodomy, lewd or lascivious acts on a child under 14 years of age, oral copulation, penetration of genital or anal opening by a foreign object, and child molestation. Any act of sexual exploitation involving an unemancipated minor (age 17 and under), including activities related to pornography and promoting prostitution or sexual exploitation of a minor.

- *Physical Indicators:* STI/genital discharge or infection, physical trauma or irritation to anal/genital area, pain upon urination or defecation, psychosomatic symptoms.
- *Behavioral Indicators:* Withdrawal or clinical depression, overly compliant or aggressive behavior, poor hygiene or excessive bathing, poor social skills, running away, poor school performance or extreme overachiever, substance abuse, fearful of home life, extraordinary fear of one gender or the other, promiscuous behavior, unusual fear of or discomfort

during pelvic exam, unusual level of passivity and disconnection from body during pelvic exam, reluctance to talk about sexual partner.

Reportable Consensual Sexual Activity: Under the Child Abuse and Neglect Reporting Act (Penal Code sections 261.5 and 288) the following must be reported:

- Sexual activity of any kind (not just intercourse) between a client who is under age 14 with a person who is age 14 or older;
- Sexual activity of any kind (not just intercourse) between a client who is 14 or 15 years old and a person who is at least 10 years older.
- Sexual intercourse between a minor who is under age 16 and a partner who is age 21 or older.

3. Child Abuse Reporting Responsibilities

If you reasonably suspect abuse or neglect of an unemancipated youth under age 18, you must make a report to CES (Children’s Emergency Services). CES may or may not investigate the report, depending on their assessment of risk to the teen. Often they will consider teen clients mature enough to protect themselves by leaving a dangerous situation. A report for suspected abuse is required even if you think that nothing will come of the report.

Liability: You are not liable unless it is proved that you knowingly made a false report. However, you can be sued in criminal and civil court for *failing* to make a required report.

If unclear as to whether a case should be reported, call Child Emergency Services for a “telephone consultation” to discuss the case. Document the call in the chart.

To make a report, talk to your supervisor. If she files the report, only one report is needed. However, if your supervisor disagrees with you and you still reasonably suspect that the child is being abused or neglected, you are required by law to report your suspicion. Your employer is forbidden by law to try to stop you from reporting or to punish you for reporting.

Inform the young person who has been abused that you must report: You have no legal obligation to do so. However, in order to establish and maintain client trust, it is imperative to inform unemancipated minor clients - before any interviewing or counseling takes place - of those instances in which you must break confidentiality *and* to inform them if a report is required. (*See sample youth confidentiality handout, Appendix ____.*)

4. What to Do If a Young Person Informs You of Abuse:

- a. *Believe her and affirm her decision* to share with you (e.g., “It must have taken a lot of courage for you to share this information.”).
- c. *Help her explore feelings* about the abuse and about having shared it with another person. Assure the youth that no one has the right to hurt her, and that even if she thinks she might have done something to bring the abuse on, it is not her fault.
- d. *Explain your reporting obligations* as described in the above section.
- e. *Assist the youth in protecting herself:* Identify a friend or relative to stay with; brainstorm an escape route from house to safe place; determine source for counseling support.
- f. *Provide referrals* for counseling and support.

5. What To Do If You Suspect Abuse:

- a. Share with the youth the abuse indicators you have noticed.

“During your exam, I noticed a huge bruise on your arm where it looked like someone grabbed you. Can you tell me what happened?”

“You seemed really uncomfortable during your pelvic exam. What was happening then?”
- b. Open a door to talking about the subject.

“I’m concerned that someone has been hurting you.”

“Does anyone ever ‘bother you’ or ‘mess with you’ in a way that you don’t like?”

“Have you ever had sex against your will?”
- c. *If the client discloses abuse*, follow suggestions outlined above.
- d. *If the client doesn’t disclose abuse*, leave the door open. Examples:

“There are a lot of things that can be difficult or scary to talk about. If you decide later that you’d like to tell me something, call me or come in.”

“You know that you have the right to be safe and that no one has the right to hurt you. If there’s ever any reason you feel like you might want some help, you can talk to me.”
- e. *Provide phone numbers* for local youth shelters. Ask if she has ever received any counseling for abuse. If not, provide referrals.

6. When Past Abuse is Discovered

- *You are required to report when:* 1) the victim is currently less than 18 years of age; 2) the victim is now an adult but there are still minor children in the home of the abuser who you reasonably suspect to be in current danger.
- *You are not required to report when:* the victim is now an adult and the abuse took place when the victim was under 18 years of age, and there are no minor children in the home of the abuser who you reasonably suspect to be in current danger.

7. When a Consensual Relationship Falls Under Abuse Reporting Laws

Please note that you are not legally required to ask a minor client about the age of her sexual partners and that a pregnancy or STI diagnosis by itself does not mandate a child abuse report

Responsibilities when consensual sex is “illegal” due to age considerations:

- You must report, even if the activity was consensual and the relationship seems healthy.
- It is up to the District Attorney’s office to decide whether or not to prosecute. In San Francisco, the DA’s office makes such decisions based on all of the facts surrounding a case which means that prosecution is often not inevitable.

Steps when a client reports “illegal” consensual sexual activity with an older partner:

- a. *If concerned about breaking client trust*, share this with the youth. Allow the client to share feelings about the relationship and your need to report it.
- b. *Explore the client’s comfort with the relationship*. Young women in particular may feel coerced to engage in sex. (See Section IV.D Coercive Sexual Activity.)
- c. *Explore possible sexual abuse/incest* with a person that the client is not mentioning. Studies show that **girls who engage in early sexual activity may have been molested** and so may be in need of protection and mental health counseling.
- d. *If the relationship seems healthy*, let the youth know that you will ask CES to take this into consideration. Let her know that CES and the SF District Attorney may not follow up in such instances.

8. Making a Report

- a. You must give your name (which will be confidential unless a court orders that the information be given). Only private individuals can report anonymously.
- b. If the situation is very serious and you feel that the child is in immediate danger, call Children's Emergency Services or the child abuse reporting line immediately. Call 558-2650 or (800) 856-5553 to initiate the report. This is a 24-hour number. If the case involves sexual abuse, also call Child and Adolescent Sexual Abuse Resource Center (CASARC), 206-8386 (24 hours). County welfare "cross reports" or informs local law enforcement.
- c. You are required to fill out a written report within 36 hours of either learning about the abuse or making the phone report. Use "Suspected Child Abuse Report Form SS8572." Obtain copies of this form from the San Francisco Department of Human Services, 558-2650 or (800) 856-5553, and have them available in your office.

9. Dealing with a Parent Suspected of Abuse

Dealing with a parent who is suspected of abusing or neglecting her child is never easy. Discuss the difficulties in case conference with other members of the health care team. Ask for emotional support, supervision and training in working with difficult families.

**V. CLIENT EDUCATION:
THE FAMILY PLANNING VISIT**

A. Scheduling the Appointment

1. Staff Materials

Preferably schedule the appointments via computer. If computerized scheduling capabilities are not available, staff should have appropriate forms. Information about public transportation and parking will be available.

2. Learning Objectives

- By the end of the appointment scheduling process, the client will be able to state appointment date and time, clinic location, address and phone number.

3. Evaluation of Education Process

- Fewer than 10% of clients express confusion or need further explanation at the end of the appointment process (as observed during evaluation session).

4. Points to Cover

Determine reason for call. Does the client want to make an appointment or just want information? If information only is needed, answer client's questions if they fall within the regular information provided by phone personnel. Otherwise, refer as appropriate.

Inform client of available appointment times and ask her preference. Confirm the date and time of the appointment she chooses.

Inform client:

- Not to come when she is on her menses
- Of the cost of services, if any
- To bring MediCal card, HAP card or other insurance card
- To bring medications
- To bring dates of last two menstrual periods
- Not to douche, use feminine hygiene products, or have intercourse for 24 hours before her appointment
- That her partner is invited to accompany her during the clinic visit, if she desires

Determine appointment needs:

- Assess client's language needs and discuss with client as appropriate.
- If client wants an IUD, Norplant or DMPA shot, schedule accordingly.

Final Points:

- Does she know how to get to the clinic? Provide directions, bus routes, parking instructions as needed
- Remind her to call in advance if she must cancel appointment
- Was all of the information presented clearly?
- Does the client have any other questions?

B. The Registration Process

1. Learning Objectives

Upon completion of the registration process, the client will be able to:

- Complete appropriate clinic informational forms (general consent for services, financial statement, etc.)
- Generally identify the clinic's services
- State the next step in the clinic process (e.g., wait for the nurse to call)

2. Materials

- Appropriate forms, pens and supplies
- Sufficient number of chairs for waiting clients placed far enough away from the registration table to ensure privacy. (Notify supervisor if the seating arrangement is inadequate.)

3. Evaluation of Education Process

- Chart audits show 100% of clients filled out and signed financial and consent forms correctly.

4. Points to Cover

- Explain to client how to complete forms or appropriate sections of forms (e.g., financial statement and consent forms). *NOTE: All minor adolescents are automatically eligible for Family PACT, regardless of parent/family income or insurance.*
- Give client "initial visit" handouts (e.g., Birth Control Methods, Breast Self-Exam, STIs, Emergency Contact information).
- Ask client if she can be contacted by mail or phone at the address and number listed; if not, request a number where a confidential message may be left.
- Ask client if she has any questions about the general consent form. Ensure client signs form.
- Tell client where she'll go next, or where to wait.
- Ask client if she has any questions.

C. The Interview/Education Process

1. Learning Objectives

By the end of the interview process, the client will be able to:

- Describe the clinic procedures performed during the clinic visit ;
- Reiterate two instructional points about each of the topics discussed during the session.

Clients requesting contraception will be able to:

- Name and briefly describe at least two birth control methods;
- Discuss the mode of action, effectiveness, instructions for use, advantages and disadvantages (including major health risks), and danger signs for the method she chooses.

2. Evaluation of Education Process

As noted during direct observation:

- 100% of clients achieve learning objective by end of education session
- 100% of clients are asked at end of education session if they have further questions

3. Staff Materials

- Demonstration birth control “kits”
- Diagrams of male and female reproductive anatomy
- Linguistically & culturally appropriate written materials about BC, STIs/HIV, BSE, TSE
- Necessary forms (i.e., referral, pregnancy test)
- Black ballpoint pen for writing in chart
- Plastic models for demonstrating IUD and diaphragm insertion (if available)

4. Procedure

All topics should be covered as per protocol guidelines:

- a. Ask client about her reason for the visit; address this need first.
- b. Review the client’s medical history and answer any questions she may have. (**Please note** that briefly addressing all topics listed on the Initial/Annual History Form will ensure that you are fulfilling Title X client education and counseling requirements.)
- c. If client is a minor, as appropriate during the session introduce the following and explore in-depth as needed:
 - Confidentiality
 - Parental Involvement
 - Coercive sexual activity
 - Abstinence
- d. If this is an initial visit, discuss as per protocol:
 - Family planning philosophy & benefits of family planning
 - Contraceptive method overview
- e. If this is a return or annual visit:
 - Ask the client about her current method of birth control.
 - Assess her degree of satisfaction with her current method and counsel accordingly.
 - Respond to any questions the client might have regarding birth control.

- f. When client chooses a new method, discuss:
 - Mode of action
 - Effectiveness
 - Instructions for use
 - Advantages and disadvantages (including major health risks)
 - Danger signs
- g. Laboratory tests:
 - Explain to client what is involved in her initial visit, including all potential tests.
 - Ask her if she understands the purpose of each test.
 - Explain any that she does not understand (how test is performed, what the test is for, and if there is a significant false positive or negative result rate).
- h. Before wrapping up the session, ask client if she has any concerns or questions that haven't been covered, including:
 - Reproductive anatomy and physiology
 - Menstrual cycle
 - How fertilization and pregnancy occur
 - Sexual response cycle and sexual satisfaction
 - BSE/TSE
 - STIs/vaginitis
 - HIV/AIDS
 - DES
 - Psychosocial issues including drug/alcohol use and abuse, sexual abuse, domestic violence, and relationship satisfaction
 - General health issues including tobacco use, physical activity/exercise, diet/nutrition and weight management
- i. If client raises concerns that the clinic services either do not address, or that you feel you cannot handle effectively within the context of the education process, refer the client to an appropriate staff member, agency or clinic and document this referral in the chart.
- j. Document all client education in the chart.

D. The Physical Exam: Female

1. Staff Materials

- Exam room stocked according to clinic guidelines (e.g., speculum, cotton swabs, and clinical instruments)
- Mirror, should client wish to view her cervix
- Linguistically & culturally appropriate educational pamphlets, diagrams, brochures, etc.
- Black ballpoint pen for writing in client's chart.

2. Learning Objectives

By the end of the physical exam process, the client will be able to:

- Correctly demonstrate how to perform Breast Self-Exam (BSE)
- Properly insert diaphragm / cervical cap or check IUD string where indicated

3. Evaluation of Education Process

- As measured during direct observation, at least 90% of all clients will meet the objectives.

4. Procedure / Points to Cover

- a. Introduce self to client using name & title. Describe your responsibilities for the client's visit. Be especially reassuring with youth and with clients for whom this is the first full reproductive health exam
- b. Clarify reason for visit and adjust exam plans accordingly; document in chart and on encounter form.
- c. Explain each step of the exam and standard lab tests, including their importance, using lay rather than technical terms. If client declines or defers any of these services, *document in client's medical record.*
 - Height (at initial, then annually after age 40)
 - Weight (at initial, annual, pill and Depo-Provera refill visits)
 - Blood Pressure (at initial, annual, pill refill visits and as indicated)
 - Thyroid palpation for enlargement or nodules (initial and annual)
 - Heart and lung auscultation checks for abnormal sounds (initial and annual)
 - Breast exam checks for dimples, increased venous patterns, orange peel appearance of skin; palpation of breast and axillae checks for lumps, nodules; instruction in performing breast self exam (initial and annual)
 - Abdominal palpation checks for enlargement of liver, masses, pain or tenderness (initial and annual)
 - Lower extremities checks for varicose veins; palpation of calves for tenderness (initial and annual)
 - Pelvic exam, including speculum, bimanual and vaginal exam; this exam to include a Pap smear for cervical cancer and STI exam/tests as indicated.
 - Screening for chlamydia at initial visit and either annually thereafter or when there is a new sex partner
 - Palpation of uterus checks for size, consistency, shape and position; ask client if she would like to view her cervix with a mirror

- Blood taken for hematocrit/hemoglobin (initial, IUD insertion work-up, IUD annual and as indicated)
 - In women >50, rectal-vaginal exam
 - Other procedures as indicated (e.g., pregnancy test, GC culture, VDRL, contraceptive-related, etc.)
- d. Ask client to demonstrate skills covered during the exam such as BSE, diaphragm insertion and removal or checking of IUD string (if applicable). If client appears confused about any aspect of the information covered during the physical exam, check her understanding and review as necessary.
- e. Ask if client has understood all procedures and if she has any questions.
- f. Document all client education in the chart.
- g. Inform “exit interviewer” of any changes in the client’s stated reason for FP visit for billing purposes.

E. The Physical Exam: Male

1. Staff Materials

- Exam room stocked according to clinic guidelines (e.g., cotton swabs, and clinical instruments)
- Linguistically & culturally appropriate educational pamphlets, diagrams, brochures, etc.
- Black ballpoint pen for writing in client's chart.

2. Learning Objectives

By the end of the physical exam process, the client will be able to:

- Correctly demonstrate how to perform Testicular Self-Exam (TSE)
- Explain the importance of major lab tests performed during the visit

3. Evaluation of Education Process

- As measured during direct observation, at least 90% of all clients will meet the above objectives.

4. Procedure / Points to Cover

- Introduce self to client using name & title. Describe your responsibilities for the client's visit. Be especially reassuring with youth and with clients for whom this is the first full reproductive health exam
- Clarify reason for visit and adjust exam plans accordingly; document in chart and encounter form.
- Explain each step of the exam and standard lab tests, including their importance, to the client using lay rather than technical terms. If client declines or defers any of these services, *document in client's medical record*.
 - Height and weight (optional)
 - Blood Pressure (stress importance of follow-up evaluation as appropriate)
 - Thyroid palpation for enlargement or nodules (initial and annual)
 - Heart and lung auscultation checks for abnormal sounds (initial and annual)
 - Breast exam checks for dimples, increased venous patterns, orange peel appearance of skin; palpation of breast and axillae checks for lumps, nodules; instruction in performing breast self exam (initial and annual);
 - Lower extremities checks for varicose veins; palpation of calves for tenderness (initial and annual)
 - Examination of the genitals and rectum (initial and annual);
 - Palpation of the prostate;
 - STI exam/tests as indicated
 - In men >50, rectal-vaginal exam
 - Other procedures as indicated
- Show and then ask client to demonstrate TSE skills. If client appears confused about any information covered during the physical exam, check his understanding and review.
- Ask if client has understood all procedures and if he has any questions.
- Document all client education in the chart.
- Inform "exit interviewer" of any changes in client's stated reason for visit for billing purposes.

F. Purpose of Standard Laboratory Tests

1. Teaching Materials

- A Pap smear swab, a diagram of the internal female anatomy should be available, particularly for explanation to the client undergoing her first pelvic exam.

2. Learning Objective

- Client will be able to identify the purpose of the Pap smear, STI testing, and/or hematocrit.

3. Evaluation of Learning Objectives

- 100% of clients will be able to describe the purpose of those laboratory tests they receive.

4. Points to Cover

a. PAP SMEAR

- Description: The clinician removes some cells from inside the cervix. These cells are placed on a microscope slide and sent to a lab. The procedure feels different for each woman ranging from no discomfort to moderate and occasionally severe discomfort.
- At the lab: the specimen will be examined for abnormal cell types. An abnormal result may be caused by an infection or by changes in the cell. Because cell changes may lead to cervical cancer, the Pap Smear is an early screening tool for diagnosing pre-cancerous conditions. *An abnormal result does not indicate the presence of cancer.*
- Waiting time: describe how long it will take to be notified of abnormal results.
- Repetition for women with normal Paps: one Pap Smear repeated annually for 3 years in a row of normal Pap Smears, and one Pap Smear every 3 years thereafter;
- Repetition for women with abnormal Paps: every 6 months.

b. STI TESTS

- If a client has a positive result, she will be contacted confidentially and advised to seek treatment and inform her partner(s). Stress the importance of treatment (self and partners) if results are positive.

c. HEMATOCRIT

- Description: the finger is pricked to withdraw a very small amount of blood. This test hurts for a split-second.
- Reason: a hematocrit tests for anemia and provides an indication of whether or not the client needs to take iron supplements.

d. OTHER TESTS

- Other tests may be done in the clinic or by referral as indicated. These include but are not limited to: urinalysis, urine pregnancy test, syphilis test, cone biopsy, and colposcopy. With the exception of the pregnancy test, the clinician will usually decide if such a referral is necessary and can explain it to the client. However, it is a good idea for all staff to be familiar with each of these tests.

e. ALL TESTS

- Ask the client if she understands the tests she will undergo and provide an opportunity for her to ask any questions she may have.

G. The Exit Interview (May be Performed by Clinician)

A. Staff Materials

- Adequate contraceptive supplies
- Paper bags or other containers for clients to confidentially carry contraceptive supplies
- Warning sign and emergency cards
- Appointment cards
- Linguistically and culturally appropriate written information on each of the educational topics discussed during the initial interview and physical exam
- Black ballpoint pen for writing in the chart

B. Learning Objectives

Upon completion of the exit interview, the client will be able to:

- Explain how to use the method selected
- Name at least one back-up method
- State when and how she will find out her test results (where indicated)
- Explain how to treat her infection and prevent re-infection (where indicated)
- State when follow-up care is due
- Identify what constitutes an emergency and what number to call in case of emergency

C. Evaluation of Education Process

As documented in client charts:

- 90% of clients can fulfill at least two of the six objectives described above
- 95% of clients given written information about warning signs and the clinic phone number and emergency number for non-clinic hours

D. Procedure / Points to Cover

Throughout the process described below, encourage the client to offer most of the information.

- a. Determine what the client knows about the method selected. Cover the following, correcting or augmenting as needed: (Clinician or RN dispenses method at this time)
 - How the method works
 - How to use the method with particular emphasis on common user mistakes
 - Importance of correct usage for effectiveness
 - Effectiveness
 - Problems associated with the method
 - How to use a back-up (second) method
 - How to obtain additional supplies
 - Importance of keeping appointments and follow-up care
 - Signs and symptoms which may indicate an emergency and need to be reported immediately (Note: give warning sign cards)
 - Provide address and phone number of local hospital in case of emergency.

- b. Clinician or RN dispenses medication prescribed and reviews the following:
 - How to use medication
 - In the case of infection, steps to prevent reinfection and further transmission, including treatment of partner, use of condoms, abstinence, prevention techniques, and importance of returning to clinic if symptoms persist
 - Ask client to review above information.
 - Ask client if she has any questions.
- c. Explain clinic policy regarding notification of lab test results. With clients in their teens, verify the information they gave to the registrar about how they can be contacted. *Clearly identify charts of all clients who cannot be contacted directly.*
- d. Ask client:
 - If she is clear about the information on her contraceptive;
 - If she understands what constitutes an emergency and who to call;
 - How she will know about her test results;
 - If she has any other questions;
 - How she feels about the care she has received at the clinic.
 - Document all client education in the chart.
- e. Make sure client knows when to return.
- f. Make sure client knows how to exit clinic.

**VI. CLIENT EDUCATION & COUNSELING:
BACKGROUND INFORMATION ON SEXUAL / REPRODUCTIVE HEALTH
AND FAMILY PLANNING**

A. Philosophy & Benefits of Family Planning

1. Teaching Materials

- Family Planning Consumer Rights Poster and/or Handout
- Handouts or brochures outlining the benefits of family planning

2. Learning Objective

- Client can state at least one principle of family planning philosophy.
- Client will be able to state at least one benefit of family planning.

3. Evaluation

Information covered during 100% of initial visits as documented in clients' charts.

4. Who Should Receive this Information

- All new clients should get brief review of information outlined below;
- Use Family Planning Consumer Rights (poster, Addendum 4) to establish basis of informed consent with all new clients or when clients switch primary birth control method;
- Thoroughly review family planning benefits with clients new to family planning:
 1. Younger adolescents
 2. Learning disabled clients
 3. Newcomers who have recently immigrated to the U.S.

5. Family Planning Consumer Rights

1. Individuals have a right to decide the number of children they want to have
2. Individuals need information on all methods of birth control in order to make an informed method choice
3. Family planning agencies can assist individuals who do/do not want to become pregnant.
4. Informed consent must be obtained from each individual who requests a method of birth control

6. Benefits of Family Planning:

1. Adequate spacing and timing of children enhances the health and well being of the father, mother and child.
2. Removing fear of pregnancy may improve sexual relations.
3. Family planning allows individuals to have children when they are psychologically ready to have them.

B. Reproductive/Sexual Anatomy and Physiology

1. Learning Objective

- Client will be able to identify at least two female and two male reproductive organs and their functions.

2. Teaching Materials

- Posters, flip charts and/or handouts of male and female reproductive anatomy.

3. Points to Cover – Female Anatomy

- a. The female reproductive organs, the vaginal canal, uterus, fallopian tubes, and ovaries are located within the pelvic region.
- b. The vagina is the organ that receives the man's penis during sexual intercourse between a man and a woman. The vagina also serves as the birth canal during the delivery of a baby.
- c. The vagina can change sizes to accommodate the penis, sex toys, or an infant's head.
- d. The ovaries are the organs which produce the woman's eggs or ova.
- e. The fallopian tubes transport mature eggs to the uterus. Fertilization occurs when the egg is traveling in the fallopian tube to the uterus.
- f. The uterus (also called the womb) is where the fetus grows. When not pregnant, a woman's uterus will be approximately the size of her fist. The uterus can expand enough to accommodate a full-term baby.
- g. The external sex organs of the female are called the vulva.
- h. The vulva consists of outer lips, inner lips, the clitoris, urethra, and vaginal opening.
- i. The size, shape and color of the vulva will vary from individual to individual.
- j. The clitoris, which sits at the top of the vulva and is protected by a little "hood" of skin, plays an important role in female sexual pleasure; approximately 75% of all women require direct clitoral stimulation in order to have an orgasm. It is the only organ in the human body (male or female) designed solely for pleasure.
- k. A woman's fertility is cyclic. Women are only fertile around the time of ovulation.

4. Points to Cover – Male Anatomy

- a. The male reproductive organs are located in the pelvic or groin area.
- b. The external sex organs of the male are the penis and the scrotum.
- c. The internal sex organs are the testes, the epididymis, vas deferens, seminal vesicles, prostate, ejaculatory ducts, Cowper's gland, and urethra.
- d. Sperm is produced in the testes and matures in the epididymis.
- e. The prostate, seminal vesicles and Cowper's gland produce the fluids that make up semen, which helps to nourish, protect and move the sperm as it travels through the penis.
- f. The penis is made of spongy tissue which fills with blood during sexual stimulation, causing an erection. At the peak of sexual excitement, semen and sperm are ejaculated from the penis through the urethra. After ejaculation, the penis returns to its flaccid state. (Assure clients who are concerned that a man cannot urinate while ejaculating because a "valve" shuts the bladder off during this process.)
- g. The size, shape and color of the penis and scrotum will vary from individual to individual.
- h. A man's fertility is continuous rather than cyclic.

C. Menstrual Cycle

1. Learning Objectives

- Client will be able to define ovulation and the two phases of the menstrual cycle.
- Client will be able to identify when in her menstrual cycle a woman is most likely to get pregnant.

2. Teaching Materials

- Chart of menstrual cycle hormones
- Diagram and/or poster of internal female reproductive anatomy.

3. Points to Cover

Phase 1: Menstruation to Ovulation

- a. Day 1 of each menstrual cycle begins with the first day of menstrual bleeding (often called a “period”). Normally, bleeding will last anywhere from 2 – 7 days with the average being 5 days.
- b. After menstruation, the ovary begins to secrete estrogen. This stimulates an egg to mature in ovary.
- c. The estrogen also stimulates the growth of the uterine lining, called the endometrium, in preparation for fertilization and implantation.

Phase 2: Ovulation to Menstruation

- a. When the estrogen reaches a high enough level, it causes luteinizing hormone (LH) to be secreted. This signals the ovary to release a mature egg (ova).
- b. The release of the egg is called ovulation.
- c. The shell of the released egg (corpus luteum) remains in the ovary and secretes progesterone, along with some estrogen. The progesterone causes the endometrium (uterine lining) to “lay quiet,” in case of implantation.
- d. After 12-16 days, the corpus luteum disintegrates if there is no pregnancy. Without estrogen and progesterone secretion, the uterine lining or endometrium sheds.
- e. This shedding of the uterine lining is menstruation.

Length of menstrual phases & female fertility

- a. From beginning to end, the average length of the whole menstrual cycle is generally between 21 – 45 days.
- b. The first part of the cycle - menstruation to ovulation - can vary enormously in length. This is why, without training in Natural Family Planning, it is difficult to determine beforehand when one will ovulate.
- c. The second part of the cycle - from ovulation to menstruation - is generally constant, lasting from about 12-16 days.
- d. High-risk days for conception begin approximately 4 days before ovulation as sperm can live in the fallopian tubes for up to 5 days and still fertilize an egg.

D. Pregnancy – How Pregnancy Occurs

1. Learning Objective

- Client will be able to explain the basic physiology of conception
- Client will be able to describe when and how fertilization occurs.

2. Teaching Materials

- Diagrams on flip charts, handouts and/or posters

3. Points to Cover

Fertilization & pregnancy usually occur as a result of vaginal intercourse:

- a. During vaginal (penis into vagina) intercourse, at the height of sexual arousal, a man will ejaculate (cum), releasing millions of sperm in fluid called semen into the woman's vagina .
- b. Once ejaculation occurs, the released sperm must swim through the opening of the uterus (cervical os) and into the fallopian tube. If the woman is at a fertile time of her cycle, she will produce cervical mucus which helps the sperm make this journey.
- c. If the sperm meet an egg in the fallopian tube, one may penetrate the egg and fertilize it.
- d. The fertilized egg travels back down the fallopian tube to the uterus.
- e. Pregnancy occurs once the fertilized egg implants itself into the lining of the uterus (endometrium), where it is nourished and develops.
- f. Rarely, the fertilized egg cannot move to the uterus, so implants itself in the fallopian tube. This is called a tubal (ectopic) pregnancy, a potentially life-threatening condition.

When fertilization is most likely to occur during a woman's menstrual cycle

- a. In most women, fertilization is most likely to occur mid-cycle, approximately 12 - 14 days before the woman's *next* period begins. This is the point during a woman's cycle when her ovaries release a mature egg.
- b. The egg takes an average of 24 hours to travel through the fallopian tube; if it is met by sperm anytime during this journey, fertilization is a possibility.
- c. Because sperm can live in the fallopian tube for up to 5 days and still fertilize an egg, it is possible for a woman to have vaginal intercourse several days before she ovulates and still become pregnant.

Other instances when pregnancy can occur:

Rarely, a woman can become pregnant if:

- a. Her male partner places his penis inside her vagina but does not ejaculate;
- b. Her male partner withdraws his penis from her vagina before ejaculating;
- c. Her male partner does not enter her vagina at all but ejaculates close to the vaginal opening.

The above are all possible because:

- a. During the first stages of sexual arousal, a man's penis releases pre-ejaculate (pre-cum) which creates a safe environment for sperm. In one study, sperm was found in this fluid.
- b. Because sperm swim, those ejaculated near the opening to the vagina may be able to find their way into the vagina and then continue on their journey to the fallopian tubes.

E. Sexual Response Cycle - Female

1. Learning Objective

- Client will be able to describe the sexual response cycle in women.

3. Points to Cover

Introduction

- a. There is no one natural sexual pattern or feeling; sexual response can involve a complex array of emotional, physical, and even spiritual responses.
- b. Sexual feelings, patterns, and acts (including the desire to be celibate) can be very diverse and still be normal.
- c. Vaginal intercourse is only one aspect of sexual activity. It is not required for either sexual pleasure or orgasm.
- d. Communication and trust can be very important in establishing a satisfying sexual relationship.
- e. Having sex usually changes a relationship dramatically. All individuals have the right to choose: to have sex, to decide against sex, to prefer sex with someone of the opposite or their own gender.
- f. Human sexuality researchers have suggested various models of sexual response; most involve between 3 – 4 phases that include some degree of each of the following: excitement/arousal/desire; climax/orgasm; resolution.

Physical process of sexual arousal

Many women do not have orgasms. Of these women, many still have satisfying sex lives. For women who don't experience orgasm and want to learn to do so, practicing masturbation or learning from a book, self-help group, or asking a partner to participate can help.

- a. When a woman becomes sexually aroused, blood fills the vessels of the pelvic area, causing a feeling of engorgement or fullness and sensitivity.
- b. The clitoris (the sensitive pea-sized gland above the urethra) swells and becomes erect. The sole function of the clitoris is to provide sexual pleasure.
- c. The vagina becomes lubricated by secretions.
- d. The cervix and uterus contract upwards and the vagina "balloons" or expands.
- e. The nipples may become erect, skin may become flushed and there is often an increasing tension or tightening of muscles throughout the body. The entire body becomes more responsive to touch.
- f. Pulse, blood pressure and breathing rates tend to increase.

Physical process of orgasm

- a. Women tend to be full-body oriented – virtually any portion of the skin may give pleasurable or exciting sensations that can result in orgasm.
- b. Orgasm results when a buildup of pelvic fullness and body tension peaks. This "climax" results in a sudden release in which a series of involuntary and pleasurable muscular contractions expel the blood from the pelvic tissues. In women, a distraction (for example, the baby crying or a telephone ringing) can be enough to move her away from orgasm and back to a more general level of excitement.

- c. Most experts describe two basic types of orgasm, both normal:
- VULVAR OR “TENTING:” felt primarily in the vulva and involving clitoral or some outside stimulation such as fantasy or breast stimulation;
 - UTERINE OR “A-FRAME:” felt deeper inside the abdomen, triggered by stimulation of the Grafenberg-spot (G-spot), an area in the front wall of the vagina, an inch or two inside the opening, and/or by pleasurable pressure on the cervix. Some women report ejaculating a milky-white fluid from the urethra during this type of orgasm.
- d. Orgasm is often followed by a relaxed, calm, or even energized feeling. Men have a “refractory” period during which it is unlikely that they will have another erection or orgasm. Women have no refractory period and may have more orgasms right away.

F. Sexual Response Cycle - Male

1. Learning Objective

- Client will be able to describe the sexual response cycle in men

2. Points to Cover

Introduction

- There is no one natural sexual pattern or feeling; sexual response can involve a complex array of emotional, physical, and even spiritual responses.
- Sexual feelings, patterns, and acts (including the desire to be celibate) can be very diverse and still be normal.
- Vaginal intercourse is only one aspect of sexual activity. It is not required for either sexual pleasure or orgasm.
- Communication and trust can be very important in establishing a satisfying sexual relationship.
- Having sex usually changes a relationship dramatically. All individuals have the right to choose: to have sex, to decide against sex, to prefer sex with someone of the opposite or their own gender.
- Human sexuality researchers have suggested various models of sexual response; most involve between 3 – 4 phases that include some degree of each of the following: excitement/arousal/desire; climax/orgasm; resolution.

Physical process of sexual arousal

- a. Men are often conditioned to focus on genital sexual stimulation; many also enjoy nipple stimulation. Men can recondition themselves to enjoy whole-body stimulation, as do most women.
- b. The most sensitive areas in most men (in order of decreasing response to touch) are: the area on the penis just behind the (glans); the ridge of the glans; the area surrounding the urethra; the shaft of the penis; the base of the penis between the top of the scrotum and anus; the scrotum and testicles; the skin around the anus.
- c. Many men (both heterosexual and gay) can learn to enjoy anal penetration and stimulation of the prostate.
- d. In men, sexual arousal causes blood to fill up the spongy tissue of the penis. This engorgement causes an erection and a heightened sexual feeling and sensitivity to touch.
- e. The nipples may become erect, skin may become flushed and there is often an increasing tenseness or tightening of muscles throughout the body. The entire body becomes more responsive to touch.
- f. Pulse, blood pressure and breathing rates tend to increase.

Orgasm

Many people link male ejaculation with orgasm. However it is not uncommon for men to ejaculate without experiencing the accompanying feelings of release, pleasure, or orgasm. Conversely, some men may experience the feelings of orgasm independent of having an ejaculation. If this occurs and neither the man nor his partner is bothered by it, this is nothing to worry about.

- a. In both men and women, an orgasm results from the buildup of pelvic fullness and body tension to a peak. This tension climaxes in a sudden release in which a series of involuntary and pleasurable muscular contractions expel the blood from the pelvic tissues.
- b. In many men, orgasm will also result in ejaculation, but as explained earlier, this is not always the case.
- c. Orgasm is often followed by a relaxed or calm feeling. After ejaculation, men have a “refractory” period during which it is unlikely that they will have another erection or orgasm. This period tends to become longer as men get older.

G. Addressing Clients' Sexual and Relationship Concerns

1. Learning Objective

- Client will be able to describe one sexual concern that is impacting her reproductive health
- Client will be able to describe one step she can take to address this concern

2. The importance of addressing a client's sexual and relationship concerns

- a. Client-centered counseling includes attentiveness to needs that may lie beyond what clients initially express as their reason for a visit;
- b. Often unexpressed concerns involve the complex interrelatedness of sexuality and reproductive health needs.
- c. In order to make informed reproductive health care choices, clients must make decisions about sexuality and sexual practices. (E.g., people's attitudes toward sexuality influence their contraceptive choice, how effectively the method is used, and their satisfaction with the method.)

3. Creating a comfortable environment

Most clients with questions about sexuality are grateful to have a trusted health professional address them, but keep in mind the sensitivity of this topic. Create a safe environment through:

- a. Use non-verbal and verbal language **that doesn't judge**.
- b. **Present screening questions as routine**; let people know that you will be asking some personal questions and assure them that you ask these questions of all clients.
- c. **Put clients on a more equal footing** by first asking what they have already heard and/or what they want to know about a topic.
- d. **Tailor information to each client**; use information to normalize and to reduce anxiety.
- e. **Talk about general facts** before moving to personal specifics. (For instance, "A lot of women need clitoral stimulation to have an orgasm.")
- f. **Use the intake / history form as a check list**; rather than "counseling from form," develop your own conversation starters for the different topics.
- g. **Develop your own simple checklist** for important questions regarding sexual satisfaction that are not on the intake form.
- h. **Remember that some of these topics can be very emotional for people**; if a client is emotional, explore the factors underlying this response.
- i. **Use appropriate client education literature** and referral sources.

4. Questions to encourage clients to talk about their sexual needs/concerns

- Do you have any questions or concerns that you would like to discuss about your sexual relationships?
- Can you tell me about your spouse, sexual partner or partners?
- What questions do you have about what might happen to your body during sex?
- Are you happy with your romantic or sexual life right now? Why or why not? Do you talk to your partner(s) about it?
- Tell me a little about your first sexual experiences (particularly for younger clients).
- When you have sex, is it usually because you want to have sex, your partner wants to have sex, or you both want to have sex?

5. The PLISSIT Counseling Model

This is a 4-stage model developed for family planning provider, educators and counselors who are not psychiatrists, psychologists or sexual therapists but who wish to address the sexual needs and concerns of clients.

Be prepared to deal with the following stages:

- a. *Permission giving*: giving a client “permission” for their thoughts and feelings; this is not related to telling a client what to do;
- b. *Limited Information giving*: usually involves discussing anatomy and physiology, as well as dispelling sex myths;
- c. *Specific Suggestions*: involve simple skill-building such as changing positions for sexual activities, using lubricants or employing the stop-start technique or referrals (e.g., for physical diagnosis of medical problems such as diabetes or medications such as antidepressants that can impair sexual functioning).

Refer for the fourth stage:

- d. *Intensive Therapy*: may be necessary for body-image problems, relationships problems, identity problems, drug use/abuse or psychological problems such as depression.

For further information on this model, visit the Association of Reproductive Health Professionals web site at:

<http://www.arhp.org/healthcareproviders/cme/onlinecme/cmeclinicalproceedings.cfm?ID=37>

6. Common client questions and concerns about sex

- How often do most couples my age have sex?
- Is it normal to have times in your marriage / relationship when you do not want to have sex?
- How often is it OK to masturbate?
- My partner wants to (fill in behavior) and I do not. What can I do?
- My partner wants less (or more) sex than I do. What can I do?
- What can I do to improve my sex life?
- Intercourse is painful for me (or my partner).
- My partner (or I) cannot maintain an erection.
- I have never had an orgasm.
- How do I know if my partner is being honest with me?

7. Common Sexual Problems in Women

- Irritation or pain with intercourse
- Tightness in the vaginal entrance
- Vaginismus (tightening of the vaginal muscles to the point where penetration becomes impossible)

8. Common sexual problems in men

- Erectile dysfunction – inability to get and /or maintain an erection
- Premature ejaculation - inability to control timing of ejaculation / ejaculating “too early”

9. Common sexual problems in both women and men

- Lack of sexual desire
- Anorgasmia – inability to experience the feelings of orgasm (may occur with or without ejaculation in men)

10. Possible causes of and approaches to overcoming common sexual problems

Please see the following charts and handouts in the appendices:

Common Sexual Problems Chart: Appendix 10.

Sensate Focus Technique for learning to control premature ejaculation: Appendix 11.

Squeeze Technique for learning to control premature ejaculation: Appendix 12.

11. Further reading

- *The Beauty Myth : How Images of Beauty Are Used Against Women* by Naomi Wolf. Perennial; (September 24, 2002)
- *Changing Bodies, Changing Lives: A Book for Teens on Sex and Relationships* by Ruth Bell Alexander, Ruth Bell. Three Rivers Press (CA); 3rd Rev edition (August 1, 1998)
- *Contraceptive Technology, 18th Revised Edition* by Robert A. Hatcher, MD, MPH et al. Ardent Media, Inc. (New York City); (August, 2004)
- *The New Male Sexuality* by Bernie Zilbergeld. Bantam; Revised edition (July 6, 1999)
- *The Sexual Male: Problems and Solutions* by Richard Milsten, Julian Slowinski. W.W. Norton & Company; New edition (September 2000)
- *For Yourself: The Fulfillment of Female Sexuality* by Lonnie Barbach, Phd. Signet Books; Rev edition (December 12, 2000)
- *Our Bodies Ourselves For The New Century* by Boston Women's Health Book Collective. Touchstone; Rev&Updtd edition (May 4, 1998)

**VII. CLIENT EDUCATION & COUNSELING:
GENERAL REPRODUCTIVE HEALTH**

A. Amenorrhea

1. Learning Objectives

As a result of the education section, the client will be able to:

- Explain female reproductive anatomy and physiology;
- List at least 3 possible causes for the type of amenorrhea (primary or secondary) that she is experiencing
- List next steps for determining the cause of her amenorrhea

2. Educational Materials

- Anatomy charts, diagrams, or pamphlets

3. Process / Points to Cover

- a. Define amenorrhea (Family Planning Clinic staff members are far more likely to see clients with secondary rather than primary amenorrhea):
 - *Primary Amenorrhea*: absence of menarche (first menstruation) by age 16; it may or may not be accompanied by development of secondary sexual characteristics
 - *Secondary Amenorrhea*: absence of menses in a previously menstruating woman for 90 days or less than six menses in one year.
- b. Discussion of primary amenorrhea:
 - *Possible factors*: hormonal, genetic (e.g., Turner's Syndrome, where there is a missing X Chromosome), congenital conditions (e.g., lack or underdevelopment of reproductive organs such as vagina or uterus), conditions that can impair hormonal functioning (i.e., low body weight, stress, intense exercise, obesity)
 - *Diagnosis*: careful physical examination, including lab tests, by a medical provider
 - *Counseling considerations*: If sexually active, client should still protect herself from unintended pregnancy since she could experience menarche at any time. She should also protect herself from STIs.
- c. Discussion of secondary amenorrhea:
 - *Review reproductive anatomy and physiology*, focus on role of hormones in menstrual cycle.
 - *Possible factors*: Use of hormonal contraceptives (i.e., OCs, DMPA), pregnancy, breast feeding, medications, recreational drug use (i.e., speed, cocaine, heroine), intense athletics, steroid use, recent extreme weight gain or loss, physiological or emotional stress, recent uterine curettage
 - *Possible causes*: anovulation, hormonal problems (i.e., LH, FSH, estrogen, progesterone, prolactin), thyroid problems, problems of the hypothalamus, pituitary disease, ovarian failure, premature menopause, serious medical problems
 - *Counseling / treatment steps*:
 1. *Test for pregnancy*: This should be the first step taken in the Family Planning setting. Advise client to abstain from sex or to use birth control during this waiting period.
 2. *Counseling*: If sexually active, client should still protect herself from unintended pregnancy since she could experience menarche at any time. She should also protect herself from STIs.
 3. *Diagnosis*: Refer to clinician for appropriate follow-up. May include a complete medical work-up, including in-depth medical history and possible laboratory tests.

B. Breast Self-Exam

1. Learning Objective

By the end of the physical exam process, the client will be able to:

- Demonstrate how to perform Breast Self-Exam (BSE)

2. Materials

- Pamphlets and diagrams should be available to augment education.
- BSE Demonstration model

3. Points to Cover

Review if and how often client is doing BSE:

1. Ask client if she does BSE regularly. If yes, reinforce need to continue.
2. If no, find out why she doesn't do BSE. Identify barriers such as:
 - Lack of knowledge of BSE and BSE procedure
 - Lack of confidence in ability to discriminate between normal vs. abnormal tissue
 - Fear of an abnormality
 - Forgetting
 - Lack of time
 - Uncomfortable about touching breasts for personal or cultural reasons
 - Discuss coping strategies for any identified barriers with client. These may include:
 - Providing description of normal breast tissue (e.g., soft, fleshy or thick)
 - Providing tactile information about the texture of normal and abnormal breast tissue by palpating an artificial model
 - Discussing plan of action in event of detection of suspected abnormality
 - Exploring ways to fit BSE into busy schedule
 - Acknowledging possible discomfort in touching own breasts
 - Discussing perceived barriers to practicing BSE
3. Ask the client to describe and show how she would perform BSE.

Discuss when to do BSE:

1. Pre-menopausal, non-lactating women: about 7 days after start of menstrual period.
2. Post-menopausal and lactating women: the first day of the or any other day they are likely to remember on a monthly basis.
3. method

Demonstrate proper BSE technique using breast model and ACS pamphlet:

1. The visual examination

- a. Look at breasts in following positions while standing up:
 - Arms at sides
 - Arms raised
 - Hands on hips
 - Bending forward
- b. What to look for:

- Skin or nipple changes
- Changes in the shape or size of either breast
- Skin “dimpling”
- A bloody or spontaneous discharge from a nipple
- Swollen lymph glands under the arm pit

2. The examination by touch

- a. Positions:
 - Arm bent (on side of examined breast) and placed behind head
 - Side-lying for women with large breasts
- b. Where to touch / Techniques:
 - Perimeter - include all breast tissue to mid-sternum, clavicle and mid-axilla
 - Palpation technique with pads of 3 or 4 fingers, using dime-sized circular motion, not lifting fingers
 - Pressure - light, medium and deep pressure for each palpation
- c. Pattern of search
 - Series of vertical strips – starting at armpit, cover all breast tissue from clavicle to bra line.
 - Make at least 6 strips before nipple and 4 strips after nipple (increase strips with increased breast size).
- d. What to look for
 - A hard or soft, distinct single lump that feels different from surrounding tissues
 - Squeeze the nipples for a bloody or spontaneous discharge
 - Swollen lymph glands under the arm pit
 - Nipple discharge

3. Auxiliary examination

Practice with feedback. This portion of the visit is done in the examining room with the provider. Client should be undressed at this point for providing feedback and return demonstration.

4. Create a Plan of Action

- a. Review when client will perform BSE.
- b. Counsel client to seek medical attention if she discovers a lump or other change/abnormality.
- c. Reassure client that most breast changes are not cancerous.
- d. Find out if client has any questions/concerns.
- e. Give client ACS BSE handout or shower card.

C. Cystitis (Lower Urinary Tract Infection)

1. Learning Objective

- Client will be able to name at least two possible risk factors for cystitis
- Client will understand how to take the prescribed medication
- Client will be able to list extra measures to be taken during treatment, and when to seek follow-up care
- Client will be able to describe two measures for preventing reinfection

2. Teaching Materials

Female pelvic models or diagrams / handouts

3. Points to Cover

a. Definition

- An inflammation or infection of the urinary bladder.

b. Cause

- In women, the urethra is short and close to the vagina & anus; this facilitates bacteria being pushed up into the urethra and reaching the bladder

c. Risk Factors

- Vigorous intercourse or sudden increase in sexual activity (“honeymoon” cystitis)
- A new diaphragm, or one that is too large or left in place too long (changing rim may help)
- Oral contraceptives and vaginal suppositories / foam may aggravate the condition
- Pregnancy (pressure from fetus doesn’t allow for complete emptying of bladder)
- Poor health habits (i.e., wiping from back to front after urination, excess caffeine, poor diet, stress)
- Undiagnosed STIs (this possibility should be considered when making a diagnosis)
- Occasionally, anatomical abnormality or prolapsed uterus or bladder

d. Symptoms

- Pain on urination
- Persistent need for urination
- Blood or pus in urine
- Occasionally, a peculiar, heavy urine odor when first urinating in the morning

e. Potential Complications

- Untreated chronic infections can lead to serious complications such as high blood pressure or kidney infection

f. Diagnosis

- The clinician examines a clean sample of urine under the microscope for bacteria, blood and white blood cells

- If a client has reoccurring urinary tract infections a culture and sensitivity may be ordered.
 - If bladder infections recur frequently or do not respond to treatment, client may be referral to a urologist
- g. Treatment
- Women who are not pregnant: antibiotics, most commonly Septra, Ciprofloxacin, Nitrofurantoin or Cephalexin in courses of 3 – 7 days
 - During pregnancy, ampicillin is usually prescribed.
- h. During Treatment Clients Should:
- Avoid intercourse & other sexual play that may irritate or spread bacteria to the urethra
 - Avoid caffeinated beverages and alcohol
 - Go to the emergency room (or other appropriate care facility) if flank pain or fever develops
 - Return if symptoms persist or recur
- i. Prevention
- Drink 6-8 glasses daily; drink extra water after engaging in sports like bicycling that can irritate the urethra
 - Urinate before and after intercourse
 - During sexual play, avoid touching hands to anus and then vagina without washing in between
 - Use adequate lubrication during sex
 - After going to the bathroom, wipe front to back; never back to front
 - Wear cotton underwear and loose-fitting clothing.
 - Avoid drinking large amounts of caffeinated beverages as these substances irritate the urinary tract.
 - Consult a herbalist as certain herbs (usually taken in tea form) may help: juniper berry, uva ursi, rose hips, horsetail or shavegrass, barberry, echinacea, cornsilk, cleavers, lemon balm, goldenseal
 - At the early onset of symptoms, drinking unsweetened cranberry juice or taking concentrate cranberry supplements with water and vitamin C may prevent an infection from developing

D. DES (diethylstilbestrol) Exposure

1. Learning Objective

- Client will be able to state whether she may have been exposed to DES en utero
- Clients with DES exposure will be able explain the impact on reproductive health care needs

2. Teaching Materials

- Brochure or handout

3. Definition

Diethylstilbestrol, or DES, is an artificial estrogen given to many pregnant women between 1941 and 1971 to prevent miscarriage. DES came under more than 200 brand names. It is important for both male and female clients born prior to 1972 to determine if they were DES exposed; if so, they are at increased risk of developing certain health problems.

4. Screening

Check to see if client was born prior to 1972. If so, ask:

- a. Does she know whether or not her mother took DES?
- b. If not, does she know if her mother was identified as being at risk for a miscarriage or took any medications to prevent miscarriage during pregnancy.
- c. If yes, she should ask her mother, if possible, about DES exposure; if the mother does not know, it may be possible to contact the attending physician or hospital of birth for records.

4. Points to Cover

a. Female clients exposed to DES have a higher risk for:

- Vaginal cancer
- Infertility
- Pregnancy-related problems: ectopic pregnancy, miscarriage, preterm labor and delivery
- Structural changes in reproductive organs

Special screenings for early cancer and other potential problems:

- Recommended annual pelvic exam is somewhat different and includes colposcopic examination to look at vaginal cells more closely

b. Male clients exposed to DES have a higher risk for the following:

- Testicular cancer
- Epididymal cysts (do not need to be treated unless they are painful)
- Varicose veins in the testes – can lower normal sperm count if left untreated
- Physical abnormalities: testicular problems, microphallus (an abnormally small penis), hypospadias (urethral opening is located on the under-surface of the penis rather than at the end), meatal stenosis (a narrowing of the opening of the penis)

Special preventive care:

While recommended for all males, the following are extremely importance for DES sons:

- TSE (Testicular Self-Exam); any suspicious changes on or near the testicles should immediately be referred to the medical provider.
- Yearly rectal exams to check for signs for prostate cancer if over 40.

E. Dysmenorrhea

1. Learning Objectives

- Client will be able to identify whether her dysmenorrhea is primary or secondary
- Client will be able to list at least 2 self-help steps she can take to lessen symptoms
- If secondary, client will be able to describe the importance of getting proper diagnosis and treatment

2. Points to Cover

a. Definition

Dysmenorrhea is the medical term for menstrual cramps:

- *Primary*: Usually begins within 1 – 3 years of first menstruation and involves no physical abnormality. Such cramps affect 50 percent to 90 percent of all menstruating women.
- *Secondary*: Usually begins in adulthood, and involves an underlying physical cause, such as endometriosis or uterine fibroids.

b. Signs & Symptoms (Primary & Secondary)

- Dull or throbbing pain in the lower abdomen
- Pain that radiates to the lower back and thighs
- Nausea and vomiting (less common)
- Loose stools (less common)
- Sweating (less common)
- Dizziness (less common)

With primary dysmenorrhea, cramps tend to decrease in intensity as women get older, and often disappear after carrying a pregnancy to term. For secondary dysmenorrhea, the underlying cause must be treated.

c. Causes

1. *Primary dysmenorrhea*: During menstruation, the uterus contracts to help expel the endometrium (lining). These contractions are triggered by prostaglandins, hormone-like substances involved in pain and inflammation; many experts believe that prostaglandins cause primary dysmenorrhea
2. *Secondary dysmenorrhea* is caused by a number of conditions, including:
 - Endometriosis (the type of tissue that lines the uterus implants itself on the fallopian tubes, ovaries or the tissue lining the pelvis)
 - Pelvic inflammatory disease (PID), an infection of the female reproductive organs, usually caused by sexually transmitted bacteria.
 - Use of an intrauterine device (IUD)
 - Uterine fibroids and polyps - noncancerous tumors and growths protrude from the uterine lining

d. When to Seek Specialized Medical Care

- *Primary dysmenorrhea* : if cramping disrupts client's life for several days a month; provider may prescribe low-dose oral contraceptives or in some cases narcotics such as codeine
- *Secondary dysmenorrhea*: All clients with secondary dysmenorrhea since pinpointing the underlying cause is the first step to successful treatment. Complications of untreated secondary dysmenorrhea vary depending upon the underlying cause, but they can be serious and include infertility, pelvic inflammatory disease and ectopic pregnancy

e. Screening, Diagnosis & Treatment for Secondary Dysmenorrhea

- Medical provider reviews medical history and performs a physical examination, including a pelvic exam to check for abnormalities in the reproductive organs and to look for indications of infection
- Additional diagnostic tests may include: noninvasive imaging tests such as ultrasound, laparoscopy (an in-office surgical procedure during which the practitioner views the pelvic cavity by making a tiny incision in the abdomen and inserting a fiber-optic tube with a small camera lens), hysteroscopy (provider inserts an instrument through the vagina and into the cervical canal to examine the canal and inside of the uterus)
- Treatment depends upon the underlying cause

f. Self-care & alternative medicine for reducing the severity of cramps

- Over-the-counter nonsteroidal anti-inflammatory drugs (NSAID), such as ibuprofen (Advil, Motrin) or naproxen (Aleve, Anaprox)
- Orgasms, through masturbation or sex
- Hot bath or using a heating pad on the abdomen may ease your cramps
- Lifestyle changes to improve your overall health, including getting regular exercise and adequate rest
- Relaxing herbal teas such as raspberry leaf, chamomile and peppermint
- Stress-relieving activities such as massage, yoga or meditation
- Acupuncture (in 1998, the NIH issued a consensus statement that acupuncture may help relieve certain types of pain, including menstrual cramps) and some Chinese herbs given under the care of a Chinese medical specialist

F. Testicular & Male STI Self-Exam

1. Learning Objectives

- Client will be able to explain the steps for performing testicular self-exam
- Client will be able to list possible signs and symptoms of both testicular cancer & STIs

2. Teaching Materials

- TES brochure & diagram or model of male reproductive tract

3. Points to Cover

a. Importance of TSE

- Testicular cancer is the most common type of cancer in males ages 18 to 40
- Testicular cancer is highly curable, especially when detected and treated early. However, if left untreated it can be life-threatening.
- Testicular cancer almost always occurs in only one testicle and the other testicle is all that is needed for full sexual function.

b. Risk factors:

- Uncorrected undescended testicles in infants and young children
- A family history of testicular cancer / having an identical twin with testicular cancer
- Injury to the scrotum or to a testicle
- Testicular cancer is five times more common among Caucasian than Black males.

c. When to perform TSE:

- Monthly, right after a hot shower when the skin of the scrotum is relaxed and soft

d. How to perform TSE:

1. Become familiar with the normal size, shape and weight of your testicles.
2. Using both hands, gently roll each testicle between your fingers – each testicle should feel firm, smooth and egg-shaped and about 1-1/2 inches long.
3. Feel Epididymis at top and back of each testicle; should feel soft, rope-like and tender
4. The following are not normal and should be reported to a healthcare provider:
 - Lump or hard area in the testicle (similar to an uncooked rice grain or small pea)
 - If the whole testicle feels harder than usual
 - If one side of the scrotum is very swollen (it is normal for one testicle to be larger)
 - Enlarged testicle, feeling of heaviness in the testicle or groin or a change in the way the testicle feels
 - Pain in the testicle
5. Other warning signs of testicular cancer:
 - aa. Enlarged male breasts and nipples
 - bb. Blood or fluid that accumulates suddenly in the scrotum

f. Check for STIs:

1. Check the skin on the scrotum and penis for sores and little bumps; if uncircumcised, make sure to pull back the foreskin and check the glans
2. Look at the urethra for redness, pain, or a yellow or white discharge
3. Feel your groin area on both sides for any lumps or swollen glands.

**VIII. CLIENT EDUCATION & COUNSELING:
PSYCHOSOCIAL ISSUES**

A. Introduction

1. Importance of These Topics to Family Planning Clients

Title X guidelines require that clients be offered the information in this section because:

- Family Planning services are the only regular source of health care for many women;
- All of these areas may be directly relevant to clients' reproductive health care, depending upon their circumstances, health status, and/or primary method of birth control.

2. Information that Must Be Covered:

- Alcohol and substance use / chemical dependency
- Domestic Violence (documented instances require a police report)

3. Information that Must Be Offered:

- Past sexual abuse

4. Section Organization and Use

This section includes the following:

- Quick assessment and education tools (5-10 minutes) developed specifically for Family Planning educators, counselors and providers;
- Extended information on each topic to use as a reference when working with clients who have specific concerns or needs in a particular area

5. General Guidelines for Sensitive Issues:

- Recognize and acknowledge your limitations
- Explain motive (concern about client)
- Explain routine nature of screening (discuss topic with all clients)
- Assure client confidentiality
- Remain supportive and non-judgmental
- Gently acknowledge symptoms/signs: e.g., dilated pupils or drowsiness indicating possible substance abuse or bruises on arms indicating possible domestic violence
- Protect client when documenting screening findings in chart; inform client of documentation
- Remember that supportive inquiry/advice may be helpful to client, even if she doesn't disclose

B. Alcohol and Substance Use/Chemical Dependency

1. Learning Objectives

- Clients will assess their risk for problems related to alcohol/substance use
- Clients experiencing chemical dependency or alcohol/substance use-related problems will:
 - a. Explore the impact of their behavior on their reproductive health;
 - b. Describe one step they can take to reduce or eliminate their use of alcohol/substances

2. Screening Requirements

Title X requires that all clients be screened for substance use/abuse and chemical dependency. Some clinic intake/history forms include a checkbox for this topic.

3. Special Note

If client is obviously high or drunk during family planning visit, suggest that she come back when she is more able to take in and remember information.

4. Background Information

- a. Indicators of possible problems
 - Self report
 - Physical evidence (e.g., track marks, dilated pupils, poor weight gain, behavior, scratching face or arms)
 - History of significant mental illness
 - Altered mental state
 - Prescription-seeking behavior
- b. Factors that increase risk
 - Homelessness
 - Domestic violence
 - History of physical, emotional, and/or sexual abuse as child
 - Partner with past or present history of heavy alcohol use/substance abuse
- d. Special concerns for women:
 - Chemical dependency carries a greater stigma for women than men
 - Fear of not being able to take care of or keep children
 - Potential legal prosecution if pregnant
 - Often women are initiated into drug/alcohol abuse by male partners who then sabotage efforts to quit
 - Fear of reprisal from partner; studies show that between 40% – 88% of women dealing with chemical dependency issues are also victims of domestic violence
 - Lack of treatment facilities that address women's special needs (i.e., child care, family planning services, parenting training, food, clothing, shelter, assertiveness training, etc.)

4. Screening and Assessment

- a. Open the conversation gently, clearly, directly, and with respect:

- Inquire about client’s general drug/alcohol intake. “Is this something you worry about?”
 - “I notice that you are [gently describe obvious symptoms such as drowsiness and slurred speech]. Are these due to alcohol or drug use?”
 - “I don’t mean to get in your business or put you on the spot, but I am concerned that you are coming into clinic high in the early afternoon.”
- b. Assess frequency, quantity, type:
1. *Alcohol use:*
 - On average, **how many days a week** do you drink?
 - On a typical day when you drink or use, **how much** do you drink?
 - What is the **maximum number of drinks** you had on any given day in the past month?

Multiply number of days by number of drinks; over 14 for men or 7 for women indicates that client could be at risk for developing alcohol-related problems.

Maximum number of drinks in one day over 4 for men or 3 for women indicates that client could be at risk for developing alcohol-related problems.
 2. *Substance use:*

Similar questions can be used to gauge potential problems with substance abuse.

In addition to frequency, ask questions about type of drug and method of use (i.e., smoking, ingesting, injecting).
- c. If problem is indicated, ask “CAGE” questions:
- **C** = Have you ever felt that you should **cut down** on your drinking / drug use?
 - **A** = Have people **annoyed you** by criticizing your drinking / drug use?
 - **G** = Have you ever felt bad or **guilty** about your drinking / drug use?
 - **E = (Eye-opener)** Have you ever had a drink or taken drugs first think in the morning to steady your nerves, get rid of a hangover, or recover from the effect of drugs the night before?
- Generally affirmative answers to:
- **Two** of the above = a positive screen for alcohol/substance use related problems
 - **Three to four** of the above = possible chemical dependency
- d. Invite client to explore impact of substance use on her life and reproductive health:
 Relationship between substance use and risk for HIV/STIs/unintended pregnancy:
- “Many people find that even after one or two drinks, they are more likely to engage in risky sexual behaviors [or forgotten to use a condom, take their OCs etc.]. Has this ever happened to you?
- Impact of substance use on client’s relationship with partner(s):
- “How does drinking [using drugs] affect your relationship with your partner(s)?
 - “How would your partner(s) react if you tried to stop drinking [or using]?”
- e. Advise and assist:
1. State your concerns for client’s health

2. Provide relevant health information (e.g., potential risk to fetus, impact of particular drug on sexual functioning, increased risk for HIV/STIs, procedure for cleaning needles, etc.)
3. Gauge patient's readiness for change
4. Negotiate an action plan:
 - **Harm reduction** (be positive – even small steps are good): decreasing use by daily increments that she finds manageable, interspersing using with periods of abstinence, avoiding drug using friends
 - **Treatment** (utilize CHN resources/team & provide choices which studies have shown increase client success): residential, individual or group counseling, 12-step, gender-specific
5. Arrange follow-up as feasible

C. Domestic (Intimate Partner) Violence

1. Learning Objectives

- Client will understand California State DV reporting requirements
- Client will be able to list two actions she can take to increase her safety and/or protect her reproductive health

2. Screening & Reporting requirements:

Both Title X and the State of California require health providers to screen for and report all suspected and confirmed cases of domestic violence to the appropriate legal authorities. Please see CHN Domestic Violence Protocols available for download at:

http://insidechnsf/DomesticViolence/provider_old_files/protocol.pdf.

3. Special Concerns for Family Planning Providers:

- a. Factors that increase risk
 - Current drug or alcohol abuse, factor in between 40% - 88% of all DV relationships
 - Young age: the highest rates occur among women ages 16 – 24
- b. Read flags among Family Planning clients
 - Seemingly “poor contraceptors”
 - Client who presents with recurrent STIs
 - Clients who repeatedly seek pregnancy termination
 - Clients who often present with chronic, multi-symptom complaints (i.e., backaches and headaches)
- c. Impact of abuse on reproductive health and contraceptive choice
 - Violent men frequently seek control over their partners’ sexuality
 - Some men do not want their partners to use contraception for fear that “their women” will then feel free to have sex outside of the relationship
 - Forced sex is a frequent form of relationship abuse, and is often accompanied by lack of control over contraception and/or safer sex
 - Women may not be able to negotiate condom use if the man considers this a threat to his masculinity

4. Screening and Assessment

“HITS” is a time-sensitive screening tool developed for Family Planning Providers:

- a. Does your partner:
 - **H = Physically hurt** you?
 - **I = Insult** or talk down to you?
 - **T = Threaten** you with physical harm?
 - **S = Scream** or curse at you?
- b. If the client does not disclose...

Use contraceptive counseling as a second opportunity for broaching the subject:

 - How does your partner feel about different methods of contraception?
 - Does your partner ever try to control the type of birth control you use?

- c. If a client reveals abuse:
- Check in regarding woman's immediate safety
 - Explain reporting requirements; report partner abuse as per CHN guidelines
 - Refer for DV services as appropriate.
 - Explore what it means for a client's health when she cannot control her own sexuality
 - Explore how client can minimize potential increased risk for unintended pregnancy and STIs; focus on sexual coercion, including which contraceptive methods (e.g., DMPA) are least intrusive.

**IX. COUNSELING AND EDUCATION:
WELLNESS & LIFESTYLE ISSUES**

A. Introduction

1. Importance of These Topics to Family Planning Clients

Title X guidelines require that clients be offered information on these subjects because:

- Family Planning services are the only regular source of health care for many women;
- All of these areas may be directly relevant to clients' reproductive health care, depending upon their circumstances, health status, and/or primary method of birth control.

2. Required Vs. Recommended Information:

- **REQUIRED** - The following topics must be covered during all initial and annual visits:
Smoking
- **RECOMMENDED** – During the course of any visit that includes education and counseling, it is recommended that clients be asked if they have any questions related to:
Exercise
Nutrition
Weight Management

4. Section Organization and Use

This section includes the following:

- A shortened version of the DPH Tobacco Free Project's "Stop Smoking Program" education and counseling guidelines for clinic personnel.
- "WAVE," a quick assessment and education tools (5-10 minutes) for the combined issues of nutrition, physical activity and weight loss
- Extended information on nutrition, physical activity and weight loss to use as a reference when working with clients who have specific concerns or needs in a particular area

B. Smoking Cessation

1. Learning Objectives

- Smokers will be able to list 3 negative consequences of smoking;
- Clients who smoke and are interested in hormonal methods of birth control will be able to describe the increased health risks of “combining” the two
- Clients will receive support for quitting appropriate to their stage of behavior change

2. Materials

- Educational brochures and pamphlets
- Referral materials
- Lung models and other educational aides if available

3. Smoking and combined oral contraceptives

According to DPH medical protocols:

- a. Combined OCs are contraindicated for smokers who are over age 35, as smoking increases the risk for cardiovascular disease in pill users.
- b. Heavy smokers (20+ cigarettes / day), age 35 and older, not be prescribed OCs;
- c. Light smokers (< 20 cigarettes / day), age 35 and older, be warned of this risk and encouraged to stop smoking.
- d. Smoking clients who still want to use these methods should be advised to quit and must sign a high-risk consent form and have their lipid levels monitored regularly.
- e. All smokers < age 35 be warned of their increased cardiovascular disease risk and encouraged to stop smoking.

4. Smoking and progestin-only contraceptives (mini-pill, patch, etc.):

According to DPH medical protocols:

- a. Contraindicated for light and heavy smokers (5+ cigarettes / day), age 40 and over, due to a slight increase in cardiovascular disease risk.
- b. Smoking clients who still want to use these methods should be advised to quit and must sign a high-risk consent form and have their lipid levels monitored regularly.
- c. All smokers < age 40 be warned of this risk and encouraged to stop smoking.

5. Smoking, general health risks and other consequences:

- a. *Teenagers / Young Adults*: bad breath, stained teeth, cost, peer pressure, loss of freedom-controlled by cigarettes, sore throats, cough, detrimental to athletic performance, frequent respiratory infections;
- b. *Parents*: increased cough and respiratory infections in children of smokers, poor role model for children;
- c. *Asymptomatic Adults*: 6x risk of emphysema 10x risk of lung cancer, 5-8 yr shorter life span, 2x risk of heart disease, cost, bad breath, wrinkles
- d. *Symptomatic Adults*: correlate Current Symptoms with Smoking: cough / upper respiratory infections, sore throats, dyspnea (abnormal or uncomfortable breathing), ulcers, angina (chest pain), osteoporosis, esophagitis (inflammation, irritation, and swelling of the esophagus), gum disease.
- e. *Reproductive-Age Women*: illnesses related to hormonal status, increased risk for cervical cancer;

- f. *Pregnant Women*: increased rate of spontaneous abortions, lower birth-weight babies.

6. How the Body Improves After Quitting

- a. *Within 20 minutes*: blood pressure drops to normal, pulse rate drops to normal, body temperature of hands and feet increases to normal;
- b. *After 8 hours*: carbon monoxide level in your blood drops to normal, the oxygen level in your blood increases to normal;
- c. *After 24 hours*: ability to taste and smell improves, chances of a heart attack decrease;
- d. *After 48 hours*: nerve endings start to re-grow;
- e. *After 72 hours*: bronchial tubes relax and make breathing easier; lung capacity increases;
- f. *After 2 weeks to 3 months*: lung functioning increases up to 33%, walking becomes easier, circulation improves;
- g. *After 1 to 9 months*: coughing, congestion, shortness of breath decrease, body's overall energy level increases;
- h. *After 5 years*: lung cancer death rate for the average pack a day smoker decreases from 137 per 100,000 people to 72 per 100,000;
- i. *After 10 years*: pre-cancerous cells are replaced with normal cells; risk of other cancers (mouth, larynx (voice box), esophagus, bladder, kidney, and pancreas) decreases; lung cancer death rate for average smoker drops to 12 deaths per 100,000 almost the rate of non-smokers.

7. Advising clients to quit smoking*

a. General facts:

- Smokers are more likely to attempt to quit when advised to do so by a health provider;
- Most smokers go through several stages of change before they stop smoking: 1) contemplation; 2) attempting to quit (often more than once); 3) succeeding in quitting; 4) working on remaining a non-smoker.

b. The 6-Step Assessment and Counseling Process:

1. Ask: systematically at every visit.

- Do you smoke?
- How much?
- For how long?
- Ever tried to quit before?

2. Advise: strongly urge all tobacco users to quit.

- *Be Clear* --
“I think it is important for you to quit smoking now and I can help you.”
“Cutting down is not enough when you are using OCs.”
- *Be Strong* --
“As your clinician, I need you to know that quitting smoking is the most important thing you can do to protect your health now and in the future. The clinic staff and I will help you.”

* Section is taken from DPH Tobacco Free Project's "Stop Smoking Program" guidelines.

- *Personalized the Message* – Tie tobacco use to current health/illness, and/or its social and economic costs, motivation level/readiness to quit, and/or the impact of tobacco use on children and others in the household.
- 3. Assess:** determine willingness to make a quit attempt
- Ask every user if he or she is willing to make a quit attempt within the next 30 days:
- If the client is willing, provide assistance.
 - If the client will participate in a stop smoking class, emphasize the benefits of participating in a support group. Refer to SFGH Stop Smoking Program (<http://insidechnsf.chnsf.org/stopsmokingprogram>);
 - If the client is unwilling, provide motivational support.
- 4. Assist:** aid the client in quitting.
- aa. Help her make a “quit plan:”
- Set a quit date – ideally, the quit date should be within two weeks.
 - Inform family, friends, and coworkers and request understanding and support
 - Anticipate challenges, particularly during the critical first few weeks. These include nicotine withdrawal symptoms.
 - Remove tobacco products from the environment. Prior to quitting, avoid smoking in places where you spend a lot of time (e.g., work, home, car).
- bb. Provide practical problem solving/skills training:
- Abstinence – total abstinence (not even a single puff) is essential.
 - Explore past quit experiences - identify what helped and what hurt.
 - Anticipate triggers or challenges - explore how the client can overcome them.
 - Limit or abstain from alcohol – since alcohol can cause relapse.
 - Other smokers in the household – this makes quitting more difficult so clients should encourage smoking housemates to either quit with them or not smoke in their presence.
- cc. Provide intra-treatment social support:
- Be supportive yourself: “My office staff and I are available to assist you.”
 - Social support as part of treatment (e.g., through “quit” groups).
 - Environmental social support: “Ask your spouse/partner, friends, and coworkers to support you in your quit attempt.”
 - Approved pharmacotherapy (as indicated) which can reduce withdrawals and increase chances of success: bupropion SR, nicotine gum, nicotine inhaler, nicotine nasal spray, and nicotine patch
 - Provide supplementary materials that are culturally/ educationally/age appropriate.
- 5. Ask:** about Medical Coverage for nicotine replacement therapy or medication.
- 6. Arrange:** schedule follow-up contact, either in person or via telephone:
- a. Timing:
- Contact #1: Should occur soon, preferably within the first week of quitting.
 - Contact #2: Within the first month. Schedule further contacts as indicated.

- b. Actions during follow-up:
- Congratulate success!
 - If tobacco use has occurred, review circumstances and elicit recommitment to total abstinence. Remind patient that a lapse can be used as a learning experience. Identify problems already encountered and anticipate challenges in the immediate future.
 - Assess pharmacotherapy use and problems.
 - If patient was referred to a class, inquiring as to successes or challenges, as well as encouragement to continue the process may prove beneficial.
 - Follow up with the Stop Smoking Program may be necessary.

C. WAVE: A 5-10 Minute Assessment and Intervention Tool for Nutrition, Physical Activity and Weight Loss[†]

1. Learning Objectives

- Clients will assess the impact that their weight, diet and level of physical activity have on their general health.
- Clients who have challenges in the areas of weight, diet and/or level of physical activity will be able to describe 2 actions they can take to meet these challenges.

2. Materials

- Informational materials on nutrition, physical activity and weight loss
- “REAP” nutritional self-assessment tool (Appendix 9)

3. Assessment

WAVE stands for **W**eight, **A**ctivity, **V**ariety (diet), **E**xcess (diet). What follows is also available in an easy-to-use “WAVE Counseling Handout,” found at Appendix 13.

a. WEIGHT

- Assess if client’s Body Mass Index (BMI) is > 25, indicating overweight (See Appendix 2 for a BMI Chart).
- Counsel client about weight loss if BMI is >25 and waist circumference:
Is > 40 inches in men
Is > 35 inches in women

b. ACTIVITY

If client answers NO to any of the following, explore whether or not she is willing to increase physical activity:

- What physical activities has the client done in the past week (i.e., walking briskly, gardening, heavy housework, dancing, sports activities, etc.)?
- Does client do a total of 30 minutes of moderate activity on most days of the week? (This does not have to be done all at one time, but may be done in 10 minute intervals.)
- Does client do “lifestyle” activities like taking the stairs instead of elevators, getting off bus a block before her stop, etc.?
- Does client usually sit down to watch TV or videos less than 2 hours per day most days of the week?

[†] Adapted from a practitioner “pocket card” assessment and counseling tool developed by the Brown Medical School’s Nutrition Academic Award Program.

c. VARIETY (diet)

- What kinds of foods does the client eat most often (e.g., Soul Food, Chinese, Caribbean, Mexican, American, etc.) and is she a vegetarian?
- Is client eating a variety of foods from important sections of the food pyramid (use a culturally appropriate version if possible)?
 - Fruits and vegetables
 - Complex starches (whole grains, rice, tubers, winter squashes & beans)
 - Calcium-rich foods (dairy, calcium-enriched soy products, canned fish, broccoli, cooked greens)
 - Healthy fats (fatty fish, nuts, seeds, olives, avocados and plant oils)
 - Adequate protein (at least 2-3 servings daily) that is lower in saturated fats (nuts, beans, poultry, lean red meat, eggs, reduced-fat dairy)
 - Adequate water (may include limited amounts of other “natural” fluids such as green or herbal tea)

d. EXCESS (diet)

- How many servings of alcohol (1 oz of hard alcohol, 6 oz. of wine, 12 oz. of beer) does the client drink per day?
 - For men, a good limit is < 1-2 per day
 - For women, a good limit is < 1 per day
- Is the client eating too much:
 - Saturated fat? Calories? Salt? Sugar? Alcohol?
- Ask about the following:
 - Serving/portion sizes
 - Preparation (for instance deep fried foods, added saturated fats, margarine)
- Does client eat out 4 or more meals per week? If so, from what types of restaurants (fast-food, vegetarian, etc.)
- Does the client indulge on the weekends?

d. DETERMINING VARIETY & EXCESS

- Ask client to do a quick one-day recall or to complete a REAP questionnaire.
- **What does the client think are the pros/cons of her eating patterns?** Dispel her nutritional myths/misunderstandings.
- **If client could benefit from improved eating habits,** assess her willingness to make changes.

3. Counseling/Education

a. WEIGHT (If client is overweight)

- State concern, e.g., “I am concerned that your weight could affect your health.”
- Give specific advice, i.e.,
 - Make 1 – 2 changes in eating habits to reduce calorie intake as identified by diet assessment.
 - Gradually increase activity and decrease inactivity.
 - Enroll in a weight management or healthy lifestyle class sponsored either by your clinic or a nearby community agency.
 - Refer to your clinic nutritionist / dietician.
- Briefly explore potential barriers and supports.
- Set up a time for follow-up.
- Give the client additional materials and resources.

b. ACTIVITY

- If client is already active:
 - Congratulate her on taking care of herself.
 - Encourage her to continue her active lifestyle.
- If client is inactive:
 - Educate: 30 minutes per day of moderate activity done in intervals of 10 minutes or more help.
 - Provide examples of moderate activity: dancing, walking briskly, climbing stairs, gardening, washing windows or floors, etc.
- If client is ready to increase her activity:
 - Briefly explore potential barriers and supports.
 - Jointly determine simple activity goals – start slowly (i.e., 10 minutes per day) and increase gradually
 - Set up a time for follow-up.
- Give all clients additional materials and resources.

c. VARIETY (diet)

What is a serving and how many servings should be eaten daily? (PLEASE NOTE:

Healthy cultural eating patterns vary and these are not hard and fast rules – the most important thing is to eat a wide variety of whole, unprocessed foods every day.)

- **Fruits** (2-4 servings): 1 medium fresh fruit, ½ cup chopped or canned fruit, ¾ cup 100% fruit juice
- **Vegetables** (≥ 3-5 servings): 1 cup raw leafy vegetables, ½ cup cooked or raw vegetables, ¾ cup vegetable juice
- **Calcium-rich foods** (1-2 servings): 1 cup milk or yogurt, 1½ oz. cheese, ½ cup cooked broccoli or turnip greens, 3 oz. canned salmon or sardines with bones, 4 oz. tofu processed with calcium

- **Healthy fats** (at every meal): 3 oz. fatty fish, handful of nuts, seeds or olives, 1/5 of an avocado, 1 tbs. salad dressing, 1tsp. oil in cooking
- **Protein** (2-3 servings): 2-3 oz. poultry, fish or lean meat, 1 cup cooked beans, 1 egg, 1½ oz. cheese, 4 oz. tofu or tempe
- **Complex Carbohydrates** (at most meals): 1 slice whole grain bread or tortilla, ½ whole grain bagel or roll, 1 oz. ready-to-eat cereal, ½ cup cooked grain, pasta, winter squash, sweet potato, yam, etc. (white potatoes are not considered a complex carbohydrate)

d. EXCESS (diet)

How much is too much?

More than occasional servings of refined carbohydrates:

- High sugar beverages like sodas, “sports” drinks & highly sweetened coffees or teas
- Sugary snacks or desserts
- Fast food, white bread, pasta made from white flour, or white potatoes

More than occasional servings of unhealthy fats:

- Processed foods with hydrogenated oils
- Margarine
- Fried foods
- High-fat desserts
- Fast food, fatty meats or high-fat dairy products

Too much salt and/or chemicals (read labels):

- Processed meats
- Canned/frozen meals & fast food
- Canned vegetables with added salt
- Salt added to food after cooking

If eating out > 4 times per week, is client selecting restaurants and foods carefully to avoid high amounts of refined carbohydrates, unhealthy fats, and salt?

e. DIETARY RECOMMENDATIONS

- **Discuss pros & cons** of client’s eating pattern keeping in mind “Variety” and “Excess” and using appropriate food pyramid as a guide.
- If client is ready, **jointly set specific dietary goals**. Make plans manageable (small steps) and realistic.
- **Consider referring** client to your clinic’s nutritionist or dietician for more extensive counseling & support
- Arrange for **follow-up**.
- **Give client educational materials** and resources as appropriate.

D. Nutrition & Diet

1. Learning Objectives

- Clients will be able to describe a minimum of 4 principles of healthy nutrition

2. Materials

- Nutritional handouts or brochures, as appropriate

3. Nutrition and Pregnancy or Oral Contraceptives

- Please see these topics for specific recommendations
- Preconception Health: The U.S. Preventive Health Services Task Force recommends that all women who are capable of becoming pregnant take a multi-vitamin with at least 400 mcg of folic acid. Please see recommendation 4j, below.

4. General Recommendations for Preventive Health[‡]

- Eat vegetables and fruits “in abundance;”* Aim for 5 – 9 servings per day. Vary the color of the fruit and vegetables you eat (red, green, orange, purple) as different colors = different vitamin content. A diet rich in a variety of fruits and vegetables can decrease heart attack/stroke risk, protect against cancer, lower blood pressure, help avoid diverticulitis, and guard against age-related vision loss;
- Eat unrefined carbohydrates/starches at most meals;* The body needs carbohydrates for energy. Healthy sources of concentrated carbohydrates include whole grains (oatmeal, brown rice), legumes (beans, lentils, dried peas), plantains, winter squashes and tubers (yams, sweet potatoes, taro). Unlike processed carbohydrates, these foods are digested slowly. This keeps blood sugar and insulin levels from rising and then falling too quickly. It also helps to control appetite and may help to prevent adult-onset (Type 2) diabetes.
- Get adequate calcium;* Pre-menopausal women should eat at least 2 servings of high-calcium, low-fat foods daily. Lactating and post-menopausal women need more. Good sources include low-fat dairy products, calcium-enriched soy products, canned fish (e.g., sardines and salmon), broccoli, and greens (collard, mustard, etc.).
- Get your daily dose of healthy fats;* Surprisingly, healthy fats improve cholesterol levels and can also protect the heart from sudden and potentially deadly rhythm problems. Good sources include fatty fish, nuts, seeds, olives and plant oils such as olive, canola, peanut, soy and sunflower.
- Get adequate protein from sources that are low in saturated fat;* Aim for a daily intake of about 9 grams for every 20 pounds in body weight. Healthy sources of protein include legumes and nuts, fish, poultry (skinless preferred), eggs (limit yolks), and reduced-fat dairy products.

[‡] This section is based on guidelines from the Harvard School of Public Health. It varies from Government guidelines and the USDA Food Pyramid, which was developed with input from organizations sponsored by the food industry such as the Soft Drink Association. A recent USDA study found that women who most closely followed USDA Food Pyramid guidelines were only 3% less likely to develop a chronic condition. By contrast, a recent Harvard Medical School study found that women who most closely followed the School’s “Healthy Eating Pyramid” guidelines lowered their risk of cardiovascular disease by almost 30%.

- f. *Limit fried foods, refined carbohydrate and heavily processed foods;* Eat these foods sparingly, or not at all, as they can increase the risk for a number of chronic conditions including heart disease, type II diabetes, and cancer. Refined carbohydrates include bread, potatoes, and pasta as well as sugars. Regarding processed foods, an easy standard to remember is that “if the ingredients include 5 things you cannot pronounce, it’s not ‘real food.’”
- g. *Use salt and sodium in moderation;* The general recommendation is to limit sodium to 2400 mg per day or to 1500 mg per day for people with high blood pressure.
- h. *If you drink alcohol, do so in moderation;* While numerous studies suggest that having an alcoholic drink a day lowers the risk of heart disease, alcohol has risks as well as benefits, so moderation is important. For men, a good balance is 1 to 2 drinks a day. For women, it's one drink per day or less.
- i. *Drink adequate water;* between 6 – 8 eight-ounce glasses daily.
- j. *Take a daily multivitamin supplement.* Even careful eaters may have holes in their nutritional intake and all of us have days when we don’t eat as well as we’d like. In addition, all women of reproductive age should take a daily multi-vitamin containing a vitamin-B complex that includes folic acid. Folic acid taken at least 3 months before pregnancy reduces the risk of giving birth to a baby with a neural tube defect by 70%; taken at least 1 year before conception, there is evidence that it may reduce the risk for pre-term labor. *Please see www.gofolic.org for more information.*

4. Food Pyramid Examples

Please refer to Appendix 5 for handouts of various culturally-based food pyramids developed in conjunction with the Harvard School of Public Health.

5. Dietary Assessment & Counseling

Please see, Section IX.C., “WAVE” Assessment & Recommendation Tool.

E. Exercise & Physical Activity

1. Learning Objectives

- Client will be able to name at least two health benefits of regular physical activity
- Client will be able to describe 3 activities for maintaining or increasing physical activity that fit within her lifestyle

2. Materials

- Printed materials as appropriate

3. Benefits of Becoming or Staying Physically Active

Aerobic activity (e.g., walking, dancing and others which increase heart rate for an extended period):

- Increased energy
- Help with losing weight and controlling appetite
- Better sleep
- Relief from stress
- Less depression / a healthier mental outlook
- Improved blood cholesterol levels – lower LDL (bad cholesterol) and higher HDL (good cholesterol)
- Lowered risk for or better management of many chronic health conditions, including:
 - Diabetes (sugar)
 - Stroke and heart disease
 - Hypertension (high blood pressure)
 - Some forms cancers (e.g., cancer of the colon)

Strength training (lifting weights, heavy housework, cleaning windows, power yoga) and flexibility (stretching, yoga):

- Increased ability to perform daily activities
- Lower likelihood for developing back pain
- Greater balance, coordination and agility
- Decreased risk for becoming physically disabled, especially as get older
- Lower risk of developing osteoporosis

Additional health benefits of exercise for women:

- Decreased PMS symptoms & menstrual cramps (dysmenorrhea)

4. Potential Adverse Affects

- Weigh benefits against potential adverse effects, including: injury, osteoarthritis, myocardial infarction, sudden death (rare)
- Vigorous sporadic exercise in otherwise sedentary individuals can be very dangerous

5. Barriers to Physical Activity

- Economic and/or time constraints
- Lack of safe opportunities (e.g., unsafe neighborhoods which preclude nighttime walks)

- Incorrect belief that physical activity must include vigorous, extended exercise to be effective

5. National Institutes of Health Recommendations

- Physical activity does not need to be vigorous to be effective.
- Moderate physical activity done in 10 minute intervals will improve health
- Recommended amounts:
 - *People in their teens & early 20's*: 60 minutes per day done on most days of the week, either at one time or in a minimum of 10-minute increments;
 - *Adults*: at least 30 minutes per day done on most days of the week, either at one time or in a minimum of 10-minute increments.

6. “Small Steps” for Increasing Physical Activity

a. Making time:

- Get up 15 minutes earlier in the morning & stretch or take a quick walk
- Jog in place, stretch, lift weights or do other exercise while watching TV
- Arrange a meeting with friends around walking or jogging
- Play physical games when spending time with your children
- Take a short walk during breaks at work

b. Quick workouts:

- Use the stairs instead of the elevator
- Walk to the bus or train stop
- Walk to each end of the mall or shopping district when you go shopping
- Park your car a few blocks away and walk

c. Moderate activities:

- Walking, dancing, raking leaves, bowling, gardening, vacuuming, climbing stairs

d. Vigorous activities (add one becomes more fit):

- Bicycling, swimming, doing aerobics, jogging/running, marching in place, skipping rope, playing sports (basketball, football, soccer, softball)

7. Physical Activity Assessing & Counseling

Please see, Section IX.C., “WAVE” Assessment & Recommendation Tool.

F. Weight Management

1. Learning Objectives

- Clients will be able to name at least two benefits of maintaining a healthy weight
- Clients using hormonal birth control methods will be able to describe the potential impact of their contraceptive choice on their weight
- Clients who are overweight will be able to list 3 actions they can take to safely lose weight that fit within her lifestyle

2. Materials

- Printed materials as appropriate

3. Effects of Hormonal Contraceptives on Weight

Combination Oral Contraceptives:

- The estrogen may cause weight gain due to increased breast, hip or thigh tissue;
- Both estrogen and progestin may cause fluid retention;

Progestin-Dominant or Progestin-Only Hormonal Methods:

- Can cause appetite increase and permanent weight gain due to increased muscle tissue;
- Hormonal-related depression may lead to increased appetite and weight gain.

4. Risks of Being Overweight / Advantages of Losing Weight:

Being overweight or obese increases the chances of developing:

- High blood pressure;
- High blood cholesterol or other lipid disorders;
- Type 2 diabetes;
- Heart disease and stroke;
- Certain cancers,

Advantages to Losing Weight if Overweight or Obese:

- A weight loss of just 10 percent will help to lower disease risk.
- Among people with chronic illness, even a small weight loss may improve blood cholesterol levels, lower blood pressure and control blood sugar levels.

5. Assessing Potential Weight-Related Health Risk & Counseling

Please see, Section IX.F or Appendix 13, “WAVE” Assessment & Recommendation Tool.

6. Weight Loss Guidelines

- Even a modest loss of 10 – 20 lbs. or 10% of body weight can have health benefits.
- Slower weight loss is safer, more effective, and more likely to last than rapid weight loss.
- Rapid weight loss and “yo-yo dieting” (repeated weight loss and gain) can have dangerous health consequences and even be fatal.

- A weight-loss “diet” that limits you to very small portions or that excludes certain foods may be hard to stick to and so will not work over the long term.
- For most people, it is most effective to create a healthy eating plan that takes into account your likes and dislikes, and includes a variety of foods for good health.

7. Tips for Safe and Effective Weight Loss

- Set realistic weight goals: Getting enough nutrients from food is impossible on less than 1,200 calories per day. A pound of fat stores 3500 calories (kcal). To lose a pound of fat a week a person must eat approximately 500 fewer calories (kcal) per day than she uses.
- Get active: This may be the most important tool for long-term weight loss. Even small amounts of moderate activity throughout the day (e.g., three brisk 10-minute walks) can speed weight loss and improve health and mood. (See Section IX.E, Physical Activity.)
- Eat healthy: Eat a wide variety of unprocessed foods that are low in saturated and hydrogenated fats and that provide your body with enough vitamins, minerals, protein, healthy fats and complex carbohydrates. If eating less than 1,600 calories per day, take a vitamin supplement. (See Sections IX.C and IX.D for more information.)
- Eat smaller amounts more often: Eating three smaller meals and two to three snacks throughout the day keeps blood sugar levels stable and helps to prevent binge eating. Become familiar with standard portion sizes (See Sections IX.C and IX.D for more information).
- Listen to your body: Pay attention to your body’s signals. Eat when you begin to feel hungry; don’t wait until you feel starved. Stop eating a little before you feel completely full.
- Limit eating to the dining table: This can help to limit snacking and food intake. Additional tips include: 1) make your plate before sitting down at the table rather than eating “family style;” 2) use smaller plates to make portion sizes appear larger; 3) don’t eat out of containers in the kitchen; 4) avoid snacking while watching television or at the movies.
- Don’t weigh yourself more than once a week: Doing otherwise could sabotage efforts since water weight fluctuates daily.
- Find support: Enlist your family and friends. Join support groups (online or through a group like Weight Watchers or Overeaters Anonymous) to share feelings, successes and challenges.

**X. CLIENT EDUCATION & COUNSELING:
CONTRACEPTION**

A. General Contraceptive Counseling Guidelines

1. Learning Objectives

- Client will be able to describe all the benefits of and risks involved in using her contraceptive method(s) of choice, as well as all available alternatives to this method.

2. Materials

- Educational brochures/handouts that are appropriate for the client linguistically, culturally and in terms of reading levels
- Birth control “sample kits” and demonstration aides or charts

3. The “GATHER” Approach to Contraceptive Counseling

(Fulfills informed consent requirements)

G = Greet client in a warm, friendly manner; help her feel at ease;

A = Ask client about her reproductive goals and needs and risk for STIs; does she already have a method in mind?

T = Tell client about her options, including abstinence, explaining the advantages and disadvantages of each; if client has already decided on a method, review other methods only briefly

H = Help undecided patients to choose (see following two sections, “Reproductive Goals...” and “Questions Clients Should Consider...”)

E = Explain and demonstrate the correct use of the method(s) the client has chosen, emphasizing how to avoid method failure and covering any warning/emergency signs

R = Review important instructions with client; clarify time and conditions for return visit; give language and reading-level appropriate written instructions for client to review later

NOTE: Document client’s informed choice by asking her to sign and witnessing appropriate method consent form(s).

4. Reproductive Goals and Contraceptive Counseling:

| GOAL | PRIMARY BC CONCERNS MAY BE: |
|-------------------------------|--------------------------------------------------------------------------------------------------|
| Delaying Birth of First Child | Effectiveness of method, future fertility, STIs, explain EC |
| Avoiding Abortion | Need for maximum effectiveness, explain EC, may want to use 2 methods consistently |
| Spacing Births | Balance of efficacy and convenience, explain EC |
| Completed Childbearing | Needs effective method for long term, offer IUD, injections, implants, sterilization, explain EC |

5. Questions Clients Should Consider When Choosing a BC Method:

- a. What are my contraceptive goals at this time? How do I feel about abortion?
- b. How will I feel using this method (e.g., more secure, afraid, embarrassed, etc.)?
- c. How will my partner(s) feel about this method?
- d. Have I ever had problems using this method in the past? If so, what has changed?

- e. Will I have trouble remembering to use this method or using it correctly?
- f. How do I feel about possible side-effects of this method (e.g., weight gain, fewer periods, longer or heavier periods, etc.)
- g. Does this method cost more than I can afford?
- h. Could this method have serious health complications for me? Has a medical provider ever told me I should not use this method?
- i. Am I opposed to this method because of my religious or moral beliefs?
- j. Is there anything about this method that might make me avoid using it (e.g., I would enjoy lovemaking less; partner(s) might be resistant, etc.)
- k. Am I at risk of HIV/STIs if I use this method? If so, do I want to also use condoms?

B. Emergency Contraception Pills (ECP)

1. Learning Objective

- Client will be able to state the conditions for use, effectiveness, and mode of action, advantages and disadvantages of using emergency contraception pills (ECP).

2. Materials

- Written ECP instruction sheet, anatomy and physiology diagrams

3. Resources

- The Emergency Contraception Hotline: 1-888-668-2528
- Website: <http://www.ec-help.org>

4. Counseling – STIs

- Patients should be counseled that this product does not protect against HIV infection (AIDS) and other sexually transmitted diseases.

5. How ECP Works

- Called the “morning after pill,” ECP is an emergency measure.
- Similar to birth control pills, ECP prevents pregnancy by:
 - a. Keeping the egg from leaving the ovary
 - b. Keeping the egg from meeting the sperm
 - c. Keeping the egg from attaching to the uterus.
- May prevent pregnancy but will not stop or harm an existing pregnancy
- Does not cause abortion.

6. 2 Types of ECP:

Note: Plan B is preferred, but MediCal only allows Plan B and Previn to be given to a client 3x each within a 12-month period.

a. Progestin Pills (Plan B)

- A progestin pill especially made for emergency use.
- Women who can't use estrogen may be able to take Plan B
- *Effectiveness:* Taken within 24 hours of intercourse, reduces pregnancy risk by 95%; taken later, the risk reduction rate is 89%.

b. Combined Pills (Preven or COCs)

- Preven is made for EC use. Several other brands of birth control pills can also be used.
- Women who can't use birth control pills on a regular basis often can use combined pills safely on an emergency basis
- *Effectiveness:* Reduces the risk of pregnancy by 75%

c. Progestin-only ECP may be preferable when:

- Client has history of thromboembolic disease.

- Breast-feeding > 6 weeks postpartum

7. Indications for Use

Within 120 hours of unprotected vaginal intercourse (i.e., unplanned, forced sex/rape, barrier method broke or slipped, missed OCs or late DMPA shot)

8. Special Counseling Considerations

- Frequent use: ECPs for emergency use only; less effective than regular contraception
- Use after 72 hours: while are effective up to 5 days after unprotected sex, the sooner used the better ECP works
- Ongoing contraception refused: contraceptive counseling recommended for all women seeking ECP, however this should not be a condition of receiving care

9. Advantages

- Provides protection against pregnancy in the case of a contraceptive emergency
- No serious harmful side effects have been reported
- Drug exposure and side effects do not last long

10. Disadvantages

- May be unnecessary (could “wait and see”)
- May be objectionable for women who believe that life begins when the egg is fertilized
- Side effects (subside within 1 – 2 days of treatment): nausea (50-70%), vomiting (22%), breast tenderness, abdominal pain, headache or dizziness
- May alter timing of next menses--may be a few days earlier or later than usual.
- NO protection against HIV and most other STIs

11. Absolute Contraindications

- Pregnant or positive pregnancy test
- History of allergic reaction to COCs or progestin-only contraceptive pills.
- Undiagnosed abnormal genital bleeding

12. Possible Contraindications

- Medications that lower blood levels of levonorgestrel may make Plan B less effective (e.g., many anti-seizure drugs, Rifampin, Griseofulvin, St. John’s Wort)
- Symptoms of UTI or STI
- Severe focal leg pain

13. Lab test prior to ECP administration

- High-sensitivity urine pregnancy test to rule out pregnancy
- Pelvic exam, if annual due or has symptoms of vaginitis, UTI or other STIs.

14. Method Use

- Take in two doses (number of pills per dose depends upon type of pill prescribed), each within 15 minutes of eating solid food:
 - a. Dose 1: ½ total number of pills, taken within 5 days of having intercourse

- b. Dose 2: ½ total number of pills, taken 12 hours later
- c. May be given extra pills in case vomiting occurs
- Do not have unprotected sex until the next period occurs (condoms recommended)

15. Follow-up (clients using hormonal methods)

- Continue with hormonal methods immediately following ECPs
- Return to clinic in 2-3 weeks for highly sensitivity urine pregnancy test
- If not continuing with hormonal method, return to clinic for pregnancy test if menses is more than 1 week late

16. Warning Signs – contact clinic immediately if experience:

- Severe pain in leg and (calf or thigh)
- Severe abdominal pain
- Chest pain
- Cough
- Shortness of breath
- Severe headaches, dizziness, weakness, or numbness
- Blurred vision, loss of vision, or trouble speaking
- Jaundice (yellowing of the skin)

NOTE: No serious side effects from emergency contraceptive pills have ever been reported.

17. PLAN B “To Go”/Advance Provision

- Educate all family planning clients about the availability and use of ECP
- Advance prescription for women who want to have ECPs on hand (e.g., in case of contraceptive failure or forgetting to take OCs) is now the standard of care; instruct clients interested in this option to ask their clinicians

C. Abstinence

1. Learning Objective

- Client will be able to state the effectiveness, advantages and disadvantages of abstinence.

2. Teaching Materials

Brochures & pamphlets; communication handout for teens

3. Counseling – STIs

- When used consistently and so to avoid all exchange of sexual fluids, this method provides 100% protection against HIV infection (AIDS) and other sexually transmitted diseases.

4. How it Works

- The only 100% effective method of preventing pregnancy and STIs.
- Involves a conscious decision not to engaging in vaginal, anal and oral intercourse.
- Abstinence may be used:
 - a. For an extended period of time (e.g., until client feels “ready” to have sex or is married)
 - b. On a case-by-case basis (e.g., because client and her partner have no condoms on hand).
- Many adults choose abstinence at particular points in their lives.

5. Effectiveness

100% when used correctly and consistently

6. Advantages

- Free and always available
- Entails no health risks
- Prevents HIV/STI transmission
- May be more consistent with some client belief systems

7. Disadvantages

- Can be difficult to use if user isn’t properly prepared
- Requires the cooperation of one’s partner
- May cause sexual frustration
- A client may get pregnant or contract an STI if she changes her mind and has intercourse without using another method of birth control/STI protection.

8. Correct Use

- **A conscious and considered choice** to use this method is crucial.
- **Partner communication and negotiation** are a must.
- **Avoid all potential contact of sperm with vagina:** the penis must not be put in or near the vagina; if ejaculation occurs, it should not happen anywhere near the woman’s vulva.
- **Outercourse:** Method may include forms of sexual activity that avoid exchange of body fluids but are pleasurable and may lead to orgasm. (See “Range of Sexual Expression Handout,” Appendix 8.)

D. Barrier Methods: Cervical Cap[§]

1. Learning Objective

Client will be able to state the effectiveness, mode of action and instructions for use, advantages and disadvantages of the cervical cap.

2. Materials

- Cervical cap, spermicidal jelly or cream, plastic model to demonstrate insertion, pamphlets

3. Counseling – STIs

- This product does not protect against HIV infection (AIDS) and most other STIs.

4. How It Works

- The cervical cap is a thimble-shaped latex device that covers the cervix. The groove on the inside of the cap creates a seal and together with the support of the vaginal wall, keeps the cap in place. *It should be used* with spermicidal jelly or cream.
- The cap acts as a barrier, blocking passage of the sperm from the vagina through the *cervical opening* and into the uterus and tubes where they can fertilize an egg.
- The spermicide placed inside the cap kills any sperm that successfully travel around its rim.

5. Effectiveness

- *Women who have had a baby:* 74% used correctly and consistently, 68% among all users
- *Women who have not had a baby:* 91% used correctly and consistently, 84% among all users

6. Advantages

- May be inserted up to 6 hours prior to intercourse, allowing for spontaneous protected sex
- Repeat applications of spermicide not needed for repeated intercourse within 48 hours
- Often can be used by women whose pelvic muscles cannot hold a diaphragm in place
- Few adverse side effects

7. Disadvantages

- Not appropriate for all types of cervixes
- May not fit all cervixes well, due to limited sizes available
- Can be dislodged from cervix during intercourse
- An odor can occur when left in the vagina for longer than 48 hours
- Must be fit by a clinician
- Increased rate of bacterial vaginosis and yeast vaginitis in women who use spermicides
- Possible increased risk of HIV transmission due Nonoxynol-9 in spermicidal cream/jelly
- May increase risk of cervical dysplasia

8. Who MAY NOT BE ABLE TO Use This Method

- History of abnormal Pap smears in the past year

[§] Special Note: The cervical cap is not provided at any of the Health Centers. Referrals are available.

- History of Toxic Shock Syndrome
- Latex allergy
- Women with a cervix who may not be adequately fit with currently available cap sizes
- Full-term delivery within the past 6 weeks or a recent spontaneous or induced abortion

9. Exam / Fitting

- Must be fit by a clinician
- A Pap smear is performed on all clients wishing to be fitted for a cap in order to identify patients who may have evidence of HPV infection.

10. Method Use

- Use the cap every time you have intercourse.
- Can be inserted at any time during a 42-hour period before intercourse. However, leaving it in the vagina for this length of time is not recommended.
- Fill the dome of the cap one-third full with spermicidal cream or jelly.
- Squeeze the rim together with thumb and forefinger and insert into vagina and directly over the cervix; some clinicians recommend waiting to have intercourse for at least 30 minutes after insertion in order to allow good suction to develop.
- DO NOT USE oil-based lubricants with the diaphragm. If additional lubrication is needed, use a water-based lubricant (e.g., K-Y jelly, spermicidal jelly or cream, saliva).
- DO NOT DOUCHE OR REMOVE CAP for at least 6-8 hours after last act of intercourse.
- DO NOT LEAVE IN longer than 48 hours.
- To remove, locate the cap rim on your cervix. Press on the cap rim until the seal against the cervix is broken, then tilt the cap off the cervix. Hook your finger around the rim and pull it sideways out of the vagina.

11. Care After Removing the Cap:

- Wash the cap with plain soap and water.
- Allow to air-dry before returning it to its case (if necessary, use cornstarch – never talk products – to speed drying time).
- Check for holes, tear or cracks before putting it away.

12. Warning Signs

Although extremely rare, a client should call the clinic or seek emergency care for any of the following symptoms, which might suggest toxic shock syndrome:

- Sudden high fever
- Sunburn-like rash
- Vomiting or diarrhea
- Dizziness, weakness, faintness
- Sore throat, aching muscles and joints

E. Barrier Methods: Condom, Female

1. Learning Objective:

Client will be able to state effectiveness, mode of action, and instructions for use, advantages and disadvantages of the female condom.

2. Teaching Materials

- Sample female condom, pelvic model, brochures.

3. Counseling – STIs

- This product, when used consistently and correctly provides excellent protection against HIV infection (AIDS) and most other sexually transmitted diseases.

4. How the Female Condom Works

- Provides a physical barrier that lines the vagina entirely and partially shields the perineum.
- The soft, loose-fitting sheath contains two flexible polyurethane rings:
 - One sits inside the condom, at the closed end of the sheath; this helps to insert the condom and to keep it in place
 - One ring forms the external, open edge and remains outside the vagina after insertion.
- The female condom is pre-lubricated on the inside with a silicone-based lubricant.

5. Effectiveness

- 95% effective when used correctly and consistently; 79% effective when considering all users

6. Advantages

- No health risks
- No prescription needed, easily available at drugstores
- Provides added lubrication
- Does not require partner involvement
- May protect against STI organisms transmitted by skin-to-skin contact of labia, scrotum or the base of penis, e.g., syphilis, herpes, venereal warts

7. Disadvantages

- May be difficult to insert
- Must use a new female condom with each sex act
- May not be able to use certain sex positions
- May be noisy during sexual intercourse (*manufacturer suggests adding lubricant*)

8. Possible Contraindications

- Women allergic to polyurethane or silicone-based lubricants
- Women unable to learn correct insertion technique
- Inability to fit properly, due to severe uterine prolapse

9. How do you use the Female Condom?

- Use a new female condom with each sex act
- May be inserted up to 8 hours before intercourse
- Do not use female condom and male condom at the same time
- Hold pouch with the open end hanging down. Use thumb and middle finger of one hand to squeeze the outside of the inner ring into a narrow oval shape for insertion. Put index finger on pouch between other two fingers. Insert pouch as far as possible into vagina, making sure inner ring is past pubic bone. Pouch should not be twisted and outer ring should be outside vagina.
- Remove immediately after intercourse, before standing. Squeeze and twist outer ring to keep semen inside pouch. Pull out gently and discard in a trash can, not a toilet.

F. Barrier Methods: Condom, Male

1. Learning Objective

Client will be able to state the effectiveness, mode of action and instructions for use, advantages and disadvantages of male condoms

2. Educational Materials

- Penis model and condoms for demonstration, samples of types of condoms offered in the clinic, educational pamphlets

3. Counseling – STIs

- When used consistently and correctly, this product provides excellent protection against HIV infection (AIDS) and most other sexually transmitted diseases.

4. How Male Condoms Work

- Condoms are sheaths that fit over the erect penis; they act as a barrier to prevent sperm from entering the vagina
- Condom types: latex, polyurethane or lambskin (processed collagenous tissue)
- Latex and polyurethane condoms reduce the risks of STIs, including HIV; lambskin condoms DO NOT protect against HIV/STI because they are more porous

5. Effectiveness

- 98% effective in preventing pregnancy when used correctly and consistently, 85% effective when considering all users
- Use with spermicides may increase effectiveness for pregnancy prevention
- If STI/HIV prevention is a primary consideration, should not be used with spermicides, as this may increase risk of HIV infection due to irritation caused by nonoxynol-9

6. Advantages

- No prescription needed; easily available at drugstores
- After abstinence, provide the best protection against HIV/STIs
- Can help men keep their erections longer
- No side-effects

7. Disadvantages

- Some people feel condoms reduce sensation, or may reduce eroticism or sexual spontaneity (discuss how they can be made a part of sexual play)
- Lubricants may be too messy; without lubrication condoms may feel dry and/or break
- A small number of people are allergic to latex, which can result in temporary skin irritation
- Require partner communication and cooperation

8. Possible Contraindications

- Women and men allergic to synthetic materials such as latex, and polyurethane (in this case, use a lambskin and a latex condom at the same time – the lambskin should be used against the skin of the partner with the allergy)

9. Use

- Check the expiration date on the package – do not use if expired
- Use every time you have sex
- Put onto the erect penis before it enters or gets near the vagina (anus or mouth)
- Leave space at the tip for semen – this will decrease risk of breakage
- Unroll the rim of the condom all the way to the base of the penis
- Use only WATER-BASED lubricants (e.g., K-Y jelly, spermicidal jelly or cream, saliva); AVOID OIL-BASED lubricants like Vaseline or baby oil
- Withdraw penis from the vagina IMMEDIATELY AFTER ejaculation
- Hold the rim of the condom onto base of the penis as the penis is being withdrawn so that the condom does not slip off
- Throw condom away; avoid letting semen drip onto vulva (or anus)
- USE ONLY ONCE! Do not re-use condoms
- STORAGE – do not store in a warm place like a wallet or back pocket for any length of time as this may make condoms brittle

10. Common User Mistakes

- Failure to use with each and every sex act (intercourse), including during menstruation
- Lack of proper lubrication
- Use of oil-based lubricants such as baby oil or lotion
- Put on after penetration has occurred

G. Barrier Methods: Diaphragm & Spermicide

1. Learning Objective

Client will be able to state the effectiveness, instructions for use, mode of action, advantages, and disadvantages of the diaphragm and spermicidal jelly/cream.

2. Materials

- Demonstration diaphragm, cream, jelly, and plastic pelvic model, educational pamphlets

3. Counseling – STIs

- This product does not protect against HIV infection (AIDS) and most other sexually transmitted diseases; it does decrease the risk for PID.

4. How It Works

- A dome-shaped rubber cup with a flexible spring rim used with a spermicidal cream or jelly.
- Prior to intercourse, the diaphragm is filled with spermicidal cream or jelly. It is then inserted into the vagina and placed over the cervix, holding the cream or jelly in place
- Blocks the cervical os, preventing sperm from entering uterus.
- The diaphragm holds spermicidal jelly or cream close to the cervix; the spermicide kills sperm that manage to travel around the rim of the diaphragm.

5. Effectiveness

- 94% if it is the correct size, is not torn and is used correctly each time
- 82% effective when all users, careful and careless, are considered together

6. Advantages

- Causes few health problems
- Can be inserted up to 6 hours before having sex, allowing for spontaneity during sex
- Can help to decrease risk of some STIs
- When fit properly, will not be felt by either partner

7. Disadvantages

- Irritation to vagina or penis caused by an allergies to latex or spermicide
- Possible increased risk of HIV transmission due to necessity of using Nonoxynol-9
- Increased rate of bacterial vaginosis, yeast vaginitis and bladder infection
- May be slightly messy
- May not always be available for unanticipated intercourse
- Taste of the spermicidal jelly or cream may interfere with oral sex
- Increased risk for toxic shock syndrome; **Should not** be used during menses for this reason

8. Contraindications

- Allergy to latex or spermicide
- No proper fit due to uterine prolapse or vaginal abnormalities (determined by pelvic exam)

- Inability to correctly insert or follow instructions for care of the
- A history of toxic shock syndrome
- Repeated urinary tract infections that persist despite efforts to refit the diaphragm
- Clients who are uncomfortable touching their genitals may find it difficult to use this method

9. Method Use

- Can be inserted up to 6 hours before intercourse by woman or her partner.
- Before insertion, place a teaspoon of spermicide inside the dome of the diaphragm. Make sure to spread some of the jelly or cream beneath the rim of the diaphragm as well.
- Insert the diaphragm while the woman is either standing, squatting or lying down.
- Insert the diaphragm as far back in the vagina as it will go. It should completely cover the cervix and fit behind the pubic bone.
- After insertion, use index finger to check that the diaphragm completely covers the cervix.
- Inserts one applicator full of jelly or cream before each additional act of intercourse. **DO NOT REMOVE** the diaphragm to insert more spermicide.
- **DO NOT USE** oil-based lubricants with the diaphragm. If additional lubrication is needed, use a water-based lubricant (e.g., K-Y jelly, spermicidal jelly or cream, saliva).
- Wait 6-8 hours after the last act of intercourse before removing the diaphragm.
- **DO NOT LEAVE** the diaphragm in place for more than 24 hours after insertion.
- **DO NOT DOUCH** (never recommended) for at least 6-8 hours after last intercourse.

10. Diaphragm Care – After Removal:

- Wash the diaphragm thoroughly using soap and water.
- Allow to air-dry before returning it to its case (can use cornstarch to speed drying time).
- Check for holes or tears before putting away.

11. When Client Should Have Her Diaphragm Refitted

- After gaining or losing ≥ 15 pounds in weight
- If she or partner experience pain or discomfort during use
- If she experiences urethral irritation related to diaphragm use
- After a pregnancy (fit at 6+ weeks postpartum)
- After pelvic surgery
- If she is having difficulty with insertion or removal

12. Warning Signs

Although extremely rare, a client should call the clinic or seek emergency care for any of the following symptoms, which might suggest toxic shock syndrome:

- Sudden high fever
- Sunburn-like rash
- Vomiting or diarrhea
- Dizziness, weakness, faintness
- Sore throat, aching muscles and joints

H. Barrier Methods: Spermicides

1. Learning Objective

To state effectiveness, mode of action, instructions for use, advantages and disadvantages.

2. Educational Materials

- Pelvic model and various types of spermicides for demonstration, educational pamphlets

3. Counseling – STIs

- Nonoxynol-9 does not prevent STIs, and may actually increase the risk of HIV transmission

4. How Spermicides Work

- Spermicides contain chemicals that immobilize and kill sperm. In the U.S. only nonoxynol-9 is currently approved for use.
- Spermicides come in the following forms: foam, suppositories, film(VCF) , jellies and cream

5. Effectiveness

- 85% when used correctly and consistently, 71% effective when considering all users
- When used with condoms, effectiveness increases to 98% (comparable to OCs)

6. Advantages

- Provide extra lubrication during sex
- No health risks.

7. Disadvantages

- **Possible allergic reaction to nonoxynol-9 = skin irritation and possible increased risk for STI/HIV transmission** due to resulting vaginal/penile /anal lacerations
- May be too messy (not true of film)
- Some people feel that may reduce sexual spontaneity (discuss how can be made part of sex)
- Spermicides contain chemical barriers (nonoxynol-9, octoxynol-9, menfegol, and benzalkonium choride that immobilize and kill sperm. Nonoxynol-9 most commonly used does not prevent STI transmission, and may actually increase the risk of HIV transmission
- Taste or smell may be objectionable, especially during oral sex.

8. Contraindications

- Women and men allergic to spermicidal ingredients or silicone-based lubricants.

9. Method Use

Use - Foam:

- Use one applicator full of foam every time you have intercourse.
- Shake container vigorously at least 20 times, then use nozzle to fill the plastic applicator.
- Best if inserted right before intercourse.
- Before the penis comes into contact with the vulva or vagina, insert filled applicator deep into the vagina and up against the cervix, release spermicide and remove applicator.
- If ejaculation doesn't occur within one hour, insert another applicator full of foam.

Use - Contraceptive Jelly or Cream:

- Use one applicator full of cream or jelly every time you have intercourse.
- Squeeze spermicidal cream or jelly out of tube and into plastic applicator until full.
- Before the penis comes into contact with the vulva or vagina, insert filled applicator deep into the vagina and up against the cervix, release spermicide and remove applicator.
- If no ejaculation within one hour, insert another applicator full of cream or jelly.
- DO NOT DOUCH right after intercourse; if desired, wait at least 6 hours.

Use - Suppositories:

- Use a new suppository every time you have intercourse.
- Before penis touches the vulva or vagina, remove the wrapping and slide the suppository deep into the vagina and up against the cervix. The cervix feels similar to the tip of your nose.
- Wait 10-15 minutes for suppository to dissolve before putting the penis into the vagina.
- If ejaculation does not occur within one hour of insertion, insert another suppository.
- DO NOT DOUCH right after intercourse; wait at least 6 hours after last act of intercourse.

Use - Vaginal Contraceptive Film (VCF):

- Use a new sheet of film every time you have intercourse.
- Be sure your fingers are completely dry.
- Before the penis comes into contact with the vulva or vagina, take one sheet of film out of its wrapper, and insert deep into the vagina placing the film against the cervix. The cervix feels similar to the tip of your nose.
- Wait between 10-15 minutes for the film to dissolve before putting the penis into the vagina.
- If ejaculation does not occur within one hour, insert another sheet of the film.
- DO NOT DOUCH right after intercourse; if desired, wait at least 6 hours after last act of intercourse before douching

10. Common User Mistakes

- Failure to use with each act of intercourse, including during the menstrual period
- Failure to wait long enough after insertion of film and suppositories
- Failure to use another application if ejaculation has not occurred within an hour
- Use of too little foam or jelly
- Failure to shake foam container before filling applicator and inserting into vagina

11. Caring for Spermicidal Supplies

- Store in a convenient location that is clean, cool and dark.
- Wash applicator with soap and water after each use. DON'T USE talcum powder.

12. Warning signs

Clients/patients should call the clinic with any of the following symptoms:

- Excessive vaginal discharge.
- Burning or irritation of the vulva or vagina (that doesn't subside).
- Burning or irritation of the penis (that doesn't subside).

I. Combined Hormonal Contraceptives: General Counseling

1. Learning Objectives

Client will be able to state effectiveness, mode of action, general advantages and disadvantages, health risks & danger signs of combined hormonal contraceptives

2. Materials

- Samples, handouts and instruction sheets, brochures

3. How Combined Hormonal Contraceptives Work

The Patch contains two types of hormones - estrogen and progestin. These hormones:

- a. Stop your body from releasing an egg, so no egg can be fertilized
- b. Cause the cervical mucus to thicken, which can stop sperm from getting into the uterus
- c. Change the uterine lining, preventing implantation of a fertilized egg (theoretical)

4. Counseling – STIs

None of these products protect against HIV infection (AIDS) and most other STIs; may provide some protection against PID but not against cervical infections.

5. Effectiveness

- Over 99% effective with perfect use in most women; typical use ratings vary depending upon the method.

6. Advantages

- Very effective
- Easy to use and safe for most women
- Most women do not experience significant side effects
- Discreet
- These methods don't require partner involvement
- Does not interrupt sex; allows for spontaneity
- Possible reduction in menstrual cramping (dysmenorrhea)
- *May be used for extended cycles in order to schedule bleeding less often; studies have found NO health risks associated with extended regimen use.*

7. Disadvantages

- Requires a prescription from a qualified health care provider
- No protection against HIV/STI infection
- May experience unscheduled spotting or bleeding or may have other changes in menstrual periods.
- There is a chance of developing some of the following: nausea or vomiting, breast tenderness, headache, mood changes, nervousness, changes in sex drive, hair loss, acne, skin pigment changes, facial hair, or change in appetite. *Usually temporary, most women don't experience them after the first three months.*

8. Contraindications or Precautions

Women should discuss with their provider if they have any of the following health concerns:

- Are taking medications or herbs that interfere with hormone absorption

- Pregnancy or completion of term pregnancy in past 21 days
- Are breast feeding
- Undiagnosed abnormal genital bleeding, including primary amenorrhea
- Current cancer or a history of cancer
- Migraines
- Diabetes
- Lupus
- Have or have had high blood pressure or high cholesterol
- Active gallbladder, liver, or pancreatic disease
- Have had blood clots, stroke or a heart attack
- Smoke, especially if over age 35
 - Currently are experiencing major depression
 - Diabetes without vascular disease
 - Elective major surgery in the next 4 weeks requiring prolonged immobilization
 - Severe asthma
 - Sickle cell anemia (carriers are not at increased risk)

9. Warning Signs

A client should call the clinic or seek emergency care for any of the following symptoms:

A = Abdominal pain (severe)

C = Chest pain/pressure (severe) cough, shortness of breath

H = Headaches (severe) weakness of muscle groups, numbness or dizziness

E = Eye problems (double vision, blurring or blindness)

S = Severe leg pain (calf or thigh) swelling or redness

10. Special Counseling Considerations

- **If experience bothersome side effects** call your clinician; s/he may be able to prescribe a different hormonal method or brand of pill with which you will have fewer problems. **DO NOT DISCONTINUE METHOD** before seeing the clinician unless warning signs occur.
- **Keep a back-up method of birth control handy** and emergency contraception “just in case.”
- **Decrease your HIV/STI risk** by using condoms

J. Combined Hormonal Contraceptives: Method-Specific Considerations, Ortho-Evra Patch

1. Definition

The Patch is a thin smooth, stick-on 1 ¾ inch square patch that contains and releases hormones into the bloodstream through the skin.

2. Materials

- Sample model of the patch, handout and instruction sheets

3. Effectiveness

- 99.5-99.9% with perfect use; 92% in typical use during first year
- Less effective in women > 198 pounds; they have a 5 – 10% increased risk of pregnancy

4. Method-Specific Advantages

- Discreet; you can wear it in a different place each week
- Stays on even with humidity, showering, bathing, swimming or exercise
- Does not cause weight gain
- *May be used for extended cycles if prefer to avoid scheduling monthly bleeding*

5. Disadvantages

- Possible increase in menstrual cramping and abdominal pain
- Amenorrhea (rare), breakthrough bleeding
- Patch may detach or result in a mild rash where worn
- A slightly increased risk of clotting over other combined hormonal contraceptives

6. Instructions for Use

Timing:

- Start on the day suggested by your provider
- Put on a new patch once a week for 3 weeks in a row, always change the patch on the same day of each week
- Week 4: Take off the used patch and throw it away. Go 7 days without wearing a patch.
- After 7 days, put on a new patch, even if your period is not over.
- NEVER GO MORE THAN 7 DAYS without a patch. If you do, you can get pregnant.

Extended Regimen:

- For women who do not want to have cyclic scheduled bleeding, may use extended patch for up to 84 days.
- Women can use continuous patches in the absence of spotting or bleeding or other contra-indications, as determined by clinician.

- **IMPORTANT NOTE:** Estrogen doses with continuous patch use are higher than with continuous oral contraceptive use and may increase some health risks.

Placement:

- Always put on clean dry skin; avoid putting creams, lotions, oils, powder or makeup on or near your patch to ensure that it sticks properly
- You can put the patch on different parts of your body excluding the breast (i.e., buttocks, abdomen, upper torso, or upper outer arm)
- Peel away half of the clear plastic (avoid touching the sticky surface)
- Apply the sticky side of the patch to the skin you have cleaned and dried, then remove the other half of the liner
- Press down firmly on the patch with the palm of your hand for 10 seconds, making sure that the edges stick well
- When taking off a used patch, fold it in half and throw it away out of the reach of children and pets.

7. If the Ortho Evra Patch comes loose or falls off:

- Try to put the patch back on the same place if it is still sticky. If it will not stick, take it off and put on a new patch on a different part of your body right the way.
- Change the patch on the same day that you always do.
- If the patch has been loose for more than a day, call your health care provider for advice and use a back-up method for 9 days.

J. Combined Hormonal Contraceptives: Method-Specific Considerations, NuvaRing

1. Learning Objective

Client will be able to state effectiveness, mode of action, and instructions for use, and advantages and disadvantages of the Vaginal Contraceptive Ring (NuvaRing)

2. Materials

- Sample model of the vaginal contraceptive ring (NuvaRing), handout and instruction sheets

3. Description

- The NuvaRing is a small, flexible, transparent plastic ring (2 inches across) that is inserted into the vagina. It is left in place for three weeks and removed for one week.

4. Effectiveness

- 99.9% with perfect use
- 98-99% in typical use

5. Advantages

- Only one insertion and removal needed every four weeks

6. Disadvantages

- No protection against HIV/STIs
- Prolonged withdrawal bleeding after the ring-free week in about one fourth of cycles
- Expulsion (2% of users)
- Vaginal discharge (14% of users)
- Some women and their partners are able to feel the NuvaRing
- Possible side-effects may include depression, or rash

7. Possible Contraindications

- Women with genital prolapse (may cause problems with placement or expulsion)

8. Method Use

Timing:

- Start the day suggested by your provider
- Always be sure to insert it and take it out on the same day of the week. (For example, if you insert the ring on a Sunday, take it out on a Sunday.)
- The very first time you use the ring, use condoms along with it for one week
- Once inserted, keep it in place for three weeks in a row. Remove after 3 weeks. (Your menstrual period will usually start two or three days after the ring is removed.)
- Insert a new vaginal ring 1 week (7 days) after the last ring was removed, even if your menstrual period has not stopped

Extended Regimen:

- Patients may decide to use rings for extended cycles.

- Replace ring every three weeks and avoid 7-day ring free interval to avoid scheduled bleeding for up to 12 months (this practice is “off label”).

Placement:

- After washing and drying your hands, remove the NuvaRing from the pouch.
- Choose a position that’s most comfortable for you; try lying down, squatting, or standing with one leg up
- Hold the ring between your thumb and index finger. Press the opposite sides of the ring together. Gently push the folded ring into your vagina as far back as it goes.
- If you can feel the NuvaRing inside, use your finger to gently push it further in..
- At the end of three weeks, remove the ring by hooking your index finger under its rim, or by squeezing the rim between your index and middle finger and pulling it out
- Place the used ring in the foil pouch it came in and throw it away, out of the reach of children and pets

9. If the NuvaRing Slips Out:

- If it has been less than 3 hours, you should be protected from pregnancy; rinse it with cool water, never hot and reinsert as soon as possible
- If it has been out for more than 3 hours, call your health care provider for advice
- Use condoms until the ring has been in place again for 7 days in a row

K. Combined Hormonal Contraceptives: Method-Specific Considerations, Oral Contraceptives

1. Objectives

Client will be able to state the effectiveness, instructions for use, advantages, disadvantages, and health risks specific to combined oral contraceptives

2. Materials

- Sample pill packs, menstrual calendar, pamphlets & instruction sheet, nutritional pamphlets

3. Description/Definition

- Hormonal contraceptives that are taken orally in pill form, one pill per day.

4. Effectiveness

- 99.7% when used perfectly
- 92% in typical use during the first year

5. Advantages

- Regulates menstrual periods; menses are light and predictable
- Menstrual cramps and pain usually decrease
- Improvement in acne
- Improvement of other medical conditions; may manage endometriosis or ovarian cysts
- Decreased risk of ovarian and uterine cancer; decreased risk of death from colorectal cancer in current users and women who have used COCs in past 10 years
- Women and teens with eating disorders (especially anorexia nervosa) may benefit from estrogen in COCs, which may protect bone mineral density
- Increased bone mineral density when used by women in their 40s

7. Disadvantages

- Must be taken everyday; are most effective when taken at the same hour each day
- For women from cultures who view menstruation as “unclean,” spotting or break-through bleeding may be a very big disadvantage
- Mild nutritional deficiency (especially if diet is low in leafy green vegetables)
- Weight gain (rare)

10. Method Use

- Prescription obtained from a clinician; a physical exam and medical history are required
- **Timing:**
 - Start COCs as per clinician instruction (on 1st Sunday after menses or day 1 of menses)
 - During the first two weeks of the first package of COCs, use a back-up contraceptive method such as condoms & spermicide (COCs begin working after two weeks of use).
 - Take one pill every day at the same time each day:
 - * If using a 28-day OC packs, the last 7 days will be placebos or iron pills.

- * If using 21-day packs, wait one week after last pill before starting next pack (always starting on the same day of the week).
- **If you forget to take your pills:**
 - *If one pill is missed but remembered within 12 hours*, take the forgotten pill immediately. Take the next pill at the usual time. Take the rest of the cycle as normal. Back-up method is needed for the next 2 days. No need for emergency contraception.
 - *If one pill is missed and the delay is longer than 12 hours*, take the forgotten pill immediately and the next pill at the next pill's usual time. Complete the rest of the cycle as normal. **FOR THE NEXT 14 DAYS**, use back-up method. No need for emergency contraception.
 - *If two pills in a row are missed*, take two pills at once with food (you may feel nauseated) and two pills the next day. Use the remainder of the pill package as you would normally. Use back-up method for the next 2 weeks.
 - *If three or more pills are missed*, **CALL PROVIDER FOR INSTRUCTIONS!** (Menses will probably begin.)

11. Nutrition and COCs

Use may deplete folic acid and B-vitamins, with folic acid and B12 being of particular concern:

- Folic acid is found in green, leafy vegetables, orange Juice, organ meats, sprouts.
- B-12 is found in eggs, dairy products, meats, fortified soy products, nutritional supplements.

L. Hormonal Methods: Progestin-Only Methods – General Considerations

1. Learning Objective

Client will be able to state the effectiveness, mode of action, instructions for use, advantages, disadvantages and possible side effects of progestin-only methods.

2. Materials

- Sample methods, menstrual calendar, pamphlets

3. Counseling – STIs

These methods do not protect against HIV infection (AIDS) and most other STIs; may provide some protection against PID. Women who are at risk should practice safer sex.

4. How It Works

- These methods contain a synthetic form of the female hormone, progesterone that:
 - Starts the 2nd phase of the menstrual cycle early
 - Stops ovaries from releasing an egg
 - Thickens cervical mucus, so sperm have difficulty swimming through the *os* into the uterus
 - Creates a thinner endometrium, making implementation of a fertilized egg difficult

5. Effectiveness

- Over 99% when use perfectly
- 92% - 99% effective typical use (higher in lactating women) depending upon the method

6. Advantages (*see individual methods for additional advantages*)

- Because they contain no estrogen the overall dose of hormones is lower:
 - Fewer women should not use these methods vs. combined hormonal contraceptives
 - They have fewer side effects than combined hormonal contraceptives
 - May be used by women who are breastfeeding
- May result in decreased menstrual cramps
- Menstrual bleeding changes such as amenorrhea (no menses)
- Possible decrease in PID and in endometrial cancer risk
- Decreased anemia
- May result in a loss of periodic bleeding

7. Disadvantages/Minor Problems (*see individual methods for additional disadvantages*)

- NO protection against HIV and most other STIs
- Slight increased incidence of functional ovarian cysts
- Must be prescribed by a clinician; requires physical exam and medical history
- Less protection against ectopic pregnancy than other hormonal methods
- May cause menstrual irregularities: spotting, breakthrough bleeding, prolonged cycles and/or amenorrhea

- Some women experience side effects such as headaches, water retention, increased body hair, moodiness or depression

8. Major Problems (*see individual methods for additional issues*)

FDA requires that women be given the same warnings as combined hormonal contraceptives, even though theoretically these methods should have far fewer complications:

- Migraine headaches
- Gall bladder disease may be accelerated in women who are already susceptible
- Hepatocellular adenoma (extremely rare)
- Circulatory disorders, abnormal clotting, MI, heart attack, strokes, high blood pressure, DVT/pulmonary embolus
- 60% increased in a rare form of cervical cancer

9. Contraindications/Precautions (*see individual methods for additional issues*)

If a woman has previously experienced these problems using combined hormonal contraceptives, this may be a contraindication for progestin-only methods:

- Nausea
- Hair loss or increasing facial hair
- Worsening headaches
- Nervousness or depression
- Significant weight gain or loss
- Breast tenderness or pain

Clients should also tell their clinician if they have any of the following:

- Known or suspected pregnancy
- History of gall bladder disease or chronic liver disease or dysfunction
- Breast mass, abnormal breast imaging or breast cancer
- Diabetes or glucose intolerance (DMPA only)
- High blood pressure or high cholesterol (DMPA only)
- Mental depression or severe premenstrual disorder (DMPA only).
- History of stroke, ischemic heart disease or coronary artery disease.
- Patients with recent onset of unexplained oligomenorrhea or amenorrhea.
- Liver disease (except pyelonephritis)
- History of malignant melanoma
- Regular use of barbiturates, prescribed medications or St. John's Wort
- Medical conditions which are seriously worsened by fluid retention
- Anticoagulation therapy or bleeding disorders (implant only)
- Unexplained anemia (implant and DMPA only)

M. Hormonal Methods: Specific Considerations for the Mini-Pill

1. Learning Objective

Client will be able to state the effectiveness, instructions for use, advantages, disadvantages and possible side effects of the Progestin-Only (Mini) Pill

2. Materials

- Sample pill packs, menstrual calendar, pamphlets, & instruction sheet

3. Description

This product is taken orally. Because the dose or hormones is so low, it is less effective than other hormonal methods of contraception. It is very important to take the pill at the same time everyday in order to avoid pregnancy.

4. Effectiveness

- 99% when use perfectly
- 92% effective typical use (higher in lactating women)

5. Advantages

- May result in decreased menstrual cramps
- May stop having periods, spotting or bleeding
- May be easier to remember to take because take exactly the same pill (color, etc.) everyday

6. Method Use

- **Timing:**
 - *Start as per clinician instructions*, on either first Sunday after menses or day 1 of menses
 - *Use a back-up method* while waiting to start and during first 7 days of first packet; if especially concerned about pregnancy consider using for the first 3 months until bleeding pattern is determined, then use mid cycle if regular bleeding pattern develops.
 - *Take one (1) pill at exactly the same time each day* regardless of bleeding pattern. If traveling to a different time zone, gradually adjust the time of day accordingly.
 - Follow instructions for use in the manufacturer's packet.
- **If experience side effects** (e.g., headaches, nausea, and irregular bleeding):
 - Call clinician.
 - **DO NOT DISCONTINUE PILLS** before seeing the clinician
- **Keep back-up method handy** and learn to use it in case you:
 - Run out of pills
 - Forget to take pills
 - Experience any pill danger signals and discontinue pill use
 - Have diarrhea or vomiting
 - Take certain prescription medications (discuss this with your prescribing clinician)
- **Keep a menstrual card record.** Bring an updated card with you to each clinic visit. If have more than 45 days with no period, see clinician for exam and pregnancy test.
- **See your clinician for check-ups as advised.**

7. If you forget to take Progestin-Only Pill:

- *Even one missed pill or late pill may result in pregnancy!*
- *Use emergency contraception (ECP) if not lactating and have had unprotected sex; this reduces pregnancy risk if used within 5 days of having unprotected sex*
- *Use a backup method for at least one week after a missed pill*
- ***One (1) missed pill:***
 - Take it as soon as you remember.
 - Take that day's pill at the regular time (if more than 3 hours late taking a Mini-Pill, use a back-up method for the next 2 days).
- ***Two (2) missed pills:***
 - Take (2) pills for the next two days.
 - Immediately start using a back-up method for the next two weeks.
 - If period does not begin within 4 - 6 weeks, see clinician for exam and pregnancy test.
- ***Three (3) missed pills:***
 - Menses will probably begin.
 - *If a Day 1 starter*, throw out the rest of the pack and start a new pack that same day. Use back-up method until back on next pill package for 7 days.
 - *If a Sunday starter*, keep taking 1 pill everyday until Sunday. On Sunday, throw out the rest of the pack and start a new pack of pills that same day. Use back-up method until back on next pill package for 7 days.

8. Warning Signs

- Return to the clinic or go to an emergency room if experiencing either of the following as these may be symptoms of ectopic pregnancy or an ovarian cyst requiring medical evaluation and intervention:
 - Cramping
 - Abdominal pain or fever

N. Hormonal Methods: DMPA – The Birth Control Shot

BLACK BOX WARNING:

In 2004, the Food and Drug Administration (FDA) required that a "black box" warning be added to the labeling of Depo-Provera highlighted that prolonged use could result in significant bone density loss, which increases the longer the drug is used. However, clients interested in this method should be counseled that several recent studies found that while Depo-Provera use in women is associated with continuous bone density loss at the hip and spine, that users of all ages experience significant gains after they quit using the drug. This provides evidence that the loss of bone mass is reversed when the method is discontinued; teen women appear to regain bone density faster than those who are older.

1. Learning Objective

Client will be able to state the effectiveness, mode of action, instructions for use, advantages, disadvantages and possible side effects of Depo-Provera Contraceptive Injections (DMPA).

2. Materials

Educational brochures

3. Counseling – STIs

This product does not protect against HIV infection (AIDS) and most other STIs. Clients who are at risk should consider condoms/safer sex practices for protection against HIV/STIs.

4. How the Method Works

- Given through an injection (shot):
 - **Depo-SubQ Provera 104:** subcutaneously (under the skin), lasts 12 – 14 weeks
 - **Depo-Provera:** Intramuscularly (in the muscle of the arm or buttocks), lasts 11-13 weeks
- Contains long-lasting synthetic progestin hormone called Depo-Medroxyprogesterone Acetate (DMPA) that works like other progestin-only methods (see Section L).
- Starts working within 24 hours.

5. Effectiveness

- 99.7% when use perfectly;
- 97% effective typical use - *woman can forget to obtain next injection on time*

6. Advantages Specific to DMPA

- Provides privacy; partner(s) do not need to know of its use
- Most women develop amenorrhea after 1 year of use
- May reduce uterine fibroids and improve endometriosis
- May help increase breast milk supply among lactating women
- May decrease frequency of seizures
- May decrease severity of Sickle Cell Anemia

7. Disadvantages

- Temporal delay in fertility - may take 3-18 months to become pregnant after last injection; counsel women to switch methods 6-8 months prior to trying to become pregnant.
- GI and abdominal discomfort and bloating may occur in first few months, decrease over time
- Fear of needles may make method unacceptable for some women
- Delivery through injection requires clients to return to clinic every 11-14 weeks (3 months)
- Side effects may last for up to 12 months after last injection
- Causes decrease in high density lipoprotein (HDL), the “good” cholesterol

8. Major Problems

- Longer-term use (> 2 years) may result in possible bone mineral loss, *which studies have found is usually reversed after method discontinuation*, may increase the risk for osteoporosis.
- Women over 40 who experience increased spotting or abnormal bleeding may require endometrial biopsy to rule out endometrial cancer

9. Special Counseling Considerations:

- Before being prescribed DMPA, the following are required: medical history review and physical exam, documentation of reason for wanting DMPA, possible high-sensitivity pregnancy test to rule out suspected pregnancy, counseling and informed consent to ensure that DMPA is an appropriate method.
- Timing of First Shot: Determined in consultation with clinician, depends upon history of recent sexual activity, pregnancy and birth control use.
- Frequency: Must return to clinic every 12 weeks for subsequent shots to guarantee continuous protection against pregnancy. Should bring an updated menstrual card for review at each visit.
- Weight Gain: Advise patient of potential weight gain issues and other potential side effects.
- Osteoporosis Risk: Remind patient that all women need adequate calcium intake. Consider using WAVE (Appendix 13) or REAP (Appendix 9) assessments. Recommend calcium supplementation if patient’s diet provides less than adequate amounts (1000 - 1300 mg daily).
- Planning Pregnancy: Instruct patient to change methods 6-18 months prior to attempting pregnancy. Fertility (ovulation) may not return for up to 2 years, but half of all users will be fertile within 10 months of their last injection.

10. Warning Signs

Client should return to clinic before next scheduled injection if experiences any of the following:

- Sudden change in bleeding pattern after first 3 – 6 months of use
- Heavy bleeding (>6 – 8 soaked pads per day) or bleeding that lasts longer than 30 days
- Signs or symptoms of pregnancy (other than amenorrhea)
- Severe depression
- Onset or worsening of episodes of migraine or other severe headaches
- Severe pain, swelling, bleeding or pus at injection site

O. Hormonal Implants – Implanon

1. Learning Objective

Client will be able to state the effectiveness, mode of action and instructions for use, advantages and disadvantages of the Implanon Implant.

2. Materials

Diagrams of implant, pamphlets and/or information sheets

3. Counseling – STIs

This product does not protect against HIV infection (AIDS) and other STIs. Women at risk for HIV/STI infection should consider using condoms/safer sex practices with this method.

4. How It Works

- A small, single-rod implant inserted just under the skin of a woman's upper arm.
- Contains a synthetic form of the progestin hormone that is used by the body over a 3-year period. After this time, the implant must be removed.
- Works in ways similar to other progestin-only methods (see Section L).
- Effective within one week of insertion; use a back-up method during the first week of use.
- Effective for 3 years; must be removed after this period.

5. Effectiveness

- Approximately 99.95% effective if used correctly.
- Implanon was not tested on women who exceeded 130% of ideal body weight; therefore, effectiveness rates for obese women are currently unknown.

6. Advantages

- Long-lasting and very effective
- Fertility may resume within 24 hours after removal
- Does not interfere with sex
- Decreased menstrual cramps and pain
- Decreased menstruation: 20% of women stop having periods
- May be used by women who are breastfeeding 4 weeks after giving birth

7. Disadvantages

- NO protection against HIV and most other STIs
- Initial expenses higher than for other temporary methods
- Requires minor surgery under local anesthesia to insert and removal
- Insertion and removal must be performed by trained clinician
- Implant may be rejected by body or cause problems at injection site (3.6% of users)
- Can be slightly visible; may cause scarring / Keloids (less than with Norplant)

8. Potential side effects:

- May have irregular periods or prolonged/excessive bleeding; after 6 months, medications can be offered to the patient to control prolonged spotting
- May gain weight (average of 2.8 pounds after one year, 3.7 pounds after two years)
- May experience vaginitis

9. Counseling Considerations:

- Post-Insertion:
 - Keep the pressure dressing on for 24 hours
 - Keep area dry the first 3 days
 - Ice packs should be applied to reduce pain and swelling.
 - Steristrips should not be removed by patient until scab over the incision has fallen off; steristrips may fall off by themselves any time
 - Expect bruising and soreness around implant site after insertion
- Menstrual Changes: Menses will become unpredictable. Overtime, may have more or less bleeding or no bleeding. The time periods may vary and may have spotting in between periods.
- Weight Gain and Side Effects: Advise patient of possible weight changes; consider using WAVE Assessment (Appendix 13) to discuss activity levels and eating patterns.
- Side Effects: Discuss other potential side effects listed on the patient consent form, including headache, mood swings, and hair changes.
- User Card/Removal: Suggest the patient save the user card in a secure place. Remind that removal is required in 3 years and that a new rod may be inserted at that time if desired. Fertility returns promptly after removal.

11. Warning signs

If client experiences any of the follow, she should contact the clinic immediately:

- Severe lower abdominal pain (ectopic pregnancy is rare but can occur)
- Heavy vaginal bleeding (miscarriage or atrophic endometrium)
- Arm pain, pus or bleeding at the insertion site (signs of infection).
- Expulsion of capsule.
- Delayed menstrual periods after previously regular periods
- Migraine headaches or any severe headaches
- Chest pain, shortness of breath
- Jaundice, severe nausea or vomiting
- Known or suspected pregnancy

P. Hormonal Implants Norplant (Levonorgesterol)

Norplant is no longer manufactured or available for insertion in the U.S. Immigrant clients may be using a two-rod/5 year version, Jadelle, available in many developing countries.

In 2002, Wyeth announced that defective Norplant lots actually demonstrated full efficacy in clinical trials. Therefore, it is no longer necessary to send Norplant clients for removal or to recommend a backup method if clients are within their 5-7 year period following insertion.

Norplant is highly effective in non-obese women for up to 7 years.

Obese women should know that Norplant's effectiveness is significantly reduced after 5 years.

1. Learning Objective

Client will be able to state the effectiveness, mode of action and instructions for use, advantages and disadvantages of Norplant Implants.

2. Materials

Diagrams of implants, pamphlets and information sheets

3. Counseling – STIs

This product does not protect against HIV infection (AIDS) and other STIs.

4. How It Works

- Norplant Implants consist of six matchstick-size rubber capsules made of silastic (Silicone)
- The implants are placed under the skin through a small incision on the inside of the woman's upper arm
- Contains a synthetic progestin hormone called Levonorgesterol, and works the same as other progestin-only methods (Section L).
- Effective for 5-7 years; effectiveness is significantly reduced after 5 years in obese women.

5. Effectiveness

- Approximately 99.5% effective.

10. Warning signs

If client experiences any of the follow, she should contact the clinic immediately:

- Severe lower abdominal pain
- Heavy vaginal bleeding or bleeding which last longer than 14 days
- Arm pain at or around site of implants
- Pus or bleeding at the insertion site (may be signs of infection)
- Expulsion of implant(s)
- Delayed menstrual bleeding after a long interval of irregular bleeding patterns
- Migraine headaches, repeated very painful headaches or blurred vision
- Known or suspected pregnancy

Q. Intrauterine Device (IUD): Copper IUD ParaGard & Mirena - Levonorgestrel (LNG) IUD

1. Learning Objective

Client will be able to discuss the effectiveness, instructions for use, and major advantages, disadvantages and health risks, including danger signs.

2. Materials

Sample IUD & insertion demonstration model and pamphlets

3. Counseling – STIs

This product does not protect against HIV infection (AIDS) and other STIs. *NOTE that contrary to wide-held beliefs , ParaGard and Mirena do not increase the risk of PID past the first 20 days after insertion.*

4. How They Work

Two types available in the U.S.: Copper IUD ParaGard and Mirena LNG IUD. Both are inserted into the uterus to prevent pregnancy.

- Copper IUD ParaGard:

- A small polyethylene (plastic) device with copper wire wrapped around the stem
- Causes a change in the uterine and tubal fluids that weaken sperm and inhibit their entry into the uterus, preventing fertilization

- Mirena (LNG) IUD:

- A small plastic T-shaped device with a reservoir of levonorgestrel (LNG) hormone in its stem that are slowly released into the uterus.
- Weakens sperm while also thickening cervical mucus, making it more difficult for sperm to reach and fertilize an egg
- LNG hormones may also inhibit production and release of mature eggs in some women

IMPORTANT NOTE: Contrary to myth, IUDs are not abortifacients.

5. Effectiveness

- Both are 99%+ effective
- The Copper ParaGard IUD is effective up to 12 years
- The Mirena (LNG) IUD is effective for 5 years

6. Advantages

Both IUD's

- Convenient; don't interfere with sex
- Only require checking string prior to sexual intercourse and after menstruation
- Rapid return to fertility
- Decreased risk of ectopic pregnancy

Copper ParaGard IUD only

- Good option for women who cannot use hormonal methods

LNG Mirena IUD only

- Lighter bleeding-more than 70% reduction in blood loss
- Decreased dysmenorrhea and menorrhagia (heavy or prolonged menstrual flow)
- Prevents endometrial hyperplasia for women using estrogen therapy

7. Disadvantages

Both IUDs

- No protection against STD/HIV
- Strings may cause partner discomfort, especially if cut too short
- Fainting may occur during insertion (uncommon)
- Expulsion may occur; rates are highest early on
- PID risk increases during first 20 days following insertion (1/1000); this is due to possible bacterial infection during insertion, and to the device itself

Copper ParaGard IUD only

- Increased blood loss (about 35%); may be associated with increased dysmenorrhea

LNG Mirena IUD only

- Irregular periods are common for 3-6 months following insertion; spotting or bleeding increases during the first few months, then decreases over time
- Amenorrhea in 20% of women after one year due to thinning of endometrium
- Slight increase in headaches, acne, breast tenderness (rates very low)

8. Who SHOULD NOT Use this Method

Both IUDs

- Pregnancy
- Known or suspected uterine, cervical or ovarian cancer
- Abnormal uterus in size or shape
- Uterine or cervical abnormalities incompatible with proper IUD placement
- History of gonorrhea, chlamydia, trichomonas or other STD within past two years
- PID or endometriosis within past 2 years
- Women or partner with more than one sex partner
- History of pelvic actinomycosis (suppurating tumors)

Copper ParaGard IUD only

- Copper allergy or Wilson's disease

LNG Mirena IUD only

- Breast cancer or other hormonally sensitivity tumor

9. Possible Contraindications

Both IUD'S

- Abnormal vaginal bleeding, unknown cause
- History of blood clotting abnormality
- Currently using anticoagulant medication
- Have never had a child and a small uterus
- HIV infection or other immunosuppression (chronic steroid use, cancer treatment, diabetes)
- Bacterial vaginosis or yeast vaginitis; treat and re-examine prior to inserting IUD
- Current cervicitis
- Actinomyces on Pap in past 3 months
- Current abnormal Pap requiring referral for colposcopy
- History of gestational trophoblastic disease (molar pregnancy)
- Unwilling or unable to check for IUD strings

Copper ParaGard IUD only

- Hgb < 10.5
- Severe menorrhagia,
- Dysmenorrhea
- Endometriosis

LNG Mirena IUD only

- Active liver disease, benign or malignant liver tumor
- Ischemic heart disease
- Current thrombophlebitis /DVT/PE

10. Prior to IUD Insertion

Medical history and medical exam required:

- Client must not be pregnant
- Must have had a recent negative Pap smear within past 12 months
- Must have had a negative chlamydia and gonorrhea test in past 3 months
- No active vaginitis or cervicitis

11. IUD Insertion

- A trained clinician nurse practitioner, physician's assistant, or physician inserts the IUD
- Client is asked to see that she can feel the IUD string before she leaves the clinic

12. Follow-up/Aftercare

- Return to clinic in 4 weeks for check-up (may be sooner if medically indicated)
- Abstain from sex for 2 weeks following insertion
- After 2 weeks, use condoms until return for IUD recheck in 4 weeks
- Clients with newly-inserted IUD should return to the clinic in 4 weeks and then annually.

- Client should check the IUD string for expulsion (*highest during first 3 months after insertion*):
 - After each menstrual period
 - Before intercourse
 - After any abdominal cramping
- Clients with inserted IUDS need annual reproductive health check-up, including a pap smear

13. If IUD string disappears or becomes shorter

- Use a backup method of birth control such as foam and condoms
- Come into clinic for exam

14. Warning Signs

Clients should contact the clinic immediately and abstain from sex if have any of the following:

- Abdominal pain, pain with intercourse
- Fever, chills with lower pelvic pain
- IUD string is shorter longer or cannot be felt
- Missed period or think you could be pregnant
- Think you may have been exposed to an STI
- Abnormal discharge with foul odor
- Unusual vaginal bleeding

CLIENTS SHOULD NEVER ATTEMPT TO REMOVE AN IUD ON THEIR OWN!

R. Client Education Material: Natural Family Planning (NFP) & Fertility Awareness Method (FAM)**

1. Learning Objectives

Client will be able to state the effectiveness, mode of action, advantages and disadvantages of these methods as well as where and how to sign up for full instruction.

2. Materials

- Pictures of different types of mucus, a sample BBT graph, & brochures

3. Counseling – STIs

This method does not protect against HIV infection (AIDS) and other STIs.

4. How They Work

- Woman monitors and records daily changes in temperature and/or mucus discharge; uses rules taught during classes with a trained instructor uses these to assess when her fertile phase begins and ends
- Fertilization of an egg will not occur if:
 - When using NFP client avoids intercourse during her fertile periods.
 - When using FAM: client employs a back-up method (e.g., condoms, spermicides, diaphragm) during her fertile times.

5. Effectiveness

- Perfect use 95% effective; typical use 75% effective
- Failure rates highest in the first three months, when learning how to use the method
- Classroom training is essential; success depends on couple's ability to:
 - a. Correctly interpret body signs and accurately identify the fertile time;
 - b. Couple's ability to follow the rules of the method they are using.

6. Advantages

- No health risks and side effects
- Maybe the only method compatible with religious and/or cultural beliefs
- Available at minimal cost and at any time
- Can be used to plan a pregnancy or to diagnose cyclic problems
- Allows women to better understand their own bodies

7. Disadvantages

- Provide NO protection against HIV and most other
- Requires extended abstinence or barrier method use each cycle
- Daily monitoring and charting may be inconvenient or difficult to do consistently
- Even women with regular periods may have unpredictable variation in cycles

** FAM and NFP are different and much more effective than the *Rhythm Method* in which a woman calculates when she can become pregnant based on a calendar of her regular menstrual cycle.

- Not as reliable with vaginal infection, cervicitis, vaginal medications, fever, illness, stress, or if woman is peri-menopausal
- Must have good communication and full commitment from both partners
- Breast-feeding or DMPA shot in past 18 months may cause irregular bleeding, making natural methods especially unreliable

8. Method Use

- Must get detailed observation and charting instructions from a trained instructor. (Books describing these methods will not provide women with the support and advice they need in order to interpret their own body changes.)
- Must chart for 1-3 cycles before method can be relied upon for pregnancy prevention.
- Woman learns to correctly identify when she is able to become pregnant by:
 - a. Keeping track of menstrual periods on a calendar
 - b. Monitoring daily changes in the following to determine fertile periods:
 - Basal body – waking - temperature (must wake up at same time each day)
 - Consistency and thickness of cervical mucus
 - Cervical position
- During fertile periods, client and her partner(s) either avoid intercourse or use a back-up method of contraception.

9. Special Comments

- It is not difficult to learn to use these methods but it does take time and practice.
- Using this method consistently takes commitment, calculation, planning and cooperation between a woman and her partner.

S. Breast-Feeding/Lactational Amenorrhea Method (LAM)

1. Learning Objectives

Client will be able to state the effectiveness, mode of action, advantages and disadvantages of breast-feeding Lactational Amenorrhea as birth control method.

2. Materials

- Lactational Amenorrhea Method (LAM) handout and pamphlets; encourage client to seek breast-feeding support (such as La Leche League) for problems and questions.

3. Counseling – STIs

This method does not protect against HIV infection (AIDS) and other STIs.

4. How It Works

- Breast-feeding causes the body to release the hormone prolactin; this inhibits ovulation

5. Effectiveness – up to 6 months post-partum

- 99.5% with perfect use; 98% with typical use

6. Advantages

- No health risks or side effects
- Can be used immediately after childbirth
- No cost
- Many benefits to infant and mother associated with breast-feeding

7. Disadvantages

- No STI/HIV protection
- Maybe difficult to breast-feed all the time
- Return of menses unpredictable
- Lower estrogen levels caused by breast-feeding may result in decreased vaginal lubrication and chronic pelvic pain (dyspareunia)
- Only temporary – not recommended after first 6 months

8. Who SHOULD NOT Use This Method

- Women who are advised not to breast-feed
- Women with blood borne infections (e.g., HIV) that could be passed to infant via breast milk
- Women taking medications or recreational drugs that are contraindication in breast-feeding

9. Method Use

- Must not have had a period since delivery
- Must breast-feed the baby day and night (90% of feedings)
- Breast-feed even if baby or mother is sick
- Breast-feed and not give baby food or formula

T. Sterilization: Female (Tubal Ligation)

1. Learning Objective

Client will be able to state the effectiveness, mode of action, advantages, disadvantages and medical risks of tubal ligation.

2. Materials

Brochures and anatomy and physiology diagrams

3. Counseling – STIs

This method does not protect against HIV infection (AIDS) and other STIs; should be used with condoms and spermicide if this is a concern

4. How It Works

- A permanent method of birth control
- Fallopian tubes are blocked or cut and sealed, preventing fertilization and transport of the ova to the uterus.

5. Effectiveness

- 99.5%; failures are due to the method, provider, or procedure, and not the user

6. Advantages

- Does not interfere with sex
- Removes fear of an unplanned pregnancy
- Permanent
- Highly effective
- Does not affect menstruation or sexual response
- No significant long term side effects
- Partner compliance not required
- Reduce rates ovarian cancer (mechanism unknown)

7. Disadvantages

- Permanent; may cause regret, especially in women under age 30
- Reversals difficult and expensive; success rates vary depending on method of tubal occlusion.
- Requires surgery and anesthesia; significant complications in about 1% of cases
- If fails, increased probability of ectopic pregnancy.
- Temporary discomfort and weakness after surgery

8. Types of Tubal Ligation

- **Methods of occlusion (obstructing the tubes):**
(While all procedures should be considered permanent, some methods result in greater damage to fallopian tubes and so are less likely to be reversible than others)
 - Fallopian tubes are “tied off;” a mechanical devise such as a ring or clamp may be used
 - Fallopian tubes are cut (in some cases may be severely damaged); ends are tied or cauterized

- **Surgical Procedures:**

- Suprapubic Mini-laparotomy: a small incision is made just above pubic hairline; small instruments are used to grasp the tubes and perform the procedure; incision scar will not be visible. May not be suitable for women who are obese or have certain medical conditions.
- Laparoscopy. A special instrument called a “laparoscope” (similar to a telescope) is inserted through a small cut beneath the navel. Physician uses the laparoscope to both see and to insert surgical instruments through it to perform the procedure.
- Postpartum Sterilization: Performed shortly after a woman gives birth. Small incision is made below the navel and procedure is performed; results in smaller incision and need for only light local analgesia; usually tubes are cut or looped and tied.
- Vaginal Tubal Ligation: A small incision is made at the back of the vagina and the tubes are sealed and partially removed through this opening; not used much because of increased risks of infection and failure.

9. Screening and Counseling Process

- Client should carefully evaluate her alternatives and be sure about her decision; she may change her mind during any point in the process.
- Physician or clinic performing procedure should provide adequate counseling, informed consent and an explanation of which procedure will be used.
- In order to prevent quick coercion, State and Federal Informed Consent Guidelines for sterilization require that the client go through a “waiting period” in between requesting and obtaining the procedure
- Procedure usually done in the hospital under local/and or general anesthesia, or epidural
- After surgery client should expect to feel pain or soreness for a few days to a few weeks. She should be careful to follow post-surgical care instructions.

10. Special Informed Consent Requirements

- FamilyPACT minimum age requirement is 18 years; MediCal minimum age is 21 years
- Public funds cannot be used to sterilize women under the age of 18
- FamilyPACT guidelines require that the sterilization consent form be signed between 72 hours and 180 days prior to performing procedure (Family Pact).
- MediCal requires consent to be signed at least 30 days prior to performing procedure, except in emergency situations.

U. Sterilization: Male (Vasectomy)

1. Learning Objective

Client will be able to state the effectiveness, mode of action, advantages, disadvantages, medical risks and sources for obtaining further counseling and sterilization services.

2. Materials

Brochures and anatomy and physiology diagrams

3. Counseling – STIs

This method does not protect against HIV infection (AIDS) and other STIs; should be used with condoms and spermicide if this is a concern

4. How It Works

- A surgical procedure performed by a physician under local anesthesia
- A small puncture is made outside the testicles
- The vas deferens (tubes which carry sperm from the testicles to the glands that manufacture semen) are sealed.
- The testicles continue to make sperm, but the sperm are no longer carried in semen and therefore fertilization cannot occur.
- After the procedure, the man will still have his normal sexual response and ejaculate normally. The only difference will be that when he ejaculates, there will be no sperm in his seminal fluid.

5. Effectiveness

- 99.5%, once the reproductive tract has been cleared of sperm.

6. Advantages

- Removes fear of pregnancy permanently
- Very safe, simpler and more effective than female sterilization
- Quickly performed, does not require general anesthesia except in rare instances
- No effect on libido/sexual performance
- Partner compliance not required
- Gives the male control over contraception

7. Disadvantages of Vasectomy?

- Permanent; regret in 5-10% of men – reversal procedures vary in success but result in pregnancy in only approximately 50% of all cases
- No STI/HIV protection
- May cause moderate amount of pain or swelling for up to a week after surgery
- Minor surgical procedure; complications (bleeding, infection) are infrequent, but possible
- Chronic pain reported in 2% of men
- No known long-term effects of the procedure documented at this time

8. Obtaining a Vasectomy

- It is important to allow adequate time for making the decision
- Get full counseling and an explanation of the procedure from a trained physician
- Follow post-surgical instructions completely, a vasectomy cannot be considered effective until all sperm has been cleared from the reproductive tract.

9. What Client Can Expect

- Procedure will be performed in a doctor's office under local anesthesia; it usually takes 15-20 minutes. The client can go home shortly after this time
- One or two small cuts will be made on the scrotum.
- The doctor will reach through these cuts to perform one of two procedures:
 - Ligation: vas deferens are cut and sealed, usually by tying the ends or through cautery (ends are "burned" with a hot iron, an electric current, a caustic or by freezing). Occasionally, the ends may be left open.
 - Ligation and excision (most common method used in developing countries): a short segment of the vas deferens is cut and removed, and the remaining two ends tied.
- Client should follow all post-surgical instructions carefully
- Client should use a backup method of contraception until semen analysis shows that sperm are not present in the semen

10. Special Counseling Considerations

- Vasectomy does not affect a man's sexual responsiveness. However, if a man already has overwhelming concerns about his sexuality before having the procedure, a vasectomy could exacerbate these problems.
- About one half to two thirds of men do develop antibodies to their own sperm following vasectomy. However, no harmful effects have been demonstrated as a result of this process.

11. Informed Consent Guidelines

- Family PACT minimum age requirement is 18 years; MediCal minimum age is 21 years
- Public funds cannot be used to sterilize women under the age of 18
- Family PACT guidelines require that the sterilization consent form be signed between 72 hours and 180 days prior to performing procedure (Family Pact).
- MediCal requires consent to be signed at least 30 days prior to performing procedure, except in emergency situations.

V. Withdrawal Method (“Pulling Out”)

1. Learning Objectives

Client will be able to state the effectiveness, mode of action, advantages and disadvantages of withdrawal as a birth control method.

2. Materials

Anatomy and physiology diagrams

3. Counseling – STIs

This method does not protect against HIV infection (AIDS) and other STIs.

4. How It Works

- Prevents fertilization; the sperm does not reach the egg

5. Effectiveness?

- Theoretical if used correctly and consistently: 96%.
- 81% in actual use because of difficulty of method

6. Advantages

- Free
- Requires no devices
- Always available
- Involves no chemicals
- No health risks or side effects

7. Disadvantages

- Difficult to use because requires that the man have great self-control
- May lessen sexual pleasure during intercourse
- Not reliable; one unduplicated study done in 1940s found semen in pre-ejaculatory fluid

8. Method Use

- Before inserting penis into the vagina, wipe off any pre-ejaculatory fluid at the tip of the penis
- When the man feels he is about to ejaculate, he removes the penis from the vagina, making sure *not to ejaculate in or near the vaginal entrance*
- Have a supply of contraceptive foam ready in case an accident occurs (even if used immediately after ejaculation, may be too late to inhibit sperm from entering uterus)
- Learn about and be ready to ECP for post-coital emergency contraception

9. Special Counseling Considerations

- Assist client to clarify her and her partner’s motivations and feelings regarding this method
- While other methods are preferred, withdrawal is better than using no contraception

**XI. CLIENT EDUCATION & COUNSELING:
SEXUALLY TRANSMITTED INFECTIONS (STIs)**

A. STI Counseling: General Education & Assessment

1. Learning Objectives

- Client will assess her STI risk
- Client will be able to describe general STI symptoms, transmission, prevention and treatment.

2. Materials

- Educational brochures, photos, charts or other teaching tools as available
- Condom demonstration model and condoms

3. Counseling Approach

- Routinely screen all clients for STI/HIV risk; make it a part of all contraceptive counseling
- Explain that because you are concerned about clients' total health, you routinely discuss HIV/STIs with all clients.
 - "Do you have any questions about this topic?"
 - "HIV is a growing concern within our community. Can you tell me what you know about this issue?"
- Gently review any red flags in the client's medical history or intake form with her:
 - "I notice that you are [gently describe possible symptoms]. Have you ever been tested for [name of possible STI]?"
 - "You mentioned that your [partner] travels for his work. Have you ever been concerned that he might see other people when he is traveling?"
- Explain why education and screening are important:
 - Anyone can get an STI given the right circumstances
 - Many people can have an STI without knowing they are infected
 - While trust is important in a relationship, people can "slip up," even in committed relationships
 - STIs are preventable
 - Most STIs can be treated and cured when caught early
 - STIs are among the most frequent causes of infertility
 - When left untreated, STIs can cause serious non-reversible damage, even death
- The "ABC" Approach: Under the Bush Administration, the Office of Population Affairs (OPA) currently requires that the "ABC" approach be used when counseling clients about HIV testing. Place the following recommendations within a client-centered approach:
 - A** = "abstinence" (adolescents and un-partnered adults)
 - B** = "being faithful" (clients in a committed relationship)
 - C** = "condoms" (clients who engage in behavior that puts them at risk for HIV/STIs)

4. Transmission

- STI germs need to live in warm, moist areas. That is why they infect the mouth, rectum, and sexual organs (vagina, vulva, penis, testes).
- STIs are spread primarily through sexual contact - oral, vaginal and anal.
- Some STIs are also spread through infected blood

5. Symptoms (indicate a need to stop having sex and get a check-up)

- Many STIs are often asymptomatic (without symptoms) in both women and men
- STI symptoms may disappear without treatment but this does not indicate that the STI has gone away – it may be silently doing severe damage that will only become evident later
- Common symptoms in both men and women:
 - Sores, bumps or blisters near the sex organs, mouth or rectum
 - Burning and pain when urinating (peeing) or when having a bowel movement
 - Need to urinate (pee) often
 - Itching around the sex organs
 - Unexplained swelling or redness in the throat
 - Flu-like feelings with fever, chills, and aches, particularly that last longer and are more severe than a “normal” flu
 - Swelling in the groin area (area around sex organs)
- Common symptoms in women:
 - Unusual discharge or smell from the vagina
 - Pelvic pain
 - Burning or itching around the vagina
 - Bleeding from the vagina that isn't part of a regular period
 - Pain deep inside the vagina when having sex
- Common symptoms in men:
 - A drip or discharge from the penis

6. Prevention

- 100% protection
 - Avoiding anal, vaginal and oral sex = 100% protection
 - Having sex with only one infected partner who also only has sex with you (mutual monogamy) – good communication required
- Excellent protection (not 100%)
 - Latex or polyurethane condoms (male or female) for vaginal, anal and oral sex on a man; latex barriers such as dental dams for oral sex on a woman; use with lambskin condoms in case of allergy to latex
 - Use adequate lubrication WITHOUT nonoxynol-9 which may increase the risk for HIV infection

- Also helpful:
 - Avoid mixing sex and drugs or alcohol as substances will lower inhibitions
 - If you have multiple partners, reduce your number of partners
 - Talk to your partner(s) about past sex partners and injection drug use
 - Before having sex, examine your partner(s) for signs of STIs
 - Get regular STI check-ups
 - Know STI signs and symptoms – if you notice a symptom, check it out

Sexual behaviors and STI risk:

- SAFE:
 - All activities within the context of a mutually monogamous relationship with an uninfected partner who has been tested
 - Fantasies, erotic conversation, etc.
 - Massage, hugging, body rubbing, dry kissing, masturbation
- VERY LOW RISK:
 - Wet kissing with no broken skin, gum disease, etc.
 - Hand-to-genital touching / mutual masturbation
 - Vaginal/anal intercourse with properly used/lubricated latex or polyurethane condom
 - Oral sex on a man using a latex or polyurethane condom
 - Oral sex on a woman using a dental dam, plastic wrap, or cut up condom
 - Shared sex toys, washed or using new condom in between partners
- UNSAFE (from least to most unsafe):
 - Shared sex toys without washing or using new condom in between partners
 - Oral sex on a woman without a latex barrier
 - Oral sex on a man without a condom (especially if oral contact with sperm results)
 - Oral-anal contact (Hepatitis A, shigella, etc.)
 - Unprotected vaginal or anal sex
 - Blood-to-blood contact (e.g., menstrual blood, needle sharing, rough sex)

8. Birth Control Options and STI Prevention

| Method | Bacterial STI | Viral STI |
|------------------------|-------------------------------------------------------------------------------|---------------------------------------|
| Condoms | Protective | Protective |
| Spermicides | No evidence of protection | Not protective; may increase risk |
| Diaphragm/Cervical Cap | Protective against cervical infection Associated with anaerobic overgrowth | Protective against cervical neoplasia |
| Hormonal | Increased risk of cervical chlamydia Protective against PID | Not protective |
| IUD | Increased risk of PID in first month of infection | Not protective |
| FAM, Withdrawal, Etc. | Not protective | Not protective |

B. STI Counseling: Clients Who Are Infected

1. Learning Objectives

- Client will be able to describe how to properly take her medications and explain the importance of doing so
- Client will be able to explain the importance of discussing her infection with her partner(s)
- Client will make a realistic STI risk-reduction plan

2. Materials

- Educational brochures, photos, charts or other teaching tools as available
- Handout on diagnosed STI
- Written instructions for prescribed treatment
- Condom demonstration model and condoms

3. Counseling Approach

A directive rather than a non-directive approach is essential in order to:

1) Increase adherence to treatment and follow-up:

- Ensure that client understands what she has and how it is transmitted
- Emphasize importance of treatment and possible long-term health consequences if treatment guidelines are not adhered to
- Discuss ways to minimize any potential unpleasant side-effects of treatment
- Stress importance of finishing prescribed medications, and coming back to the clinic for follow-up, even if symptoms disappear earlier
- Explain importance of avoiding sexual contact during treatment
- Discuss presumptive partner treatment with client

2) Offer guidance on talking to partners about exposure:

- Use the term “infection” rather than “disease” as this may have less stigma attached
- Explore how client can inform her partner(s) about her infection; take into account potential dangers to client’s safety (e.g., in domestic violence situations). Tips include:
 - Practice saying the words out loud; role-play with a friend or in front of a mirror
 - Choose a neutral setting and a time when you won't be distracted or interrupted.
 - You are not lecturing or confessing. You're sharing personal information.
 - Be natural, speak with confidence and remain calm; your delivery and body language becomes your message, too.
 - People usually act as you expect; expect your partner to be accepting and supportive.
- If client feels she cannot inform her partner herself, use STI caseworkers at City Clinic; call 487-5500, explain situation/infection and ask for a referral to the appropriate disease control investigator

- Reportable STIs: If client has chlamydia, syphilis, or inform her of the legal need to report; if a clinician, call City Clinic's Reporting Hotline at 487-5555.

3) Prevent new infections:

- Assess behaviors that might have lead to infection
- Educate client about STI prevention
- Review current birth control practices in light of need for STI prevention; urge client to use condoms or other latex barriers as appropriate to her sexual activities,
- Link STI prevention to client's other reproductive goals – e.g., wishing to have children in the future
- Assist client in formulating a realistic risk-reduction plan

C. Information on Common STIs

1. Learning Objectives

- Client will be able to have her questions answered regarding most commonly diagnosed STIs in Family Planning clinics

2. Materials

- Educational brochures, photos, charts or other teaching tools as available

3. Bacterial Vaginosis (BV):

- Definition: A vaginal infection in which the normal bacteria in the vagina are replaced with high concentrations of unhealthy anaerobic bacteria.
- Transmission: may or may not be sexually transmitted; repeat infections indicate the possible need for partner treatment. Women who have sex with other women have been found to have increased rates of BV, a possible indication of infection through shared vaginal secretions. Nonsexual causes include wearing thongs and nylon (rather than cotton) underpants, poor hygiene or wiping from the anus toward the vagina after going to the bathroom. Douching can also be a factor.
- Symptoms: A thin, white vaginal discharge; a fishy odor, most notable after intercourse, sexual arousal or menses; genital irritation. *Up to 50% of women with BV are asymptomatic.*
- Diagnosis: A clinician will examine the vagina for signs of BV and perform laboratory tests on a sample of vaginal fluid to look for bacteria associated with BV.
- Treatment: Metronidazole (Flagyll) or Clindamycin taken orally or applied topically as a gel or cream. There are no over-the-counter treatments that have been documented as effective.
- Complications: BV infection has been linked to increased risk for the following: HIV and other STIs; infection following surgical procedures such as a hysterectomy or an abortion; pregnancy complications such as preterm delivery.
- Patient Education: Stress importance of completing medications and cover use and potential side effects of oral treatments; advise patient not to interrupt treatment during menses and not to use tampons during treatment with vaginal creams; counsel on importance of perineal hygiene; clients should avoid douching because it changes vaginal pH; explain that BV recurrence rates are relatively high and that she should call the clinic if symptoms return; counsel and encourage safer sex practices, as appropriate.

4. Chlamydia:

- Definition: bacterial infection caused by chlamydia trachomatis, the most common of all STIs; thought to be the major cause of PID and female infertility
- Transmission: vaginal, anal or oral sex with someone who has chlamydia; can be spread to the eyes by touching infected fluids from the vagina or penis
- Pregnancy considerations: can be transmitted during birth to a baby and cause infections of the eyes, ears, lung or even death.
- Symptoms:

- Can be asymptomatic; signs/symptoms may appear within 30 days of infection but then will go away. However the infected person remains infected and can pass Chlamydia to a sex partner.
- *Men*: discharge, pain or itching from anus or head of the penis, pain with urination.
- *Women*: pain and itching of the anus or vulva or vagina, discharge from the vagina, unusual bleeding from vagina or anus, pain with urination, pain when having sex.
- Lab test/Diagnosis: tissue culture or urine test.
- Treatment: treated and cured with antibiotics.

5. Gonorrhea

- Definition: a bacterial infection; second-most common reported infectious disease in the U.S.
- Transmission: vaginal, anal or oral sex with someone who has chlamydia; can be spread to the eyes by touching infected fluids from the vagina or penis.
- Symptoms:
 - Can be asymptomatic; signs/symptoms may appear and then go away. However the infected person remains infected and can pass gonorrhea to a sex partner.
 - *Men*: discharge from anus or head of the penis, frequent urination, painful urination.
 - *Women*: abnormal vaginal or anal discharge, abnormal menses, painful urination, sore throat if obtained through oral sex on another man.
- Pregnancy: can be transmitted to infant during birth and cause rhinitis, anorectal infection, scalp abscesses, blindness.
- Diagnosis: requires sample/culture from vagina, urethra, anus or throat depending upon site of infection.
- Treatment: treated and cured with antibiotics

6. HIV/AIDS:

- HIV (Human Immunodeficiency Virus) = the virus that causes AIDS. HIV invades the body's immune system, multiplying within white blood cells (T-cells) and leaving a person susceptible to opportunistic infections. Having HIV means being infected with the virus; the person may or may not have symptoms but can still pass HIV to others. It can be months or years before an infected person begins to feel sick
- AIDS (Acquired Immune Deficiency Syndrome) = the most severe form of HIV infection. The immune system becomes so suppressed that the person is vulnerable to many diseases and infections such as KS, toxoplasmosis, CMV, PCP, pulmonary tuberculosis, recurrent pneumonia, and invasive cervical cancer.
- Transmission: unprotected sexual intercourse with a partner who is infected with HIV, sharing needles for IV drug use with someone who is infected with HIV, mother to fetus or baby, and blood transfusions before 1985.
- Client Education/Assessment
 - An HIV/AIDS fact sheet should be given to every new client; regardless of what service she may seek. It should also be provided to return clients whenever appropriate.

- An HIV Risk Assessment may be given to every new client; if indicated, HIV antibody testing and counseling should be made available to the client as indicated or requested.
- Because of confidentiality concerns, the risk assessment form or the client's plan for further evaluation may or may not be entered into the medical record.
- Diagnosis/Testing for HIV: the HIV antibody test (blood test or oral culture) is safe, private, free of charge, and should be available on-site.
- Treatment: No cure, but treatments (cocktails) can slow viral progression/replication

7. Herpes:

- Definition: a viral infection caused by the herpes simplex virus; one of the most common STI, an estimated 33% of sexually active adults in the Bay Area are infected.
- Transmission: sexual contact or skin to skin contact with someone who is infected. Carriers may be contagious up to several days before a sore appears and also when asymptomatic.
- Symptoms: painful blisters near the genital sex organs, rectum, and/or mouth; can also be found on the cervix of a woman. Blisters generally last 7-15 days and tend to reoccur. Recurrences can be caused by stress, illness, or friction (such as rubbing against the vagina during intercourse). Subsequent outbreaks tend to be less severe than initial occurrences.
- Pregnancy: an active herpes outbreak during labor and delivery can potentially cause serious illness or death in the baby, particularly with the first outbreak.
- Prevention: condoms offer some protection, but only if completely cover lesions. As condoms can cause abrasion, increased risk of transmission is a concern.
- Diagnosis: Clinician may be able to diagnose during visual examination depending on the stage of the herpes lesions; lab tests may be needed.
- Treatment: no cure; treatment with acyclovir (Zovirax), famciclovir (Famvir) or Valacyclovir may partially control the symptoms when used to treat first clinical episodes or recurrent episodes or when used as daily suppressive therapy. Good health habits and stress reduction techniques have also been found to be successful
- Patient Education: Counseling is crucial to: 1) helping patients cope with the infection; 2) preventing sexual and perinatal transmission. The psychological effect of HSV infection in clients with symptoms is frequently substantial; among persons with asymptomatic or unrecognized genital herpes it is often small and transient. Common concerns include the severity of initial clinical manifestations, recurrent episodes, sexual relationships and transmission to sex partners, and ability to bear healthy children. The misconception that HSV causes cancer should be dispelled. Although initial counseling can be provided at the first visit, many patients benefit from learning more about the disease after initial diagnosis, through web sites such as <http://www.ashastd.org> and <http://www.ihmf.org>, printed materials, and support groups.

8. Hepatitis B or C:

- Definition: caused by a virus; a disease that can cause serious liver problems.
- Transmission: vaginal, anal and oral sex with an infected person (Hepatitis B, rare with Hepatitis C); contact with infected blood, e.g., through sharing needles to inject drugs, piercing

or tattooing or sharing items that can break the skin such as toothbrushes, combs or razors (Hepatitis B & C)

- Symptoms: Many people have no symptoms or mild symptoms like tiredness, jaundice, dark urine, pain in your stomach and joints; in about 10% of infected people, can cause serious liver damage and even death.
- Pregnancy: A mother with hepatitis B or C can pass it to her baby during birth. (Hepatitis C is not usually passed during birth but it can happen.)
- Diagnosis: a blood test can show current or past hepatitis infection and can tell if the virus is affecting your liver.
- Treatment: No cure; supportive and symptomatic care

9. Genital Warts:

- Definition: viral infection caused by several types of human papilloma viruses (HPV); certain types of HPV can cause cervical cancer
- Transmission: vaginal or anal sex with an infected person
- Symptoms: Many people are asymptomatic; soft, fleshy, painless growths around or on the vulva/vagina, penis, anus, urethra or perineum; women may have growths on the vaginal walls or cervix
- Pregnancy: warts may enlarge and obstruct the birth canal, necessitating a cesarean delivery
- Diagnosis: made through signs on the external genitalia, colposcopy; biopsy may be required in the presence of cervical abnormalities
- Treatment: No cure; but therapies to reduce warts include patient-applied solutions or creams, cryotherapy (freezing with liquid nitrogen), provider-applied acids or resins, and surgical removal

10. Trichomonas:

- Definition: a vaginal infection caused by ; most common causes are yeast, trichomonas, and bacterial vaginosis (formerly non-specific vaginitis/gardnerella vaginitis).
- Transmission: may or may not be sexually transmitted; repeat infections indicate the possible need for partner treatment. Nonsexual causes include wearing nylon (rather than cotton) underpants, taking antibiotics (which disturb the normal balance of flora in the vagina), leaving tampons in for extended time periods, poor hygiene or wiping from the anus toward the vagina after going to the bathroom. Birth control pills also tend to change the pH of the vagina, which may cause recurrent yeast infections for some women. Poor diet can also be a factor.
- Symptoms: a change in vaginal discharge (yeast tends to be white and cheesy and itchy, trichomonas tends to be green and/or foamy and/or foul-smelling, bacterial vaginosis tends to be gray and creamy with a fishy odor).
- Diagnosis: a sample of vaginal secretions taken by the clinician and examined under the microscope can diagnose these or other vaginal
- Treatment: standard treatment for yeast is an anti-fungal cream. Flagyl, an antiprotozoal drug, is the standard treatment for trichomonas and bacterial vaginosis.

XII. PREGNANCY TESTING AND COUNSELING GUIDELINES

A. Policy

1. Function

Setting: All SFDPH Clinics that provide Family Planning Services

Importance: A major component of the Family Planning Program and a primary entry point for women into family planning services

Primary purposes:

- To provide client with education and counseling that will assist her in clarifying and achieving her reproductive goals.
- To identify early pregnancy and assist the client in making an informed decision regarding pregnancy outcome.
- To provide appropriate follow-up, referrals and emphasize importance of seeking care in a timely manner. To refer for early prenatal care or high-risk prenatal care, as indicated.

2. Indications

Client phone contact and referrals:

- Pregnancy referral information may be provided by phone for the woman who has not had a pregnancy test, but she should be encouraged to make an appointment for a pregnancy test, either with this agency or other appropriate referral.
- The client must be given three referrals whenever possible for the option of her choice.
- Language-specific referrals must be given when possible for LEP client(s).

3. Client conditions/contraindications

Must be performed prior to any other family planning service when a client:

- a. Suspects she is pregnant or as dates indicate.
- b. Is unsure of the date of her last menstrual period OR if there is a discrepancy between the date the client gives and her pregnancy symptoms:
 - Is reproductive-age and has PID, lower abdominal pain, or pelvic masses and pelvic pain even if tubal ligation or recent menses
 - Prior to furnishing Emergency Contraception Pills for immediate use
 - Is late for DMPA shots
 - Is following “off-cycle” start of hormonal methods
 - Has heavy bleeding or spotting
- c. Has positive signs and/or symptoms of pregnancy

4. Conditions for giving pregnancy test results

- a. In person and only to the client in order to protect confidentiality;
- b. In a private environment that is conducive to counseling;
- c. Present all options in an unbiased manner *with every client*: prenatal care, adoption, pregnancy termination, contraception, infertility care

5. As a result of the counseling session, the client should understand

- Her options, including description, approximate cost of services, and time constraints
- Advantages and disadvantages of her options

- Specific resources for reaching her goal, including the support of her partner, friends and/or family, medical care, financial aid, transportation, bilingual services, counseling and education

6. Documentation

- The client's decision regarding her pregnancy, including all referrals, must be documented in client's medical record.

B. ADMINISTRATION

1. Program Management

- a) Program responsibility and management exists with the DPH Family Planning Coordinator. These responsibilities include:

- Providing pregnancy counseling staff with adequate opportunities for meeting all pregnancy counseling protocol training and certification requirements.
- Providing sites with support in overseeing the certification and continuing evaluation of pregnancy counselors.
- Maintaining and coordinating the referral system utilized by pregnancy counselors.
- Reviewing, updating and providing all sites with appropriate client education materials.
- Maintaining contact with contract services and funding sources.
- Coordinating QI activities including chart reviews and client satisfaction surveys.
- Reviewing and updating pregnancy counseling and testing protocols and manuals as needed

- b) Onsite Administration: The Nurse Manager at each Family Planning site is directly responsible for the quality and operation of that site's pregnancy testing and counseling program. Duties include:

- Setting hours.
- Ensuring that clients are able to obtain a pregnancy test within one week of calling for an appointment.
- Ensuring that pregnancy testing and counseling staff are properly trained and certified utilizing attached "Pregnancy Counselor Evaluation Tool".
- Working with the Family Planning staff to assess pregnancy counseling staff needs for updated information and advanced training and providing all pregnancy counselors with an opportunity to receive such training whenever possible.
- Scheduling staff to conduct pregnancy testing and counseling.
- Reviewing client feedback on referral services and working with the Family
- Planning staff to assure that referrals are accessible and appropriate.
- Maintaining familiarity with the Title X and California Department of Health Services Family PACT standards for pregnancy testing and counseling.

2. Pregnancy Counselor Certification Requirements

(See Pregnancy Counselor Certification and Evaluation Forms, Appendix 6 & Appendix 7.)

a) Conditions of certification

Coordination: Each site's Nurse Manager will coordinate certification of competency.

Initial training program: Before beginning to provide pregnancy testing and counseling services, all counselors must attend an initial Agency-approved training program. Excepted from this

initial training are staff with documented pregnancy counseling experience within the past two years, or those who have completed a program that incorporates pregnancy counseling as part of the curriculum, e.g., FP or OB/GYN NP training programs or PA training programs. The initial training will include the following:

- Anatomy and physiology of reproduction and the menstrual cycle
- Birth control methods
- Prenatal, abortion, and adoption education and referral
- Sexually transmitted infections and HIV/AIDS
- Infertility screening, education and referral
- Adolescent psychosexual development and counseling that includes a discussion of abstinence, STI/HIV, parental involvement and counseling about coercion
- Sexual abuse counseling and reporting
- Communication and counseling skills
- Assessment for high-risk factors
- The proper use of all pregnancy testing and counseling forms
- Mandatory reporting responsibilities
- Understanding/awareness of all pertinent agency resources

On-the-Job Training: After completing the initial training program the Nurse Manager will arrange an on-the-job training program for the pregnancy counselor candidate to consist of:

- 1) Training in the use of the laboratory pregnancy test currently utilized within the Agency; this will include the counselor's accurate performance on one positive and one negative test utilizing this laboratory test. This performance will be supervised by the site's Nurse Manager and documented on the skill list.
- 2) The counselor will observe an experienced, certified pregnancy counselor performing a total of five (5) pregnancy counseling sessions, broken down as follows:
 - One (1) prenatal referral counseling session
 - One (1) abortion referral counseling session
 - One (1) negative pregnancy test counseling session
 - One (1) adolescent counseling session of any type
 - One (1) undecided
- 3) The counselor will be observed and evaluated by an experienced, certified pregnancy counselor conducting a total of five (5) pregnancy counseling sessions, broken down as follows:
 - One (1) prenatal referral counseling session
 - One (1) abortion referral counseling session
 - One (1) negative pregnancy test counseling session
 - One (1) adolescent counseling session of any type
 - One (1) undecided

Evaluation of sessions observed must be documented on the “Pregnancy Counselor Certification Form” and placed in the counselor’s file.

After Certification: The new pregnancy counselor will begin conducting pregnancy counseling sessions on her own. We encourage ongoing consultation with a senior/experienced counselor.

Documentation: Pregnancy testing and counseling will be included on the skills list and be reviewed with the annual evaluation.

3. Ongoing Counselor Training and Evaluation Requirements

After completing certification, each pregnancy counselor will be evaluated on an annual basis and this will be documented on the skills list. Two (2) types of evaluation will be used:

- a. Peer review: of pregnancy testing and counseling skills using the “Pregnancy Counseling Certification Form” as a guide.
- b. Continuing education: all pregnancy counselors are required to attend at least one Agency-approved in-service/training each year to update pregnancy counseling skills and/or general family planning education knowledge and expertise.

4. Program Review and Evaluation

- a. Pregnancy testing and counseling services:

ANNUAL REVIEW: The Continuous Quality Improvement Committee will review and update protocols and manuals at least annually or more often, if needed.

CLIENT SATISFACTION SURVEYS: Clinics will conduct an annual client satisfaction survey, in coordination with other clinic services client satisfaction surveys.

- b. Educational information:

CLIENT EDUCATION MATERIALS: The Family Planning Program will provide all Pregnancy Counseling sites with a standardized, approved set of client education materials.

REVIEW COMMITTEE: The Family Planning Program will coordinate a committee to review and evaluate all program materials in order to ensure that they meet client needs and community standards. This committee will meet at least annually.

- c) Referral Sources:

The Family Planning Program is responsible for the referral system used by pregnancy counselors. Referral resources will be updated annually and include the following:

- Prenatal care (including teen and high-risk)
- Abortion (first and second trimester), including medication options
- Adoption services (including separate lists for placing and adopting children)
- Social services
- Mental health services
- Family planning services
- Primary and specialty care
- Referral lists include information on fees, transportation, bilingual services, Medi-Cal acceptance, and hours of operation.

C. Clinic Procedure

1. Hours for Testing

Pregnancy testing is offered at all San Francisco Department of Public Health Clinics. Each site varies the hours during which they offer services in order to meet client and clinic needs. Service hours must be prominently displayed at each site.

2. Confidentiality

Refers to protection of the following from all non-clinic staff, including other clients who may be present at the clinic site (e.g., in the waiting room or directly outside of a counseling area):

- a. Client's identity
- b. Purpose for clinic visit
- c. Pregnancy test results
- d. Emotional responses
- e. It is the responsibility of the Center Director at each site to ensure that a client's confidentiality is protected throughout the counseling process.

3. Pregnancy Diagnosis

Techniques for diagnosing pregnancy/indications for use:

- a. Highly sensitive urine pregnancy test: Sure-View Urine HCG is the basic screening test.
- b. Qualitative and Quantitative Serum hCG test: quantitative used to rule out ectopic pregnancy AND/OR to follow-up on miscarriages and abortion.
- c. Bimanual exam for pelvic dating by an MD, PA or NP under the following circumstances:
 - Client's history and physical symptoms are inconsistent with test results OR client is unsure of her LMP
 - Pregnancy test results are positive, gestational age questionable (i.e., unsure of LMP) and seeking a TAB or is undecided
 - Client has been using medications or drugs which may affect the accuracy of the hCG Urine test result (for instructions, refer to manufacturer's information sheet)

4. Clinic Flow

- a. SCHEDULING: Determine LMP; schedule appointment accordingly.
- b. REGISTRATION:
 - Instruct client to fill out a Pregnancy Test and Counseling Form.
 - Provide specimen container. Label specimen container with client name and have her leave the specimen in a designated area which protects the client's confidentiality.

5. Laboratory

- a. Test urine sample with the Sure-View Urine hCG pregnancy test.
- b. Document results in the Laboratory Log.

6. Counseling and Referral – All Test Results

- a. STAFF REQUIREMENTS: Must be a registered R.N, certified pregnancy counselor, or a counselor who is in the process of being certified and has already completed 3 observation sessions. (See attached Pregnancy Counselor Certification Requirements)
- b. PRE-SCREENING: If client has chosen TAB and has symptoms of a gynecological problem (e.g., vaginal discharge, lower abdominal pain, etc.), consult with clinician for possible pelvic exam and STI treatment OR refer for **immediate** STI/GYN check to avoid endometritis.
- c. PROCEDURE FOR ALL SESSIONS:
 - aa. *Review client's history form*; note responses that are incomplete, contradictory, or which provide cause for concern. Give the client her test result.
 - bb. *Verify* that client has no condition that may affect the validity of the pregnancy test.
 - cc. *Refer the client for pelvic dating* on site in the case of any of the following conditions:
 - If history and physical symptoms are inconsistent with the test results or if the client is unsure of her LMP
 - If pregnancy test results are positive, gestational age questionable (i.e., unsure of LMP) and seeking a TAB or is undecided
 - If the client has been using medications and/or drugs that may affect the accuracy of the Sure-View Urine hCG test result
 - dd. *Screen for a possible ectopic pregnancy*. If any of the following symptoms are present, **immediately refer** to a clinician for evaluation & possible pelvic OR if not available to San Francisco General Hospital, GYN Clinic or Emergency Room.
 - Lower abdominal pain
 - Spotting/bleeding
 - Fever
 - Severe dizziness

Instruct all clients to be aware of ectopic symptoms and to seek care immediately at an emergency room should they develop symptoms.
 - ee. *Screen for medical risk factors* (e.g., history of HIV/STI, genetic problems, intrauterine infection, suspected substance use/abuse, chemical/occupational hazards) to determine the need to expedite the move into primary care in the case of a negative test result or appropriate referrals if the test result is positive.

Refer to the Pregnancy Referral Resource Handbook in the case of any of the following:

- Suspected or confirmed substance use/abuse
- Significant need for obtaining food and/or shelter
- Family/domestic violence.
- Suspected or confirmed child abuse/neglect
- Teen clients (under 17)
- Psychiatric problems

ff. Provide following as needed:

- Written results *must be given* to all clients with a positive test; *form must be used* for Medi-Cal and AFDC referrals and can also be given to other clients.
- An opportunity to explore feelings
- Information about pregnancy options
- Assistance/support in problem-solving, decision implementation
- Education
- Referral and information for HIV testing and counseling

Referral requirements for all clients: Whenever possible, three language-specific referrals/resources must be provided for the option chosen. If undecided, then three referrals/resources must be given for each option.

Referral guidelines for high-risk clients: In order to expedite referrals and to better ensure follow-up, make a call to the agency during the counseling session for clients who:

- Are at-risk for HIV infection
- Are presenting ectopic pregnancy symptoms
- Fit the definition of high-risk pregnancy

7. The Negative Test Result

Assess whether or not the client is seeking pregnancy.

A. If the test result is NEGATIVE and the client is NOT SEEKING PREGNANCY:

- Explain the possible causes of amenorrhea
- Assess for additional pregnancy tests or pelvic exam
- Schedule a return visit if indicated
- Provide information and counseling about birth control
- Provide STI/HIV information/education; refer for testing and counseling as appropriate
- Screen for pregnancy planning information and provide preconception counseling:
 - Multivitamin with 400 mcg of folic acid supplementation unless history indicates need for high dose folic acid supplementation.
 - Guidelines for a healthy pregnancy.
 - Smoking, alcohol, substance abuse, domestic violence and pregnancy
- Screen for personal or family history putting her in potentially high risk category for maternal or fetal difficulties (see pregnancy counseling form); refer to clinician for further evaluation for any identified factors.

B. If the test result is NEGATIVE, client is NOT SEEKING PREGNANCY AND is UNDER AGE 18:

In addition to above, reinforce the Adolescent Counseling Guidelines, per Title X Regulations (see Family Planning Protocols, Section IV for details):

- **STI/HIV:** discuss the client's risk for STI/HIV infection

- **Abstinence:** Ascertain how client feels about being sexually active. Discuss the choice of abstinence from anal, vaginal and oral intercourse as the only 100% effective method of birth control and STI prevention.
- **Parental Involvement:** Explore how client feels about discussing her pregnancy counseling visit with her parent(s)/guardian. Help her find ways of enhancing communication with her parent(s)/guardian about sexuality and sexual decision-making if she is open to this
- **Coercive Sex:** Screen for possible involvement in coercive sexual activity – when she has sex, is it usually because she wants to, her partner(s) wants to, or both she and her partner(s) want to do so. Counsel accordingly.

C. If the test result is NEGATIVE and the client IS SEEKING PREGNANCY:

- Explain possible causes of amenorrhea
- Assess for additional pregnancy test or pelvic exam
- Provide information about basic fertility awareness
- Refer for infertility services as appropriate
- Provide STI/HIV information/education, particularly as it related to infertility; refer for testing and counseling as appropriate
- Provide preconception counseling:
 - Multivitamin with 400 mcg of folic acid supplementation unless history indicates need for high dose folic acid supplementation.
 - Guidelines for a healthy pregnancy.
 - Smoking, alcohol, substance abuse, domestic violence and pregnancy
- Screen for personal or family history putting her in potentially high risk category for maternal or fetal difficulties (see pregnancy counseling form); refer to clinician for further evaluation for any identified factors.

8. The Positive Test Result

A. Inform the client of the pregnancy test result and what it means:

- Review client's three options with her – to continue with the pregnancy and keep the baby; to continue with the pregnancy and make an adoption plan; pregnancy termination.
- Assess client's intent to continue or terminate the pregnancy as well as her interest in making an adoption plan for her baby.

B. Screen for a possible ectopic pregnancy. Positive clients with any of the following symptoms must be examined by a clinician (OR if not available to San Francisco General Hospital, GYN Clinic or Emergency Room) for possible referral to an emergency facility or other follow-up:

- History indicative of ectopic pregnancy;
- Pelvic infection;
- Any of the following symptoms (see pregnancy counseling form): Lower abdominal pain, spotting/bleeding, fever, severe dizziness

Instruct all clients to be aware of ectopic symptoms and to seek care immediately at an emergency room should they develop symptoms.

B. If test result is POSITIVE and client DESIRES CONTINUATION of the pregnancy:

- Approximate the gestational age (can be done using the pregnancy wheel).
- Screen for a high-risk pregnancy (see pregnancy counseling form) and refer as appropriate.
- Emphasize importance of early and continual comprehensive prenatal care.
- Provide information on exposure to common toxics including the teratogen registry telephone number, 1-800-532-3749.
- Discuss common discomforts and symptoms of early pregnancy.
- Provide three (3) written referrals for prenatal care and for adoption, as appropriate
- Provide information and phone numbers for the following services: prenatal/perinatal care programs, Medi-Cal, WIC, genetic counseling services, HIV testing and related programs as appropriate.
- Discuss the following as it relates to pregnancy: nutrition, exercise, substance use/abuse, need to limit alcohol consumption and to avoid exposure to tobacco (e.g., through both smoking and 2nd-hand smoke) – refer as appropriate.
- If HIV-positive, refer to Primary Care Clinic.

C. If test result is POSITIVE and client is UNDECIDED:

- Approximate gestational age.
- Referral to an on-site clinician for a pelvic exam and pelvic dating if more than ten (10) weeks LMP or if LMP is unknown.
- Assist client to develop a plan for reaching a decision; encourage making a decision within the relative safety of first vs. second trimester abortions.
- Give three language-specific referrals for each option which the client is considering, whenever possible.

D. If test result is POSITIVE and client DESIRES PREGNANCY TERMINATION:

- Referral to an on-site clinician for pelvic exam and pelvic dating if more than ten (10) weeks LMP or if LMP is unknown.
- Basic explanation of the abortion procedure and possible risks.
- Information about birth control.
- Information about STIs.
- Information about the following services as appropriate: Medi-Cal, family planning clinic services, counseling services and social services.
- Three language-specific referrals, whenever possible, for pregnancy termination.

9. Chart Documentation

- A. Note all blanks and inconsistencies on the Pregnancy Test & Counseling form; review these areas with the client and document same.

- B. Record client's decision and all referrals on the Pregnancy Test & Counseling form for inclusion in the medical record.
- C. Sign name and title.
- D. Document all follow-up:
 - In the case of a suspected ectopic pregnancy, follow-up is required to determine the resolution of the problem.
 - When client is undecided, follow-up is also desired, but only with permission of the client.

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APPENDICES

Appendix 1: Adolescent Development Chart

| |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Characteristics of Early Adolescence (approximately ages 11 – 15) |
| Rapid physical growth and sexual maturation results in a focus on the physical aspects of development, idealized expectations for physical appearance and skills |
| Adolescents (particularly girls) who physically mature early may receive attention and experience feelings for which they are not prepared to deal with socially – thinking is very concrete and focused on immediate situations vs. long-term consequences |
| Preoccupation with body image leading to dieting or exercise common - recent evidence suggests extreme behaviors are the result rather than the cause of other psychological problems and may influence other behaviors such as sexual risk taking and alcohol/substance use |
| Shift from family toward peer groups as a source of security and status leads to an intense need to belong to a group, usually of the same sex. Friendships become more intimate with increasing sharing of ideas, opinions, and activities |
| Conformity in social behavior and physical appearance assumes greater importance, often leading to stereotypical gender behavior |
| Rudimentary capacity for abstract, operational thinking + a lack of “real world” experience means that many youth at this stage of development: 1) find it difficult to thoroughly assess possible consequences of their actions; 2) are more likely to believe or trust others (i.e., sexual partners) who may not have their best interest at heart; 3) don’t have the tools or capacity for adequate future planning. Therefore, they often need fairly extensive assistance in making decisions, in particular with identifying and assessing the pros and cons of all available options. |
| b. Characteristics of Middle Adolescence (approximately ages 14 – 17) |
| Rapid growth in cognitive skills results in the social expectation that they are capable of operating on abstract levels regardless of their actual levels of competence. |
| Peer relationships play a large role in the middle adolescent's separation and individuation - achieving psychological independence from parents becomes particularly important and sexual activity may be seen as one way to achieve this. |
| Experimentation with alcohol, cigarettes, marijuana, and sexual intercourse increases sharply. |
| An equally strong motivated to do what is right as they develop behavioral maturity, acquire social skills, and learn to control their impulsiveness, resolve conflicts, and say no to peer pressure. |
| c. Characteristics of Late Adolescence (approximately ages 16 – 20) |
| Principal tasks are establishing clear vocational goals and a sense of personal identity. |
| Shift from concrete to a pattern of formal operational thinking , enabling them to think about not only what is but what might be. They are thus more likely to see the connection between current behaviors and longer range consequences than peers who use concrete operational thought. |

Appendix 2: BMI Chart

BMI is determined using both weight and height, which provides a better idea of an individual's approximate amount of lean tissue versus fat tissue. BMI is calculated by dividing one's weight by the square of one's height. A healthy BMI range is between 19 and 22. People within this range live the longest. Death rates are higher for people with an index over 25.

TABLE 1: Lists weights that fit within a healthy BMI range:

| MEN | | | | WOMEN | | | |
|------|---------|---------|---------|-------|---------|---------|---------|
| Ht | Small | Medium | Large | Ht | Small | Medium | Large |
| 5'6 | 136-142 | 139-151 | 146-154 | 4'11 | 103-113 | 111-123 | 120-134 |
| 5'7 | 138-145 | 142-154 | 149-158 | 5'0 | 104-115 | 113-126 | 122-137 |
| 5'8 | 140-148 | 145-157 | 152-172 | 5'1 | 106-118 | 115-129 | 125-140 |
| 5'9 | 142-151 | 148-160 | 155-176 | 5'2 | 108-121 | 118-132 | 128-143 |
| 5'10 | 144-154 | 151-163 | 158-180 | 5'3 | 111-124 | 121-135 | 131-147 |
| 5'11 | 146-157 | 154-166 | 161-184 | 5'4 | 114-127 | 124-138 | 134-151 |
| 6'0 | 149-160 | 157-170 | 164-188 | 5'5 | 117-130 | 127-141 | 137-155 |
| 6'1 | 152-164 | 160-174 | 168-192 | 5'6 | 120-133 | 130-144 | 140-159 |
| 6'2 | 155-168 | 164-178 | 172-197 | 5'7 | 123-136 | 133-147 | 143-167 |
| 6'3 | 158-172 | 167-182 | 176-202 | 5'8 | 126-139 | 136-150 | 146-170 |
| 6'4 | 162-176 | 171-187 | 181-207 | 5'9 | 129-142 | 139-153 | 149-170 |
| 6'5 | 166-180 | 175-192 | 186-212 | 5'10 | 132-145 | 142-156 | 152-173 |
| 6'6 | 170-185 | 180-198 | 192-218 | 5'11 | 135-148 | 145-159 | 155-176 |

TABLE 2: Provides a picture of weight/height ratio that is greater than that considered healthy :

| Height | Weight in lbs. | Height | Weight in lbs. |
|--------|----------------|--------|----------------|
| 4'10" | ≥ 119 | 5'8" | ≥ 164 |
| 4'11" | ≥ 124 | 5'9" | ≥ 169 |
| 5'0" | ≥ 128 | 5'10" | ≥ 174 |
| 5'1" | ≥ 132 | 5'11" | ≥ 179 |
| 5'2" | ≥ 136 | 6'0" | ≥ 184 |
| 5'3" | ≥ 141 | 6'1" | ≥ 189 |
| 5'4" | ≥ 145 | 6'2" | ≥ 194 |
| 5'5" | ≥ 150 | 6'3" | ≥ 200 |
| 5'6" | ≥ 155 | 6'4" | ≥ 205 |
| 5'7" | ≥ 159 | 6'5" | ≥ 209 |

Appendix 3: Disease Risk Relative to Normal Weight and Waist Circumference

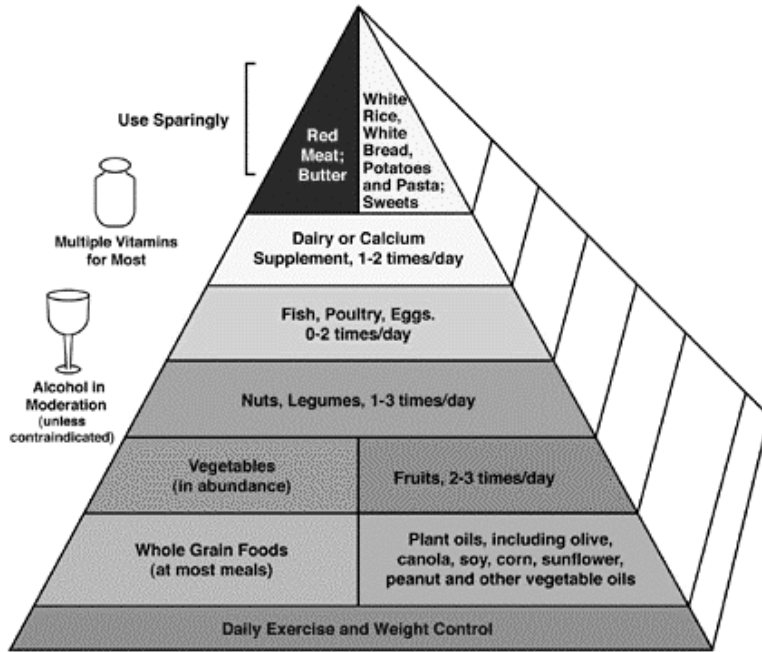
| | BMI (kg/m²) | Obesity Class | Men 102 cm (40 in) or less Women 88 cm (35 in) or less | Men > 102 cm (40 in) Women > 88 cm (35 in) |
|--------------------|-----------------------------------|--------------------------|-------------------------------------------------------------------|-------------------------------------------------------------|
| Underweight | < 18.5 | | - | - |
| Normal | 18.5 - 24.9 | | - | - |
| Overweight | 25.0 - 29.9 | | Increased | High |
| Obesity | 30.0 - 34.9 | I | High | Very High |
| | 35.0 - 39.9 | II | Very High | Very High |
| Extreme Obesity | 40.0 + | III | Extremely High | Extremely High |

Appendix 4: Common Medical Abbreviations

| Abbreviation | Term | Info Desired |
|--------------|--------------------------------------------------------------|-------------------------------------------------------------------------------------------------------|
| LMP | Last Menstrual Period | The date the woman's last menstrual period began |
| LNMP | Last Normal Menstrual Period | The date the woman's last normal menstrual period (as defined by what she normally experiences) began |
| DES | Diethylstilbestrol | A hormone commonly given to women in the 60s to prevent miscarriage |
| STD / STI | Sexually Transmitted Disease/ Sexually Transmitted Infection | Diseases that are transmitted through sexual activity |
| HBP | Hypertension/High Blood Pressure | Indicates that the client has high blood pressure |

Appendix 5: Food Pyramid Examples

Healthy Eating Pyramid



Source: Harvard Medical School

The Traditional Healthy Asian Diet Pyramid



The Traditional Healthy Latin American Diet Pyramid



The Traditional Healthy Mediterranean Diet Pyramid



Appendix 6: Combination Hormonal Contraceptives: Contraindication Chart

| | |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>ABSOLUTE CONTRAINDICATIONS:</p> <ol style="list-style-type: none"> 1. Thrombophlebitis or thromboembolic disorder (or history thereof). (Call MD if patient anticoagulated). 2. Cerebrovascular disorders (or history thereof). 3. Ischemic heart disease or coronary artery disease 4. Known or suspected carcinoma of the breast (or history thereof). 5. Known or suspected estrogen-dependent neoplasia (or history thereof). 6. Pregnancy, known or suspected 7. Benign or malignant liver tumor (or history thereof). 8. Undiagnosed abnormal genital bleeding. 9. Unstable hypertension (BP_s \geq160 or BP_D \geq100). 10. Age over 40 and smokes any cigarettes or age 35-40 and smokes \geq15 cigarettes a day. 11. Valvular heart disease with complications. (MD consult if no complications). 12. Adrenal insufficiency, conditions that predispose to hyperkalemia, i.e., renal insufficiency [3]. | <p>RELATIVE CONTRAINDICATIONS:</p> <ol style="list-style-type: none"> 1. History of gestational diabetes [1]. 2. Women using combination hormone methods solely for noncontraceptive indications. 3. Family history of diabetes. 4. History of hepatitis, drug abuse or impaired liver function [1]. 5. Conditions likely to make patient unreliable or unable to follow instructions (mental retardation, major psychiatric illness, alcoholism, drug abuse, history of repeatedly using contraceptives or other medication incorrectly). 6. Age 35-40 year of age and smokes <15 cigarettes a day. 7. Diabetes [1]. 8. Asthma requiring medication (unless drug-drug interaction requires M.D. evaluation). 9. Inability to place ring intravaginally (either self or partner) [4]. 10. Severe pelvic relaxation [4]. 11. Skin irritation with patches [5]. 12. Asymptomatic cholelithiasis. 13. Severe depression. 14. Weight >90 Kg or 198 pounds (consideration for patches). |
| <p>STRONG RELATIVE CONTRAINDICATIONS (REQUIRES M.D. CONSULTATION):</p> <ol style="list-style-type: none"> 1. Severe headaches, particularly vascular or migraine with aura 2. Elective major surgery planned in next 4 weeks or major surgery requiring immobilization. 3. Long-leg cast or major injury to lower leg. 4. Known impaired liver function at present time. 5. Cardiac or renal disease (or history thereof). 6. Use of rifampin, griseofulvin, methylphenidate (Ritalin) or St. John's Wort. 7. Use of anticonvulsant medication (except valproic acid or ethylsuximide (Zarontin)). 8. Use of retroviral agents, such as Indinavir, Ritonavir. 9. Previous cholestasis during pregnancy or jaundice with OC use. 10. Systemic lupus erythematosus. 11. Hypertriglyceridemia (triglycerides >300). 12. History of malignant melanoma. 13. History of multiple family members with unexplained thrombosis (at risk for thrombophilia). 14. Daily, long term treatment for chronic conditions with ACE inhibitors, angiotensin-II receptor antagonists, potassium sparing diuretics, heparin, aldosterone antagonists, and NSAIDs [3]. 15. Small bowel absorption problems (irritable bowel syndrome, drugs that block fat absorption from GI tract, small bowel resection or gastric bypass surgery) [7]. | <p>[1] See specific protocols for evaluation and management.</p> <p>[2] Combination hormonal methods not contraindicated in patients with previous cholecystectomy.</p> <p>[3] Contraindication only for drospirenone-containing OCs.</p> <p>[4] Contraindicated for vaginal ring only</p> <p>[5] Contraindicated for patches only.</p> <p>[6] Contraindicated for oral contraceptive patches.</p> <p>[7] Presents problems for oral contraceptives only.</p> |

Appendix 7: Pregnancy Counselor Certification Form

City and County of San Francisco
Gavin Newsom, Mayor

Department of Public Health



Maternal and Child Health Section FAMILY PLANNING PROGRAM

PREGNANCY COUNSELOR CERTIFICATION & EVALUATION FORM

COUNSELOR NAME _____

I. OBSERVATION OF PREGNANCY TESTING & COUNSELING SESSIONS

The Counselor has observed an experienced Certified Pregnancy Counselor conduct the following {5} "Pregnancy Counseling Sessions":

- One [1] prenatal referral counseling session
- One [1] abortion referral counseling session
- One [1] negative pregnancy test counseling session
- One [1] adolescent counseling session
- One [1] undecided pregnancy counseling session

Date _____

II. OBSERVED CONDUCTING PREGNANCY TESTING & COUNSELING SESSIONS

The Counselor has been observed & evaluated by an experienced and Certified Pregnancy Counselor conducting the following {5} "Pregnancy Counseling Sessions":

- One [1] prenatal referral counseling session
- One [1] abortion referral counseling session
- One [1] negative pregnancy test counseling session
- One [1] adolescent counseling session
- One [1] undecided pregnancy counseling session

Date _____

Signature, Certified Pregnancy Counselor: _____

Appendix 7: Pregnancy Counselor Evaluation Form

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| <p><i>FAMILY PLANNING PROGRAM</i></p> <p>PREGNANCY COUNSELOR EVALUATION FORM</p> |
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= INITIAL SKILLS CERTIFICATION = ANNUAL SKILLS REVIEW

PERFORMANCE CRITERIA: *S = Satisfactory* *U = Unsatisfactory*

SATISFACTORY: Fully meets performance standards and expectations.

UNSATISFACTORY: Performance contains deficiencies and requires prompt improvement in pregnancy counseling job assignment. An unsatisfactory rating in any given area may result in an overall rating of unsatisfactory. Must be justified through documentation in the comments section. If sufficient improvement is not demonstrated, corrective action is required.

| I. COMMUNICATION/COUNSELING SKILLS: | S | U | COMMENTS |
|-------------------------------------|---|---|----------|
|-------------------------------------|---|---|----------|

- | | | | |
|-------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|--|
| 1. Introduces self and role | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Establishes rapport with client | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Uses appropriate direct and indirect questions | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Sensitive to client's body language | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Sensitive to client's emotional needs | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Effective use of translator (<i>when appropriate</i>) | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Allows for questions | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Reviews all of the client's available contraceptive options without bias | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9. Ensures client understands all available contraceptive options without bias | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10. Checks to ensure client understands the advantages and disadvantages of her contraceptive options | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11. Informed consent for desired method <i>as appropriate</i> | <input type="checkbox"/> | <input type="checkbox"/> | |

II. MEDICAL HX FORM:**S U COMMENTS**

1. Reviews and completes client's pregnancy counseling and testing form, carefully reviews for gaps and inconsistencies *as appropriate*
-

III. LAB PROCEDURES:

1. Performs quality controls on pregnancy screening test used within the agency (*when appropriate*)
2. Accurately conducts the agency's current pregnancy screening test urine (hCG)
-

IV. GENERAL PROTOCOLS:

1. Completes all items on the pregnancy counseling and testing form
2. Screens for ectopic pregnancy
3. Screens for high risk behaviors: STI/HIV
4. Screens for substance use
5. Provides client with [3] language-specific referrals & information for each area required
6. Documents in chart: client's decision, including all referrals per State & Federal Guidelines
-

V. PROTOCOLS: POSITIVE TEST RESULT

1. Cover/checks approximate gestational age
2. Screens for high risk pregnancy
3. Refers for pelvic dating (*when appropriate*)
4. Provides information about contraception and emergency contraception (*as appropriate*)
5. Provides information about adoption (*as appropriate*)
6. Provides nutritional counseling information regarding (*as appropriate*)
-

VI. PROTOCOLS: NEGATIVE TEST RESULT**S U COMMENTS**

1. Explains possible causes of amenorrhea
2. Provides information about fertility awareness

3. Provides information about birth control and emergency contraception *(as appropriate)*
4. Provides infertility information *(as appropriate)*

5. Refers client to family planning services *(as appropriate)*
6. Provides nutritional counseling information regarding supplementation *(as appropriate)*

VII. RESOURCES:

1. Reviews client's need for the following resources:
 - Support of partner, friends and relations
 - Medical Care
 - Transportation
 - Linguistic Services *(as appropriate)*
 - Counseling and education
-

VIII. ANNUAL TRAINING REVIEW *(To be used once a year, after counselor has completing initial certification form)*

1. Peer Review: The pregnancy counselor has been reevaluated on "pregnancy testing and counseling skills" *by an agency approved certified pregnancy counselor.*
 2. Continuing education: The pregnancy counselor has attended at least one agency-approved in-service/training this each year.
-

IX. COMMENTS: *Initial Certification* *Annual Skills Review*

Counselor's Signature: _____

Date: _____

Evaluator's Signature: _____

Date: _____

Appendix 8: Range of Sexual Expression Handout

SAFER SEX:

Safer sex describes practices to reduce the risk of catching sexually transmitted infections (STIs).

100% SAFE:

1. Abstinence from any activity that includes an exchange of semen, vaginal secretions and blood;
2. Solitary masturbation: (including “phone sex” and cybersex);
3. Mutual monogamy between 2 uninfected partners (be aware that many monogamous people have been infected with STIs by partners they trusted to be non-monogamous)

RANGE OF SEXUAL EXPRESSION & STI RISK

The best way to get a good sense of what behaviors put you more at risk for contracting an STD including HIV is to think of sexual activity as a risk continuum from safe to dangerous.

NO RISK

- holding hands
- fantasy
- masturbation
- deep kissing
- mutual masturbation
- sharing sex toys
- rimming (oral/anal contact)
- oral sex on a woman
- oral sex on a man without ejaculation
- oral sex on a man with ejaculation
- insertive vaginal intercourse
- receptive vaginal intercourse
- insertive anal intercourse
- receptive anal intercourse

HIGH RISK

REDUCING THE RISK

1. Condoms (male/female) for vaginal and anal intercourse and for oral sex on a male;
2. Dental dams or plastic wrap for oral sex on a woman and/or rimming.

ADDITIONAL GUIDELINES

1. Know your partner, especially their STI/HIV status;
2. Communicating with your partner: Be assertive in saying what you want and don't want;
3. Avoid combining alcohol or recreational drugs with sex as this WILL increase the likelihood that you engage in unsafe activities

Source: “Guide to Safer Sex” at <http://www.sexuality.org>

Appendix 9: REAP Nutritional Self-Assessment Tool

| Topic | In An Average Week, How Often Do You: | Usually/ Often | Sometimes | Rarely/ Never |
|--------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|-----------------------|
| MEALS | 1. Skip breakfast? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | 2. Eat 4 or more meals from fast food or take out restaurants? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| GRAINS | 3. Eat <u>less than 3 servings</u> of whole grain products per day? Serving = 1 slice 100% whole grain bread, 1 cup high-fiber cereal (like Shredded Wheat, Grape Nuts, oatmeal), 3-4 whole-grain crackers, ½ cup rice or whole wheat pasta, 1 corn tortilla | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| FRUITS & VEGIES | 4. Eat <u>less than 2 – 3 servings</u> of fruit a day? Serving = ½ cup or 1 medium fruit or 4 oz. 100% fruit juice | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | 5. Eat <u>less than 3-5 servings</u> of vegetables (including root vegetables like taro or cassava) per day? Serving = ½ cup cooked or diced vegetables or 1 cup leafy raw vegetables | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| CALCIUM-RICH | 6. Eat or drink <u>less than 2-3 servings</u> of calcium-rich foods per day? Serving = 1 cup milk or yogurt; 1½-2 oz. cheese, 4 oz. tofu, ½ cup cooked greens, 3 oz. canned fish | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | 7. If you eat dairy, do you use <u>reduced-fat (1%-2%)</u> or <u>skim milk</u> instead of whole milk? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | 8. <u>Use regular cheese</u> instead of low-fat or part-skim cheeses as a snack, on sandwiches, pizza, etc.? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| FATS | 9. <u>Eat healthy fats</u> that come from plant sources at most meals? Examples of healthy fats include avocados, olives, nuts, seeds, coconut milk, and plant-based oils such as olive, corn, peanut and sunflower. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| PROCESSED FOODS | 10. <u>Eat highly processed foods</u> like non-organic TV dinners or snacks that include a lot of chemical ingredients? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | 11. <u>Eat fried foods</u> such as potato chips, fried chicken, batter-dipped and fried fish, etc.? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| | 12. <u>Eat or drink refined carbohydrates</u> such as white bread/pasta, white potatoes, regular soda, sugary snacks or desserts? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

* Adapted from a tool developed by the Brown Medical School's Nutrition Academic Award Program.

Appendix 10: Responding to Common Sexual Problems Chart

The following information is structured around the PLISSIT counseling model which is structured around a four-step process: 1) *Permission* giving - to the client “permission” for her/his thoughts and feelings; 2) *Limited Information* on human anatomy, physiology and sexual response; 3) *Specific Suggestions* for skill building; 4) *Intensive Therapy* referrals. In all instances, the counselor/educator should discuss Stage 1.

| Possible Causes | Giving Limited Information | Making Specific Suggestions | Intensive Therapy / Make Referrals for |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Organic factors:</p> <p>Alcohol drug use / abuse</p> <p>Medications, including common antidepressants</p> <p>Health problems such as diabetes</p> <p>Fatigues and stress</p> <p>Psychological conditions such as depression</p> <p>Use of hormonal contraceptives</p> <p>In women, lack of: 1) lubrication; 2) enough foreplay</p> | <p>Sexual response cycle and potential impact of various organic factors</p> <p>Impacts of fatigue and stress</p> <p>Impact of some hormonal BC methods on sexual response</p> | <p>(Clinicians) Discuss possible changes in contraceptive method</p> <p>Explore conditions under which client is having sex – possible partner communication regarding same</p> <p>Proper lubrication</p> <p>Changing position for sexual activities (anorgasmia in women)</p> | <p>Drug abuse treatment</p> <p>Medical work-up / consultation regarding possible underlying problems related to health or prescribed medications</p> <p>Intensive therapy for clinical psychological conditions such as depression</p> <p>For erectile dysfunction - drugs such as Viagra or herbal remedies</p> |
| <p>Emotional factors:</p> <p>Not wanting to have sex</p> <p>Fear of intimacy</p> <p>Fear of pregnancy / STIs</p> <p>Performance anxiety</p> <p>Negative experiences such as sexual assault or abuse</p> | <p>Sexual response cycle</p> <p>Effectiveness of various BC methods in preventing STIs / pregnancy</p> | <p>Skills for Partner Communication</p> <p>Sensate focus (Handout, Appendix 11)</p> <p>Squeeze Technique for premature ejaculation (Handout, Appendix 12)</p> <p><i>Referral may be key</i></p> | <p>Sex therapy</p> <p>Therapy or counseling for issues such as fear of intimacy and prior sexual abuse</p> |
| <p>Relationship issues:</p> <p>Lack of trust</p> <p>Unresolved conflicts</p> <p>Inability to discuss sexual needs and desires with partner</p> | <p>Sexual response cycle and potential impact of various relationship factors</p> | <p>Extended foreplay</p> <p>Partner communication skills</p> <p><i>Referral is key</i></p> | <p>Relationship counseling / therapy</p> <p>Individual counseling / therapy</p> |
| <p>Socio-cultural Factors</p> <p>Ambivalent or guilty feelings regarding sex</p> <p>Lack of self-esteem</p> <p>Poor body image</p> | <p>Briefly explore with client how value conflicts or concerns are impacting desire & response</p> | <p>Stress commonality of client experiences</p> <p><i>Referral is key</i></p> | <p>Individual counseling / therapy</p> |

Appendix 11: Sensate Focus Technique

FIRST DEVELOPED BY:

Masters and Johnson

USED TO:

Reduce anxiety caused by goal orientation
Increase communication, pleasure and closeness
Learn how to respond erotically with all parts of the body
Generally enhance partners' sexual relationships

INTRODUCTION:

In the sensate focus touching exercises, partners take turns touching each other while following some essential guidelines. In the following descriptions, we assume that the one doing the touching is a woman and the one being touched is a man. Of course, homosexual as well as heterosexual couples can do these exercises, and in either case the partners periodically change roles.

STEP 1:

The person who will be doing the touching takes some time to set the scene so that it is comfortable and pleasant -- for example, by unplugging the phone and arranging a warm, cozy place with relaxing music and lighting.

STEP 2:

The two people then undress and the toucher begins to explore her partner's body, following this important guideline: She is not to touch to please or to arouse her partner, but for her own interest and pleasure. The goal is for the toucher to focus on her perception of textures, shapes, and temperatures. The non-demand quality of this kind of touching helps reduce or eliminate performance anxiety, which can inhibit arousal for both partners. The person being touched remains quiet except when any touch is uncomfortable. In that case, he describes the uncomfortable feeling and what the toucher could do to make it more comfortable; for example, "that feels ticklish, please touch the other side of my arm." The guideline helps the toucher attend fully to her own sensations and perceptions without worrying whether something she is doing is unpleasant to her partner.

STEP 3:

The two people switch roles, following the same guidelines as before.

STEP 4:

During the first sensate focus experiences, intercourse and touching breasts and genitals are prohibited. Only after the partners have focused on touch perceptions and on communicating uncomfortable feelings do they include breasts and genitals as part of the exercise. Again, the toucher explores for her own interest and pleasure, not her partners. After the inclusion of breasts and genitals, the partners progress to a simultaneous sensate focus experience. Now they touch one another at the same time and experience feelings from both touching and been touched.

Source:

Clinical Sexology Associates
Article by Joseph Marzucco, PA, PhD
http://www.csa-info.com/articles/sensate_focus.html

Appendix 12: Squeeze Technique

FIRST DEVELOPED BY:

Masters and Johnson

USED TO:

Assists men who ejaculate prematurely to: 1) identify their point of "ejaculatory inevitability" (that point where ejaculation cannot be stopped); 2) take corrective action before that point is reached.

INTRODUCTION:

This method requires a great deal of patience and practice, but is very effective. To make the technique work, one needs to set aside private and uninterrupted time at least three times per week. One shouldn't be discouraged if this method does not work in the first few trials -- it may take several weeks to notice a change in performance. The process involves self-manipulation until just before the point of no return, at which point one stops the manipulation and applies the technique.

STEP 1:

Stroke and caress the whole genital area. This consists of the glans, the shaft of the penis, the testicles or balls, the area behind the gonads which is called the perineum, and the anal rim; 5 parts altogether.

STEP 2:

Practice touching and pleasuring all these parts to become very aware of how each feels in the stages of arousal prior to ejaculation.

STEP 3:

Increase pleasure to a high state of arousal. When reaching the point of no return, squeeze the penis firmly and hold it for at least 20 to 30 seconds. The place to squeeze is just below the glans, the rounded part at the top of the penis. In the case of a foreskin, pull it back so the glans is uncovered. The erection may subside, but, with further manipulation one can achieve another erection.

STEP 4:

Repeat this technique three times prior to allowing yourself to ejaculate. If you happen to stimulate yourself too much prior to the fourth trial, repeat the process again at a later date remembering to stop the manipulation earlier.

SPECIAL GUIDELINES:

4. Practice this exercise at least three times per week.
5. For the best results men should practice the same technique by having their partner stimulate them and then apply the Squeeze Technique just prior to ejaculation. This will promote partner communication and involvement.
6. Try to incorporate the Squeeze Technique into normal foreplay.
7. After successfully mastering the Squeeze Technique, progress to sexual intercourse. For the best results, the woman should be on top and you should be on the bottom with minimal movement. Couples should communicate about when to slow down the thrusting or stimulation. If the male partner becomes too excited, halt the intercourse and apply the Squeeze Technique.

Source:

Bernie Zilbergeld, Ph.D., *The New Male Sexuality*

Appendix 13: WAVE Nutritional and Physical Activity Intervention Card

| <p>Weight</p> <p>Assess if client's Body Mass Index (BMI) is > 25, indicating overweight:</p> <table border="1"> <thead> <tr> <th>Height</th> <th>Weight in lbs.</th> <th>Height</th> <th>Weight in lbs.</th> </tr> </thead> <tbody> <tr> <td>4'10"</td> <td>≥ 119</td> <td>5'8"</td> <td>≥ 164</td> </tr> <tr> <td>4'11"</td> <td>≥ 124</td> <td>5'9"</td> <td>≥ 169</td> </tr> <tr> <td>5'0"</td> <td>≥ 128</td> <td>5'10"</td> <td>≥ 174</td> </tr> <tr> <td>5'1"</td> <td>≥ 132</td> <td>5'11"</td> <td>≥ 179</td> </tr> <tr> <td>5'2"</td> <td>≥ 136</td> <td>6'0"</td> <td>≥ 184</td> </tr> <tr> <td>5'3"</td> <td>≥ 141</td> <td>6'1"</td> <td>≥ 189</td> </tr> <tr> <td>5'4"</td> <td>≥ 145</td> <td>6'2"</td> <td>≥ 194</td> </tr> <tr> <td>5'5"</td> <td>≥ 150</td> <td>6'3"</td> <td>≥ 200</td> </tr> <tr> <td>5'6"</td> <td>≥ 155</td> <td>6'4"</td> <td>≥ 205</td> </tr> <tr> <td>5'7"</td> <td>≥ 159</td> <td>6'5"</td> <td>≥ 209</td> </tr> </tbody> </table> <p>Counsel client about weight loss if BMI is >25 and waist circumference:</p> <ul style="list-style-type: none"> Is > 40 inches in men Is > 35 inches in women | Height | Weight in lbs. | Height | Weight in lbs. | 4'10" | ≥ 119 | 5'8" | ≥ 164 | 4'11" | ≥ 124 | 5'9" | ≥ 169 | 5'0" | ≥ 128 | 5'10" | ≥ 174 | 5'1" | ≥ 132 | 5'11" | ≥ 179 | 5'2" | ≥ 136 | 6'0" | ≥ 184 | 5'3" | ≥ 141 | 6'1" | ≥ 189 | 5'4" | ≥ 145 | 6'2" | ≥ 194 | 5'5" | ≥ 150 | 6'3" | ≥ 200 | 5'6" | ≥ 155 | 6'4" | ≥ 205 | 5'7" | ≥ 159 | 6'5" | ≥ 209 | <p>Activity</p> <p>Ask client about any physical activity in the past week: walking briskly, gardening, heavy housework, dancing, sports activities, etc.</p> <ol style="list-style-type: none"> Does client do a total of 30 minutes of moderate activity on most days of the week? (This does not have to be done all at one time, but may be done in 10 minute intervals.) Does client do "lifestyle" activities like taking the stairs instead of elevators, getting off bus a block before her stop, etc.? Does client usually sit down to watch TV or videos less than 2 hours per day most days of the week? <p>If client answers NO to any of the above questions, explore whether or not she is willing to increase physical activity.</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------|----------------|----------------|-------|-------|------|-------|-------|-------|------|-------|------|-------|-------|-------|------|-------|-------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|------|-------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Height | Weight in lbs. | Height | Weight in lbs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4'10" | ≥ 119 | 5'8" | ≥ 164 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4'11" | ≥ 124 | 5'9" | ≥ 169 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'0" | ≥ 128 | 5'10" | ≥ 174 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'1" | ≥ 132 | 5'11" | ≥ 179 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'2" | ≥ 136 | 6'0" | ≥ 184 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'3" | ≥ 141 | 6'1" | ≥ 189 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'4" | ≥ 145 | 6'2" | ≥ 194 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'5" | ≥ 150 | 6'3" | ≥ 200 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'6" | ≥ 155 | 6'4" | ≥ 205 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5'7" | ≥ 159 | 6'5" | ≥ 209 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Variety</p> <p>What kinds of foods does the client eat most often (e.g., Soul Food, Chinese, Caribbean, Mediterranean, American, etc.)?</p> <p>Is client eating a variety of foods from important sections of the food pyramid (use a culturally appropriate version if possible)?</p> <ul style="list-style-type: none"> • Fruits and vegetables • Complex starchy carbohydrates (whole grains, rice, tubers, winter squashes & beans) • Calcium-rich foods (dairy, calcium-enriched soy products, canned fish, broccoli, cooked greens) • Healthy fats (fatty fish, nuts, seeds, olives, avocados and plant oils) • Adequate protein (at least 2-3 servings daily) that is lower in saturated fats (nuts, beans, poultry, lean red meat, eggs, reduced-fat dairy) • Adequate water (may include limited amounts of other "natural" fluids such as green or herbal tea) | <p>Excess</p> <p>How many servings of alcohol (1 oz of hard alcohol, 6 oz. of wine, 12 oz. of beer) does the client drink per day?</p> <ul style="list-style-type: none"> • For men, a good limit is ≤ 1-2 per day • For women, a good limit is ≤ 1 per day <p>Is the client eating too much:</p> <ul style="list-style-type: none"> • Saturated fat? • Calories? • Salt? • Sugar? • Alcohol? <p>Ask about the following:</p> <ul style="list-style-type: none"> • Serving/portion sizes • Preparation methods (for instance deep fried foods, added saturated fats, margarine) <p>Does client eat out 4 or more meals per week? If so, from what types of restaurants (fast-food, vegetarian, etc.)</p> <p>Does the client indulge on the weekends?</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p>Determine VARIETY and EXCESS using one or both of the following methods:</p> <ul style="list-style-type: none"> • Ask client to do a quick one-day recall; ask client to complete a REAP questionnaire. <p>What does the client think are the pros/cons of her eating patterns? Dispel her nutritional myths/misunderstandings.</p> <p>If client could benefit from improved eating habits, assess her willingness to make changes.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

WAVE Recommendations*

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|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>Weight</p> <p>If client is overweight:</p> <ol style="list-style-type: none"> 1. State concern, e.g., “I am concerned that your weight could affect your health.” 2. Give specific advice, i.e., <ol style="list-style-type: none"> a. Make 1 – 2 changes in eating habits to reduce calorie intake as identified by diet assessment. b. Gradually increase activity and decrease inactivity. c. Enroll in a weight management or healthy lifestyle class sponsored either by your clinic or a nearby community agency. d. Refer to your clinic nutritionist / dietician. 3. Briefly explore potential barriers and supports. 4. Set up a time for follow-up. | <p>Activity</p> <p>If client is already active:</p> <ol style="list-style-type: none"> 1. Congratulate her on taking care of herself. 2. Encourage her to continue her active lifestyle. <p>If client is inactive:</p> <ol style="list-style-type: none"> 1. Educate: 30 minutes per day of moderate activity done in intervals of 10 minutes or more help. 2. Provide examples of moderate activity: dancing, walking briskly, climbing stairs, gardening, washing windows or floors, etc. <p>If client is ready to increase her activity:</p> <ol style="list-style-type: none"> 1. Briefly explore potential barriers and supports. 2. Jointly set simple activity goals – start slowly (i.e., 10 minutes per day) and increase gradually 3. Set up a time for follow-up. |
| <p>Variety</p> <p>What is a serving and how many servings should be eaten daily? (PLEASE NOTE: Healthy cultural eating patterns vary and these are not hard and fast rules – the most important thing is to eat a wide variety of whole, unprocessed foods every day.)</p> <p>Fruits (2-4 servings): 1 medium fresh fruit, ½ cup chopped or canned fruit, ¾ cup 100% fruit juice</p> <p>Vegetables (≥ 3-5 servings): 1 cup raw leafy vegetables, ½ cup cooked or raw vegetables, ¾ cup vegetable juice</p> <p>Calcium-rich foods (1-2 servings): 1 cup milk or yogurt, 1½ oz. cheese, ½ cup cooked broccoli or turnip greens, 3 oz. canned salmon or sardines with bones, 4 oz. tofu processed with calcium</p> <p>Healthy fats (at every meal): 3 oz. fatty fish, handful of nuts, seeds or olives, 1/5 of an avocado, 1 tbs. salad dressing, 1 tsp. oil in cooking</p> <p>Protein (2-3 servings): 2-3 oz. poultry, fish or lean meat, 1 cup cooked beans, 1 egg, 1½ oz. cheese, 4 oz. tofu or tempe</p> <p>Complex Carbohydrates (at most meals): 1 slice whole grain bread or tortilla, ½ bagel or roll, 1 oz. ready-to-eat cereal, ½ cup cooked grain, pasta, winter squash, tuber</p> | <p>Excess</p> <p>How much is too much?</p> <p><u>More than occasional servings of refined carbohydrates:</u></p> <ul style="list-style-type: none"> • High sugar beverages like sodas, “sports” drinks & highly sweetened coffees or teas • Sugary snacks or desserts • Fast food, white bread, pasta made from white flour, or white potatoes <p><u>More than occasional servings of unhealthy fats:</u></p> <ul style="list-style-type: none"> • Processed foods with hydrogenated oils • Margarine • Fried foods • High-fat desserts • Fast food, fatty meats or high-fat dairy products <p><u>Too much salt and/or chemicals</u> (read labels):</p> <ul style="list-style-type: none"> • Processed meats • Canned/frozen meals & fast food • Canned vegetables with added salt • Salt added to food after cooking <p><u>If eating out > 4 times per week</u>, select restaurants and foods carefully to avoid high amounts of refined carbohydrates, unhealthy fats, and salt.</p> |
| <ol style="list-style-type: none"> 1. Discuss pros & cons of client’s eating pattern keeping in mind “Variety” and “Excess.” 2. If ready, jointly set specific dietary goals. Make plans manageable (small steps) and realistic. 3. Consider referring client to nutritionist or dietician for more extensive counseling & support 4. Arrange for follow-up. 5. Give client educational materials and resources as appropriate. | |

* Adapted from a tool developed by the Brown Medical School’s Nutrition Academic Award Program.

Appendix 14: Youth Confidentiality Handouts

TIPS FOR TEENS

The Truth about CONFIDENTIALITY...

Confidentiality means privacy. It means that when you, as a young person from 12 – 17 years old, talk with your health care provider about certain issues like sex, drugs, and feelings, she or he will not tell your parents or guardians what you talk about UNLESS you give your permission.

What should I talk to the doctor or nurse about?

You can talk to your doctor or nurse about ANYTHING! Fill your doctor or nurse in if you...

- Think you might be **pregnant**
- Need **birth control**
- Think you have a **sexually transmitted infection (STI)**
- Need information about **alcohol, tobacco or other drug use**
- Want to talk about **personal, school, family issues or feelings about sex and sexuality**

What will my doctor or nurse tell my parents?

According to the laws of the State of California, your doctor or nurse cannot tell your parents or guardians anything about your exam if you're seen for any confidential service. These include:

- Sexuality
- Mental Health
- Substance Abuse

You, as a young person, can consent for care on your own in these areas. You need your parent or guardian's consent for other health services such as physicals, care for colds, flu and injuries.

HOWEVER ... Some things cannot remain confidential.

Your health care provider may need to contact someone else if you say you:

- Are being abused, physically and/or sexually
- You are going to hurt yourself or someone else
- You are under age 16 and are having sex with someone who is 21 years old or older.
- You are under age 14 and having sex with someone who is age 14 or older.

!!!

Even though you don't have to ask your parents, it's a good idea to talk with them or another adult that you trust about the medical care you need.

We want you to be safe.

If you have any questions about confidentiality, please ask us!

Source: *Adolescent Provider Toolkit*, Adolescent Health Working Group, San Francisco, CA: SFPDH, 2002.

For Parents and Guardians: A Letter from Your Teen’s Health Care Provider

Dear Parent or Guardian,

Now that your daughter or son is a teenager, there are some things I would like to share with you that are important to providing the best care. Your son or daughter’s body is changing, and so are his or her feelings. There are many health risks during the teenage years that we try to prevent, such as accidents, violence, unprotected sex, alcohol and drug use, and stress.

Some areas of teen health that we may discuss during the appointment are:

- Diet, exercise and body image
- Fighting, danger and violence
- Sexuality and sexual behavior
- Safety and driving
- Smoking, drugs and alcohol
- Working/jobs
- Depression and stress
- Peer pressure and alcohol
- Dating and relationships
- Family life

It is good to stay close to your child. It is also important for you to allow her or him some time alone to talk about their health and changes in their bodies and lives. This will help your teenager make good decisions.

We encourage teenagers to share information about their health with their parents or guardians. However, there are some things that your teenager would rather discuss with a doctor, nurse, or counselor. *California law allows teenagers to receive some health care services on their own. Health care providers MUST keep these services CONFIDENTIAL.* This means that we will only share this information with you should your teenager say it’s alright. We will also share this information should someone be in danger.

If your teenager receives any of the following services, by law we cannot give you information about these visits without permission from your son or daughter:

- The prevention or treatment of pregnancy or sexually transmitted infections and other contagious diseases
- The diagnosis and treatment of sexual and physical abuse
- Care and counseling for drug or alcohol problems

We ask that you support these rules and help your teen learn to care for his or her own health. We look forward to providing medical care to your child. We will be happy to talk to you about any questions or concerns you may have about this letter and your child’s health.

Source: *Adolescent Provider Toolkit*, Adolescent Health Working Group, San Francisco, CA: SFPDH, 2002.