MAIN CONTENTS

Chapter 3: Counselling

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1. Introduction

This chapter supports trained professionals within and outside the health system in strengthening the knowledge, skills, and attitudes needed to provide client-centred sexual and reproductive health counselling that promotes voluntary and informed decision-making by clients. Counselling is a cross-cutting element in sexual and reproductive healthcare and is critically important for all people of reproductive age and particularly for youth (ages 15–24 years), in both development and humanitarian contexts. The counselling guidance provided in this chapter should be applied to all sexual and reproductive healthcare provided in these Client-Centred Clinical Guidelines.

1.1 What is counselling?

Counselling is defined as the exchange of information based on an assessment of the client's needs, preferences, and lifestyle to support decision-making, as per the client's intentions. Counselling fundamentals are based on coercion-free and informed choice; neutral, understandable, and evidence-based information; and a collaborative and confidential decision-making process ensuring quality, respectful, and timely care, and dignity [1].

A rights-based, client-centred approach to counselling ensures that the client's rights are being respected (see *Section 2.3*) and that the power relationship between the client and the counsellor is equal (see *Section 3*).

Counselling supports clients to:

- Assess and understand their situation more clearly.
- Identify a range of options and goals for improving their situation.
- Make their own informed decisions, which fit their values, feelings, situational needs, and rights, and provide informed consent.
- Feel empowered to manage their situation, gain agency, and act on their decisions.
- Develop skills such as being able to talk about sex with a partner.

Acronyms

HIV	human immunodeficiency virus
LGBTI	lesbian, gay, bisexual, transgender, and intersex
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
WHO	World Health Organization

2. Counselling in sexual and reproductive health

Quality-integrated sexual and reproductive health counselling involves healthcare providers effectively utilizing an amalgamation of core counselling principles, skills, knowledge, and processes that are contextualized to a client's local environment and to the individual communication needs of clients [2]. *Section 2* details each of these core components and *Figure 1* (next page) provides a schematic overview of counselling in sexual and reproductive health.

2.1 Integrated sexual and reproductive health counselling

In development and humanitarian contexts, it is essential to recognize that counselling serves as an entry point for identifying unmet sexual and reproductive health needs that have potentially life-threatening consequences [3].

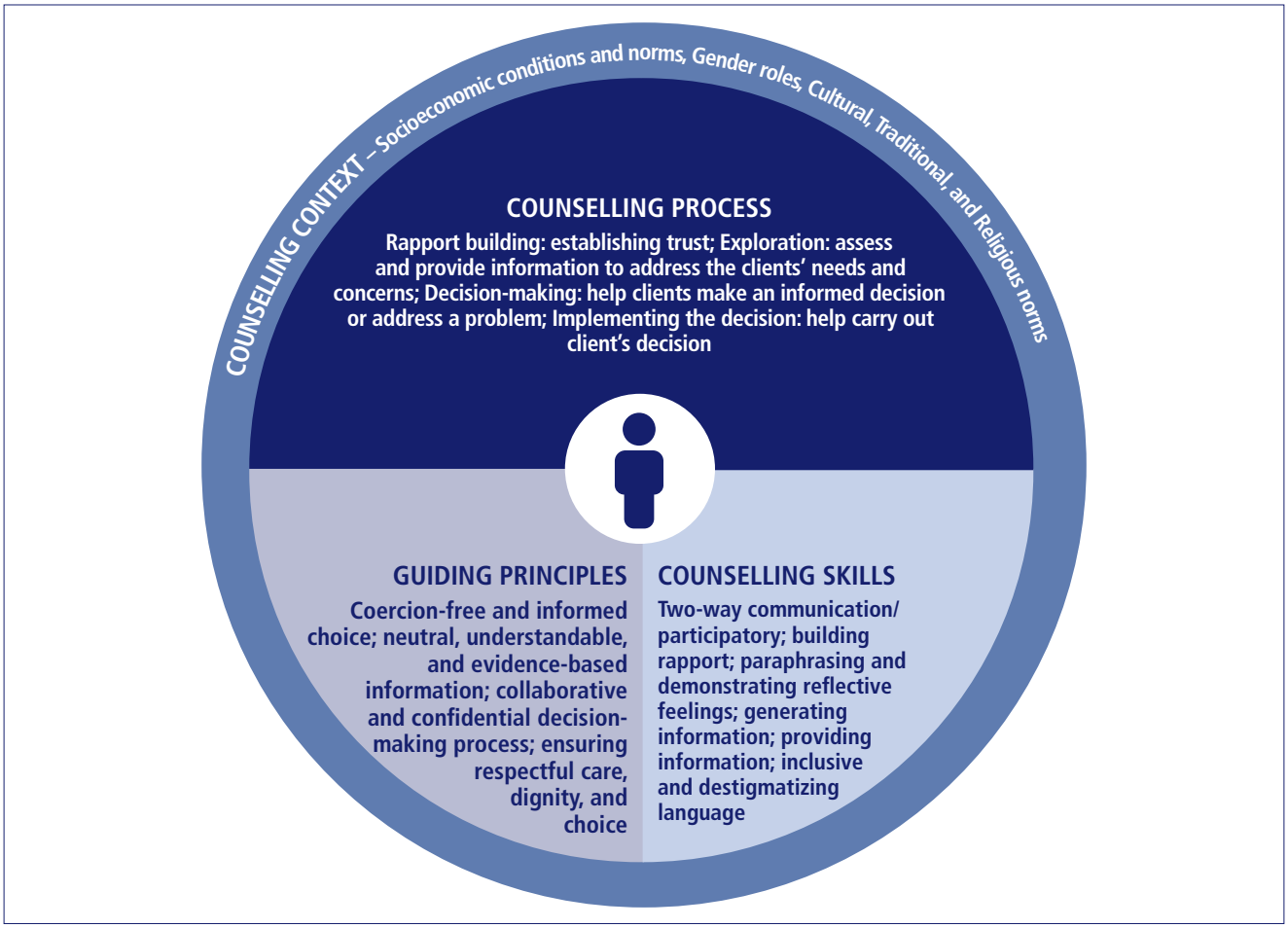
Counselling in sexual and reproductive health should be adapted to the local context, taking into account the needs of the community and the compounding barriers (e.g. structural, sociocultural, traditional, disability-related, religious, and spiritual) and their impact on a client's ability to access care.

In sexual and reproductive healthcare, integrated counselling implies weaving different issues into one counselling session to ensure a holistic view. In turn, this allows the client to assess their sexual and reproductive health needs and manage their sexual life [4].

In sexual and reproductive health settings, integrated counselling can be used to:

- help the client to clarify their needs and desires to use contraception
- help the client to make an informed, free choice of a contraceptive method
- help the client learn about the contraceptive method of choice
- help the client to understand how to use the contraceptive method of choice properly
- help the client overcome anxieties and make adequate decisions if challenges occur
- help with concerns about sexually transmitted infections (STIs), including HIV
- prepare the client for pregnancy and parenthood
- help the client make informed decisions about breastfeeding
- help the client decide to move/not move through a full pregnancy
- help survivors of sexual and gender-based violence (SGBV) acquire the tools they need to cope with their trauma
- discuss any issues around sexuality and sexual relations, including sexual orientation, gender identity and expression, sexual well-being, infertility, menopause, erectile dysfunction, and other sexual and reproductive health issues
- learn about the norms, laws, and rights in their community and how to uphold them in the healthcare provided
- provide referrals for clinical and community social services

FIGURE 1: Schematic overview of the counselling process



Source: Adapted with permission from WHO [2]. A handbook for building skills: Counselling for maternal and newborn health. Geneva. WHO; 2014.

2.2 Who can counsel sexual and reproductive health clients?

In many settings, there may not be a formal specialist counsellor. However, as per national policies, several providers such as trained and competent public health officers, nurses, psychologists, educators, doctors, social workers, or community workers can provide counselling [5].

People who are motivated to counsel are more likely to make empathetic and proficient counsellors and to possess the following characteristics:

- Commitment to practicing and promoting the sexual and reproductive health and rights principles outlined in *Section 2.3*.
- Good communication skills (verbal and non-verbal) as described in *Section 2.4*.
- Have explored personal values, beliefs, and attitudes on all aspects of sexual and reproductive health and rights, and provide client-centred counselling that includes:
    - being non-judgmental
    - knowing oneself and not imposing one's values on clients
    - being respectful, empathetic, warm, and approachable
    - being motivated and committed to the client's rights and well-being
    - being open and willing to learn continuously and from one's own mistakes
    - knowing and demonstrating sensitivity for people with different values, cultures, and ways of life

2.3 Clients' rights: counselling principles

The following rights-based principles underpin standards for sexual and reproductive health counselling. As with other guidance in this chapter, counsellors should contextualize the application of these recommendations and ensure these principles are applied when counselling clients on specific sexual and reproductive health matters. Similarly, a facility should be accessible for all groups of people, including young people and people with different types of disabilities, and offer varied sexual and reproductive healthcare to ensure people have a selection of care options to choose from and receive the integrated care they need (see *Chapter 2: Facility requirements and client history/ examination* for detailed guidance on sexual and reproductive health facility requirements). Human rights standards in relation to programme implementation of the counselling principles in *Table 1* (next page) are detailed in the World Health Organization's (WHO) *Quality of care in contraceptive information and services, based on human rights standards: A checklist for health care providers* [6].

Important!

For the purposes of this chapter, the terms 'healthcare providers' and 'counsellors' are interchangeable and encompass a variety of professions that when trained can provide counselling services

TABLE 1: Sexual and reproductive health and rights counselling principles

Principles	Application in counselling
Principle 1: Non-discrimination	All people have the right to be treated equally regardless of age, gender, race, sexual orientation, gender identity, colour, religion, language, marital status, refugee status, whether they are a survivor of sexual and gender-based violence (SGBV), and/or have a disability. Counselling should not vary in quality because of clients' characteristics, including residence, age, health status, insurance status, drug use, or employment in sex work [6]. Thus, every client should receive respectful care and be treated with dignity.
Principle 2: Availability of information and services	Healthcare facilities, digital counselling platforms, and communities should have a sufficient number of trained counsellors (if possible, counsellors of different genders) to provide education, information sharing, and counselling interventions. In addition, information, education, and communication materials that are age and context appropriate, sensitive to gender, accessible for people with disabilities (e.g. available in different formats such as braille for blind people), and respectful of confidentiality should be available [7].
Principle 3: Accessible information and services	Counselling services are provided through virtual platforms or in a physically accessible and geographically reasonable setting that ensures confidentiality where education, information-sharing, and counselling activities take place, such as in the facility, at home, online, by telephone, in the community, etc. Counselling activities should be equitable to the needs of different populations in a community, especially marginalized groups such as adolescents and people with disabilities. Counselling services should have convenient hours, regardless of location or the virtual platforms utilized [7]. In addition, transportation opportunities for people with disabilities should be ensured, especially during crisis settings. Safety getting to and from the facilities for marginalized groups is imperative and especially during humanitarian settings.
Principle 4. Acceptable information and services	The counsellor should be friendly, warm, and welcoming, and help to bring these same qualities to the counselling session. An example would be to provide a separate space for adolescents to be counselled [8]. The counsellor should avoid overwhelming the client with information, should tailor the counselling session to the client's needs, and utilize visual aids to facilitate discussions, such as flip charts, anatomical and sexual and reproductive health posters, or pelvic models. The pictorials and text should use simple language and images, and should be understandable for a variety of clients with different needs (e.g. people with language or other disabilities).
Principle 5. Quality	The counsellor's knowledge and skills are up to date, not only on quality counselling, but also on evidence-based information required to counsel clients on specific sexual and reproductive health topics, services, trends, and changes in sexual and reproductive health needs in their locality [9]. The counsellor does not let their personal values negatively impact their professional responsibilities and thereby inhibit the clients' rights to coercion-free, informed choice and decision-making [10]. The counsellor establishes referral pathways with other health and community services for sexual and reproductive health matters in their locality, including abortion care, contraception, prevention of STIs including HIV, support, and/or care for survivors of SGBV [9]. The counsellor records information on data collection forms (i.e. logbooks, case files, informed consent, and release of information forms) [11]. To ensure quality counselling, health facility or digital health counselling platform managers should assess the candidates and staff on their sexual and reproductive health counselling knowledge and communication skills, and guarantee continuous training, supportive supervision, and clinical updates in sexual and reproductive health and rights.

Principles	Application in counselling
Principle 6: Informed decision-making	Clients are treated with respect and understanding. Counsellors must refrain from coercion and avoid manipulating a client into what they think is best for them; this is especially true for adolescents and people with disabilities. The counsellor is supportive to the client and gives them full information (i.e. procedure/method options and processes, symptoms, and side effects, etc) in an accessible format that they can understand so that they can make an informed decision. For example, using a sign language interpreter and/or using approachable language to ensure that all clients are able to make an informed decision. See *information box* (next page) providing detailed guidance on consent/assent procedures [11].
Principle 7: Privacy and confidentiality	The counsellor protects medical information against unauthorized disclosures, respects the dignity of the client, guaranteeing privacy and confidentiality [12,13]. It must be clearly stated to the client that the conversation, any clinical procedures, and any follow-up will remain confidential unless they wish any other party to know. The client should be informed of any limits to confidentiality (e.g. mandatory national reporting) before the consultation or examination begins. The counsellor ensures the session is provided in a safe environment and in a private space where others cannot hear. For confidentiality purposes, the counsellor should always ask if the client wants their accompanying support person (e.g. relative, partner, friend, sign language interpreter, etc) in the counselling or procedure room. Any additional support person must ensure confidentiality (for example, by signing a written confidentiality agreement). The counsellor should not tell others what clients have said and should immediately put away clients' records to ensure proper and safe data management [5].
Principle 8: Participation	Good communication builds good rapport, trust, and participation from the client throughout the counselling session [12]. The counselling room is arranged so that the communication between the client and the counsellor is private and confidential. This facilitates discussing risk factors, including sexuality, sexual relationships, and sexual behaviour. This also helps the client identify solutions for their situation and implement them [13].
Principle 9: Accountability	The counsellor holds themselves accountable for respecting the rights of each client when providing information, education, and counselling on sexual and reproductive health issues. Confidential client-feedback forms/satisfaction surveys are one of many methods counsellors can implement to help improve their counselling quality [14].

Source: Adapted from World Health Organization, Johns Hopkins Bloomberg School of Public Health [5].

Informed and voluntary consent/assent process

Counsellors must know the procedures for obtaining informed and voluntary consent from the client to participate in clinical care.

1. Determine the capacity of the client to understand and make a decision about their clinical care based on the information provided, free of inducement, coercion, or discrimination.

a. Be aware of the national legal age of consent, but acknowledge "that, in accordance with evolving capacities, children have the right to access confidential counselling or advice and information without the consent of their parents or legal guardians" [6]. If the client is below the legal age to provide consent to clinical care, consider that in "situations where it is in the best interest of the child or adolescent, informed consent should be sought from that child or adolescent" [6].

b. People with disabilities have the right to be recognized in their own capacity to make decisions over their sexual and reproductive life. While legal frameworks might vary, people with disabilities should be informed and asked for consent in all scenarios by identifying and incorporating support mechanisms and reasonable adjustments in their decision-making [15]. See *information box* (below) containing practical suggestions for seeking informed consent from people with disabilities.

2. Attain and document consent and assent.

a. Once clients have received education and counselling, have been found eligible for sexual and reproductive healthcare, have received answers to any questions, and have made a voluntary and informed choice to receive sexual and reproductive healthcare, the provider must ask them to sign a consent/assent document.

b. Clients must be informed that they can revoke their consent at any point in time and that the provider must respect their decision.

c. Verbal consent is required when written consent cannot be provided through digital health platforms.

d. In certain scenarios, such as providing counselling to migrants, refugees, and ethnic communities, adequate and confidential interpretation must be provided in order to ensure consent.

e. Consent is not required if the client is unconscious and needs life-saving care.

Practical suggestions for seeking informed consent from people with disabilities [16]

When offering sexual and reproductive healthcare to people with disabilities, practitioners seeking informed consent:

1. Assume that all people with disabilities have the capacity to consent to services. Until demonstrated otherwise, healthcare providers should not assume that a client with a disability cannot give their consent to receive healthcare. This is true for people with all types of impairments, including intellectual or cognitive disabilities. Follow the guidelines for communicating with people with disabilities and speak directly to the client, even if they are accompanied by a family member or caregiver.

2. Recognize that capacity to consent is a fluid concept and refers to the ability to consent to particular healthcare at a particular point in time. In other words, capacity may change over time and may not be the same for all types of decisions. Healthcare providers should approach the process of seeking informed consent as an ongoing discussion with a client, and not a one-time event.

continued

Practical suggestions for seeking informed consent from people with disabilities [16] ***continued***

3. Be attentive to how information is communicated. For a client to give their informed consent, they must understand the information on which that consent is based and how the information is communicated to them. It may be helpful for clients to make big decisions by thinking through smaller steps, such as talking through their goals for healthcare, the procedures that will take place, the actions they will need to take, and so on. Providers should take the time to work with clients and discuss decisions in detail, to be sure that they understand what they are consenting to.
4. Remember that clients who lack the capacity to consent have a right to information and should be involved in decision-making. Healthcare providers should always share information, listen to clients, and explain how and why decisions have been made.

2.4 Communication skills in counselling

To support the client's informed and voluntary decision-making, a counsellor needs effective verbal and non-verbal communication skills that help them with [11]:

- **Building rapport**: use warm and welcoming, non-judgmental language (not assuming clients' gender and using gender-neutral language), demonstrate reflective feeling skills by paraphrasing, showing empathy, and expressing that you understand and are listening to the client, and lastly, comfortably broach the topic of sexuality and confidentiality.
- **Generating information**: ask open-ended questions and practice active listening and paraphrasing skills to assess clients' needs, explore risks, and ensure both parties understand one another.
- **Providing information**: communicate knowledge about evidence-based sexual and reproductive healthcare in a way that is not overwhelming and in a language that the client can understand. This will encourage clients to think about their sexual health context and set goals for change if necessary.

Healthcare providers should also utilize inclusive and destigmatizing language:

- The words that providers choose to use or not use will vary depending on cultural differences, age group, and personal preferences (e.g. use gender-neutral and non-stigmatizing language and ask the client how they would like to be addressed) [17]. Moreover, providers should use non-discriminatory and sensitive language when addressing marginalized groups such as people with disabilities (e.g. not using 'disabled' or 'crippled', instead a person with walking difficulties). Providers need to be able to develop a language for talking about sex and sexuality that feels comfortable and appropriate within the context in which they work.
- Body language and simple verbal messages can contribute to stigmatizing or destigmatizing human sexuality. Providers should choose words and tone of voice that address sexuality and sexual relationship issues without promoting shame or stigma.
- Terms like 'normal'/'abnormal' and 'transactional sex' should be used with care. Expressions such as 'promiscuity', 'indulging in sexual activities', and 'premarital' or 'extra-marital' sex should be avoided.
- Providers should be inclusive of all people seeking sexual and reproductive healthcare. They should acknowledge and respect that each client may have confronted challenging experiences, including sexual violence and abortion.

2.5 Counselling framework: REDI

The principles and communications skills providers should use when counselling clients are discussed in *Sections 2.3 and 2.4*. REDI, which stands for Rapport building, Exploration, Decision-making, and Implementing the decision is an efficient four-step client-centred counselling process to aid new and returning clients make voluntary and informed decisions suited to their situation, social circumstances, and comprehensive sexual and reproductive health needs [12].

Important! Do no harm! Provide survivor-informed care

Counsellors should be informed on the prevalence of sexual and gender-based violence (SGBV) in their contexts and be sensitive to a survivor's history and experiences. WHO encourages healthcare providers to raise the topic of violence and safety with clients who have visible injuries or conditions they suspect to be related to SGBV. However, if the client does not disclose, the provider should not pressure the client to do so, but respect their wishes, informing them of the sexual and reproductive healthcare available and offering referrals and any follow-up visits as needed. Remember, while women and girls are predominantly affected by SGBV, men and boys, people who identify as lesbian, gay, bisexual, transgender, and intersex (LGBTI), and people with disabilities are also impacted by SGBV. Research indicates that people with disabilities and people who identify as LGBTI are at a higher risk of facing any kind of violence or SGBV. Women, girls, and boys with disabilities are up to 10 times more likely to experience SGBV in their lives [18]. See *Chapter 10: Sexual and gender-based violence* for detailed guidance on counselling survivors of SGBV.

3. Gender and power dynamics in counselling

It is important to avoid gender stereotypes contaminating the process of counselling. The provider should take an approach that centres the client. A rights- and evidence-based approach to counselling is committed to facilitating equality and personal power between women and men, and addressing stigmatization and discrimination with regard to disability and sexual orientation.

In many settings, more women than men seek counselling. The concept of talking about feelings and exploring emotional and psychological difficulties has been embedded in gender socialization and how women and men consider and evaluate themselves. Depending on the context (e.g. conflict settings where boys are used as child soldiers and used to inflict violence/sexual violence) [8], men and adolescent boys may need specific approaches in counselling, considering that they may be compelled to keep emotions secret and have feelings of shame and isolation. For guidance on engaging men in sexual and reproductive health and rights, refer to the resource list provided in *Section 7.1*.

An individual's position within their family and sociocultural environment impacts their knowledge of and ability to exercise their sexual and reproductive health and rights [12]. In many settings, issues of dominant male masculinity may make it difficult for female clients to talk to male providers and for male clients to talk to female providers. Therefore, clients should be offered the option to speak to a counsellor of the same gender if they prefer. The power imbalance is not always on the side of the provider. Clients can also consciously or unconsciously exercise power and/or manipulate the provider. Providers need to be aware of this and discuss it with clients. Providers are also encouraged to consult other counsellors for support in such cases.

Counsellors must refrain from power imbalances that can cause discrimination and any form of reproductive coercion, specifically for survivors of SGBV, clients seeking abortion care, adolescent clients, sexual and gender diversity minority populations, or clients with disabilities.

Important!

People with diverse sexual orientations, gender identities and expressions, and sex characteristics should never be considered in pathological terms in the context of sexuality education, counselling, or sexual and reproductive health and rights programmes and care. See *Sections 4.1* and *4.2* for guidance on minimizing the stigmatization and discrimination of LGBTI communities.

4. Sexuality and sexual health counselling

Sexuality is an important part of human life. Lack of open and honest communication about sex and sexuality means that it can be difficult for individuals and communities to get accurate information and support with issues relating to sexual and reproductive health. Talking about sex and sexuality can be difficult for both counsellors and clients.

Counsellors can play an important role in creating safe spaces for clients to explore the positive and challenging sides of their sexual orientation, and to develop greater confidence in their sexual relationships and sense of sexual self.

As part of their commitment to sexual and reproductive health and rights, to decreasing stigma, and increasing recognition of sexuality as a positive aspect of human life, providers can put the following into practice:

- Being **sex positive:** the counsellor understands the positive impact that sex and sexuality have on people's lives, and supports their client to have enjoyable, equitable, and safe sexual relationships, and/or to be happy with their sexuality.
- Being **sex critical:** the counsellor is able to identify and critically reflect on what the community sees as 'normal'/'abnormal', 'good'/'bad' in sexuality and sexual relationships, and is aware of who has the power to label sexuality in this way.
- **Engaging in self-reflection:** the counsellor is able to reflect on personal values and experiences; personal attitudes or 'rules' about sexuality, sex, marriage, condoms, pornography, sexual pleasure, female sexuality, or same-sex sexual relationships; who decides on these rules and what happens to those who do not follow them; how the provider can explore possibilities with the client for living by different kinds of rules.

Important!

Adolescents and people with disabilities are often not seen as individuals who have the right to enjoy a sexual life and make decisions about their sexual health or orientation and expression. Additionally, the sexual life of older people is sometimes overlooked or stigmatized, but sexual activity can remain an important aspect of health and well-being throughout a person's lifetime. It is important for counsellors to adopt the practice of being sex positive, sex critical, and self-reflective about their own misconceptions and prejudices, and ensure these populations receive quality care.

4.1 Sexuality counselling

According to WHO's definition of sexuality, many biological, social, cultural, economic, environmental, religious, and contextual factors influence people's sexual behaviours, relationships, feelings, orientations, desires, and attitudes, and each person's experiences and expressions of sexuality are unique.

There are issues that providers need to be aware of when discussing sexuality, sexual and gender diversity, sexual relationships, and the link between sexual and reproductive health (e.g. the use of contraceptives) and sexual difficulties with their clients.

Sexual well-being contributes significantly to quality of life and can positively affect safer sex and positive relationships. However, with often negative and conflicting messages about sexuality, clients can be confused, ashamed of their bodies, insecure about their sexuality, and disempowered to exercise their sexual and reproductive rights. For example, gender norms, sexism, ageism, homophobia, transphobia, disablism, and other forms of prejudices and stereotypes limit people's development and opportunities for sexual expression, particularly for young people, people with disabilities, and people with diverse orientations, gender identities and expressions, and sex characteristics.

To effectively provide counselling on sexuality and sexual well-being, including pleasure, providers need to understand the context of sexuality and the diversity

of people's sexualities should always be recognized, valued, and celebrated in the counselling process.

Sexuality includes a range of physical and emotional experiences that an individual can have in relation to sexual expression in the distinct phases of their life. This includes experiences of pain, anger, anxiety, boredom, and disappointment, as well as experiences of desire, enjoyment, and pleasure. Sex and sexual relationships can be painful or enjoyable, unpleasurable as well as pleasurable, uncomfortable as well as satisfying, and empowering – sometimes all at the same time. All these aspects need to be included or understood in the counselling process.

Sexuality counselling explores the connection between what sexuality means for the individual and for the relationships the client has, and can help to explore the fears and obstacles they encounter in asserting themselves [13].

4.2 Topics for sexuality and sexual health counselling

The following sections provide a description of sexuality and sexual relationship topics, and special considerations a counsellor may discuss with their clients during counselling sessions.

4.2.1 Sexual diversity

Sexual diversity is a term that embodies all of the characteristics related to diverse sexual orientations, gender identities and expressions, and sex characteristics [19].

In many contexts, clients with sexual and gender diversity experience oppression, discrimination, and stigmatization. Sexual orientation or same-sex sexual relationships can influence a client's sexual and reproductive health and rights, sexual well-being, and willingness to talk to providers.

Intersex people have external or internal sexual characteristics that exemplify the wide diversity of biological sex in human beings. Intersex shows that not all bodies fit into the male-female dichotomy.

Both transgender and intersex youth and adults should be supported to make autonomous decisions about their own bodies and receive proper information and guidance from providers about surgeries or hormone therapies.

Providers should reflect on their comfort level and values working with clients whose sexual orientations, gender identity, and expression differ from their own, and be careful not to impose their values on clients.

It is important that providers are aware of the legal aspects related to sexual orientation. This will help them to raise the topic of sexual orientation with their clients.

Providers should never assume that they know the sexual orientation of their client and always use gender-neutral and inclusive language. See *Chapter 1: Guiding principles and approaches* for further details on inclusivity and gender-neutral language.

4.2.2 Sexual concerns

Different negative factors can harm a sexual relationship. These range from physical and emotional issues to dependencies, past sexual experiences, and communication difficulties. By asking the client about the issues that hinder and stimulate sexual play and pleasure for them, counselling can support clients to weigh these issues and decide where there is a possibility of increasing positive stimulating experiences and addressing negative experiences.

There is no standard set of questions in a counselling session to support clients to develop confidence in their sexuality. However, there are some simple exploratory questions that counsellors can try using to open conversations about sex and sexuality and tease out discussion about sexual enjoyment, pleasure, discomfort, and pain.

WHO recommendations on 'Brief sexuality-related communication' [20] encourage providers to explore and address sexuality in counselling sessions by:

- **Attending**: setting up the relationship with the client. While brief sexuality-related communication is shaped around the context and needs of the individual client, there are some typical questions that healthcare providers can use in a socially appropriate manner

to initiate the subject of sexual health, such as "Do you have any questions or concerns about sexual matters?"

- **Responding:** asking questions that open the conversation about sexual health and sexuality, such as "Are you satisfied with your sexual life?"; "Is your sexual life going as you wish?"; or "How do you feel in your sexual relationships?"
- **Personalizing**: identifying the existence of sexual concerns, difficulties, dysfunctions, or disorders and the dynamics of any interplay between these, such as "What difficulties do you have in using condoms?"; "Some people who have had a particular challenge (e.g. cancer, hypertension, diabetes, menopause, a disability, AIDS treatment – whatever the client is facing) tell me that they have had sexual difficulties; how is it for you?"

4.2.3 Sexual pleasure and sexual relationships

Sexual pleasure can mean different things to different clients and can be experienced individually or as a shared experience.

A focus on pleasurable, positive sexual experiences can help to open discussions to work towards safer sexual behaviours and stronger negotiation skills. Furthermore, communicating sexual preferences to partners and experiencing sexual pleasure as a result may lead to greater self-confidence and self-esteem, which may in turn reinforce the ability to make empowered decisions about safer sex and equitable relationships.

Some discussion points to cover in counselling on sexual pleasure and sexual relationships may include:

- Physical and psychological satisfaction/enjoyment
  - the physical and psychological satisfaction/ enjoyment in the client's sexual encounters
  - what makes the sexual relationships more or less pleasurable
- Self-determination
  - the ability of the client to freely choose a sexual encounter
  - being forced to engage in a sexual relationship
- Consent
  - challenges to reach consensual agreements about what the client wants/does not want to do with sexual partners
- Safety
  - what makes the client feel safe/unsafe in their sexual relationships
  - what is their most common method of protection
  - in which situations does the client feel more safe/ less safe
  - challenges to have safe sexual relationships
- Privacy
  - what are the main challenges to ensure privacy
  - factors beyond the control of the client to have privacy in sexual encounters
- Confidence
  - which factors limit the ways the client expresses themselves during the encounters
  - is there something the client feels limited by (e.g. disability, body image); the role of the partner in making the client feel less or more confident
- Communication/negotiation
  - capacity of the client to talk with partner(s) about what they want in a sexual encounter
  - capacity to propose to explore new things

4.2.4 Sexual dysfunctions

Providers should discuss sexual dysfunction, possible causes and treatment, and encourage clients to seek support where necessary. The two most common dysfunctions individuals experience are:

Difficulty reaching an orgasm

- This can be a concern for people of all ages. In surveys about orgasms, women tend to report greater difficulty reaching orgasm than men. However, the quality and timing of orgasms can be an issue for people of all genders.
- Providers can discuss pleasure and the importance of orgasms. Does the client think sex should necessarily involve orgasm? Can it still be enjoyable/satisfying if not?

- Reaching orgasm is often not as simple as it might seem from films/television and pornography. For example, many women find that it is difficult or impossible to reach orgasm during only penetrative (penis in vagina) sex and are likely to require clitoral stimulation. It could be helpful to talk about the internal structure of the clitoris and the number of nerve endings in the outer part of the clitoris compared with the vaginal canal.
- Sometimes pressure to reach orgasm during sex can exacerbate the issue and result in feelings of failure. Providers can talk to the client about what makes them feel relaxed, and how they might initiate sex (solo or partnered) that does not focus on orgasm as a goal, but on pleasure/intimacy.

Pain during sex

- Pain during sex can be caused by a person's state of mind, relationship issues, medications, medical/gynaecological and surgical conditions, or by a partner or unwanted sexual pressure [21].
- No one should feel pressured to have sex that they do not enjoy or sex that causes them pain. See *Chapter 10: Sexual and gender-based violence* for guidance on counselling survivors of sexual violence and referral pathways.
- Find out what your client means by sex. Do they mean penetrative sex? If so, talk about alternative methods of giving and receiving pleasure, and how important it is to them to have this type of sex.
- Pain in the vagina could be the result of an infection, vaginismus, or irritation caused by cosmetic products. Pain in the pelvis could be due to pelvic inflammatory disease, endometriosis, or fibroids. It is important to ask questions to ascertain the cause of the pain.
- Pain may also be due to a lack of arousal, and penetrative sex may be painful for those who are first experiencing it, or for post-menopausal clients experiencing vaginal dryness. It is important to talk about consent and enjoyment as well as lubrication – both natural and synthetic.
- Contraception and condom use may play a big part in how physically comfortable a person is having penetrative sex; providers should talk about the method the client is using and how it feels for them.

Sexual and reproductive healthcare providers should consider referring clients with severe sexual dysfunctions that create difficulties for clients and partners to a specialist. Providers need to know where they can refer clients for trustworthy, sex positive, and unbiased care.

5. Enabling environment

Counselling may have negative connotations in some communities due to embarrassment and stigmatization of sexuality and sexual and reproductive health and rights. It is important that current and potential clients feel supported and accepted to seek the care they need to manage their reproductive lives.

Counsellors have a role to play in addressing adolescent health; disability inclusion; diverse sexual orientations, gender identities and expressions, and sex characteristics; and social issues in the community. Counsellors are often highly regarded and respected and can lead discussions on inequality, harmful practices, and other sensitive and sometimes controversial sexual and reproductive health issues.

Creating an enabling environment for counselling involves a multisector/stakeholder approach that links facilities with local government bodies, schools, youth-led organizations, organizations of people with disabilities, family members, and religious and community leaders [8,22,23]. Similarly, strengthening support within health facilities and communities improves referral pathways along the continuum of care and creates an environment that empowers individuals to develop positive sexual and reproductive health-seeking behaviours [24].

5.1 Health facility strengthening

For a health facility to provide quality sexual and reproductive healthcare for all population groups, counselling must adhere to the nine rights-based principles (see *Table 1*) and must meet the

facility requirements outlined in *Chapter 2: Facility requirements and client history/examination*. The facility's environment and characteristics impact a client's decision to seek and return for information, counselling, and care [5,11].

5.2 Community engagement

In some contexts, it may be the first time that sexual and reproductive health and rights education, information, and counselling are initiated, and it is essential, therefore, to build trust with community members. Giving information and education before counselling builds trust, makes the provider–client interaction more effective, and saves time in counselling consultations where learning is enhanced because the client receives information and education linked to their specific needs. In turn, the client feels empowered to provide informed consent for healthcare and release of information for referrals.

Table 2 describes community engagement strategies that tackle the compounding barriers people face and help catalyse positive sexual and reproductive health behaviours. These strategies are rights based and designed to be implemented in informal and formal settings, including in humanitarian settings, and are adaptable to meet the needs of participants and the most marginalized groups.

Table 2: Community engagement strategies for positive sexual and reproductive health

Strategy	
Engaging religious leaders and community organizations of women; young people; people with diverse sexual orientations, gender identities and expressions, and sex characteristics; and people with disabilities	Working with community leaders is crucial to counter inaccurate information and dispel any existing myths and misconceptions around sexual and reproductive health and rights and counselling that a community might have. Meaningful engagement with community organizations that represent women; young people; people with diverse sexual orientations, gender identities and expressions, and sex characteristics; and people with disabilities destigmatizes the sexual and reproductive health and rights of these populations, and provides an opportunity for direct dialogue and referral to healthcare
Comprehensive group engagement (CGE) [25] and group information-giving (GIG)	CGE and GIG move beyond outreach to decision-makers and leaders, to groups of people to promote open dialogue and understanding of sexual and reproductive health and rights. The facilitator should provide clear information and material to the particular communities. Unlike group counselling, CGE and GIG are not confidential, therefore it is important that participants talk about issues in a general way and do not disclose personal information. The ideal group size depends on the venue and the time available, but generally between 10 and 15 people provides opportunity for discussion. These group activities are highly effective when engaging men and boys and marginalized communities. For additional guidance on the CGE approach, refer to the resource list in *Section 7.1*

continued

continued

Strategy	
Values clarification and attitude transformation (VCAT) [10]	VCAT helps participants reflect on their personal experiences and the driving forces in their communities that help shape their attitudes and beliefs on sexual and reproductive health and rights. VCAT workshops are intended to deeply explore these issues and are designed to challenge participants' perceived notions and to pave the way for acceptance and support of sexual and reproductive health and rights. Trained VCAT facilitators can conduct standalone VCAT workshops or integrate VCAT activities into other community engagement initiatives. Moreover, VCAT workshops can be conducted with different community groups on various sexual and reproductive health and rights issues in locations conducive to the participants. For information on VCAT training packages, refer to the resource list in *Section 7.1*
Comprehensive sexuality education (CSE) [26]	CSE is an evidence-based community engagement approach that is delivered for children, adolescents, and youth. IPPF defines CSE as "A holistic, developmental and age-appropriate, culturally and contextually relevant and scientifically accurate learning process grounded in a vision of human rights, gender equality, sex positivity and citizenship that is aimed at empowering adolescents and young people." CSE empowers them to "improve and protect their health, well-being, and dignity; and support them in developing critical thinking skills, citizenship, and equal, healthy and positive relationships." For additional guidance on CSE, refer to the resource list in *Section 7.1*

6. Healthcare delivery models for counselling

With health systems under pressure from pandemics, humanitarian crises, and/or limited financial and human resources, equitable access to quality information and counselling becomes scarce [27]. Digital health and group counselling are innovative approaches to expand access outside the formal health system for individuals who wish to practice self-care, and for marginalized and under-served populations who face compounding barriers in accessing quality counselling [27,28].

Best practices for in-person one-on-one counselling have been discussed in detail in this chapter. All counselling concepts provided in this chapter can also be utilized and adapted for the additional counselling delivery models described in the following sections.

6.1 Relationship counselling

Counsellors are often confronted with questions and difficulties, many of which are not directly related to sexual and reproductive health or sexuality, such as difficulties in relationships and marriage (e.g. dowry; early and forced marriage; financial and household issues), mental health among adolescents, or difficulties and disagreements between children and parents.

Important! An intersectional approach should be integrated into sexual and reproductive health programming and healthcare

Individuals with all identities, circumstances, and needs should have the same sexual and reproductive health rights as others. This includes taking into account people's religion, national and ethnic origin, age, disability, and sexual orientation. Ensure that all sexual and reproductive health programmes and healthcare along the continuum of care are rooted in a rights-based and evidence-based approach (see *Table 1*).

Important!

Increasing the knowledge and understanding of parents or one partner should not jeopardize a child's or the other co-partner's decision-making ability. The consent/assent guidance in *Section 2.3* outlines the protocol for practitioners to utilize when counselling clients. For couples that demonstrate positive communication and mutual respect, the counsellor can encourage couple communication and shared decision-making.

Many concerns can be related to gender norms, social issues, or economic issues of the individual clients, couples, or the children and parents. These issues often need long-term investment, are not quickly addressed in one or two sessions, and clients may need to be referred for more specialized care.

Sometimes counsellors will have a negotiating role that will have specific requirements for working with couples or with parents and children, such as:

- Making sure that each person can discuss freely, without feeling judged or bullied, and that another person is not dominating the discussion.
- Helping the clients cope with emotions, such as feeling betrayed, undermined, and not listened to, and mitigating any power imbalances.
- Ensuring no form of coercion, threat, or violence inhibits an individual's right to bodily autonomy and safety. The counsellor should provide an overview of what to expect in the joint counselling session and document each party's full consent for counselling separately.

6.2 Group counselling

A group counselling session provides space for people to assess and explore their comprehensive sexual and reproductive health needs and options and make an informed decision about the circumstance(s) impacting their lives [26]. In group counselling, the counsellor builds rapport, guides the exploration of the issues around disease and/or pregnancy prevention, options for risk reduction for STIs (including HIV) and other diseases, and other sexual and reproductive health information over several sessions.

Group counselling consultations are private and confidential, just as they would be in a one-to-one counselling session. These sessions can be held inside a health facility or a safe and accessible location. Group counselling involves a trained counsellor and a small group of people (typically up to 10) who will feel comfortable talking together.

Group counselling can be around a particular sexual and reproductive health topic or for specific marginalized groups (e.g. adolescents, young people living with HIV, survivors of SGBV, people with disabilities) and consist of learning methodologies that provide a pathway for group members to make informed decisions about their comprehensive sexual and reproductive health needs. Methods may include icebreakers and trust-building exercises, experience sharing, discussion only, skill development, and problem-solving [29].

6.3 Digital interventions: telephone and online counselling

Counselling through telephone and telephone hotlines has existed for decades and has proven effective during pandemics and crisis settings, and especially for adolescents, youth, and people with mobility difficulties.

Online counselling is also known as e-counselling, e-therapy, cyber-counselling, and tele-counselling. Online counselling can occur through emails, video conferencing, internet phone services, or online chat.

While telephone and online counselling have advantages and disadvantages (see *Table 3* – next page), these interventions should target counselling marginalized groups and individuals to expand contact coverage and generate demand [30]. These digital health interventions should complement non-digital information-sharing and counselling approaches and avoid exacerbating inequities where people do not have access to technology [30].

Table 3: Advantages and disadvantages of telephone and online counselling

Advantages	Disadvantages
• No geographical limits, especially helpful in pandemics. • No need to make other arrangements to make appointments (e.g. childcare, time off work, etc). • Online counselling gives anonymity to the client, which many clients value – they may be willing to disclose their issues more freely than they would face to face. • Ideal for people who find travelling difficult, have mobility difficulties, or live in hard to reach and remote areas. • Provides an effective way to access counselling that may not previously have been available for the person. • Removes the stigma of physically attending a counselling session. • Can be accessed at any time – many online counselling services offer a 24-hour service. • Provides the same ethical and confidential standards as face-to-face counselling. • Usually no need to commit to set times for the counselling, although some online counselling services may insist on prior appointments. • Most online counselling services will aim to respond to any emails within 24–48 hours. • Gives the client more time. The client may send an email or submit questions via a forum; they will have time to think and reflect about the counsellor's answer and the advice given; they also have time to ask questions. • Less costly than seeing a counsellor face to face. • Writing down concerns in an email can help clients to think about what they are saying, how they phrase it and so on, which is an important part of the counselling process.	• Not available to those without access to digital or telecommunication platforms. • Non-verbal communication is an important part of counselling. There is minimal non-verbal communication from the client and the counsellor. The counsellor may not pick up on signals that they may have done with face-to-face communication. Furthermore, the client may not see how the counsellor is responding to them, which may cause confusion. • A practical difficulty that can occur with telephone and online counselling is connection issues (internet, phone reception) or issues for people with hearing impairments. • Poor connectivity or loss of internet connection can delay treatment, responses, and emails, which can impact the client – the counsellor and client should agree what they should do in this situation. • There are potential security issues if someone hacks the client's or counsellor's computer/mobile phone, therefore confidentiality may be compromised. • With online counselling, there is not always an immediate response, which a client may want. • As with any communication, misunderstanding or miscommunication may occur. The counsellor may think that a particular issue is more important to the client, whereas another issue is actually more important. The client may also misunderstand what the counsellor is saying. • Online counselling demands that the client and provider have computer/digital literacy skills and can express their views in writing (if using emails and chatrooms). • Online and telephone counselling are not always appropriate for clients with complex or serious conditions (e.g. disabilities). • While online or telephone counsellors should have the same ethical guidelines as others within their own country, they may not be the same guidelines as in the client's country. For example, the client may be in country A, whereas the counsellor could be in country B, where there are different ethical guidelines or standards.

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7.1 Resources

In addition to the reference list, the following list provides further tools and resources that focus on rights-based, client-centred sexual and reproductive health counselling.

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