

# Serving Diverse Groups

## Key Points for Providers and Clients

### *Adolescents*

- **All contraceptives are safe for young people.** Unmarried and married youth may have different sexual and reproductive health needs.

### *Men*

- **Correct information can help men make better decisions about their own health and their partner's health, too.** When couples discuss contraception, they are more likely to make plans that they can carry out.

### *Women Near Menopause*

- **To be sure to avoid pregnancy, a woman should use contraception until she has had no monthly bleeding for 12 months in a row.**

### *Clients With Disabilities*

- **People with disabilities deserve full and sometimes adapted information and the same respectful and conscientious care as other clients.**

## Adolescents

Young people may come to a family planning provider not only for contraception but also for advice about physical changes, sex, relationships, family, and problems of growing up. Their needs depend on their particular situations. Some are unmarried and sexually active, others are not sexually active, while still others are already married. Some already have children. Age itself makes a great difference, since young people mature quickly during the adolescent years. These differences make it important to learn about each client first, to understand why that client has come, and to tailor counseling and the offer of services accordingly.

## Provide Services with Care and Respect

Young people deserve reproductive health services that meet their needs and are nonjudgmental and respectful, no matter how young the person is. Criticism or unwelcoming attitudes will keep young people away from the care they need. Counseling and services do not encourage young people to have sex. Instead, they help young people protect their health.

Appropriate sexual and reproductive health services, including contraception, should be available and accessible to all adolescents without requiring authorization from a parent or guardian by law, policy, or practice. As much as possible, programs should avoid discouraging adolescents from seeking services and avoid limiting their choice of contraceptives because of cost.

To make services friendly to youth, you can:

- Show young people that you enjoy working with them.
- Offer services that are free or as low cost as possible.
- Offer a wide range of contraceptive methods, including long-acting reversible methods.
- Counsel in private areas where you and the client cannot be seen or overheard. Ensure confidentiality and assure the client of confidentiality.
- Listen carefully and ask open-ended questions such as “How can I help you?” and “What questions do you have?”
- Use simple language and avoid medical terms.
- Use terms that suit young people. Avoid such terms as “family planning,” which may seem irrelevant to those who are not married.
- Welcome partners and include them in counseling, if the client desires.
- Try to make sure that a young woman’s choices are her own and are not pressured by her partner or her family. In particular, if she is being pressured to have sex, help a young woman think about what she can say and do to resist and reduce that pressure. Practice with her the skills to negotiate condom use.
- Speak without expressing judgment (for example, say “You can” rather than “You should”). Do not criticize even if you do not approve of what the young person is saying or doing. Help young clients make decisions that are in their best interest.
- Take time to fully address questions, fears, and misinformation about sex, sexually transmitted infections (STIs), and contraceptives. Many young people want reassurance that the changes in their bodies and their feelings are normal. Be prepared to answer common questions about puberty, monthly bleeding, masturbation, night-time ejaculation, and genital hygiene.

- Be aware of young people's norms about gender and gently encourage positive, healthful norms. In particular you can help young women feel that they have the right and the power to make their own decisions about sex and contraception. You can help young men to understand the consequences of their sexual behavior for themselves and for their partners.

## All Contraceptives Are Safe for Young People

Young people can safely use any contraceptive method. Age is not a medical reason for denying any method to adolescents.

- Young women are often less tolerant of side effects than older women. With counseling, however, they will know what to expect and may be less likely to stop using their methods.
- Unmarried young people may have more sex partners than older people and so may face a greater risk of STIs. It is important when counseling young people to consider STI risk and how to reduce it.

For some contraceptive methods there are specific considerations for young people (see contraceptive method chapters for complete guidance):

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### Long-acting reversible contraceptives—implants and IUDs

- Implants, copper-bearing IUDs, and LNG-IUDs may be good choices for many young women because:
  - These methods are very effective—fewer than 1 pregnancy per 100 women in the first year of use.
  - Once in place, these methods do not require any action by the user. She does not have to plan in advance for sex.
  - They work for a number of years.
  - They are quickly reversible. Once the implant or IUD is removed, a woman can again become pregnant.
  - It is not obvious that the woman is using a contraceptive method.
- IUDs are more likely to come out among women who have not given birth because their uteruses are small.

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### Injectable contraceptives

- Injectables can be used without others knowing.

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### Oral contraceptives

- Some young women find taking a pill every day particularly difficult.
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## Emergency contraceptive pills (ECPs)

- Young women may have less control than older women over having sex and using contraception. They may need ECPs more often. It is safe to use ECPs multiple times between monthly bleedings. Using combined oral contraceptives or a long-acting reversible method would be more effective in the long run.
- Provide young women with ECPs in advance, for use when needed. ECPs can be used whenever she has any unprotected sex, including sex against her will, or a mistake has occurred when using contraception.

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## Female sterilization and vasectomy

- Provide with great caution. Young people and people with few or no children are among those most likely to regret sterilization.

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## Male and female condoms

- Protect against STIs as well as pregnancy. Many young people need protection against both.
- Readily available, and they are affordable and convenient for occasional sex.
- Young men may be less successful than older men at using condoms correctly. They may need practice putting condoms on.

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## Diaphragms, spermicides, and cervical caps

- Although among the least effective methods, young women can control use of these methods, and they can be used as needed.

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## Fertility awareness methods

- Until a young woman has regular menstrual cycles, fertility awareness methods should be used with caution.
- Need a backup method or ECPs on hand in case abstinence fails.

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## Withdrawal

- Requires the man to know when he is about to ejaculate so he can withdraw in time. This may be difficult for some young men.
  - One of the least effective methods of pregnancy prevention, but it may be the only method available—and always available—for some young people.
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# Men

## Important Supporters, Important Clients

To health care providers, men are important for 2 reasons. First, they influence women. Many men care about their partner's reproductive health and support them. Others stand in their way or make decisions for them. Thus, men's attitudes can determine whether women can practice healthy behaviors. In some circumstances, such as avoiding HIV infection or getting help quickly in an obstetric emergency, a man's actions can determine whether a woman lives or dies.

Men are also important as clients. Important family planning methods—male condoms and vasectomy—are used by men. Men also have their own sexual and reproductive health needs and concerns—in particular regarding sexually transmitted infections (STIs)—which deserve the attention of the health care system and providers.

## Many Ways to Help Men

Providers can give support and services to men both as supporters of women and as clients.

### *Encourage Couples to Talk*

Couples who discuss family planning—with or without a provider's help—are more likely to make plans that they can carry out. Providers can:

- Coach men and women on how to talk with their partners about sex, family planning, and STIs.
- Encourage joint decision-making about sexual and reproductive health matters.

In this Handbook most chapters include a box, *How Can a Partner Help?*. The points in this box can be useful when counseling couples or helping a client get her partner's support with her method.



- Invite and encourage women to bring their partners to the clinic for joint counseling, decision-making, and care.
- Encourage the man to understand and support his partner to choose the contraceptive method she prefers.
- Encourage the man to consider taking more responsibility for family planning—for example, by using condoms or vasectomy.
- Suggest to female clients that they tell their partners about health services for men. Give informational materials to take home, if available.



### **Provide Accurate Information**

To inform men's decisions and opinions, they need correct information and correction of misperceptions. Topics important to men include:

- Family planning methods, both for men and for women, including safety and effectiveness
- STIs including HIV—how they are and are not transmitted, signs and symptoms, testing, and treatment
- The benefits of waiting until the youngest child is 2 years old before a woman becomes pregnant again
- Male and female sexual and reproductive anatomy and function
- Safe pregnancy and delivery

### **Offer Services or Refer**

Important services that many men want include:

- Male condoms and vasectomy services
- Information and counseling about other contraceptive methods, particularly methods that must have male cooperation, such as fertility awareness-based methods and female condoms
- Counseling and help for sexual problems
- STI/HIV counseling, testing, and treatment
- Infertility counseling (see Infertility, p. 392)
- Screening for penile, testicular, and prostate cancer

Like women, men of all ages, married or unmarried, have their own sexual and reproductive health needs. They deserve good-quality services and respectful, supportive, and nonjudgmental counseling.

# Women Near Menopause

A woman has reached menopause when her ovaries stop releasing eggs (ovulating). Because bleeding does not come every month as menopause approaches, a woman is considered no longer fertile once she has gone 12 months in a row without having any bleeding.

Menopause usually occurs between the ages of 45 and 55. About half of women reach menopause by age 50. By age 55 some 96% of women have reached menopause.

To prevent pregnancy until it is clear that she is no longer fertile, an older woman can use any method, if she has no medical condition that limits its use. By itself, age does not restrict a woman from using any contraceptive method.

## Special Considerations About Method Choice

When helping women near menopause choose a method, consider:

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**Combined hormonal methods** (combined oral contraceptives [COCs], monthly injectables, combined patch, combined vaginal ring)

- Women age 35 and older who smoke—regardless of how much—should not use COCs, the patch, or the —combined vaginal ring.
- Women age 35 and older who smoke 15 or more cigarettes a day should not use monthly injectables.
- Women age 35 or older should not use COCs, monthly injectables, the patch, or the combined vaginal ring if they have migraine headaches (whether with migraine aura or not).

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**Progestin-only methods** (progestin-only pills, progestin-only injectables, implants)

- A good choice for women who cannot use methods with estrogen.
- During use, DMPA decreases bone mineral density slightly. This may increase the risk of developing osteoporosis and possibly having bone fractures later, after menopause. WHO has concluded that this decrease in bone mineral density does not place age or time limits on use of DMPA.

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**Emergency contraceptive pills**

- Can be used by women of any age, including those who cannot use hormonal methods on a continuing basis.
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## Female sterilization and vasectomy

- May be a good choice for older women and their partners who know they will not want more children.
- Older women are more likely to have conditions that require delay, referral, or caution for female sterilization.

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## Male and female condoms, diaphragms, spermicides, cervical caps, and withdrawal

- Protect older women well because of women's reduced fertility in the years before menopause.
- Affordable and convenient for women who may not have sex often.

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## Intrauterine device (copper-bearing IUDs and LNG-IUDs)

- Expulsion rates fall as women grow older and are lowest in women over 40 years of age.
- Insertion may be more difficult due to tightening of the cervical canal.

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## Fertility awareness methods

- Lack of regular cycles before menopause makes it more difficult to use these methods reliably.
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## When a Woman Can Stop Using Family Planning

Because bleeding does not come every month in the time before menopause, it is difficult for a woman whose bleeding seems to have stopped to know when to stop using contraception. Thus, it is recommended to continue using a family planning method until 12 months with no bleeding have passed.

*Hormonal methods* affect bleeding, and so it may be difficult to know if a woman using them has reached menopause. She can switch to a nonhormonal method. She no longer needs contraception once she has had no bleeding for 12 months in a row.

*Copper-bearing IUDs* can be left in place until after menopause. The IUD should be removed 12 months after a woman's last monthly bleeding.



## Relieving Symptoms of Menopause

Women experience physical effects before, during, and after menopause: hot flashes, excess sweating, difficulty holding urine, vaginal dryness that can make sex painful, and difficulty sleeping.

Providers can suggest ways to reduce some of these symptoms:

- Deep breathing from the diaphragm may make a hot flash go away faster. A woman can also try eating foods containing soy or taking 800 international units per day of vitamin E.
- Eat foods rich in calcium (such as dairy products, beans, fish) and engage in moderate physical activity to help slow the loss of bone density that comes with menopause.
- Vaginal lubricants or moisturizers can be used if vaginal dryness persists and causes irritation. During sex, use a commercially available vaginal lubricant, water, or saliva as a lubricant if vaginal dryness is a problem.

## Clients with Disabilities

Health care providers should treat people with disabilities in the same way that they should treat people without disabilities: with respect. People with disabilities have the same sexual and reproductive health needs and rights as people without disabilities, but often they are not given information about reproductive and sexual health or adequate care. People with disabilities are more vulnerable to abuse than non-disabled people. They are at increased risk of being infected with HIV and other STIs. Many have been sterilized against their will, forced to have abortions, or forced into unwanted marriages, and many have experienced gender-based violence. Health care programs, including family planning programs, need to follow the relevant articles of the UN Convention on the Rights of Persons with Disabilities, especially the articles that address health, family life, and legal rights.

To counsel clients with disabilities, health care providers need to consider their preferences and the nature of their disability. For example, barrier methods may be difficult for some people with a physical disability, and women with an intellectual disability may have trouble remembering to take a pill each day or dealing with changes in monthly bleeding.

Like all clients, people with disabilities need sexual and reproductive health education to make informed choices. People with intellectual disabilities have the same rights as other people to make their own decisions about contraception, including sterilization. They may need special support to do so. For a client with an intellectual disability who is unable to communicate her or his preferences clearly, someone whom the client trusts should

participate and help to make an informed choice that is as consistent as possible with the client's preference. Especially for the choice of sterilization, health care systems should ensure that a process of supported decision-making is available.

To care for people with disabilities, programs should make it known in the community that they serve people with disabilities without discrimination. Facilities should be made physically accessible—for example, with ramps for wheelchairs and large bathrooms with grab bars. Outreach programs should make a special effort to identify and reach people in the community who have limited mobility. Print materials should have simple graphics, large print, and Braille, if possible, and information should be available in audio formats, such as CD or cassette tape, as well as in print. Providers may need especially to demonstrate actions as well as describing them, to speak slowly, and to pause often and check comprehension.

Learning to respect the rights of people with disabilities and to care for them should be part of pre-service training for health care providers, and it should be reinforced with in-service training periodically. Moreover, meeting and talking with people with disabilities can give providers valuable information about how to make services more respectful and accessible. Often, the changes needed are easy.

### **What is supported decision-making?**

In supported decision-making, supporters, advocates, or others help people with disabilities to make their own decisions, free of conflict of interest or undue influence, and without giving decision-making power to someone else. This process may include documenting informed consent. (See *Ensuring Informed Choice*, p. 229, in Chapter 12 – Female Sterilization.)