

# **Integrating Issues of Sexuality into Egyptian Family Planning Counseling**

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# **Integrating Issues of Sexuality into Egyptian Family Planning Counseling**

## **SUMMARY**

Adequate counseling is necessary for greater acceptance and for sustained and effective family planning use. In addition to providing technical information (e.g. side-effects), family planning counseling should include issues related to gender and sexuality that can be affected by the family planning method chosen (e.g., potential changes in sexual desire due to hormonal methods). This counseling is particularly relevant for coitus-dependent barrier methods.

The Population Council studied the acceptability of including sexuality issues in family planning in Egypt, a conservative society with social restrictions around discussions of sex. The study focused on the following research questions:

1. Would family planning clients in Egypt accept discussing issues of sexuality during family planning counseling?
2. Would family planning providers in Egypt accept training on gender and sexuality?
3. Would training in sexuality and gender have an impact on providers' attitudes and counseling practices, and on clients' acceptance of barrier methods?

The study was conducted in six family planning clinics selected from Ministry of Health and Population and Clinical Services Improvement Project clinics. Clinics were randomly assigned to three intervention and three control clinics. Physicians and nurses/counselors in all six clinics received contraceptive update training. In addition, providers in intervention clinics received three days of training on issues of gender and sexuality as they relate to family planning use.

The study design included both a descriptive and a hypothesis testing component. The descriptive component examined clients' acceptance of sexuality counseling and providers' acceptance of the sexuality training. Client acceptance of discussing issues of sexuality was assessed qualitatively using focus group discussions. Client exit interviews were also conducted with family planning clients from both intervention and control clinics to gauge their satisfaction with various aspects of providers' counseling behavior. In the exit interview, clients who received sexuality counseling were asked to indicate if they were embarrassed by the discussion they had with service providers.

Provider acceptance of sexuality training was assessed through observation of providers' reactions during the course, course evaluation forms, and a provider questionnaire that was completed six weeks after the training course. The hypothesis testing component used a post-test only non equivalent control group design. The impact of sexuality training on providers' attitudes towards barrier methods and sexuality counseling was measured using multi-item indices relating to the principal features of barrier methods and dimensions of the sexuality counseling. Changes in

counseling practices were measured both qualitatively and quantitatively using “mystery clients” and client exit interviews.

Client acceptance of barrier methods was also measured in the two groups of clinics using client exit interviews. Three levels of acceptance were distinguished: Level 1 included receiving a barrier method; Level 2 included the client’s expression of the possibility of using a barrier method in the future; and Level 3 included client approval of barrier methods without indicating a possibility of using them in the future.

The study sample included 25 service providers and 503 female clients. The provider sample included all physicians and nurses/counselors who worked in the study clinics. The client sample included all new and continuing family planning clients who visited the study clinics during the data collection period with the purpose of receiving a family planning method or switching to a different method. Seven mystery clients were recruited to report on providers’ counseling practices. Also, five focus group discussions were held in order to measure clients’ acceptance of sexuality counseling.

The study results showed that sexuality counseling is acceptable to family planning clients in Egypt. Sexuality-related problems and concerns were found to be very common in the study group. In focus group discussions participants indicated a desire to discuss their sexuality-related problems or concerns with family planning service providers but that they felt embarrassed to initiate this discussion. According to participants it would help if the provider asked them some routine questions about their sexual relations with their husbands. In discussing their sexual problems/concerns female clients tend to prefer a female provider, especially a doctor. Exit interviews showed that three out of four clients (n = 174) who reported having a sexuality-related discussion with service providers did not feel embarrassed by the discussion.

Moreover, clients in intervention clinics were more likely than those in control clinics to indicate that the provider encouraged them to ask questions (95% versus 84%) and to indicate that they received all the information they expected from the service provider (89% versus 81%).

Training family planning service providers on issues of sexuality is both feasible and acceptable to providers. Observation of providers’ initial reactions to the training course showed that they were greatly interested in the subject matter. In the course evaluation as well as the provider questionnaire that was administered six weeks after the training course, providers expressed an appreciation of the training course and requested additional training on management of sexual problems.

The study results suggest a positive impact of the sexuality training course on providers’ attitudes towards barrier methods. For all three barrier methods investigated in this study (male condom, female condom, and foaming tablets), providers’ attitude scores were consistently more positive in intervention than in control clinics. Providers’ attitudes about sexuality counseling however, did not change substantially as a result of the training. Many providers in the intervention clinics still feel embarrassed to discuss sexual issues with their clients. Also, many providers still believe that most sexual problems need a specialist for managing them and believe that asking clients about their sexual history would embarrass them.

The sexuality training course seemed to have an unexpected negative impact on providers' practices in relation to counseling about barrier methods. Although providers in intervention clinics were more likely than those in control clinics to mention foaming tablets to their clients (77% versus 61%), they were less likely to give complete information about the female condom and foaming tablets compared with providers in control clinics. This finding suggests that providers may have focused on the new sexuality counseling component at the expense of counseling on barrier methods.

Clients in intervention clinics were significantly more likely to receive counseling about the impact of the chosen family planning method on their sexual relations (42% versus 22%). Clients in intervention clinics were also more likely than those in control clinics to report having a sexuality-related discussion, not related to family planning, with the service provider (44% versus 18%).

Mystery clients report that providers in intervention centers were less inhibited in discussing sexuality-related issues with their clients and that they encouraged clients to present their sexuality-related questions/concerns. However, mystery clients reported several deficiencies in the content of sexuality counseling.

Providers were not able to adequately handle clients' complaints about a loss in sexual desire, and some providers seemed unaware of potential changes in sexual desire associated with use of hormonal methods. In managing clients' complaints about the loss of sexual desire, providers were likely to blame the woman rather than to examine the dynamics of the sexual relationship with her husband or the social context in which those relations took place.

The study results also suggest a positive association between training providers on sexuality-related counseling and client acceptance of barrier methods. Clients in intervention clinics were more likely than those in control clinics to receive a barrier method (9% versus 2% in control clinics). It should be noted that at the time of the study the male condom was the only barrier method available to most clients. There was no difference in the potential use of barrier methods between intervention and control clinics (31%). However, client approval of barrier methods (as measured by the multi-item attitudinal index) was more positive among clients in intervention clinics compared with those in control clinics.

Recommendations for refining existing family planning training programs and services include:

- Issues of sexuality should be integrated into family planning counseling. Accordingly, counseling protocols should explicitly include mentioning to the client the potential effect of each method on sexual relations. Also, history-taking should include a brief section that investigates the dynamics of sexual relations.
- Family planning service providers should receive training on the management of basic sexual problems, especially those related to family planning use.
- Health education messages should encourage the public to bring their sexuality-related questions or concerns to family planning providers.

- Linkages should be established between family planning clinics and university or teaching hospitals for referral of cases with more complex sexual problems that are beyond the capabilities of family planning providers.
- Medical schools in Egypt need to increase the number of hours assigned to sexology training for undergraduates.
- A wider range of barrier methods should be made available to family planning clients.

# **Integrating Issues of Sexuality into Egyptian Family Planning Counseling**

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## **STUDY TEAM**

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# **Integrating Issues of Sexuality into Egyptian Family Planning Counseling**

## **BACKGROUND**

Sexuality is at the heart of family planning. Whether verbalized or not, sexuality is crucial in choosing a family planning method, how effectively it will be used, and how satisfied the client will be with the method (Haffner and Stayton 1998; Moore and Helzner 1996). The 1994 International Conference on Population and Development recognized the relationship of sexuality to reproductive health and acknowledged that sexuality issues must be addressed in reproductive health care settings (Haffner and Stayton 1998).

Although counseling about family planning methods has received a great deal of attention in the Egyptian family planning program during the last ten years, discussions between family planning service providers and clients tend to focus primarily on technical aspects of method use, namely how the method works, how it should be used, and potential side-effects. Issues concerning the impact of the chosen method on husband-wife relations rarely figure into the consultation. For example, providers seldom discuss possible changes in sexual desire associated with some hormonal methods. Likewise, IUD users are often not informed of the potential impact that extended periods of bleeding associated with IUD use have on relations with their husbands.

The need to discuss issues of sexuality is even greater with methods that are coitus dependent, such as barrier methods (Stewart 1998). A client who receives such a method should receive information on how she and her spouse can reduce the method's interference with sexual pleasure. The client should also learn strategies that she can use to convince her husband in case he opposes using a barrier method.

For several reasons, providers and clients seldom raise sexuality-related issues relevant to the selected family planning method. Clients are often too shy to address their sexual concerns or questions regarding a specific method to providers. Providers are also inhibited to initiate a discussion of this topic with clients, and in many cases they lack the technical knowledge and skills to answer sexuality-related questions from clients. It is noteworthy that the subject of sexology is taught in very few medical schools in Egypt.

Before this study it was not known if including issues of sexuality in family planning counseling would be feasible or acceptable in the Egyptian society, a

conservative society with social restrictions around discussions of sex. Client acceptance of this type of counseling has never been examined in Egypt, although there are anecdotal reports about clients' need for this type of information. It was not known if clients would regard the family planning setting as an appropriate venue for discussing these issues or if the provider's sex would have any bearing on clients' acceptance of discussing such sensitive issues. Also, it was not known if public sector service providers would agree to assume the expanded role given the high caseload in some clinics, or if in-service training about issues of sexuality would change providers' attitudes and behaviors.

## **STUDY OBJECTIVES**

### **Long-term Objective**

To help couples achieve their reproductive goals and lead a healthier sex life.

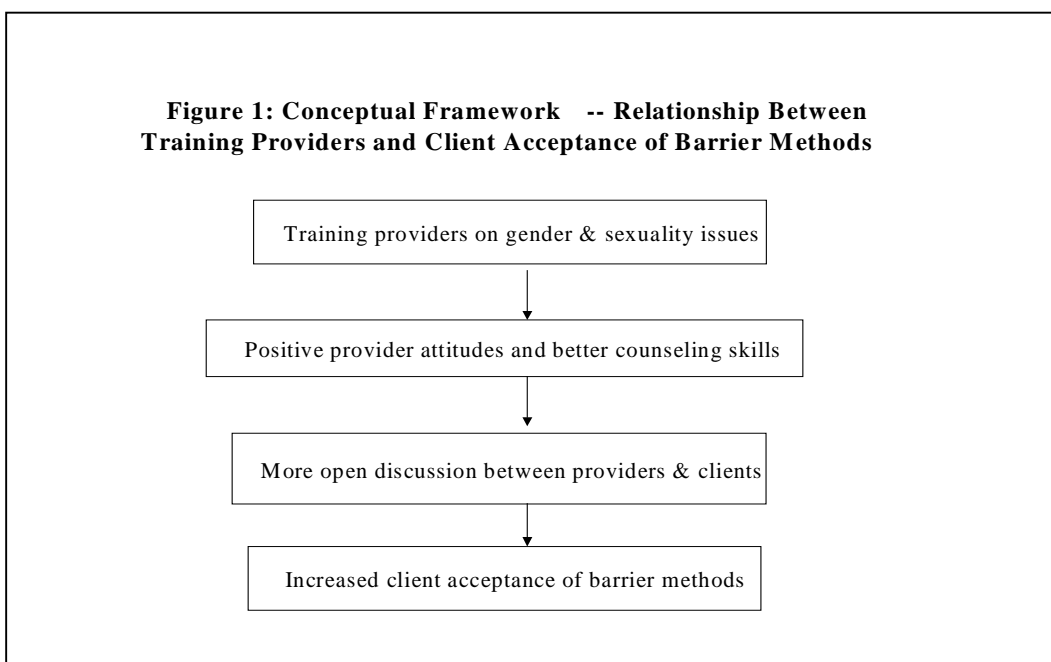
### **Short-term Objectives**

1. To assess client and provider acceptance of discussing sexuality issues during the family planning consultation.
2. To examine the feasibility and effectiveness of training providers to counsel clients on matters related to sexuality.
3. To examine how introducing sexuality issues in family planning counseling affects clients' acceptance of barrier methods.

## **CONCEPTUAL FRAMEWORK**

Figure 1 shows the conceptual framework that guided the design of this study. As mentioned above, providers are often reluctant to discuss sexuality-related issues during family planning counseling because they lack the technical and communication skills to provide such counseling. Training family planning providers on issues of gender and sexuality is expected to have a positive impact on providers' attitudes and counseling behaviors. As providers acquire adequate technical knowledge and counseling skills, they should have more open and comprehensive discussions with clients. Providers should be able to discuss the impact of each method on the client's sexual relations with her husband.

**Figure 1: Conceptual Framework -- Relationship Between Training Providers and Client Acceptance of Barrier Methods**



Providers should also be better able to address clients' questions or concerns regarding sexual relations with their husbands. Clients will be encouraged to address their questions or concerns and consequently will gain a better understanding of available contraceptive methods, including barrier methods.

It should be noted that the above relationship between training providers on issues of gender and sexuality, provider performance, and client outcomes is not unidirectional. Positive interactions with clients (e.g., when providers and clients have an open discussion about the clients' sexuality-related questions) could reinforce providers' attitudes about this type of counseling and could encourage them to discuss those issues more openly in subsequent consultations.

## **THE STUDY INTERVENTION**

Training of service providers was a key component of this study; therefore, this report devotes a relatively large section to describing the two training courses used in this intervention. All providers who participated in the study received contraceptive update training on family planning methods. In addition, providers in intervention clinics received training on sexuality related counseling. Both training courses took place at the Regional Center for Training (RCT) in Cairo, which is the leading training institution for family planning service providers in Egypt. Each training course was conducted in two rounds,

each including half the number of participants. Senior officials at the Ministry of Health and Population (MOHP) and Clinical Services Improvement (CSI) Project requested the above schedule so all providers will not be away from the clinics at the same time.

Participants in the training courses were physicians and nurses/counselors who worked in the study clinics. In addition, the family planning directors from two of the three study governorates were invited to attend the training in order to alleviate their concerns about the nature of the study and to ensure their cooperation with the study team. At the trainers' request, physicians and counselors/nurses were combined in all sessions, since most of the issues that are addressed in this training are important to both physicians and nurses. The trainers believed that physicians and nurses / counselors should learn how to deal with such problems as a team. Instruction in both training courses was in Arabic.

#### **(a) Contraceptive Update Training**

Interviews with clinic managers conducted during the preparatory phase revealed that providers in the study clinics had received training on family planning methods at different points in time (some of them received it this year while others received it in previous years). All providers who participated in the study attended the contraceptive update training course to ensure a minimum level of uniformity in providers' technical knowledge about all contraceptive methods. The contraceptive update training took place May 17-20, 1999. The two-day contraceptive update training covered different family planning methods with an emphasis on barrier methods: male condom, diaphragm, foaming tablets, and cervical cap. The female condom was introduced to providers for the first time in this training.<sup>1</sup> An OB/GYN specialist and a nurse/counselor, both from RCT, presented the course. The course was evaluated using pre- and post-tests of providers' knowledge.

#### **(b) Sexuality Training**

Only providers who worked in intervention clinics (plus the two family planning directors) received the three-day training course on matters related to sexuality counseling. A total of 17 providers attended this training (14 females and 3 males), which took place between May 29th and June 3rd. The objectives of the sexuality training course were as

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<sup>1</sup> USAID/Egypt planned to provide sufficient supplies of the female condom so that client acceptance of this barrier method could be assessed. But due to delays in receiving those supplies, clients were only shown samples of that method but could not be given the method to try with their husbands.

follows:

1. Provide trainees with technical knowledge about the physiology of the human sexual response and some of the related problems that are seen by family planning providers.
2. Analyze gender and sexuality issues as they relate to family planning use.
3. Improve provider skills for couple counseling on sexuality issues related to family planning use with special emphasis on barrier methods.

Trainers for this course were Dr. Nabil Younis (Professor of OB/GYN at Al-Azhar University), Dr. Maali Gumei (Professor of Nursing with a specialty in counseling), and Dr. Abdel-Aziz El-Shoubary (OB/GYN specialist and consultant to MOHP). All three trainers have extensive experience in conducting similar training courses.

Because of the sensitive nature of the subject, there were very careful and elaborate preparations for the sexuality training course. The above group was convened to determine the course content and format. An advisory group was composed of experts in the fields of reproductive health counseling, gender issues, as well as training. The group also included program managers from MOHP and CSI along with the two study investigators.



Dr. Maali Gumei and Dr. Abdel Aziz El Shoubary explaining how to use a female condom

The content of each session was discussed with the advisory group prior to the conduct of training. The training curriculum used modified versions of manuals that were developed by International Planned Parenthood Federation.<sup>2,3</sup> To make the manuals more

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<sup>2</sup> Belize Family Life Association, Sexual Health Project Workshop (April 24-28, 1995).

suitable to the Egyptian setting, provocative subjects such as masturbation, homosexuality, and adolescent sexuality were deleted from the curriculum. The following topics were covered in the sessions:

1. Definitions of sexuality and sexuality issues as they relate to family planning methods
2. Human sexual response and commonly encountered sexual problems
3. Gender issues as they relate to sexuality and family planning
4. Husband-wife communication and negotiation skills
5. Technical and social issues related to management of STDs/RTIs
6. Incorporating sexuality issues into family planning counseling.

The topic of female genital mutilation (FGM) was not covered in a separate session due to its sensitivity. However, trainers believed it is an important component of sexuality in Egypt and therefore included it at separate points in the training course. The approach taken was two-fold. First, trainers discussed with participants the potential negative effects of FGM on female sexual response and husband-wife relations. Second, trainers discussed strategies for helping circumcised women experience better sexual relations with their husbands. Some of the training exercises used FGM as a topic to engage the trainees in practice counseling situations. Also, participants received two documents on FGM: “Medical Facts about FGM” and “FGM from the Point of View of Islam.”

The training format was largely participatory with ample time for discussion, role plays, and brain storming. A copy of the training agenda is attached in the Appendix. To measure changes in knowledge as a result of the training, participants filled out a pre- and a post-test at the beginning and at the end of the course. In addition, they filled out daily evaluation forms to assess the quality of each session. Participants’ knowledge scores increased significantly as a result of the training (65% in the post-test compared to 44% in the pre-test). Participants’ reactions to training are described in the “Findings” section.

Over a six-week period following the training, investigators made supervisory visits to the study clinics. During those visits, providers discussed with the investigators any sexuality related problems that they managed during the follow up period, and

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<sup>3</sup> Gill Gordon and Peter Gordon. 1992. Counseling and Sexuality: A Training Resource. London: International Planned Parenthood Federation.

investigators provided feedback about their management.

## **RESEARCH QUESTIONS**

- 1- Would family planning clients in Egypt accept discussing sexuality issues during family planning counseling?
- 2- Would family planning providers in Egypt accept the training on sexuality counseling?
- 3- Would sexuality training change providers' attitudes and counseling practices?
- 4- Would sexuality training for family planning providers increase client acceptance of barrier methods?

## **RESEARCH METHODS**

### **Study design**

Study clinics were randomly assigned to intervention and control clinics. Providers in both groups of clinics received the contraceptive update training. In addition, providers in intervention clinics received the above training on gender and sexuality. To answer research questions 1 and 2, the study used a descriptive design. Clients' acceptance of discussing sexuality was measured using focus group discussions with family planning clients as well as exit interviews with clients. Providers' reactions during the training were recorded by the investigators during the training courses. Providers' opinions about the training course were measured immediately after the course using a course evaluation form and six weeks later using an interviewer-administered questionnaire.

To answer research questions 3 and 4, a post-test only non equivalent control group design was used. Providers' attitudes and behaviors were compared in the two groups of clinics.

Client acceptance of barrier methods was also measured in the two groups of clinics. The "Variables and Measures" section provides more information on the types of data collected to answer each research question.

## **Study Sites**

The study was conducted in six clinics (three intervention and three control clinics). Four of the study clinics were Ministry of Health and Population (MOHP) Gold Star clinics (clinics rated by MOHP supervisors as top quality clinics), and the remaining two were selected from clinics of the Clinical Services Improvement (CSI) Project. MOHP and CSI senior staff helped select the study sites. Three of the selected clinics were in the governorate of Gharbeya, one in the governorate of Dakahleya, and two clinics in the governorate of Menia. Clinics in intervention and control groups were matched on a number of characteristics: provider gender, number of providers per clinic, client socio-economic characteristics, clinic location (rural versus urban), and client load. Matched clinics were randomly assigned to intervention and control groups.

## **Study Sample**

All physicians and nurses/counselors who worked in the study clinics were to be included in the study ( $n = 28$ ). However, the final sample included 10 physicians and 15 nurses. One physician and one nurse did not attend the training course. Also, one physician from a control clinic resigned during data collection for reasons unassociated with the study.

The client sample included all new and continuing female clients (clients who came to the clinic with the purpose of switching to a different method) who visited the study clinics during the data collection period. Clients who visited the study clinics for method resupply or follow-up were not included in the study because they were not eligible for counseling on different family planning methods.

The initial plan was to include all eligible clients who visited the study clinics during the two weeks of data collection. However, several of the study clinics, especially control clinics, received a very low caseload during the data collection period. Data collection was extended for a third week in two of the study clinics to recruit more clients.

The total number of clients who were recruited was 504. There was one refusal from a client who decided to leave the clinic before completing the exit interview. The final sample therefore included 503 clients (320 clients from the intervention clinics and

183 from control clinics).

## VARIABLES AND MEASURES

### Client acceptance of sexuality counseling

The following two indicators measured clients' acceptance of sexuality counseling:

1. Clients' reported embarrassment after receiving sexuality counseling
2. Clients' satisfaction with the provider performance, which was evaluated on four points:
  - provider listening to client
  - provider treating client well
  - provider encouraging client to ask questions
  - provider giving client sufficient information
  - In addition qualitative methods were used to measure client acceptance of different aspects related to sexuality counseling, namely embarrassment to raise sexuality related questions, sex of provider who would provide such counseling, as well as provider type client.

### Providers' acceptance of sexuality training

The following variables measured provider acceptance of sexuality training:

1. Provider level of interest and reactions during the training course
2. Providers' opinions about the sexuality training course measured immediately after the course and six weeks later.

### Providers' attitudes about sexuality counseling

A multi-item index relating to the principal dimensions of sexuality counseling was developed. Items on the index are shown in Text Box 1. A 3-point Likert scale was used

***Text Box 1:***  
***Statements used to measure providers' attitudes about sexuality counseling***

- Discussing sexual issues should only be done with clients who clearly suffer from a sexual problem.
- I feel embarrassed to discuss sexual issues with my clients.
- Most sexual problems need a specialist to manage them.
- Asking the client about her sexual relationship would be embarrassing to her.

for each item. Responses were coded as follows: agree=0, disagree =2, and don't know =1. A simple summation score was computed based on providers' responses to the above statements with a maximum possible score of 8 and a minimum of 0. Higher scores indicated more positive attitudes towards integrating sexuality issues into family planning counseling. The resulting scale score had a low internal consistency reliability (0.53) which led to the use of the individual items in further analysis and not the overall scale score.

### **Providers' attitudes about barrier methods**

Three eight-item indices were incorporated in the provider questionnaire that probed attitudes about each of the three barrier methods (male condom, female condom, and foaming tablets). Items on each index are shown in Text Box 2. Providers were asked if they agreed or disagreed with each of those statements. Responses were coded as follows: agree=0, disagree=2, and don't know/not sure=1. The maximum possible score on the index was 16 and the minimum was 0. A higher total score on each index indicated more positive attitudes towards this barrier method.

#### ***Text Box 2:***

#### ***Items used to measure providers attitudes about barrier methods***

- The male condom/female condom/foaming tablet is easy to use.\*
- Most husbands refuse the male condom/female condom/foaming tablet.
- Most clients refuse the male condom/female condom/foaming tablet.
- The male condom/female condom/foaming tablet reduces sensation during intercourse.
- The male condom/female condom/foaming tablet is not reliable in preventing pregnancy.
- The male condom/female condom/foaming tablet is associated with illicit relationships.
- It is difficult to convince clients to use the male condom/female condom/foaming tablet.
- Talking about male condom/female condom/foaming tablets with the client is very embarrassing.

*\*This statement was reversed in the analysis.*

Internal consistency reliability for the three indices was as follows: 0.55, 0.65, and 0.60 respectively. Indices for measuring provider attitudes in general had a low internal consistency reliability due to the small number of provider respondents (n=25).

## Providers' counseling practices

Counseling practices of interest were:

- Information given to clients about barrier methods (continuous variable)
- Any discussions between providers and clients on the potential effect of the family planning method they received on sexual relations with their husbands (dichotomous variable)
- Any sexuality-related discussion, not related to use of contraception, that took place between clients and service providers during the consultation (dichotomous variable).

In addition, qualitative methods were used to assess providers' counseling practices, such as content of information given to clients, provider's reaction to the client's request/question about sexuality, provider objectivity, and level of comfort in discussing issues of sexuality with client.

Three levels of information about barrier methods were distinguished. Level 1 includes mentioning the barrier method to the client as one method of contraception. Level 2 includes mentioning more detailed information to the client about individual barrier methods as shown in Text Box 3. A summation score was computed based on the total number of items mentioned by the service provider. The score range for each method was 0-5 (a score of 0 means none of the items were mentioned while a score of 5 means all items were mentioned). Level 3 includes discussing with the client sexuality issues that are pertinent to using a particular method (e.g., method impact on sexual relations and strategies that the client can use to convince her husband about using a barrier method).

### ***Text Box 3:***

#### ***Items used to measure Level 2 information given by providers to clients***

- How the method prevents pregnancy
- How to use the method
- Method's efficacy in preventing pregnancy
- Advantages of the method
- Side-effects of the method

## Clients' acceptance of barrier methods

Three levels of acceptance of barrier methods were distinguished. A client who left the clinic in possession of a barrier method was considered Level 1 acceptor.

A client who expressed a possibility of using a barrier method in the future but did not leave the clinic with the method is Level 2 acceptor. A client who indicates approval of barrier methods on a multi-item index but had no stated intention of using them in the

future and did not leave the clinic with the method was a Level 3 acceptor. Items on the client attitude index are shown in Text Box 4. A client who said she would never try a barrier method in the future, who disapproved of their use on the multi-item index was considered a rejector.

Three indices were used, one for each barrier method (male condom, female condom, and foaming tablets). The same statements were used for each of the three barrier methods. There were three possible responses to each statement: agree (score=0), not sure/don't know (score=1) and disagree (score=2). The total attitude score for each barrier method would therefore range from 0-14 with a lower score indicating a negative attitude towards that method. Internal consistency reliability values for the male condom, female condom, and foaming tablet indices were as follows: 0.67, 0.74, 0.75 respectively.

### **Explanatory variables**

These variables included client characteristics, husband characteristics, and provider characteristics. Client characteristics included age, education, working status, number of living children, residence (rural versus urban), region (upper versus lower Egypt), previous use of family planning, and previous use of barrier methods. Husband characteristics included husband's education, occupation, and availability (the latter variable could influence use of barrier methods). Provider characteristics included provider age, group (physician versus nurse/counselor), number of years in the study clinic, and number of years in the field of family planning.

**Text Box 4:**  
**Items used to measure clients' Level 3 acceptance of barrier methods:**

- My husband refuses it/ could refuse it.
- Bothers me during intercourse.
- Bothers the man during intercourse.
- I'm afraid to get pregnant while using it.
- I'm afraid it would cause inflammation.
- It interrupts the sex act.
- It needs some preparation before use.

*\* The above statements were presented for each of the three methods.*

## **SOURCES OF DATA**

### **Investigators' notes about the training course**

These notes included investigators' comments about participants' reactions during the training course and their level of interest in relation to each of the sessions.

### **Course evaluation forms**

At the end of the course participants filled out an evaluation form in which they wrote their opinions about the course and made suggestions for improving it.

### **Provider interview**

This was an interviewer administered questionnaire that included information about the following: provider characteristics, provider attitudes about the training course, provider attitudes about sexuality counseling, and provider attitudes about the three barrier methods (male condom, female condom, foaming tablets).

### **Client exit interview**

This was also interviewer-administered. It included information about the following: client characteristics, husband characteristics, client reactions to discussions on sexuality-related issues in the index consultation, clients' attitudes about the three barrier methods (male condom, female condom, foaming tablets), clients' reports about providers' counseling practices in relation to barrier methods as well as to sexuality counseling.

### **Focus group discussions**

In focus group discussions clients were asked about family planning related and non-family planning related sexual problems that they encounter, how they manage them, their views about presenting their sexual problems to family planning service providers, and characteristics of the service provider most suited to manage such problems.

### **Mystery client reports**

These reports provided a qualitative assessment of providers' counseling practices on matters related to sexuality (more on recruitment of mystery clients is described in "Data Collection Procedures"). Mystery clients were used instead of "regular" clients because investigators anticipated that very few clients would normally raise questions or prompt discussions pertaining to sexuality.

Debriefing of mystery clients probed into the following: (a) providers' reaction to the client's request/question about sexuality, (b) content of information given to the client

in relation to her problem, and (3) provider objectivity and level of comfort in discussing issues of sexuality with the client.

## **DATA COLLECTION PROCEDURES**

### **Investigators' notes**

During the training course the principal investigator and the study coordinator independently recorded their observations about participants' reactions to the training course. After the course they discussed their observations with each other and synthesized their field notes.

### **Course evaluation forms**

At the end of the sexuality course each participant completed a course evaluation form.

### **Provider and client interviews**

A data collection team composed of nine data collectors and three field supervisors were in charge of provider and client exit interviews. All data collectors were female while supervisors included one female and two males. Data collectors and supervisors received 1.5 days of theoretical training and a half -day of practical training in three family planning clinics in Cairo. Supervisors and data collectors were blinded as to which clinics were intervention and which were control clinics. Client and provider consent were obtained before the interviews. The interviewer read the consent statement to the client because the majority of clients who go to public sector clinics are illiterate. Providers on the other hand read the informed consent statement themselves and signed the form. The provider interviews were completed during the first day of data collection in each clinic. Client exit interviews were completed after the clients had received services and were ready to leave the clinic.

### **Focus group discussions**

A total of five focus group discussions were held in this study, three of which were held at the intervention sites and one in a control site.

The fifth discussion was held in a non-study site in Menia City due to difficulty in conducting the focus group discussion session at the intervention site in Menia, which is a

rural health unit. Participants in that session were reluctant to talk about any sexuality-related issues/concerns in a group. Later, investigators learned that almost all residents in this village were related and thus may have found it embarrassing to discuss sexual problems in public. The study team decided to hold another focus group discussion in a family planning clinic in Menia City to gain some insights about client attitudes in Upper Egypt.

Focus group discussions were held with family planning clients after they had received services. Any family planning client (current user or previous user) was eligible for participation in the focus group discussions. The principal investigator and study coordinator facilitated the discussions, which were tape-recorded and transcribed. Participants' consent was sought for participation in the focus groups and for use of the tape-recorder. On average, discussions lasted an hour and 15 minutes. At the end of the discussion each participant received a small monetary compensation for her participation (L.E. 10).

### **Mystery clients**

Mystery clients were recruited from family planning clients who had expressed to the study team a sexuality-related problem or concern during the focus group discussions. Mystery clients were only recruited from control clinics. A client was eligible to serve as mystery client if: (1) she was a current family planning user, (2) she had not been to the intervention clinic before, (3) she expressed during focus group discussions a sexuality-related question or concern, and (4) she had shown during focus group discussions some articulateness as well as openness about discussing her problem.

After the focus group discussions the principal investigator or the coordinator approached the client and asked her if she would like to see a doctor who has received special training on sexuality-related problems. The two researchers helped the client phrase her question(s) to the provider but they did not accompany her to the clinic. Clients were not given a script but were asked to think of all their problems/concerns and to report them to the provider. They were asked to observe everything that the provider does or says. Mystery clients were asked not to mention any affiliation with the study at the clinic.

To keep the experience of mystery clients as close to real clients as possible, no mystery client was sent to more than one clinic. Mystery clients received a monetary compensation

of L.E. 20 to cover their transportation as well as any other incurred expenses. Debriefing of mystery clients was done by the study coordinator immediately after the consultation either at a different clinic or at a nearby coffee shop. A total of seven mystery clients were recruited. In general, recruitment of mystery clients was difficult. In some instances women were not willing to see a provider at a clinic that they have not been to before. In other instances, women who had agreed to serve as mystery clients did not show up on the assigned date. It was particularly difficult to send mystery clients to clinics during evening shifts.

## FINDINGS

### I. Participants' Characteristics

#### A. Providers' Characteristics

A total of 10 physicians and 15 nurses/counselors participated in the study (Table 1). With the exception of two physicians, all providers who participated in the study were female. The mean provider age was 36.2 years which was significantly higher among providers in control clinics than in intervention clinics (40.9 years versus 30.0 years respectively,  $p < 0.05$ ). On average physicians were about six years older than nurses/counselors (39.7 versus 33.9 years respectively).

**Table 1: Selected Characteristics of Service Providers Who Participated in the Study**

Characteristic	Intervention Centers n=15	Control Centers n=10	Total
<b>Provider category (%)</b>			
Physician (all female)	40.0	40.0	40.0
Counselor/nurse (all female)	60.0	60.0	60.0
<b>Mean age*(years)</b>	33.0	40.9	36.2
<b>Mean no. of working years in the study clinic*</b>	5.7	10.3	7.6
<b>Mean no. of years in the field of FP</b>	8.9	11.5	10.0

\*  $p < 0.05$

On average providers in the control sites have been working in the field of family planning for about 11 years while those in the intervention sites for about 9 years. Providers in the control clinics have worked for more years in their clinics compared to

those in intervention clinics (mean = 10.3 years versus 5.7 years,  $p < 0.05$ ). Provider age and number of years in study clinic were therefore potential confounders and were controlled for in the analysis, but due to the small sample the ability to successfully hold these characteristics constant in all analysis was limited.

### ***B. Clients' Characteristics***

On average clients were 29 years old with no statistically significant differences between clients in intervention and control groups (Table 2). More than one-third of the study clients were illiterate (38%), while a considerable portion of clients had university education (11%). The majority of clients were homemakers (76%). The percentage of homemakers among the clients in the control group was significantly higher than those in the intervention group, 83.6% and 71.3% respectively ( $p < 0.01$ ). Clients in the control group had significantly more children than those in the intervention group (mean = 3.1 vs. 2.6 respectively,  $p < 0.01$ ). As shown in Table 2, about three quarters of clients in both groups have previously used contraception and about one in every six clients used a barrier method before (there was no significant difference between study groups). As mentioned above, only new and continuing family planning clients were eligible for the exit interview. Two-thirds of the study clients were not using a family planning method when they came to the clinic while the remaining third were switched to a different method during the index consultation.

In the exit interview clients were asked a number of questions related to the characteristics of their husbands. As shown in Table 2, one quarter of husbands were illiterate, while 19 percent completed secondary education. The majority of husbands worked as manual laborers (42%). There were no significant differences between the two study groups with regard to husband characteristics.

To summarize, clients in intervention and control groups were comparable on most socio-demographic characteristics with the exception of level of education, working status, and number of living children. These differences were controlled for in the analysis.

**Table 2: Selected Characteristics of Study Clients**

Characteristic	Intervention n=320	Control n =183	Total 503
	Percentage	Percentage	Percentage
<b>Age in years</b>			
16 – 19	4.4	4.4	4.0
20 – 29	50.9	51.4	51.0
30 +	44.7	44.3	45.0
<b>Client's education</b>			
Illiterate	37.2	39.3	38.0
Reads and writes	10.0	18.6	13.0
Intermediate	40.6	34.4	38.0
University	12.2	7.7	11.0
<b>Woman's work status**</b>			
Working	28.8	16.4	24.0
Homemaker	71.3	83.6	76.0
<b>Number of living children**</b>			
Mean	2.6	3.1	2.8
<b>Husbands' education</b>			
Illiterate	25.9	23.5	25.0
Reads and writes	13.8	20.2	16.0
Intermediate	38.8	42.7	41.0
University	21.6	13.7	19.0
<b>Husbands' occupation</b>			
Manual laborer	39.1	45.9	42.0
Farmer	12.2	12.0	12.0
Gov. employee	34.1	30.1	33.0
Other	14.4	12.1	13.0
<b>Outcome of client's visit</b>			
Received a method	60.9	73.8	66.0
Changed a method	39.1	26.2	34.0
<b>Client used contraception before</b>	75.6	77.0	76.0
<b>Client used barrier method Before</b>	13.8	16.9	15.0

*N.B. cases with missing data are excluded.*

*\*\* p<0.01*

*Source: Client exit interview*

## II. Clients' Acceptance of Sexuality Counseling

The focus group discussions with clients explored in more depth the impact of any family planning methods women previously had used on their sexual relations, any sexual problems or concerns that they might have, and their preferences with regard to the service provider for

*"I often couldn't have sex with my husband because of the IUD (bleeding)... he asked me to take it off... he said it's no problem to get pregnant, but this IUD ... no."*

**(A 30 year old participant from Menia City)**

managing their sexual problems/concerns. The results of the focus group discussions indicate clients' need for sexuality counseling and a need to examine their acceptance of discussing sexuality-related issues during the family planning consultation. Focus group participants expressed a number of family planning related sexual problems. Such problems included IUD threads bothering the husband during intercourse, extended periods of bleeding that negatively affect the frequency of sexual intercourse, and condom's interference with sensation, especially for the husband. According to participants those complaints often create a considerable amount of tension between husbands and wives with the result that women often have to switch methods or stop family planning use entirely.

*"I had a problem for four years but was embarrassed to mention it to the doctor."  
(A 30 year old participant from Gharbeya)*

*"We wish family planning providers would talk to us about those things... if the doctor asks us those questions we would tell her about our problems but otherwise I would be embarrassed to tell her."  
(A 35 year old participant from Gharbeya)*

Women also complained of other sexual problems that are not family planning related. Several women complained of loss of sexual desire. At the end of a long day

women said they are often too tired to want to have sex with their husbands. However, husbands tend to get offended and often get angry at their wives for rejecting them.

*"She (female doctor) is a woman like me. Sometimes there are sensitive things that I will be embarrassed to mention to a male doctor. But the female doctor has everything that I have."  
(A 22 year old participant from Gharbeya)*

Sources of adequate information to help clients solve their sexual problems are very

limited. Being such a sensitive topic, many women prefer to keep their sexual problems to themselves and hope that they would go away spontaneously. If the problem does not go away, women often consult a trusted relative or a friend. According to focus group participants, women usually see a doctor only if the problem gets very severe or if the friend/relative's advice does not work. This is part of the culture of silence surrounding women's health problems (Khattab 1992). From participants' reports the situation seems to be even worse with sexual problems because of the social restrictions around discussions of sex.

*"No one can talk about those things (sexual problems). Maybe it will go away... it's just too personal... it's not right to talk about it..."  
(A 40 year old participant from a village in Menia)*

Although the majority of clients seem to consider their sexual relations with their husbands to be very private, clients do not see a problem in responding to questions about their sexual relations as long as they see the relevance of such questions to the choice of a family planning method. Clients, however, find it embarrassing to initiate such a discussion with service providers because they are often afraid that they may be taking too much of the doctor's time or they may sound inappropriate. According to clients' reports, some encouragement or prompting from doctors could take away some of the embarrassment.

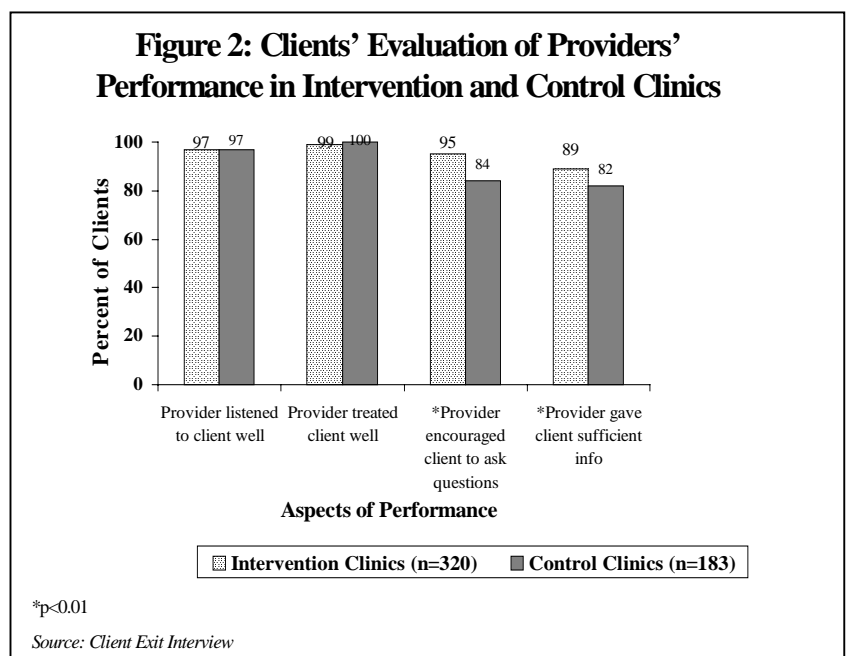
***“People don't know me here (in this clinic). I can say whatever I want. But with a doctor in my village it would be embarrassing. We see each other all the time.”***  
**( A 35 year old participant from Gharbeya)**

Clients said they would only discuss their sexual problems/concerns with a doctor whom they already know and feel comfortable with. If a client is a family planning user, she would go to the same family planning clinic because she already knows the staff in that clinic. However, confidentiality is a very major concern for clients. Some clients prefer to go to a clinic that is far from their village/neighborhood to be sure that their problem will not be revealed to other people in their community.

In the exit interview clients who said a discussion had taken place between them and service providers on issues related to sexuality (n=174 out of total of 503 clients) were asked if they felt embarrassed as a result of that discussion. Less than one-third of those clients (29%) said they did.

Clients in the two groups of clinics were asked several questions to measure their satisfaction with provider

performance. Figure 2 shows that the majority of clients in both groups thought that providers listened to them and treated them well. However, significantly more clients in



intervention clinics than control clinics indicated that providers encouraged them to ask questions (95.0% versus 83.6%,  $p<0.01$ ) and also more clients in the intervention group indicated that they received all the information they were expecting from providers (88.8% versus 81.4%,  $p<0.01$ ). The above findings persisted even after controlling for client level of education. This may suggest that clients in intervention clinics were more appreciative of the interaction they had with service providers, which presumably involved more discussion of sexuality-related issues. Unfortunately, it was not possible to control for provider characteristics such as age and years of experience because there was no item on the client questionnaire that would identify the provider who was seen by that client.

### III. Providers' Acceptance of Sexuality Training

During the training sessions the study team observed that providers were in general extremely interested in the content of the sexuality training course. At first some providers, especially younger women, seemed uncomfortable and reluctant to take part in any discussions. However, by the second and third sessions participants became more relaxed and agreed that this type of training was greatly needed.

Providers mentioned that they do encounter in their clinical practice a variety of sexual problems, which they are often unable to manage due to insufficient training in medical school. The two most common complaints that are presented to them by clients are a lack of sexual desire

and an inability to reach orgasm. Several participants asked if this

was due to female circumcision, which was confirmed by course facilitators. However, they also explained to participants that even though the damage is irreversible, they should be able to help clients (as much as possible) who have undergone this procedure to have a more pleasurable sex life with their husbands.



Family planning providers' interactive training learning about sexuality counseling at the Regional Center for Training

Trainers also recommended that trainees advise clients against performing this practice on their daughters. Interaction between participants and trainers was high in most sessions. However, the study team observed that the session on *talking about sex* made some participants uncomfortable. The mention of oral and anal sex was repulsive to some participants. They also observed that compared with doctors, nurses were less interested in the session on *human sexual response*. Participants' evaluation of the course was very positive. However, the following suggestions were made in the course evaluation: (1) make the course longer, (2) include more supervised practical training, and (3) add in more role-play exercises.

Table 3 shows providers' opinions about the sexuality training as measured by the provider interview that was conducted six weeks after the training. The majority of providers (73%) indicated that most of the information that they received in the course was new to them.

**Table 3: Providers' Views about the Sexuality Training Course (Intervention Group) (n=15)**

<b>Views</b>	<b>Percent</b>
<b>Information covered during training was new?</b>	
Most was new	73
Some was new	13
Not new	13
<b>Counseling style changed as a result of training?</b>	
Yes	100
<b>Reported changes in style*</b>	
Encouraged to talk about sexuality	53
Including sexuality issues in FP counseling	40
Better explanation of barrier methods	27
Better discussion of all methods	27
<b>Topics to be covered in future training*</b>	
Sexual problems and their management	73
Human sexual response	33
Other	27
<b>Suggestions for future training courses</b>	
Same format	40
Different format	60
<b>Suggested changes in future training courses (n=9)*</b>	
More practical training	78
More problem solving	22
Longer duration of training	22
Other	22

\* Multiple responses were allowed.

Source: Provider Interview

All providers indicated that their style in providing family planning counseling has

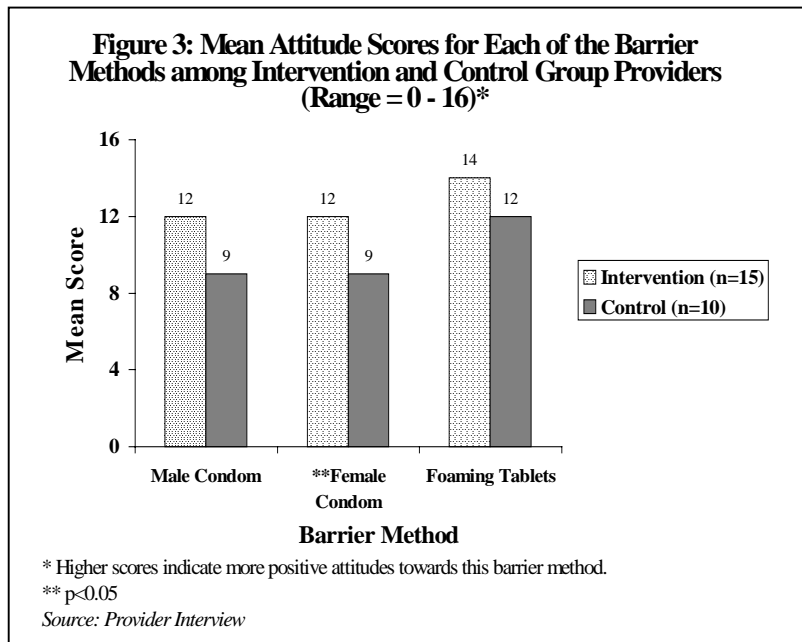
changed as a result of the training. More than half of providers (53%) said that now they feel encouraged to discuss sexual issues with their clients or that they have started including issues of sexuality in family planning counseling (40%). When asked about topics that they needed to learn more about, the majority of providers (73%) said they would like to learn about the management of sexual problems. One-third of providers (33%) mentioned a need to learn about human sexual response. Suggestions for future training courses included more practical training on the management of sexual problems (e.g., more case studies).

#### IV. Effects of Sexuality Training on Providers' Attitudes

##### A. Attitudes about Barrier Methods

As shown in Figure 3 mean provider attitude scores with regard to all three barrier methods were higher in the intervention group compared to the control group. Mean scores were 11.7 versus 9.1 respectively for the male condom, 12.2 versus 9.0 respectively for the female condom, and for foaming tablets they were 14.2 versus 11.7 respectively. The

difference between intervention and control groups with regard to the female condom was statistically significant, while for the male condom and foaming tablets it was of borderline significance ( $p=0.06$  and  $0.08$ , respectively). This borderline significance could be due in part to the small size of the provider sample in each group. The above findings suggest a positive impact of the sexuality training



course on providers' perceptions of barrier methods. It is noteworthy that provider attitudes about the male condom and the female condom did not vary by provider age. However, attitudes towards foaming tablets were significantly more positive among providers who are less than 40 years old compared with providers who are 40 or above (mean scores=13.9 versus 10.3,  $p<0.01$ ). As mentioned above, providers in control clinics

were significantly older than those in intervention clinics. However, due to the small provider sample it was not possible to measure the effect of the intervention while controlling for provider age.

**B. Attitudes about Sexuality Counseling**

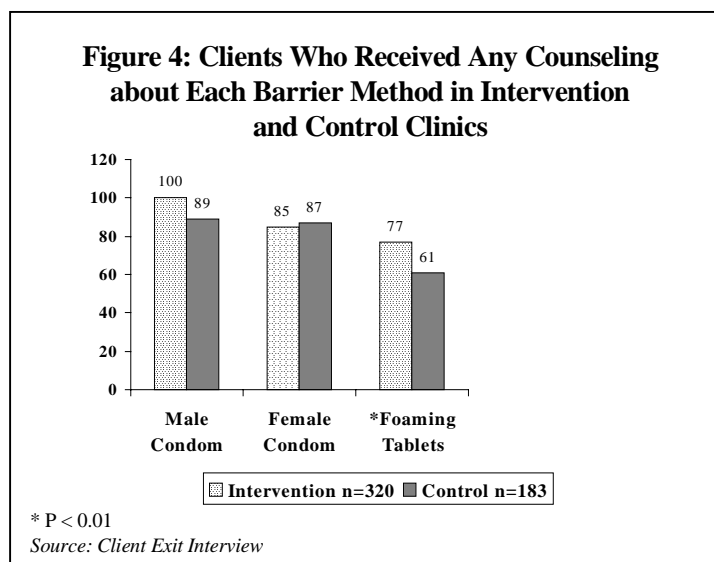
As mentioned in the “Research Methods” section, providers were given four statements to measure their attitudes about integrating issues of sexuality into family planning counseling. For the first statement, “*Discussing sexual issues should only be done with clients who clearly suffer from a clear sexual problem,*” significantly more providers in the intervention group compared with the control group disagreed with that statement (80% versus 20%,  $p=0.01$ ). As for the two statements, “*I feel embarrassed to discuss sexual issues with my clients,*” and “*Most sexual problems need a specialist to manage them,*” there were no significant differences between providers in the two groups with regard to agreement or disagreement with these statements. Providers agreement with the fourth statement, “*Asking clients about their sexual history would be embarrassing to her,*” however, was not in the expected direction. More providers in the intervention group compared with the control group agreed with above statement (60% versus 10%,  $p=0.04$ ). This finding suggests a need for direct observation of interactions between providers and clients to identify aspects of providers’ counseling practices that may lead to client embarrassment.

Analysis of responses to the above statements by provider age revealed no differences between providers who were less than 40 and those 40 or above. These results suggest that the sexuality training was more effective in changing providers’ attitudes about barrier methods but less so in changing providers’ attitudes about including sexuality issues in family planning counseling.

## V. Effects of Sexuality Training on Providers' Counseling Practices

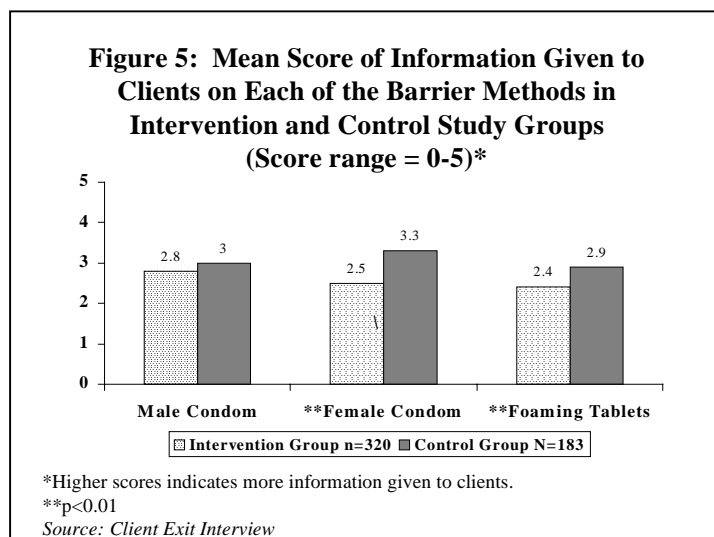
### A. Counseling on Barrier Methods

Clients were asked if each of the three barrier methods was mentioned to them by the service provider (Level 1 information). Figure 4 shows no differences between clients in intervention and control clinics with regard to counseling about the male condom and the female condom. However, foaming tablets were more likely to be mentioned to clients in the intervention group than those in the control group (76.5% versus 61.1% respectively,  $p < 0.01$ ). It should be



noted that some clinics experienced a shortage in foaming tablets during the data collection period. This may explain this difference between intervention and control clinics. Interestingly providers in control clinics gave more information about the female condom (mean information score = 3.3 versus 2.5 respectively) and foaming tablets (2.9 versus 2.4 respectively) than providers in intervention clinics (Figure 5).

This difference was statistically significant ( $p < 0.01$ ). The content of information given about the male condom was not different in intervention and control clinics, however. Although providers in control clinics were less likely to mention foaming tablets to their clients, when they did mention the method they were more likely to give complete information about that method than providers in the intervention sites.



These results are unexpected since the section on provider attitudes showed that sexuality training may have had a positive impact on providers' perceptions of barrier methods. Providers in intervention clinics were probably more excited about the newly acquired skills of sexuality counseling rather than counseling about barrier methods and therefore were more likely to try those new skills at the expense of counseling on barrier methods.

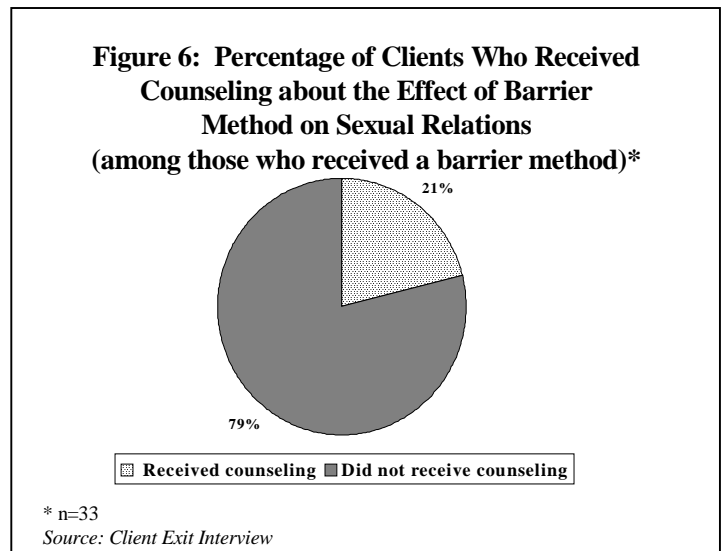
Providers in control clinics on the other hand, only received training on barrier methods, and therefore were more keen on using this new skill. The above association between sexuality training and provider counseling on barrier

methods may have been mediated by a number of provider characteristics. Unfortunately, it was not possible to control for those characteristics in the analysis since the client questionnaire did not identify the provider who was seen by that client, as mentioned earlier.

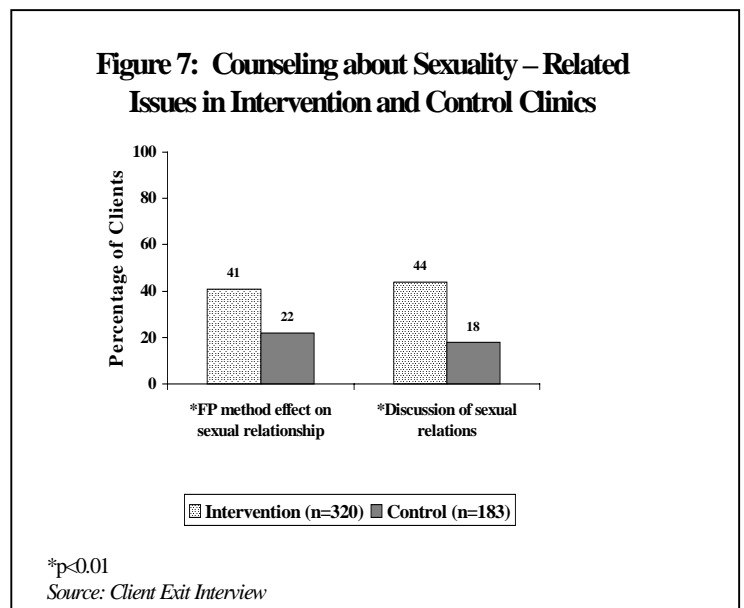
Level 3 information was measured by asking clients if they were counseled on the effect of barrier methods use on sexual relations. Among clients who received barrier methods, only 21.2 percent received counseling on the effect of the method on sexual relations (Figure 6). Unfortunately because of the small number of clients who received barrier methods, it was not possible to compare intervention and control group clinics with regard to Level 3 information.

### **B. Counseling on Sexuality-Related Issues**

According to results of the exit interview, 34 percent of clients received counseling on the potential effect of the family planning method on their sexual relations. Figure 7 shows that more clients in the intervention than in the control clinics were counseled about the effect of family planning method on their sexual relations (41.3% vs. 21.9% respectively,  $p < 0.01$ ).



Also, significantly more clients in the intervention group than in the control group had a sexuality-related discussion with the service provider that was not related to use of contraception (44.1% versus 18.0%,  $p < 0.01$ ) even after controlling for level of clients' education. Among clients who discussed sexuality, the most frequently mentioned subjects were pain during intercourse and questions about reaching orgasm.



Mystery client reports complemented the results from the exit interviews (mystery clients were only sent to intervention clinics). All names are fictitious in the seven mystery client reports that follow:

**Clinic 1:** Two clients, Mona and Azza, visited Clinic 1.

Mona complained about a loss of sexual desire and vaginal itching. Mona currently uses an injectable contraceptive. Mona first saw a counselor and then a doctor. According to Mona, both the counselor and the doctor were friendly and were interested in discussing her problem. However, neither of them was helpful enough. The counselor asked Mona about her problem but did not provide any answers. The doctor gave Mona very limited information. She advised Mona to switch to the IUD because the injectable was causing her loss of desire. Mona was not satisfied with the advice because she had previously used an IUD but had problems with it. She would have liked the doctor to discuss her concerns about using an IUD.

Azza said she was using an IUD and presented with the same complaints as Mona (loss of sexual desire along with vaginal itching). The doctor told Azza that her loss of desire was due to a vaginal infection. Azza was not satisfied either because she expected the doctor to prescribe a medication for her and to give her information on how to gain back her sexual desire and her husband's love and affection.

**Clinic 2:** Two mystery clients, Iman and Hanaa, were sent to Clinic 2.

Iman complained of a burning sensation and dizziness after intercourse. Iman described the doctor as being very knowledgeable and confident. The doctor respected Iman's privacy and gave her plenty of information about her condition. Hanaa complained of prolonged and heavy menstruation associated with the IUD. Hanaa, however, had a bad experience with the doctor she saw. As soon as she mentioned to the doctor that she had her period, the doctor yelled at her "*How could you come for examination when you have your menses?*" Hanaa tried to explain to the doctor that she has had her period for 10 days and that this was the reason for her visit to the clinic. But according to Hanaa, the doctor would not talk any more. Hanaa said she would prefer to go to the other clinic (control clinic) because staff in that clinic treated clients more respectfully.

**Clinic 3:** Three mystery clients, Amal, Hanan and Karima, were sent to Clinic 3.

All three presented complaints about a loss of sexual desire. Amal is currently using an IUD. She feels embarrassed to have sex with her husband because her in-laws live with her in the same house. Her husband is angry with her because of her "attitude." Hanan is using an injectable. She has not had her menses since she started using the injectable. She is concerned that the menstrual blood would accumulate in her abdomen. Karima is using an IUD and complains that the IUD threads are pricking her husband.

All three clients saw a nurse and a doctor at the clinic. The nurse and the doctor were sitting in the same room. According to the clients, both the nurse and the doctor encouraged them to speak and made them feel at ease. The advice that was given to the three clients was that sexual desire "comes from within" and that family planning methods do not affect sexual desire. Clients were advised to "get themselves into the mood" for having sex with their husbands, for example, by dressing nicely and putting the kids to bed early. Amal was told that she was probably not having sexual desire because she was circumcised. The nurse told her about erogenous parts (other than the clitoris) in a woman's body so her husband could touch those parts during foreplay in order to get her excited. Hanan was told that her lack of desire may be because her husband is not giving her enough foreplay. Hanan was advised to switch to the IUD because the injectables could delay pregnancy after stopping them. Karima was told (without a vaginal exam) that perhaps her IUD was not inserted properly and that is why it is pricking her husband.

All three clients said they were very pleased with the interaction they had with the doctor and the nurse. They said they learned many things from this interaction. Karima said that this was the first time a provider talked to her about such things. Amal said, *“This experience gave me the courage to ask about my sexual problems. If any question comes to my mind I will go and ask it to my doctor.”* Hanan too was pleased with the interaction. However, she said she was not sure she can follow the advice about creating an atmosphere for good sexual relations because she is living with her in-laws.

## **VI. Impact of Sexuality Training on Clients’ Acceptance of Barrier Methods**

This section examines results that measure the impact of sexuality training on clients’ acceptance of barrier methods (Level 1, 2, and 3 acceptance). Of all clients who participated in the study, only 7 percent (n=33) received a barrier method during the index visit to the clinic (Level 1 acceptance). Of those clients the majority (79%) received a male condom only. The rest received foaming tablets either alone or combined with a male condom. As mentioned earlier, at the time of data collection there was a nationwide shortage of foaming tablets and no female condoms were provided to any of the study clinics. Because of the small number of clients who received barrier methods it was not possible to examine the type of received barrier method by study group. Clients in the intervention group were more likely than those in the control group to receive a barrier method (8.8% versus 2.2 %,  $p<0.01$ ). Unfortunately because the number of clients who received barrier methods was too small it was not possible to control for potential confounders such as client level of education or number of living children.

As shown in Table 4 the majority of clients who received a barrier method (intervention and control groups combined) said the method was chosen by the doctor (63.6%). Apparently, barrier methods were mostly prescribed as a transient method until the client receives another method e.g. a client who wants to insert an IUD but who is in the middle of her menstrual cycle would be given a pack of condoms and asked to come back immediately after her next period for insertion. The majority of clients said they would use the barrier method they received for one month or less (30%) or until condition is cured or until they get their next menses (21%).

**Table 4: Choice of Barrier Method and Expected Duration of Use  
(Among Clients Who Received a Barrier Method, n=33)**

	Percentage
<b>Who chose the method?</b>	
Client	33.3
Provider	63.6
Other	3.1
<b>Expected duration of use of barrier method</b>	
One month or less	30.0
Temporarily until cured/next menses	21.0
For good	3.0
Don't know	24.0
No response	21.0
<b>Total</b>	100.0

Source: Client Exit Interview

Clients who did not receive a barrier method during their visit to the clinic (n=469, 93% of sample) were asked if they would consider using one anytime in the future (Level 2 acceptance). About one-third of these clients (31.3%) said they would. Table 5 shows no differences between clients in the intervention and control groups with regard to potential use of a barrier method in the future.

**Table 5: Client's Acceptance of Barrier Methods  
(Among Clients Who Did Not Receive a Barrier Method n=469)**

	Percentage
<b>Clients who would consider using a barrier method in the future (n=147)</b>	
<i>Conditions in which clients would use a barrier method</i>	
Problems with other methods	79
To rest from other methods	28
Other methods not available	4
Husband is travelling	3
If she hears that barrier methods are good	2
Other	5
<b>Clients who would not consider using a barrier method (n=322)</b>	
<i>Reasons for not considering a barrier method</i>	
Not reliable	42
Satisfied with current method	26
Difficult to use	23
Husband does not like	20
Cannot try something I don't know	16
Afraid to forget or use incorrectly	12

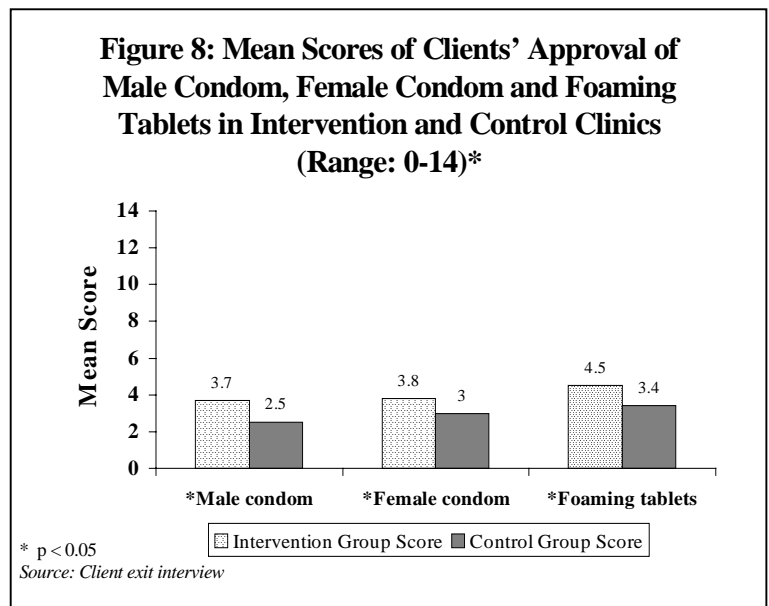
N.B. Multiple responses were allowed.

Source: Client Exit Interview

The most frequently cited reason for potential use of a barrier method was dissatisfaction with the other methods (79%). Among the clients who indicated that they would not consider using a barrier method (42%), the principal reason given centered upon beliefs that barrier methods are not reliable and asked to come back immediately after her next period for insertion.

Level 3 acceptance measured client approval of each of the three barrier methods among those who said they would not consider using a barrier method in the future. Figure 8 shows that for each of the three methods, mean scores of clients in the intervention group were significantly higher than those in the control group, which indicates more positive

attitudes towards barrier methods among clients in the intervention group (3.7 versus 2.5 for the male condom, 3.8 versus 3.0 for the female condom, 4.5 versus 3.4 for foaming tablets  $p < 0.05$ ). The above differences persisted even after controlling for clients' level of education. It is interesting to note that the effect of the intervention on client approval of barrier methods was more pronounced among clients with at least two children than among clients with 0-1 child. This finding warrants further investigation.



In general the above results are in agreement with those on providers' attitudes towards the three barrier methods. It is intuitive to argue that positive provider attitudes towards barrier methods will be transferred to their clients. When clients in the intervention group see that providers speak positively about barrier methods they tend to change their attitudes about those methods and are more likely to approve of their use.

## DISCUSSION OF FINDINGS AND PROGRAMMATIC IMPLICATIONS

The present study attempted to explore the possibility of introducing sexuality issues into family planning counseling with the ultimate goal of helping couples in Egypt achieve their reproductive intentions and lead a more healthy sex life. For the first time in Egypt, this study examined client and provider acceptance of discussing issues of sexuality during the family planning consultation. It also examined the feasibility of training providers on this type of counseling and the impact of such counseling on clients' acceptance of barrier methods on a wide scale.

- ***The study results suggest that sexuality-related questions and concerns are highly salient among family planning clients in Egypt.*** Focus group discussions revealed a number of sexual problems that are associated with family planning use. These problems could explain a significant proportion of method discontinuation in Egypt where method discontinuation is 25% in the first year (according to DHS findings, El-Zanaty 1999).
- ***Discussion of sexuality-related issues is not only acceptable but is strongly desired by clients.*** However, clients do not know how to bring their sexuality-related problems/ concerns to the attention of the service provider. Clients said they would like the provider to initiate the discussion with them on such issues.
- ***The majority of clients who had a sexuality-related discussion with service providers did not feel embarrassed by this discussion.*** This negates the widespread belief that clients in Egypt would be embarrassed to discuss issues pertaining to sexuality with service providers. In fact, the family planning clinic may be the most suitable place for clients to present their sexuality-related questions or concerns. Besides providing a source of competent care, the family planning clinic has the relative advantage (over other clinics) that the client and provider have already established rapport with each other. Those relations could help clients overcome some of their shyness in presenting their problems.
- ***Training family planning service providers on matters related to gender and sexuality was both feasible and acceptable.*** Providers were very interested in the subject matter and were eager to learn more about management of sexual problems.

- ***The three-day training course on sexuality was successful in changing some attitudes and counseling behaviors of providers.*** Providers' attitudes about barrier methods became more positive probably as a result of the training. Also, providers became less inhibited in discussing sexuality-related issues with their clients. As a result of the training, providers were more likely to discuss with clients the potential impact of the family planning method that they received on their sexual relations. Providers were also more likely to discuss with clients other non-family planning related sexual problems.
- ***Providers' attitudes about sexuality counseling have not changed much as a result of the training.*** Despite the training, providers still feel embarrassed to discuss issues related to sexuality with their clients; many of them believe that most sexual problems need a specialist for their management or believe that their clients would feel embarrassed if issues of sexuality are brought up during the consultation.
- ***The training course seemed to have an unexpected negative impact on providers' counseling practices in relation to barrier methods.*** Although providers in intervention clinics were more likely to mention all three barrier methods to clients, these providers were less likely to give complete information to clients, especially with regard to the female condom and foaming tablets. This could be a result of the lack of availability of these methods. It may also be a result of providers' preoccupation with the new counseling component (sexuality counseling).
- ***The three-day training course was not strongly effective in improving providers' technical skills.*** Some providers were still unaware of the role of some family planning methods in reducing sexual desire. In general providers were unable to adequately respond to clients' complaints about loss of sexual desire. In addressing this problem providers were likely to put the blame for loss of sexual desire on the woman. Providers did not seem to take into account the social environment in which the woman lived and how this might impact her relations with her husband. Although some providers made the link between female genital mutilation and inability to reach orgasm, none of the providers seized the opportunity to advise clients against circumcising their daughters.

- ***The three-day training course may not have been sufficient to change providers' attitudes and behaviors with regard to sexuality counseling.*** A longer course may have been more effective especially since training on issues of sexuality in medical and nursing schools is almost non-existent in Egypt. Also, the training course may not have given enough focus to socio-cultural aspects of sexual relations. The training course may have been more effective if counseling protocols that included items on sexuality were adopted in the study clinics.
- ***The study results suggest a positive association between training providers on sexuality-related counseling and client acceptance of barrier methods.*** This association seemed stronger with client approval of barrier methods than with actual use. It should be noted however that the barrier method choices available to study participants were very limited due to shortages of foaming tablet supplies. It is also unfortunate that female condoms did not arrive at the FRONTIERS office in Cairo in due time since this method could be acceptable to a segment of family planning clients in Egypt.

## RECOMMENDATIONS

- ***The national family planning program should integrate sexuality issues into the standard content of all family planning counseling.*** Counseling protocols need to include mentioning to the client the potential effect of each method on her sexual relations with her husband. Explicit discussion about the effects of female genital mutilation on sexual dysfunction should be incorporated into these guidelines. In the meantime, providers should be able to help clients who are already circumcised experience more enjoyable sexual relations. Also, history-taking should include a section on the dynamics of the client's sexual relations. This information will help providers and clients choose family planning methods that best suit the clients' physical, psycho-social, and sexual needs.
- ***The need to train family planning service providers on issues of sexuality cannot be overemphasized.*** Family planning providers need to receive training on management of simple sexual problems and to refer those cases that are beyond their capabilities to manage. It would be helpful to involve a multi-disciplinary team of physicians, sociologists, psychologists as well as gender specialists in the development and

conduct of the training course. Training should highlight the impact of contextual factors on sexual relations.

- ***A referral mechanism should be established so family planning providers can refer clients with more complex sexual problems to more specialized centers.*** Linkages can be made with teaching or university hospitals since these hospitals are more likely to have sexologists on staff.

- ***The public needs to know that sexual problems deserve care like any other health problem.*** Health education messages should be addressed to clients encouraging them to address their sexuality-related concerns or questions to family planning providers.



Recommendations and suggestions for utilization discussed during the final dissemination seminar of the study

- ***Medical schools in Egypt need to increase the number of hours assigned to sexology training for undergraduates.*** Linkages should be made between the OB/GYN department and the sexology department so the association between family planning methods and sexual relations becomes clear to students.
- ***A wider range of barrier methods should be made available to family planning clients in Egypt.*** Although barrier methods may not be the most effective family planning method, they may be suitable for a segment of clients who cannot or who do not want to use the IUD or hormonal methods. Barrier methods are also suitable for clients who are in transition between two methods such as those initiating hormonal methods after the first five days of their menstrual cycle. Such clients are at high risk of an unwanted pregnancy. More acceptability studies are needed to examine client and provider attitudes towards different barrier methods.

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# APPENDIX I

## TRAINING COURSE AGENDA

### GENDER AND SEXUALITY-RELATED ISSUES IN FAMILY PLANNING USE

- LOCATION:** Regional Center for Training on Family Planning and Reproductive Health (RCT)
- DATES:** 29/5/99 – 3/6/99 (two groups, three days each)
- PARTICIAPANTS:** Physicians and counselors/nurses in selected MOHP and CSI clinics
- OBJECTIVES:**

By the end of the course, participants will have:

- Acquired knowledge about human sexual response, some related medical problems and their management;
- Analyzed gender and sexuality issues as they relate to family planning use;
- Acquired skills with regard to counseling couples on sexuality-related issues and use of barrier methods.

#### *Day 1*

- 9:00 – 9:30                      Opening / Introduction
- 9:30 – 11:30                    Session 1: Definition of sexuality, sexuality issues as they relate to use of FP methods  
Dr. Abdel-Aziz El-Shobary  
Dr. Maaly Guemei
- 11:30 – 11:45                    *Coffee break*
- 11:45 – 1:45                    Session 2: Human sexual response and commonly encountered sexual problems, and the role of the family planning service providers  
Prof. Nabil Younis
- 1:45 – 2:00                      *Break*
- 2:00 – 4:00                      Session 3: Values clarification: gender perspectives in FP, beliefs about male and female sexuality

Dr. Maaly Guemei  
Dr. Abdel-Aziz El-Shobary

**Day 2**

8:30 – 10:30      Session 4: Husband's role in FP decision making and use of barrier methods, strategies for enhancing husband-wife communication  
Dr. Maaly Guemei  
Dr. Abdel-Aziz El-Shobary

10:30 – 10:45      *Coffee break*

10:45 – 12:45      Session 5: STDs, RTIs: technical aspects and social issues  
Dr. Abdel-Aziz El-Shobary  
Dr. Maaly Guemei

12:45 – 1:00      *Break*

1:00 – 3:00      Session 6: Gaining comfort in discussing sexual issues in family planning counseling, taking sexual history  
Dr. Maaly Guemei  
Dr. Abdel-Aziz El-Shobary

**Day 3**

8:30 – 10:30      Session 7: Protocols for including sexuality issues in family planning counseling  
Dr. Abdel-Aziz El-Shobary  
Dr. Maaly Guemei

10:30 – 10:45      *Coffee break*

10:45 – 12:45      Session 8: Practical training at RCT clinic  
Dr. Abdel-Aziz El-Shobary  
Dr. Maaly Guemei  
Dr. Nahla Abdel-Tawab

12:45 – 2:30      Session 9: Feedback from trainers and final discussion  
Dr. Abdel-Aziz El-Shobary  
Dr. Maaly Guemei  
Dr. Nahla Abdel-Tawab

2:30 – 3:00      Graduation