

# SEXUAL PLEASURE

The forgotten link in sexual and reproductive health and rights



*TRAINING TOOLKIT*

**GAB** SEXUAL HEALTH  
AND WELLBEING

Global Advisory Board (GAB) for Sexual Health and Wellbeing

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# CONTENTS

|  |     |
|--|-----|
| <b>List of acronyms</b> .....  | 4   |
| <b>Glossary of terms</b> .....   | 5   |
| <b>Preface</b> .....   | 8   |
| <b>Section 1 - Introduction</b> .....  | 10  |
| <b>Section 2 - Training modules</b> .....  | 17  |
| <b>A. Understanding sexual pleasure for health and wellbeing</b> .....                       | 17  |
| <b>Module 1:</b> Creating a safe environment for sharing and learning.....                   | 18  |
| <b>Module 2:</b> Unpacking sexuality, sexual health, sexual rights and sexual pleasure.....  | 22  |
| <b>Module 3:</b> Personal and professional reflections: attitudes, values and ideas.....     | 38  |
| <b>Module 4:</b> Risk-based approach vs pleasure approach in sexual health promotion.....    | 44  |
| <b>B. Sexual pleasure approach in sexual and reproductive health services</b> .....          | 53  |
| <b>Module 5:</b> Basics in language and messaging.....                                       | 54  |
| <b>Module 6:</b> The <i>Pleasuremeter</i> .....  | 64  |
| <b>Module 7:</b> Case studies on implementing the pleasure approach.....                     | 70  |
| <b>Module 8:</b> Overcoming fears and addressing embarrassing questions.....                 | 86  |
| <b>Module 9:</b> Practising the sexual pleasure approach.....                                | 90  |
| <b>C. Looking to the future and thinking about evaluation</b> .....                          | 94  |
| <b>Module 10:</b> Planning ahead and evaluation.....   | 95  |
| <b>Section 3 - Conclusions</b> .....   | 102 |
| <b>Annexes</b> .....   | 103 |
| Annex 1 - Handouts and exercises for the modules.....  | 104 |
| Annex 2A - Talking about sexual pleasure with women during gynaecological examinations.....  | 113 |
| Annex 2B - Responding to clients' concerns about female genital mutilation and pleasure..... | 115 |
| <b>Endnotes</b> .....  | 117 |

# LIST OF ACRONYMS

|               |  |
|---------------|--|
| <b>BSC</b>    | Brief sexuality-related communication                            |
| <b>FGM</b>    | Female genital mutilation  |
| <b>GAB</b>    | Global Advisory Board for Sexual Health and Wellbeing            |
| <b>HIV</b>    | Human immunodeficiency virus                                     |
| <b>IPPF</b>   | International Planned Parenthood Federation                      |
| <b>LGBTIQ</b> | Lesbian, gay, bisexual, transgender, intersex, queer/questioning |
| <b>PrEP</b>   | Pre-exposure prophylaxis   |
| <b>SGBV</b>   | Sexual- and gender-based violence                                |
| <b>SRH</b>    | Sexual and reproductive health                                   |
| <b>SRHR</b>   | Sexual and reproductive health and rights                        |
| <b>STI</b>    | Sexually transmitted infection                                   |
| <b>WAS</b>    | World Association for Sexual Health                              |
| <b>WHO</b>    | World Health Organization  |

# GLOSSARY OF TERMS

**Adolescent:** A person aged 10–19 years, as defined by the United Nations.

**Anal sex:** Sexual activity involving penetration of the anus.

**Bisexual:** A person who is attracted to both men and women.

**Child:** A person under the age of 18, as defined by the United Nations.

**Cisgender:** A person whose gender identity matches the sex that they were assigned at birth.

**Coercion:** The action or practice of persuading someone to do something by using force or threats.

**Discrimination:** Any unfair treatment or arbitrary distinction based on a person's race, sex, religion, nationality, ethnic origin, sexual orientation, gender identity, disability, age, language, social origin or other status.

**Equity:** Fair and impartial treatment, including equal treatment or differential treatment to redress imbalances in rights, benefits, obligations and opportunities.

**Gay:** A person who is primarily attracted to and/or has relationships with someone of the same sex. Although commonly used for men, some women also use this term.

**Gender:** The social attributes, opportunities, roles and relationships associated with being male, female or transgender. These are socially determined and learned through socialization processes. Gender differences vary between cultures and countries: this means that they are not fixed.

**Gender expression:** How a person expresses their own gender to the world, such as through names, clothes, how they walk, speak, communicate, societal roles and their general behaviour.

**Gender identity:** A person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned to them at birth. This includes a personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech and mannerisms.

**Gender non-conformity/non-conforming:** People who do not conform to either of the binary gender definitions of male or female, as well as those whose gender expression may differ from gender norms. In some instances, individuals are perceived as gender non-conforming by other people because of their gender expression. These individuals may not perceive themselves as gender non-conforming. Gender expression and gender non-conformity are clearly related to individual and social perceptions of masculinity and femininity.

**Gender-based violence:** Violence that results in – or is likely to result in – physical, sexual or psychological harm to someone based on gender discrimination, gender roles and expectations, or the differential power status assigned to gender.

**Heteronormativity:** The belief that heterosexuality is the normal or default sexual orientation.

**Homophobia:** The fear, discomfort, intolerance or hatred of homosexuality and sexually diverse people.

**Homophobic violence:** A type of bullying that is based on actual or perceived sexual orientation or gender identity.

**Homosexual/homosexuality:** A person who is sexually attracted to people of the same sex.

**Informed consent:** Process for obtaining voluntary agreement to participate in research or an intervention.

**Intercourse:** Sexual activity involving penetration of the vagina or anus by the penis.

**Intersex:** People who are born with sex characteristics (including genitals, gonads and chromosome patterns) that do not fit typical binary notions of male or female bodies. Intersex is an umbrella term used to describe a wide range of natural bodily variations, some of which may not be physically apparent. Being intersex is distinct from a person's sexual orientation or gender identity: an intersex person may be straight, gay, lesbian or bisexual, and may identify as female, male, both or neither.

**Lesbian:** A woman who experiences sexual attraction to, and the capacity for an intimate relationship with, primarily other women.

**Masturbation:** Stimulation of the genitals and other parts of the body to experience sexual pleasure.

**Men who have sex with men:** Men who have sex with men, regardless of whether they also have sex with women or have a personal or social gay or bisexual identity. This concept includes men who identify as heterosexual, but who have sex with other men.

**Oral sex:** Sexual activity using the mouth and tongue to stimulate a partner's genital or anal area, providing sexual pleasure.

**Orgasm:** The climax of sexual excitement, characterized by intensely pleasurable feelings centred mainly in the genitals and (in men) usually accompanied by ejaculation.

**Outercourse:** Sexual activity between individuals that does not involve vaginal or anal intercourse.

**Questioning:** A person who is exploring their sexual orientation or gender identity.

**Sex:** Classification of people as male, female or intersex, assigned at birth, based on anatomy and biology.

**Sexual orientation:** A person's capacity for profound emotional and sexual attraction to, and intimate and sexual relations with, individuals of a different gender, the same gender or more than one gender.

**Sex-positive:** An attitude that celebrates sexuality as a part of life that can enhance happiness. Sex-positive approaches strive to achieve ideal experiences, rather than solely aiming to prevent negative outcomes.

**Stigma:** Negative opinions or judgements held by individuals or society that reflect on a person or group. Discrimination occurs when stigma is acted on.

**Transgender:** A person whose gender identity differs from their sex at birth. Transgender people may be male-to-female (female identity and appearance) or female-to-male (male identity and appearance). Transgender people may be heterosexual, homosexual or bisexual.

**Transsexual:** A transgender person who is in the process of, or has undertaken, treatment (which may include surgery and hormonal treatment) to make their body correspond to their preferred gender.

**Violence:** Any action, explicit or symbolic, which results in – or is likely to result in – physical, sexual or psychological harm.

**Young person:** A person between 10 and 24 years old, as defined by the United Nations.

**Youth:** A person between 15 and 24 years old, as defined by the United Nations.

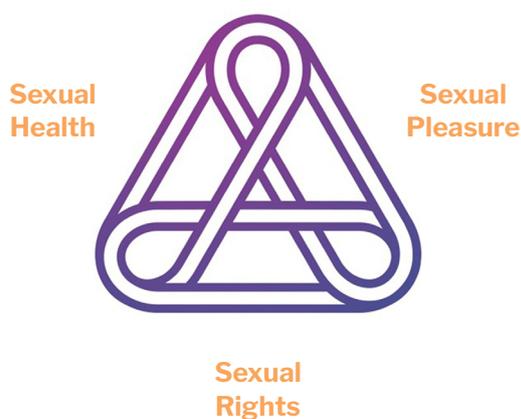
# PREFACE

## The Global Advisory Board for Sexual Health and Wellbeing

The World Health Organization’s working definition of sexual health clearly states that sexual and reproductive health does not only relate to the absence of illness or disease, but rather a positive state of wellbeing. Unfortunately, many sexual health interventions only focus on the risks and potentially negative consequences of sexual activity. Such an approach fails to acknowledge an individual’s sexual rights, as well as their particular desires, relationships, pleasures and agency. This can obscure discussion of the positive realities of sexuality.

The Global Advisory Board (GAB) for Sexual Health and Wellbeing was convened by Durex to advocate for a positive and inclusive approach to sexuality. The GAB is leading an initiative to promote sexual pleasure and create effective, meaningful links between sexual health, sexual rights and sexual pleasure.

**Figure 1 - GAB triangle**



Historically, the connection between sexual health, sexual pleasure and sexual wellbeing has been understood, and, in recent years, there has been increased awareness of the fundamental importance of human rights as a basis to achieve and maintain sexual health.<sup>1</sup> However, the links between these three concepts are not explicitly addressed in policies, programmes and services, and therefore don’t receive equal attention or are sometimes completely neglected.

The GAB aims to highlight the importance of incorporating sexual pleasure in policies, programmes and services throughout the life cycle, with a special focus on young people. To date, not only has very little attention been paid to the intersections between these three concepts, but there has also been a lack of clarity about the content and implications of these terms in policy, law, programmes and service delivery. What’s more, the GAB recognizes that this has fostered “an atmosphere in which it is possible to manoeuvre these terms to reinforce varied and often harmful political agendas”. The GAB’s main goal is therefore “to positively influence attitudes, behaviour, technical, legal and policy interventions towards better sexual health, sexual rights and sexual pleasure”.

The GAB has developed a working definition of sexual pleasure that links sexual health, sexual rights and sexual pleasure. This definition forms the basis of this document:

*“Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to contribute to sexual health and wellbeing. Sexual pleasure should be exercised within the*

*context of sexual rights, particularly the rights to equality and non-discrimination, autonomy and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people's human rights and wellbeing."*

For more information visit [www.gab-shw.org](http://www.gab-shw.org)

One of the GAB's areas of focus is building the capacity of future health professionals. Currently, there is a shortage of practical resources for health professionals to help them provide sex-positive counselling and support to their clients when delivering services. To this end, the GAB has developed this innovative and practical toolkit for medical students and public health professionals. It explains how to integrate issues related to sexual pleasure and wellbeing in the delivery of counselling for sexual and reproductive health services.

The GAB's vision is to implement this toolkit, supporting groups of medical, public health, social work and psychology students across the globe. This will contribute to an increased number of sexual and reproductive health programmes and services that are sex-positive: based on the pleasure approach (rather than risk-based), with sexual pleasure and its links to sexual health and sexual rights at the core. This valuable toolkit – which is aimed at trainers – is the first step towards achieving this long-term vision.



# SECTION 1. INTRODUCTION

## Rationale

In many parts of the world, talking about sex and sexuality can be difficult for both sexual and reproductive health (SRH) service providers and their clients. Usually, services and information focus on the risks of sexual behaviour and on reducing negative public health outcomes: preventing unintended pregnancy, improving maternal health, and reducing new infections for HIV and other sexually transmitted infections (STIs). We often fail to address the reasons why people form relationships, have sex and engage in 'risky' sexual behaviour in the first place – reasons such as pleasure, intimacy, reciprocity, love, closer social relationships, economic advancement and social prestige.

Sexuality is a significant part of our clients' lives. But a lack of open and honest communication about sex makes it hard for individuals and communities to access accurate information and support with issues related to sexuality and sexual pleasure.

The closed culture around discussing sexuality also means that it can be difficult for clients and providers to talk about sexual relationships, sexual wellbeing and pleasure in professional contexts. It's often easier to stick to 'safe' topics, such as contraception, pregnancy choices and STI treatment options, or focus on clients' experiences of poor health, pain or discomfort. Talking about sexual enjoyment and desire is usually taboo.

Yet talking about sexual wellbeing and sexual pleasure should be commonplace in service provision. When partners do communicate openly and frequently about sex, condom use and contraception, research suggests that they are more able to practise safer sex and make joint decisions about sex and contraception. Studies show that young women's acceptance of contraception was not so much based on their knowledge but much more on the nature of their relationship: whether they felt they could openly discuss expectations with their partner.<sup>2</sup> Other studies have argued that denying the possibility of pleasure in sexual activity, particularly for women and girls, has a negative impact on their active negotiation of safer sex.<sup>3</sup> This is not only limited to communication between heterosexual couples. The analysis of the relationship between open communication and safer sex/condom use applies to all couples, including LGBTIQ couples.<sup>4</sup> However, being open can be difficult in cultural contexts where such discussion is seen as unacceptable, where couples lack privacy and where women's unequal position and lack of power limit open communication and joint decision-making.

## What is this toolkit and who is it for?

The toolkit is intended to train future service providers around the world (medical, public health, social work and psychology students, among others), although it can also be used by existing health professionals. It will enable trainers and facilitators to strengthen health professionals' skills so that they can provide quality SRH services, based on GAB's comprehensive triangular approach linking sexual health, sexual rights and sexual pleasure. Increased knowledge and skills will improve the quality of care given to individual clients, families and the community. This will also help health professionals to explore personal values, opinions and prejudices.

## What can you expect from this toolkit?

The toolkit provides specific guidance on how SRH providers can put a sex-positive approach into practice in order to explore issues related to sexual pleasure with their clients (regardless of their sexual orientation or gender identity). This is in line with GAB's commitment to decrease stigma, improve SRH services and increase recognition of sexuality as a positive aspect of human life.

We elaborate on how to proactively incorporate information about sexual pleasure when communicating with clients; how to feel confident to answer questions; and support clients with autonomous decision-making regarding their sexual relationships and sexuality in general. We acknowledge that some clients may have experienced sexual- and gender based-violence and that providers need to be aware of this. This is not, however, the focus of the toolkit.

This toolkit is not intended to develop the basics of counselling skills, but to extend existing skills beyond the usual information and counselling on SRH. Nor is it an in-depth training manual on clinical sexology. It complements the training on SRH service delivery, professional communication and counselling provided to students of higher

education institutions around the world. In this toolkit, we see counselling as a method to trigger new perspectives and catalyse change.

## Who can use the toolkit?

The modules can be used by any trainer or facilitator with some experience of interactive and participatory training with health professionals (both students and existing providers). Trainers and educational staff who have experience of facilitating workshops on sexual and reproductive health and rights (SRHR) might find it easier to implement the modules.

As a trainer, before you start using the modules, we advise you to read them and seek more information on certain topics, if needed. In most modules, we provide references where you can find more information about the topic.

You don't need to be a sexologist to use the modules. Most trainers and educators have the skills to build a rapport with learners, listen carefully, help identify needs and concerns, and give information.

Most importantly, you need to be interested in the subject, willing to explore it and not feel embarrassed discussing sensitive issues related to sex, sexuality and sexual pleasure.

**TIPS** for the trainer:

✓ **Being 'sex critical'** means critically engaging with dominant social and cultural norms about sexuality and supporting the workshop participants to be critical of these norms too. Being critical doesn't mean that you have to disagree with the dominant social norms about sex and sexuality in your community. But you do need to be able to identify what is considered 'normal' and 'abnormal', 'good' and 'bad' within your community and think about whose interests these categories serve. Who has the power to define what is 'normal' and 'good'?

✓ **Self-reflection:** Reflect on your own values and experiences. Ask yourself: what are the principal attitudes or 'rules' in the communities where you live and work regarding sexuality, sex, marriage, condoms, pornography, sexual pleasure, female sexuality or same-sex relationships? Who decides on the rules? What happens to those who don't stick to the rules? Is it possible to live by different kinds of rules?

✓ **In practice:** In contexts where there are negative and contradictory messages about sex, gender, sexuality and pleasure, it can be challenging to be positive about sex, sexuality and sexual pleasure. Your learners – referred to in this toolkit as 'participants' – may need space to talk about these contradictory messages and how they feel about them.

**Working in faith-based and conservative contexts**

There are many differences among health professionals based on gender, ethnicity, sexual orientation and religion. A considerable number of students and trainers practise a religion. This resource includes a range of topics and questions to explore the opportunities and barriers to promoting dialogue on religion, faith, culture and sexuality.

Issues related to sexual orientation and same-sex relationships can be difficult to address due to cultural and religious beliefs. Health professionals should not be required to compromise their religious beliefs. Instead, they should be prepared to work with diverse populations and seek professional development if they do not feel competent to work with them.

Sexuality and sexual pleasure can be controversial and uncomfortable topics, especially within and between health professionals from different faith groups and/or religious health educational institutions. An unwillingness and inability to discuss sex and sexuality may, for example, limit knowledge of the full range of options that are known to be successful in HIV prevention, including oral sex or condom use.

We believe that it's important to hold onto values about sexuality and sexual pleasure from a sexual rights perspective while at the same time realizing that this may pose challenges in some cultures and for some religious groups. It is only through discussion that we can begin to address these complex issues. As a trainer, finding common ground between faith and sex-positive values of dignity, equality, respect and compassion is vital.

Religious professionals and trainers may feel pressured to choose between acknowledging the complexities of sexuality and relationships and upholding long-held traditions and beliefs that are at the heart of their faith. But the promotion of sexual health and rights needs to address much broader aspects

than personal behaviours or beliefs. Effective health interventions involve challenging social, political, economic and religious structures, systems and inequalities that affect women, youth and special groups.

As a trainer, consider how the issue appears for different faith groups and for people without a faith. Clearly distinguish between what is a fact and what is your value or belief. Introducing sexuality and sexual pleasure can be tricky but a trainer's instinct should always be to treat religious and non-religious expressions equally.

### **TIPS** for adopting neutral policies and practices:

- ✓ If you feel or say no to a certain expression, be clear what the alternative is from your religious point of view.
- ✓ Even if you have certain religious beliefs, you still need to deliver the training in a neutral, respectful, professional and academic way.
- ✓ Keep in mind that all around the world there is a wide diversity of sexual practices, some of which change across time and contexts, and which are influenced by many factors, such as technology. To start a conversation, it's crucial to keep an open mind and contextualize them in a sexual rights framework. Reflecting on the diversity of sexual practices in your own context is always a good start.

We hope that this resource inspires conversations on religion, faith, sexuality and sexual pleasure and motivates you to find common ground between faith, sexual rights and sex-positive values.

## Understanding national legal aspects of sexual health, sexual rights and sexual wellbeing

While there is a growing interest among health professionals in exploring the social, cultural and economic aspects of sexuality in a range of contexts around the world, much less is known about the role of law in influencing sexuality and sexual wellbeing, and shaping access to SRH services. This is despite the fact that every state around the world – without exception – has developed legislation that directly or indirectly regulates and restricts the expression of sexuality and access to SRH services for different groups of people, in different circumstances. This varies from country to country.

Health professionals need to be familiar with the national laws and policies that affect the sexual health, sexual rights and sexual pleasure/wellbeing of their clients. Direct laws include those that limit a service provider's obligations to provide confidential access to services in particular situations, for instance, where a child is at risk. Such laws rely on professional judgement and may be interpreted in line with professionals' own expectations or socio-cultural beliefs. Indirect legal barriers are laws that don't directly restrict sexual expression or access to SRH services, but nonetheless may function in this way. Laws specifying the age of consent may restrict access to SRH services, as a young person may fear being criminalized for having sex. Lack of legal recognition of sexual diversity or gender identities can also operate as an indirect legal barrier. This can have the effect, for example, of facilitating service provision to people with gender-binary identities, thereby marginalising transgender and intersex people.

Laws do not, however, only function as barriers to SRH services. They can also create a framework through which young people are empowered to make informed decisions about sexual health matters and safeguard their own sexual health. Laws providing for compulsory comprehensive sexuality education in schools are an example of a legal

framework that can empower young people to access services and make informed decisions about their sexual health. Confidentiality duties imposed on service providers are also an example of a ‘facilitative’ law.

## Methodology to implement this toolkit

The methodology reflects our vision of a rights-based perspective and learner-centred approach. This means that the modules don’t dictate how things ‘ought to be’, rather, they start from participants’ own experiences. Research shows that this approach produces better results, promotes critical thinking skills, and helps participants explore their own values and internalize information.

### In practice, what does this mean for you as a trainer?

- ▶ Create a safe space and promote trust. Ask participants what would help them to feel ‘safe’ and the best ways to work together. Everyone should feel involved, listened to, comfortable, without fear of being laughed at, especially when they take risks with new ideas or by sharing personal experiences. It is also important to ensure the safety and privacy of the physical space.
- ▶ Encourage participation, particularly among those who feel alone or intimidated. Various conditions and situations can trigger such feelings, for example, differences in social power associated with gender, social class or age.
- ▶ Reassure participants that you respect their privacy and ask the same of them: remind them not to disclose information exchanged during the training/workshop. Tell participants that they are not forced to disclose personal information and that they have the right not to participate or share if doing so makes them feel uncomfortable.

It’s worth pointing out that the training modules in this toolkit can be implemented based on the needs of a training group, for instance, by working through a specific section, rather than all.

### Workshop components

This toolkit includes three sections with a total of ten training modules. The first modules guide participants through a personal process to understand the links between sexual health, sexual rights and sexual pleasure; reflect honestly on their own personal values, questions and experiences about sexuality; and then share these values with the group. This provides an opportunity to deepen participants’ understanding of issues related to sexuality and sexual pleasure. It entails exploring the challenges faced in participants’ own experiences and ideas for introducing sexual wellbeing and sexual pleasure in their (future) work as health professionals.

Subsequent modules provide participants with the opportunity to put this into practice through case studies, which can be challenging. They explore how to include messages on sexual pleasure and links between sexual health, sexual rights and pleasure within participants’ own work. An innovative approach to sexual history taking is introduced: the ‘*Pleasuremeter*’.

The final modules look to the future: how participants will use what they have learned during the workshop in their personal and professional life. Finally, the workshop will be evaluated.

Outcome statements have been developed at the beginning of each module, indicating what the participants should achieve. These include general outcomes that should direct your workshop, even if you use different activities.

The toolkit includes specific objectives for each activity. These activities have been designed - and the training programme structured - in such a way as to build on the learning and experiences of the previous day’s work, so we encourage you to follow this sequence where possible. If your group moves away from the topic at hand, you can use these outcomes as a guide to bring you back

to the workshop programme. Each module gives you key information that you need to be aware of before conducting the module. Notes are also provided that you, as facilitator, can use to follow up the exercises and lead the discussions.

### **How to use the toolkit effectively**

The training modules can be adapted to meet the specific needs of a training group. Deciding on the content and length of the workshop requires sufficient time to assess the learners' needs and interests. This might be achieved through a series of discussions and meetings with a selected group.

Questions that can be asked to get a better understanding of learners' needs include:

- ▶ Which aspects of sexuality and sexual pleasure need to be addressed in your work?
- ▶ In which areas do you feel confident?
- ▶ In which areas do you need more training, practice and support?
- ▶ What kind of problems exist in your community with regard to discussing sexuality and sexual pleasure?
- ▶ Which aspects of sexuality and sexual pleasure do clients in your community find difficult to discuss?

Based on your assessment you can decide which modules you will use in your training/ workshop.

You may decide to run a workshop lasting between one and three days or arrange regular sessions of two hours. We strongly recommend that you cover all the modules in the toolkit because training in sexuality and sexual pleasure is a gradual process. Before you can start practising counselling and communication skills, participants need to get to know and trust each other, so it's a good idea to engage in some ice breaking activities to build trust before turning your attention to sexuality.

Understanding the concepts of sexuality is important for participants. This entails understanding their own values and beliefs and how this can influence their professional work before they can practise communication and counselling on sexuality and sexual pleasure.

Consider the number of participants. We think 25-30 participants is the maximum number that can be trained effectively. If you work with a large group, we recommend that you work with a co-facilitator. Make sure you conduct the training with some sensitivity, for example, you may decide that for some activities you offer women the chance to work together in pairs or groups.

As you will notice, you can run most of the activities in small groups. This can be particularly helpful for those who find large groups intimidating. While the training should challenge participants, it should not leave them feeling threatened or attacked: you need to make sure that people are supported too. This is essential because some people have had distressing sexual experiences in their lives which they may never have shared with anyone. If they remember those during the workshop they can feel vulnerable.

At an early stage, you may ask questions that allow opinions to be shared without self-disclosure. Of course, these 'safeguards' for individual participants will need to be carefully dismantled as the workshop progresses towards an open and secure discussion. Role modelling on the part of the facilitator will bring about change. It will also enhance participants' ability to role model behaviour when dealing with clients.

Having said all this, it's important to point out that for many people, training in sexuality and sexual pleasure is an enjoyable and enriching experience!

## Further reading

CORAM/IPPF (2014). Over-protected and under-served: a multi-country study on legal barriers of young people's access to sexual and reproductive health services'.

IPPF/WAS (2016). 'Fulfill: Guidance document for the implementation of young people's sexual rights'. Available at: <https://www.ippf.org/resource/fulfil-guidance-document-implementation-young-peoples-sexual-rights-ippf-was>

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## SECTION 2. TRAINING MODULES



### A. Understanding sexual pleasure for health and wellbeing

In this first section of the training toolkit, the modules introduce the ‘sexual pleasure approach’ in the delivery of sexual and reproductive health (SRH) services.

Objectives:

- ✓ To create a safe environment for learning and sharing, to explore sexuality and sexual pleasure, and address personal challenges in discussing sexuality.
- ✓ To clarify main concepts and definitions regarding sexual health, sexual rights and sexuality.
- ✓ To increase awareness of the various components of sexuality and sexual pleasure, including cultural and religious aspects and gender-related, personal attitudes and experiences.
- ✓ To understand the shift in thinking about sexual health and sexuality, from a risk to a pleasure approach.

# MODULE 1



## Creating a safe environment for sharing and learning

Reflecting on sexual pleasure with a group will spark discussions around sex and sexuality. These can be sensitive and personal topics, both for you as facilitator and for the participants. It is therefore essential that a safe space is created in the group so that everybody feels comfortable to share, ask questions, discuss, reflect and learn. There are many ways in which you can do this. The exercises below are provided as guidance.

### **By the end of this module, participants will have:**

- ▶ Understood the objectives and process of the training.
- ▶ Agreed how to work together and formulated some basic principles to ensure the safety and inclusion of all participants.
- ▶ Established a mutual understanding of the importance of sharing, exchanging and learning from each other's experiences.

## Key information

- ▶ Participants need to clearly understand the objectives and process of the workshop/training. The facilitator needs to clarify what participants can expect with regard to the context and participatory approach. It's important to explain that the focus is on sexual pleasure as part of SRH service delivery. When health professionals don't have access to accurate information or possess the skills to support clients, this could result in clients feeling anxious and guilty. This, in turn, can lead to a loss of sexual self-esteem and sexual problems, even violent relationships.
- ▶ This workshop does not cover the principles and skills of counselling, nor does it share in-depth information on the medical aspects of SRH. It does not address sexual problems or sexual dysfunctions in detail.
- ▶ The workshop does not address the legal aspects of sexuality and sexual pleasure in detail. However, it is important that health professionals know national and local laws and policies on sexual health, sexual rights and access to sexual health services. See the Introduction (page 13) for more information.
- ▶ The anticipated outcomes of the workshop are to foster a positive approach to sexuality, and explore how sexual pleasure and wellbeing can be integrated in participants' work as health professionals, within a sexual rights framework.
- ▶ The approach is learner-centred. It gives participants the opportunity to explore and nurture positive values and attitudes towards sexuality and sexual health, and respect for human rights and gender equality. The training also aims to empower participants to develop the skills and attitudes needed to treat clients with respect, acceptance, tolerance and empathy, regardless of their sexual orientation, gender identity/expression, age, religion or (dis)ability.
- ▶ After explaining the workshop, it's good to start with one or two ice breaker exercises so that learners can get to know each other better and a positive group atmosphere is created. This of course depends on how familiar the group members already are with each other. You may decide to start with one or two name games. If the group members are familiar with each other, you may decide to have one or two games for people to get to know each other better on a more personal level. You may also ask some participants to bring their preferred energizers and games.
- ▶ Participants arrive at a workshop with certain expectations, worries or even fears. It's worth sharing these in the group. As facilitator, this gives you an idea as to whether the content and approach of the training suits participants' expectations so you can allay their concerns and fears. If not, you can adapt some elements. There are many creative ways to elicit participants' expectations and fears.
- ▶ Talking about sex and sexuality isn't easy for everyone: cultural, religious and regional variations must be acknowledged and respected at all times. Ask participants what would make it easier for them to talk about these issues. Confidentiality is crucial. Discuss with participants how they want to keep information and each other's experiences confidential. As facilitator, you are a role model so you need to be open in communicating about sex and sexuality, without embarrassing the participants.

# EXERCISE 1



15 minutes

Getting to know each other/  
How do we want to work together?

**Materials:**

- ▶ Flipchart paper, marker pens

Explain that it is vital that everyone feels comfortable and safe to share and learn. To do this, suggest that the group agrees ways to work together. These agreements will be displayed on the wall throughout the training/workshop and group members can remind each other of the rules, when needed.

Ask everyone what would make them feel comfortable in the group. Propose an agreement. Examples include:

- ▶ Do not interrupt others – let them finish talking
- ▶ There are no stupid questions
- ▶ Respect each other's opinions
- ▶ Mobile phones off
- ▶ Be punctual.

After each proposal, check if the group agrees. If yes, write the agreement on a flipchart.

If there are no more proposals, put the flipchart paper on the wall so the rules remain visible throughout the training/workshop.

Mention again that people can remind each other of the agreements, if necessary.

If people want to propose additional agreements during the training/workshop, this is possible and they can be added to the list.

## EXERCISE 2



15 minutes

### Exploring hopes and fears

#### Materials:

- ▶ Post-it notes, pens, flipchart paper, marker pens
- ▶ Optional: handouts with agenda

- ▶ Start by asking the question to the group as a whole: 'What would make you feel unhappy if we hadn't addressed it during the workshop?'
- ▶ Give each participant a few post-it notes.
- ▶ Ask them to write down at least one hope/expectation and one fear on a post-it note. If they have more, they can use more post-it notes.
- ▶ Ask them to put their post-it notes on a big flipchart paper (one for expectations and one for fears) when they are ready. You can also ask participants to share what they've written before they put their post-it note on the paper. Not everybody might be comfortable doing this, however, so it depends on the group. The post-it notes should be anonymous.
- ▶ As facilitator, try to organize the post-it notes as much as possible, creating categories of hopes/expectations (e.g. gaining knowledge, knowing what follow-up actions to take) and fears (e.g. lack of knowledge and experience to share, difficulties in adopting the approach in their context).
- ▶ Discuss concerns in talking about sexuality and sexual pleasure. This workshop is not about personal disclosure – it's about exploring personal attitudes and being open to other values.
- ▶ Share the categories of hopes and fears with the group.
- ▶ Share the objectives and agenda of the training/workshop.

It is important to acknowledge that some participants may experience talking about sexuality in an open way as difficult or exciting. This workshop is not a licence to behave in inappropriate ways towards other participants.

#### TIP



#### Sharing objectives/agenda:

you can prepare this beforehand on flipchart paper and put them in the room for display. Explain how you will try to meet all expectations and dispel any fears or concerns.

# MODULE 2



2

## Unpacking sexuality, sexual health, sexual rights and sexual pleasure

**This module, which provides the foundation of the workshop, includes three topics:**

- pg. 23** A. Introduction to the World Health Organization's (WHO) working definitions of sexuality, sexual health and sexual rights.
- pg. 27** B. Introduction to the Global Advisory Board's (GAB) working definition of sexual pleasure; exploring and unpacking the diversity of sexuality and sexual pleasure.
- pg. 34** C. Showcasing the links between sexual health, sexual rights and sexual pleasure in sexual and reproductive health (SRH) services, information and education.

**By the end of this module, participants will have:**

- ▶ Understood the definitions and concepts of sexual health, sexual rights and sexual pleasure.
- ▶ Understood the meaning of the concepts in their personal and professional life.
- ▶ Gained a better understanding of the diverse, rich experiences and expressions of sexual pleasure, and of the uniqueness of sexual pleasure for each individual.
- ▶ Established the links between sexual health, sexual pleasure and wellbeing within the sexual rights framework.



# A. Introduction to WHO's working definitions

## Key information

**Sexuality** is “a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.” (WHO, 2006)

**Sexual health** is “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

**Sexual rights:** “The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws. Rights critical to the realization of sexual health include:

- ▶ the rights to equality and non-discrimination
- ▶ the right to be free from torture or to cruel, inhumane or degrading treatment or punishment

- ▶ the right to privacy
- ▶ the rights to the highest attainable standard of health (including sexual health) and social security
- ▶ the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- ▶ the right to decide the number and spacing of one's children
- ▶ the rights to information, as well as education
- ▶ the rights to freedom of opinion and expression, and
- ▶ the right to an effective remedy for violations of fundamental rights.

The responsible exercise of human rights requires that all persons respect the rights of others. The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination.” (WHO, 2006, updated 2010)

# EXERCISE 1



20 minutes

What are sexuality, sexual health and sexual rights?

## Materials:

- ▶ Flipcharts, marker pens

## Instructions

Ask everyone to get into teams of 4-5 people. Each team briefly defines sexuality, sexual health and sexual rights. Alternatively, ask each team to define one term. Once completed, each team presents their definitions to the others.

## Questions/points for discussion

- ▶ Which concept was the hardest to define? Which concept was the easiest to define? Why is that?
- ▶ Across all teams, what are the major similarities between the concepts?
- ▶ And the most striking differences?

After discussing each definition share and explain WHO's working definitions.

## Notes for facilitator

Sexuality, sexual health and sexual rights are complex topics. Currently, there are international working definitions of sexual health and sexual rights, developed by WHO.

As mentioned in WHO's definitions of sexuality and sexual health, many biological, social, cultural, economic, environmental, religious and contextual factors influence people's sexual behaviours, relationships, feelings, identities, desires and attitudes. Therefore, each person's experiences and expressions of sexuality are unique. Sexual diversity should always be recognized, valued and celebrated.

Sexuality develops throughout the lifespan. It may be expressed on your own, with a partner, in casual or long-term relationships, in marriage and at different ages. You can learn about sex at every stage of your life. People's motivations to have sex, their sexual behaviour within relationships, their sexual orientation and gender identity, intimacy, desire and how they perceive themselves may change at different stages of the life cycle. Legal and cultural aspects also shape sexuality and sexual and reproductive health. Although we all experience some sexual changes as we age, we do not lose our desire or ability for sexual expression. Among the elderly, although the desire and ability to have sexual intercourse may wane, the need for touch and intimacy remains.

There can be confusion among service providers and medical professionals as to the real meaning of sexual health and sexual rights. Sexual health is usually seen as the absence of diseases or dysfunctions, while sexual rights and sexual pleasure are rarely analysed in the context of service provision. These are core elements of an individual's health, and yet they often remain unseen by health professionals.

## EXERCISE 1 CONTINUED...

### The definition of sexual health implies that clients need to have access to:

- ▶ Gender-based violence prevention, support and care
- ▶ Psychosexual counselling related to sexuality, sexual identity, and sexual relationships
- ▶ Comprehensive sexuality education and information
- ▶ Services for the prevention and management of STIs, including HIV, and other diseases of the genitourinary system
- ▶ Prevention and management of cancers of the reproductive system.

The concept of sexual rights can make people feel uncomfortable. Not only does it represent different things to different actors but it remains controversial within many legal and political spaces, particularly when it concerns young people (but not only them). Common misconceptions are that sexual rights only refer to the rights of LGBTIQ people and sex workers or that they are just about the right to have sex. Sexual rights, however, apply to all people.

This isn't really anything new. We can track sexual rights back to the Programme of Action of the International Conference on Population and Development (1994) and the Beijing Platform for Action (1995), where it was stated that people have the right to pursue a "satisfying and safe sex life."

The fulfilment of health, sexual health and sexuality is closely related to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents, other consensus documents and in national laws. These include the Universal Declaration of Human Rights; International Covenant on Civil and Political Rights; International Covenant on Economic, Social and Cultural Rights; Convention Against Torture; Convention on the Elimination of all forms of Discrimination Against Women; Convention on the Rights of the Child; and Convention on the Rights of Persons with Disabilities.

Discrimination, stigma, violence, fear, ignorance and some cultural and traditional beliefs threaten people's ability to claim their sexual rights around the world. Adolescents and young people are especially vulnerable to violations of their sexual rights. Evidence shows that by empowering people to decide on matters concerning their sexual and reproductive health, service providers can improve their clients' health outcomes.

The legal situation of a country can conflict with sexual rights, including freedom of sexual expression and sexual diversity, access to SRH services for young people and parental consent. It is important to acknowledge this conflict and discuss how to address it in a personal and professional context.

## Sexuality

There are two ways in which you can look at sexuality:

### **From a societal perspective:**

Sexuality has a different meaning in different contexts and societies. There are often one or more groups in society who decide what should or shouldn't happen in the bedroom.

There are societies that are more closed with rules and regulations that dictate how people should behave sexually (e.g. religious societies) and societies where sexual rules are open and a matter of individual choice.

There are societies where the norms and values of the community outweigh individual perspectives and those where the individual is more important than the community.

### **Example: the topic of masturbation**

- ▶ Closed and religious community: masturbation is seen as a sin for everyone.
- ▶ Closed and individual: a medical authority states that masturbation is bad for your health.
- ▶ Open and individual: masturbation is seen as a personal choice.
- ▶ Open and community: a feminist political movement states that masturbation is the best way to enjoy your own body.

### **From an individual perspective:**

One way to look at sexuality from an individual perspective is by considering three levels:

1. What is the person's physical capacity to have sex (influenced by factors such as illness and age)?
2. What motivates the person to have sex?
3. What does the person actually do?

Motivation is the crucial link between the person's capacity to have sex and what s/he does. A disconnect between two or all of these components can create discomfort, dissatisfaction and sexual problems.

There are many reasons why people have sex. People from around the world often mention satisfaction and pleasure as the main reasons for sexual relations. But the list of reasons grows as people think why human beings might want to have sex, including reproduction, boredom, being forced, economic reasons and power. The motivation to have sex or not depends on values and morals in society; socialization, education and messages; gender roles and personal sexual history. What the person does and how s/he behaves depends on personal, relational and societal circumstances, contexts and opportunities.

## B. Understanding the diversity of sexual pleasure

### Key information

Working definition of sexual pleasure (GAB, 2016):

“Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to contribute to sexual health and wellbeing. Sexual pleasure should be exercised within the context of sexual rights, particularly the rights to equality and non-discrimination, autonomy and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people’s human rights and wellbeing.”

For more information, visit: [www.gab-shw.org](http://www.gab-shw.org)

This definition links different elements and concepts:

- ▶ (Sexual) health
- ▶ (Sexual) rights
- ▶ Individual preferences and experiences
- ▶ Societal influences

In the modules in this toolkit, we will use the GAB’s definition of sexual pleasure as the foundation for discussions and learning.

Sexual pleasure is diverse. Its experiences and expressions vary in relation to age, sexual orientation, gender identity and many other characteristics. Human beings experience it in a variety of ways, however, many of these expressions are stigmatized. This part of the

#### Here’s a guide to the terminology used in the definition:

- ▶ **Autoeroticism:** experiencing sexual feelings without known external stimulation: sexual gratification obtained solely through stimulation by oneself of one’s own body. Fully autoerotic people are only aroused by themselves – they prefer masturbation to being with another person.
- ▶ **Self-determination:** the freedom and capacity to make your own decisions; to act as you choose and determine your personal, relational and political independence.
- ▶ **Consent:** to agree to and accept someone else’s proposal.
- ▶ **Autonomy:** from the Greek for ‘self-rule’, it is the ability or capacity to make informed choices, free of coercion, based on one’s own personal beliefs and values.
- ▶ **Bodily integrity:** self-determination and autonomy over one’s own body.

module will explore the diversity of sexual pleasure, as well as the importance of the sexual rights framework to address and understand this diversity.

People experience their sexualities in very different ways. Sexuality includes one’s sense of awareness, experience and expression of eroticism, sexual pleasure, intimacy, sexual orientation and gender identity, among others.

## Sexual pleasure, the life cycle, gender and sexuality

- ▶ Participants may have different views on the meaning of sexual pleasure, and this will be reflected in their professional and personal life. When people think about pleasure, they might only think of its physical dimensions. But, as the GAB's definition explains, sexual pleasure goes beyond physical satisfaction and is very much related to each individual's freedom of sexual expression.
- ▶ As the GAB's definition also explains, sexual pleasure can take place in solitary or shared erotic experiences. In a relationship, it may be something you wish for yourself and your partner(s). However, many people don't know how they or their partner(s) can experience sexual pleasure, especially in the case of women's sexual pleasure.
- ▶ Experiencing sexual pleasure should not be taken for granted: it needs to be learnt. In order for it to enhance one's health, it should be based on the factors outlined in the GAB's definition: self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate. There are no universal norms and values. Diverse cultures at different historical moments think of sexuality and sexual pleasure in entirely different ways.
- ▶ Sexual pleasure is for all ages. It can have a different meaning or be a unique experience across all stages of the life cycle. Sexual orientation is defined by numerous factors and does not constitute something that an individual chooses – no one decides to be heterosexual, gay or bisexual. It is different from preferred sexual practices or acts. For instance, the fact that a man enjoys being penetrated with a sex toy does not mean he is gay.
- ▶ Gender, sexuality and pleasure are closely interwoven. Gender is not just a binary category relating to men and women only. Gender is something we live, perform and construct. Gender is constructed by the society we live in; it intersects with inequality and power differences. In most societies, it matters whether and how you live your life as a woman, a man, or other gender identity. Gender identity is the inner conviction that one is a man, woman, a blend of both or neither (which can differ from the sex assigned at birth), while gender expression refers to the ways in which we publicly express that identity.
- ▶ Typically, gender roles and stereotypes shape what happens in a sexual relationship. Inequities between men and women are often reflected in sexual relationships. Double standards about sexual activity exist in many cultures. Young women are supposed to be innocent, know nothing about sex and abstain from sex before marriage. If they carry condoms, they may be accused of 'sleeping around' and may have a 'bad reputation'. Young men may be afraid to ask questions about sex as this could reveal their lack of experience, and in order to be seen as a 'real' man they may feel forced to be sexually active.
- ▶ Gender roles and norms may result in women – particularly young women – feeling that they don't have the right to refuse sex if their partner or an older person asks for it. These differences can result in disagreements about methods to prevent HIV, STIs and unintended pregnancy, and can lead to abusive situations. Therefore, it is crucial that service providers understand the relationship between gender, sexuality and the capacity to enjoy sexuality in order to be able to discuss it with their clients.

- ▶ “The story of sex in committed modern couples often tells of a dwindling desire and includes a long list of sexual alibis, which claim to explain the inescapable death of Eros,” Esther Perel’s book, ‘Mating in captivity’ states. “There is the idea that long-lasting committed relationships are accompanied with dull sex lives, when we love someone, we feel responsible and secure. Responsibility and security clash with desire. So as the length of our relationship increases, we become closer to the individual, we have a greater sense of security, and we lose the desire we had at the start of our relationship. Just realizing that the ebbs of desire can be accompanied by upward flows of desire, as long as there is an open communication and transparency between partners, is one way to ensure expectations for sex don’t get in the way of pleasure from sex, especially in the context of long-term relationships.”



## EXERCISE 2

What does sexual pleasure mean to you?



30 minutes

### Materials:

- ▶ Small pieces of paper, pens
- ▶ Handout with GAB's definition of sexual pleasure

2

### Step 1

Ask everyone to write down what sexual pleasure means for them personally (or a fantasy) on a piece of paper. Keep it anonymous!

Ask each person to crumple the paper into a ball and throw it around the room, like a snowball fight. At the end, everyone opens one of the balls and reads out what is on the paper.

Remind participants that this is a safe and non-judgmental space, so reactions should be respectful.

Categorize the different responses on a flipchart (optional) and discuss them.

### Questions/points for discussion

- ▶ What makes a sexual experience pleasurable?
- ▶ Something that feels sexually pleasurable in one situation might not feel exciting or may even be unpleasant in another situation. Why is that?
- ▶ How is sexual pleasure linked to self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations?
- ▶ How can a person's feeling of sexual pleasure change during the life cycle?

### Step 2

In pairs, ask everyone to discuss with a partner two or three things they have heard about sexual pleasure (from family, friends and society at large).

As a group, discuss the similarities and differences between what people have learnt about sexual pleasure, where and from whom.

### Questions/points for discussion

- ▶ What strikes you the most? Are there major differences or similarities between the things that people in the group have learnt about pleasure from others?
- ▶ Which social group has the greatest impact on our attitudes towards sexual pleasure? Why?

## EXERCISE 2 ALTERNATIVE EXERCISE

 30 minutes

What is acceptable or unacceptable in sexual pleasure?

**Materials:**

- ▶ Cards and handout with GAB's definition of sexual pleasure

### Instructions

Draw an imaginary line in the room and place a card at one end with the word 'acceptable' and at the other end a card with 'unacceptable'. The middle of the line will be 'don't know'.

Read out statements of individual sexual practices and ask participants to position themselves on the line, according to what extent they accept each practice or not.

Statements can include:

- ▶ Sex between two partners of the same sex
- ▶ Oral sex
- ▶ Anal sex
- ▶ Sex without protection/condom
- ▶ Sado-masochistic acts
- ▶ A 40-year-old woman having sex with a 15-year-old boy
- ▶ Masturbation
- ▶ Having sex with multiple partners

After each statement have a discussion with participants about why they chose that position on the line. Ask the participants located on each side of the spectrum to convince the others of their position. Finally, discuss situations when certain acts can be acceptable or unacceptable.

### Additional questions for discussion

- ▶ What do you know about other people enjoying sex? What kinds of things do you hear? What were you told about sex when you were younger/before you got married?
- ▶ How does someone/a couple go about having a good sex life? What does this entail?
- ▶ What kinds of touch can be enjoyable? Are there any intimate/sexual activities that you'd like to know more about?

At the end of either exercise, introduce and explain the GAB's working definition of sexual pleasure.

### Notes for facilitators for both exercises

- ▶ Most people want a good quality of life. This usually means having a chance to be healthy and happy. We want to be safe and respected. We want to have the opportunities to grow and learn. We want to matter in the world and pursue our dreams. And we want to live together in peace. Positive sexual relationships are a part of that.

## EXERCISE 2 CONTINUED...

- ▶ Service providers need to understand the variety of messages that exist around sexuality and how they can positively or negatively influence someone's ideas and experiences of pleasure.
- ▶ To enable clients to make independent decisions, it is essential that health professionals position them as autonomous sexual beings with the right to experience desire and pleasure in their daily lives and to have control and agency over their bodies – whether they are sexually active or not. This is particularly relevant to those whose rights and sexualities are socially stigmatized or denied, such as gay, bisexual and trans people, people living with HIV and people with disabilities.
- ▶ Opening up a discussion on pleasure doesn't just mean talking about what constitutes good or bad sex, or conveying facts about the erogenous zones of the body and sexual acts that can trigger pleasurable sensations. It's about understanding what pleasure means in the context of sexual health and sexual rights. Values, norms, culture and religion all shape how people experience sexual pleasure.
- ▶ The positive aspects as well as prejudices and stereotypes that exist around sexual pleasure all come from various sources, such as family, friends, classmates and work colleagues. Each source can exercise different levels of influence when it comes to developing our ideas related to sexual pleasure – this very much depends on the individual's particular situation.
- ▶ In most societies, sex is taboo and is not openly discussed, even within married couples. This is the main reason why it's crucial to talk openly as a health professional about sex, sexuality and sexual pleasure, and to suggest to clients that they may benefit from talking openly in their relationships with partners, family and community members.
- ▶ Within the context of sexual rights, people can live out their preferred sexual practices as long as others are not harmed or forced into certain acts.
- ▶ What is acceptable in sexual pleasure? People need certain stimuli or acts to experience sexual pleasure. Some are considered 'abnormal' in one society (such as sexual relations between two people of the same sex), while they can be totally accepted in other societies.
- ▶ Pleasure can outweigh safety when it comes to sex, for example, men who do not want to use a condom because they find it less pleasurable. That's why it doesn't make sense to talk about safer sex without discussing pleasure. Discussing physical pleasure (how and whether they are experiencing it) with a client often brings to light issues such as inequity, consent, or other factors that restrict the pursuit of pleasure.
- ▶ Some practices aimed at enhancing sexual pleasure can put the person who practises them or their partner(s) at risk, for example, the use of Sildenafil to sustain an erection or 'rough' sex with a partner. Actions to increase sexual pleasure are only acceptable when they don't cause harm to the person(s) carrying them out, and if they don't cause harm or violate the rights of the partners involved.
- ▶ Some people have sexual fantasies that have nothing to do with their relationships – they can discuss them but may not want to make them happen.

## EXERCISE 2 CONTINUED...

Talking about sexual pleasure can be challenging. When you deliver the workshop in a faith-based context, discuss the following questions with participants:

- ▶ Is there a difference between the position of the community and real life situations? How do people bridge the gap between the values in the community and their own lives?
- ▶ What is the difference between culture and religion with regard to sexuality and sexual pleasure? What kind of different ideas do people have about the same religions?
- ▶ What are the differences between religious teachings on sexuality and the reality of people's intimate lives? What are the risks of not talking about sexuality and keeping relationships secret?
- ▶ How can you start a discussion in your faith community, create the right environment and bridge the gap between very different ideas and values?

### **TIPS** to enjoy sexual relationships that truly enhance pleasure and health:

- ✓ Treat your partner as a human being, not as a body or object.
- ✓ Strike the right balance between play, seriousness, sensuality and intimacy.
- ✓ Try to give pleasure to your partner and accept being pleased.
- ✓ Communicate what you want and don't want to happen.
- ✓ Be safe.

## C. Linking sexual health, sexual rights and sexual pleasure in SRH services, information and education

For programmes and services to be holistic and go beyond a risk-based approach, they need to be based on the intersection between sexual health, sexual rights and sexual

pleasure. By addressing all three areas equally we believe we can improve SRH services and enhance our clients' sexual lives.

2

EXERCISE 3



 20 minutes

Links between sexual health,  
sexual rights and sexual pleasure

**Materials:**

- ▶ Flipcharts, marker pens and handouts

**Steps**

- ▶ Ask everyone to get into teams of four or five people.
- ▶ Each team is given the WHO definitions of sexual health and sexual rights and the GAB's definition of sexual pleasure.
- ▶ Each team suggests an example of a sexual and reproductive health intervention where they can connect sexual health, sexual rights and sexual pleasure e.g. contraceptive services to young people or HIV testing.
- ▶ Each team presents their example to everyone and explains how meaningful links can be made in that particular service.
- ▶ The group discusses which of the concepts developed by the team are present in the GAB's definition and which are not.

**Notes for facilitator**

The link between sexual health and sexual rights becomes clearer when you link sexual health with the right to information, the right to equality, freedom from all forms of discrimination and the right to the highest attainable standard of health.

What about sexual pleasure? The links between sexual pleasure, sexual rights and sexual health are included in the GAB's definition of sexual pleasure. They can be addressed in the context of service delivery in a variety of ways, including sexual history taking, counselling and the resources provided to clients. Exploring the connection between sexual health,

## EXERCISE 3 CONTINUED...

sexual rights and sexual pleasure can shape sexuality issues within relationships. For example, the guilt a person experiences around his sexuality (because of certain ideas he grew up with) may have an impact on him practising safer sex practices with a partner of the same sex. Knowing and understanding his sexual right to self-expression may boost his self-esteem and help remove barriers to discussing condom use. This can enhance his sexual wellbeing.

It is important to link sexual health, sexual rights and sexual pleasure with people's agency. Enabling people to discuss sexual pleasure can empower them to discuss other sexual issues. For instance, if a young woman is able to tell her partner what she likes or dislikes, and to negotiate the quality of sexual relationships, it's more likely that she will be able to discuss other issues, such as contraception and condom use.

The GAB's definition explains sexual pleasure in the context of sexual health and sexual rights.

### Examples of how to make the links in SRH services between sexual pleasure, sexual rights and sexual health:

- ▶ Providing contraceptive services to young people

**Sexual health:** prevention of unintended pregnancy; choice of contraceptives; dual protection against unintended pregnancy, HIV and other STIs.

**Sexual rights:** respecting young people's rights to make autonomous choices about their bodies and to decide whether to have children, the number and spacing of their children, and to have the information, education and means to do so.

**Sexual pleasure:** understanding consensual sex and its importance for pleasure; how the use of contraceptives affects pleasure; improved confidence to use contraceptives and to practise safer sex.

- ▶ HIV testing

**Sexual health:** awareness of HIV status; information about treatment, care and support; understanding safer sex.

### Sexual rights encompass:

1. the right to equality and non-discrimination: the right to services, regardless of marital status, age, (dis-)ability, HIV status, sexual orientation or gender identity, occupation (e.g. sex worker) etc.
2. the right to privacy and confidential services without parental/spousal consent.
3. the right to the highest attainable standard of health (including sexual health): the right to know one's HIV status and access effective counselling, support and services.
4. the rights to information and education: the right to age- and context-appropriate, unbiased, accurate and comprehensive information on HIV, HIV prevention, testing, sexuality and HIV services.

## EXERCISE 3 CONTINUED...

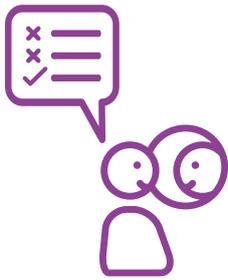
5. the rights to freedom of opinion and expression: the right to make informed decisions about HIV prevention methods.
6. the right to freedom of sexual expression: everyone should be able to express their sexual identity and access confidential, stigma-free services.

**Sexual pleasure:** how to enjoy sex and be safe, regardless of HIV status.

## Further reading

- ▶ Laan Ellen, Walter Everaerd (1995). 'Determinants of female sexual arousal; psychophysiological theory and data; annual review of sex research'. 6 32-76
- ▶ National Sexuality Resource Centre <http://kinseyconfidential.org/sexual-literacy/>
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# MODULE 3



## Personal and professional reflections: attitudes, values and ideas

This module explores different attitudes, values and ideas related to sexual pleasure. It will prompt reflection on how these ideas can affect the personal life and professional practice of sexual and reproductive health providers.

### **By the end of this module, participants will have:**

- ▶ Explored how personal experiences shape their attitudes and values with regard to different aspects of sexuality and sexual pleasure.
- ▶ Gained a better understanding of how personal attitudes can influence professional practice.

## Key information

- ▶ A rights-based approach to communication and counselling means that all people of different race, ethnicity, sexual orientation, gender identity, religion, language, (refugee) status etc have the right to be treated equally. Adolescents, married or unmarried people, or those people with a mental/physical disability have the same rights to counselling services, adapted to their needs and contexts. The quality of SRH services or advice should not vary because of personal characteristics such as the client's residence, health status, insurance status, drug use or sex work.
- ▶ Providers need to reflect on how comfortable they feel about sexuality and sexual relationships as this can have a significant impact on how they communicate with their clients. They need to be aware of their comfort level in working with clients whose sexual values and experiences differ from their own.
- ▶ Providers should be aware of their own beliefs as well as the legal aspects related to sexuality, sexual orientation and gender identity. This will help them to bring up different forms of sexuality and sexual orientation and identity with their clients.
- ▶ Providers don't have to agree with or share the same values as the clients they support. But they must respect their clients' values and attitudes or actions based on these. The only exceptions are when a person is engaging in illegal, potentially harmful or dangerous behaviour.
- ▶ Service providers must be careful not to impose their values and attitudes – including religious beliefs – on clients' personal relationships e.g. young people, people living with HIV or people with a disability.
- ▶ Providers need to understand the difference between scientifically based facts and their own values before they can explore the connection between what sexuality means for the individual and their relationships. This will enable them to help clients explore the fears and obstacles that hinder their self-expression.
- ▶ Providers must never assume that they know their clients' sexual life, sexual orientation or gender identity.

# EXERCISE 1



20 minutes

## Fact or value?

### Materials:

- ▶ Slides or (flipchart) paper with statements

Ask participants whether they think the following statements are true or whether they are a myth (you can add similar statements and prepare alternative lists):

- ▶ It is easier for men to experience sexual pleasure than women
- ▶ Good sex is spontaneous
- ▶ Good sex should end in an orgasm
- ▶ Sex = intercourse
- ▶ Penis size matters in giving and receiving sexual pleasure
- ▶ Men need an erection to have sex
- ▶ Men want more sex than women
- ▶ Sexual relationships should be controlled, for example, young people shouldn't have sex before marriage
- ▶ Gay men have more sexual partners than heterosexual men
- ▶ Having more sexual partners implies that the person is 'high-risk'
- ▶ Sex is a voluntary action between adults
- ▶ When you have a good sexual relationship, you shouldn't masturbate.

### Questions/points for discussion

- ▶ Try to unpack why these statements are often defined as fact. What are the underlying values?
- ▶ Try to unpack how these values influence participants' and their clients' sex lives in a positive or negative way.
- ▶ As service provider, how do your personal attitudes shape your relationship and interaction with clients?

## EXERCISE 1 CONTINUED...

### Notes for facilitator

All the statements are subjective values but are often presented as facts. It's vital to make a distinction between an evidence-based fact and a value.

Each society has different values around sexuality. Some are clear and open for everyone and others are more hidden. They can all contribute to how people develop ideas on sexuality and sexual pleasure.

### Some answers you can give

- ▶ Regardless of sexual orientation and gender identity/expression, everyone can experience sexual pleasure. Many prejudices and stereotypes have historically limited women's sexual expression, but both sexes have the same potential to experience sexual pleasure in their lives.
- ▶ Sex doesn't have to be spontaneous to be good: it may be helpful to discuss when and where to have it, and what you want and don't want to happen.
- ▶ Many women (and men) don't always have an orgasm during sex but nevertheless enjoy the intimacy and togetherness.
- ▶ There are many ways to enjoy a sexual experience together: it could be intercourse, oral sex or mutual masturbation. One form of sex is not better than another.
- ▶ There is no scientific basis for the idea that penis size matters to give or receive more pleasure.
- ▶ Men don't need to have an erection to have sex. This is a myth that has become even more ingrained in our culture with the introduction of drugs such as Sildenafil. Many men experience a lack of erection from time to time; this doesn't need to be a problem. In fact, being so goal-oriented about sex means that people miss out on a lot of pleasure. Using one's hands, mouth and imagination, there are many ways to satisfy a partner and experience sexual pleasure. Skin is the largest sex organ and the mind the most potent one. Putting pressure on oneself to get an erection will only make it less likely.
- ▶ All individuals have the right to have sexual relationships. The most important thing is to be able to decide freely (without coercion or violence), if, when, with whom and how you want to have sex, and for you to be able to communicate and negotiate safety and the quality of the relationship with the partner.
- ▶ In some HIV/STI prevention programmes, people who have multiple sexual partners are automatically categorized 'high-risk'. In fact, what increases the chance of acquiring HIV and other STIs is how an individual has sexual relationships, not with how many people. If someone reports having 30 partners over the last year but using condoms with everyone for any type of penetrative sex, that indicates that s/he is confident about discussing safety with every partner, and the chance of acquiring an infection is low. Conversely, someone who only has one partner but is not confident about discussing sex – including condom use and sexual safety – with that partner is more likely not to use any form of protection when having intercourse.

## EXERCISE 1 CONTINUED...

- ▶ Masturbation can be practised by everyone at any point of their lives and is the safest sexual practice that exists!
- ▶ Sexual orientation (if someone is gay, heterosexual or bisexual) does not define whether an individual is monogamous or has multiple sexual partners.

### How providers' values determine their interaction with clients

Although the goal of a rights-based approach to service delivery is an equal relationship between providers and clients, in reality, this is not always easy to achieve. Differences in gender and age as well as an imbalance in knowledge can influence the process of counselling. In many settings, issues of dominant male masculinity may make it difficult for female clients to talk to male providers, and male clients to talk to female providers. Clients can also exercise power or manipulate the provider, consciously or unconsciously. Providers should be aware of power and discuss the issue with clients.

It's important to recognize gender stereotypes that might contaminate the process of counselling. A rights-based approach to counselling is committed to facilitating equality and shared power between women and men, and eliminating stigma and discrimination on the basis of sexual orientation and gender identity.

Traditionally, more women than men seek support for sexual issues. The concept of talking about feelings and exploring emotional and psychological difficulties has, for many years, been seen as a 'female' rather than 'male' trait. This has been embedded in gender roles and expectations and how women and men consider themselves. However, this is slowly changing, with more men seeking counselling and seeing it as both positive and relevant. Men have emotional needs in the same way as women: they feel anger, grief, shame, sadness and anxiety in the same way. The difference is that women have traditionally been allowed to name these feelings and seek support for them, while men have been silenced through male gender roles. Depending on the context, men may need a specific approach, as they may feel the need to keep their emotions secret, and experience shame and isolation.

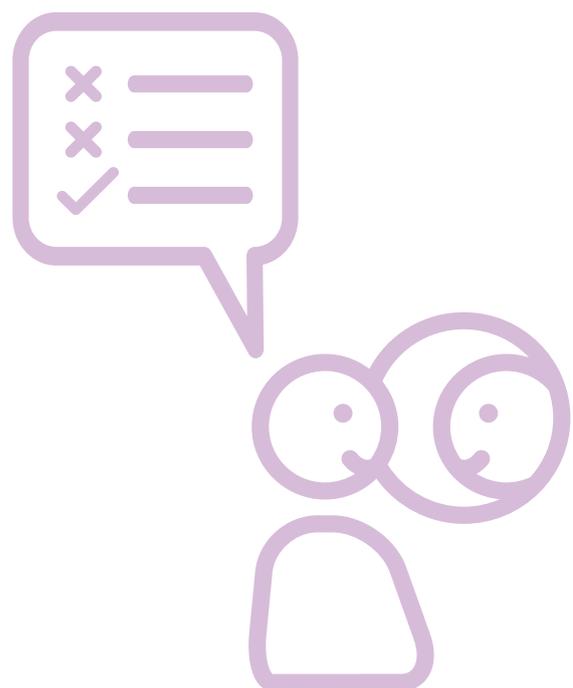
Severe restrictions on sexual freedom are imposed on LGBTIQ clients in many states around the world. These restrictions take the form of active prosecution of individuals and a failure to protect individuals from discrimination and harm. In every country, LGBTIQ youth face some degree of discrimination on the basis of their sexual orientation or gender identity. Due to stigma and internalized self-stigma, access to counselling is limited. Even less support is available for the health and safety of transgender people and gender non-conforming clients. Healthcare providers can address these issues at different levels: by integrating evidence-based, non-stigmatizing information in their communication and counselling and by ensuring a safe, non-judgemental environment.

Sexuality may have a negative connotation for clients in some communities. Sometimes actions need to be taken to overcome clients' embarrassment and stigma so that they can ask for support on issues regarding sexuality and SRHR. It is important that (potential) clients feel supported and accepted to seek help and that providers from the same community can separate their personal values and attitudes about SRHR from their professional expectations, values and ethical obligations.

## EXERCISE 1 CONTINUED...

For those participants who practise a religion, discuss and explore the opportunities and barriers to promoting dialogue on religion, faith, culture and sexuality. Questions include:

- ▶ What is the common ground between your faith and the sexual rights values of dignity, equality, respect and compassion?
- ▶ How can you create the right environment and bridge the gap between the differences in ideas and values that you and your clients hold?
- ▶ How can you, as provider, navigate in closed cultures to address sexual pleasure issues with clients?



# MODULE 4



## Risk-based approach vs pleasure approach in sexual health promotion

Historically, most public health campaigns, programmes and interventions to promote sexual health have been based on a risk approach, elaborating messages about the dangers of unprotected sex. A pleasure approach in the promotion of sexual health is fundamental to reduce the stigma surrounding sexuality and address elements such as consent, privacy and communication that are key enabling factors for pleasure to contribute to sexual health and wellbeing.

### **By the end of this module, participants will have:**

- ▶ Gained insight into the value of the pleasure approach in public health interventions, including promotion of safer sex.
- ▶ Understood how to move from a risk-based approach to a pleasure approach as a health professional.

## Key information

- ▶ Public health campaigns or interventions aimed at improving sexual health (including counselling related to the provision of SRH services) have mainly focused messaging on preventing the negative consequences of sexuality, such as unintended pregnancies, HIV and STIs. While it is important to disseminate information on these negative outcomes, in many cases they dominate the messages around sexuality. This approach fails to recognize that some of the primary factors at the root of sexually risky decisions relate to pleasure, and therefore fails to address them.<sup>5</sup>
- ▶ Historically, sexuality has been the subject of shame and stigma in many parts of the world. Sexual health or sex education programmes that only focus on promoting fear or shame about the unwanted consequences of unprotected sex exacerbate the stigma surrounding sexuality. Promoting fear of the negative outcomes of sexual activity constitutes a risk-based approach for sexual health programmes and interventions. Within the risk-based approach, sexual pleasure is always the elephant in the room. Discussions only focus on viruses, bacteria, medical check-ups and testing, but never on the satisfaction derived from erotic practices and the factors associated with pleasure, such as self-determination, consent, safety, privacy, confidence, communication, being able to negotiate with the partner(s), and self-exploration.
- ▶ A pleasure approach in sexual and reproductive health programmes and interventions puts pleasure at the centre, as an element that is intrinsically linked to sexual health and sexual rights. A pleasure approach or a sex-positive approach is “an attitude that celebrates sexuality as a part of life that can enhance happiness, bringing energy and celebration. Sex-positive approaches strive to achieve ideal experiences, rather than solely working to prevent negative experiences. At the same time, sex-positive approaches acknowledge and tackle the various risks associated with sexuality, without reinforcing fear, shame or taboo surrounding the sexualities of young people.”<sup>6</sup>
- ▶ Other studies have elaborated on the benefits of this approach: “There is growing evidence that promoting pleasure in male and female condom use, alongside safer sex messaging, can increase the consistent use of condoms and the practice of safer sex. This is the ‘power of pleasure’.”<sup>7</sup> The authors cite examples of certain organizations’ work in this area in Australia, Mozambique and Cambodia, among others.
- ▶ Both approaches – based on pleasure or risks – in sexual health promotion are reflected in the way providers deliver information or counselling to their clients, in educational materials and campaigns. Providers should be aware that clients are mostly exposed to messages that reinforce the risk-based approach. They should strive to identify and modify these messages in order to implement the pleasure approach.

## Key differences between the two approaches for SRH programmes and interventions



### Pleasure approach

1. Focuses messaging on sexuality as a source of pleasure and wellbeing for everyone, and highlights the importance of achieving ideal sexual experiences.
2. Recognizes that sexual pleasure is the main reason why people have sex and that pleasure determines the ways in which we make decisions in our sex lives.
3. Actively promotes pleasure as a key ingredient for people to practise safer sex and use protection. Examples include:
  - ▶ A female condom can help stimulate the clitoris.
  - ▶ Ultra-thin condoms allow for the feeling to be practically skin-to-skin.
  - ▶ Foreplay is vital to enhance pleasure and have better sex.
  - ▶ Lubrication makes the friction in vaginal or anal sex much more pleasurable.
  - ▶ Anal/vaginal penetration is not the only way to experience sexual pleasure. Rubbing, mutual masturbation and other non-penetrative practices can be very pleasurable.
4. Promotes reflection and discussion on the links between sexual pleasure, sexual health and sexual rights, such as self-determination, consent, privacy, safety, communication, diversity, negotiation and confidence.
5. Promotes normalizing messages about sexual pleasure within a sexual health and sexual rights framework. Examples include:
  - ▶ It is your sexual right to have as many partners as you want. What's essential is that you are able to decide if, when, how and with whom you have sex; that you are satisfied; and that you feel confident talking to your partner about pleasure and bringing up the topic of safety.



### Risk-based approach

1. Focuses messages solely on HIV, STIs, unintended pregnancy, and other unwanted consequences of sexual activity.
2. Does not take into account the importance of understanding why people have sex, including to experience pleasure or enjoy each other.
3. Reinforces fear or shame as the main motivator for people to use sexual protection, e.g. if you have sex without a condom, you will get HIV so you'd better use a condom.
4. Discusses only medical/biological information about these unintended consequences, such as symptoms, testing and treatment.
5. Reinforces traditional beliefs that can fuel stigma around sexuality in the process of providing education, counselling and information to clients or assessing a client's situation. Examples include:
  - ▶ Having multiple sexual partners is synonymous with 'high-risk'.
  - ▶ It is not acceptable to have sex below a certain age.



## Pleasure approach continued...

- ▶ Talking about sexual pleasure is fundamental to gaining confidence and feeling empowered – this will lead to better decisions about your sexual health.
- ▶ There are no ideal forms of relationships. Pleasure is diverse. Some people have fulfilling sex lives in monogamous relationships, while others do not and choose to have different arrangements, such as open relationships.
- ▶ Having a specific sexual orientation or gender identity does not mean someone is 'higher risk'.

6. A pleasure approach does not mean that accurate information about STIs is omitted. This information must be included. A pleasure approach means catalysing a fundamental shift in messaging and attitudes towards sexuality: from fear and shame to the factors needed to achieve sexual satisfaction, happiness and fulfilment.



## Risk-based approach continued...

- ▶ Men are inherently risk-takers; women don't usually experience as much pleasure as men (gender norms).
- ▶ Talking about sexuality is something private that no one should be asked to discuss in a clinical setting.
- ▶ Sexual monogamy should be the ideal.
- ▶ Gay men engage in higher risk practices.



# EXERCISE 1



30 minutes

## Representations of the risk-based approach and pleasure approach

### Materials:

- ▶ Videos, pens and paper

Present four videos of different sexual health campaigns designed by various organizations in order to prompt reflection among participants on the risk-based and pleasure approaches. It is useful to analyse sexual health campaigns as they offer clear representations of both approaches.

We include the following videos in this toolkit:

- ▶ From the US Centers for Disease Control, PrEP - an HIV prevention option: <https://www.youtube.com/watch?v=TR8-3uAuZGo>
- ▶ From the Test Bangkok campaign, Bottoms up: [https://www.youtube.com/watch?v=GQIZtJ\\_Dowc&index=2&list=PLqCXfvLIH0hu803eDJqbnEjDjckXNo6oM](https://www.youtube.com/watch?v=GQIZtJ_Dowc&index=2&list=PLqCXfvLIH0hu803eDJqbnEjDjckXNo6oM) or, Birthday Surprise: [https://www.youtube.com/watch?v=seggqghc4yk&list=PLPhSC\\_k7Y4YeHJPC2ibfvQcyOT167bZWd](https://www.youtube.com/watch?v=seggqghc4yk&list=PLPhSC_k7Y4YeHJPC2ibfvQcyOT167bZWd)
- ▶ From RFSU (a Swedish sex education organization), WEEKDAY x RFSU - Be Carefree, Not Careless - Keep a condom in your 5th pocket: <https://www.youtube.com/watch?v=FvnqvPA6fyU>
- ▶ From the NYC Department of Health, #PlaySure: <https://www.youtube.com/watch?v=9AKArNM73xw>

Ask everyone to score each video from 1 to 10 in terms of the approach they use to promote sexual health (1 represents a 100% risk-based approach, and 10 represents a 100% pleasure approach).

After presenting the four videos, ask each participant to give their score. The group obtains the scores of each video and ranks them accordingly.

### Questions/points for discussion

- ▶ In which video was the pleasure approach most apparent? In which one was the risk-based approach most apparent? Why?
- ▶ Which video was difficult to locate on one side of the risk/pleasure spectrum? Why?
- ▶ Which elements of the risk-based approach did you see in the videos that ranked lowest?
- ▶ Which elements of the pleasure approach did you see in the videos that ranked highest?
- ▶ What is more important as a message – pleasurable sex or safer sex? Or both?

## EXERCISE 1 CONTINUED...

### Notes for facilitator

- ▶ Sexual health programmes and interventions based on the pleasure approach are rare because sexual pleasure is a profound taboo in society and within certain public health circles.
- ▶ For a programme or intervention to be based on the pleasure approach, it needs to go beyond providing information and education about the physical aspects of pleasure, and focus on the key links between sexual pleasure, sexual health and sexual rights.
- ▶ Service providers need to constantly check if the messages given to clients in educational and clinical settings fall under the risk-based or pleasure approach. They should strive to provide accurate, scientific information within the pleasure approach.

## EXERCISE 2



30 minutes

### Framing messages based on both approaches

#### Materials:

- ▶ Flipcharts, marker pens

Split the group into five teams. Ask each team to develop between three and five bullet point messages using both the risk-based approach and pleasure approach for a topic that is randomly assigned to them. Some of the topics that can be used for this exercise are:

- ▶ Condom use
- ▶ Sexual diversity
- ▶ Sexual relationships in adolescence
- ▶ Sexual violence
- ▶ Contraception

Each team presents their messages, followed by a plenary discussion.

#### Questions/points for discussion

- ▶ Which approach was easier to use when developing these messages? Why?
- ▶ Does the pleasure approach mean that we have to avoid conveying information on biological aspects related to sexuality?
- ▶ What does the pleasure approach mean to you, after doing this exercise?

#### Notes for facilitator

The pleasure approach is about changing attitudes and shifting the discourse around sexuality. Sexuality should not be about fear, shame or stigma, but about happiness, satisfaction and fulfilment.

The pleasure approach does not mean that we have to exclude biological information about sexuality or information about STIs/HIV. Rather, it means that we should educate clients on ideal experiences – not only prevent negative ones. In practice, this entails providing more comprehensive care to clients, as other issues connected to health and rights are addressed.

#### Example: condom use

Negative messaging focused on risk:

- ▶ Avoids risks.
- ▶ If you don't use a condom you'll get ill and you could die.

## EXERCISE 2 CONTINUED...

- ▶ You are irresponsible if you don't use condoms.

Positive messaging focused on pleasure:

- ▶ Using a condom gives you more confidence and enhances your sexual enjoyment because you don't have to worry.
- ▶ You can integrate condoms in a loving and exciting way in your love making.
- ▶ It stimulates communication between you and your partner.
- ▶ It shows you care for your partner.

### **TIPS** In practice, what does this approach mean for healthcare providers?

- ✓ Try to strike a balance between addressing the unwanted consequences of sex and enjoyment of the sexual relationship.
- ✓ Avoid intensifying guilt and shame – your clients already feel those emotions and there is no need to fuel them. A negative risk-based approach could further prevent individuals from talking about it and being able to engage in pleasurable sexual activity.
- ✓ Although sex is alluded to everywhere – on TV, in films, magazines, newspapers, cell phones, text messages, websites and social media – it is rare to have access to honest discussions and accurate information about sexuality.
- ✓ A more positive approach in your communication about SRH should be adopted within an environment necessary to address the stigma, taboos and discomfort so often associated with sexuality. You must develop the skills to encourage openness from the client by being frank, kind and non-judgemental.

## Further reading

- ▶ Higgins, J.A., and Hirsch, J.S. (2008). 'Pleasure, power, and inequality: incorporating sexuality into research on contraceptive use.' *American Journal of Public Health* 98.10 (2008): 1803-1813.
- ▶ Philpott, A., Knerr, W., and Boydell, V. (2006). 'Pleasure and prevention: when good sex is safer sex'. *Reproductive Health Matters*, 14(28), 23-31.
- ▶ Philpott, A., Knerr, W., and Maher, D. (2006). 'Promoting protection and pleasure: amplifying the effectiveness of barriers against sexually transmitted infections and pregnancy'. *The Lancet*, 368(9551), 2028.
- ▶ Pleasure project  
<http://thepleasureproject.org/>
- ▶ IPPF (2016). 'Putting sexuality back into comprehensive sexuality education'.  
<http://www.ippf.org/resource/putting-sexuality-back-comprehensive-sexuality-education>
- ▶ IPPF SARO (2014). 'Technical brief: sexuality counselling'.

## SECTION 2. TRAINING MODULES



### B. Sexual pleasure approach in sexual and reproductive health services

This section covers the basics of language and messaging required to implement the pleasure approach in SRH service delivery. The *Pleasuremeter* – an innovative tool designed to implement the pleasure approach in sexual history taking – is introduced. Strategies are outlined on how to overcome fears and address embarrassing questions. Case studies are featured that illustrate how to implement the pleasure approach in counselling related to the provision of different SRH services, as well as a role play exercise to put this approach into practice.

Objectives:

- ✓ To create a safe environment for learning and sharing, to explore sexuality and sexual pleasure, and address personal challenges in discussing sexuality.
- ✓ To clarify main concepts and definitions regarding sexual health, sexual rights and sexuality.
- ✓ To increase awareness of the various components of sexuality and sexual pleasure, including cultural and religious aspects and gender-related, personal attitudes and experiences.
- ✓ To understand the shift in thinking about sexual health and sexuality, from a risk to a pleasure approach.

Please note that this section is not intended to train participants as sex therapists. The focus is on showcasing how the pleasure approach – linking sexual health, sexual rights and sexual pleasure – can be incorporated in counselling and communication with clients.

# MODULE 5



## Basics in language and messaging

Body language and simple verbal messages can significantly increase or reduce the stigma surrounding sexuality in the delivery of sexual and reproductive health services. This module offers guidance in developing basic messages that health professionals can use to talk about sexual pleasure with their clients without fuelling shame or stigma.

### **By the end of this module, participants will have:**

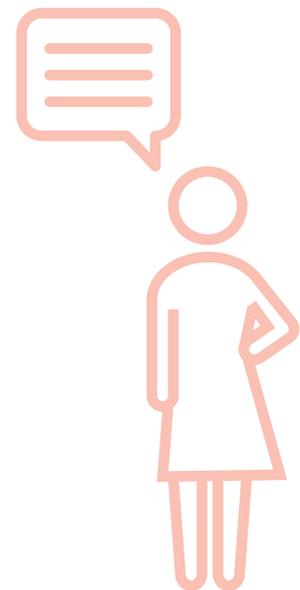
- ▶ Explored the importance of the use of language and non-verbal expressions when communicating about sexual pleasure in the professional health context.
- ▶ Practised using 'sexual words' in the professional context.

## Key information

- ▶ **Feel comfortable as a provider discussing sex, sexuality and sexual pleasure:** Talking openly about sexuality, including sex, and feeling comfortable discussing these issues with clients enables service providers to deliver the most appropriate services and information for each individual. Service providers may be nervous to discuss sexuality as they think they lack the skills, feel uncomfortable, worry about being offensive or simply lack time. Luckily, many providers already have all the skills they need to do this: they want to help the client, they listen carefully and are willing to learn. Nevertheless, many providers assume that their clients' sexual health needs and identity conform to social norms and do not adapt their own behaviour, language and attitudes accordingly.
- ▶ **Service providers don't have to be 'sex experts'** to adopt a positive, analytical and holistic approach and talk to clients about sex and sexuality. Encourage participants to dispel any fears they have about being an expert. Instead, they should focus on listening to their clients' experiences so that they can educate them about their lives – something that they are already probably good at.
- ▶ **Safe and non-judgemental environment:** Health professionals must create an environment where clients feel comfortable expressing themselves openly about sexuality without fear of judgement. This helps them to share and assess their sexual and reproductive health needs with confidence.
- ▶ **Medical examinations:** Certain medical conditions can reduce sexual pleasure. Some illnesses, such as diabetes, can lead to sexual problems. Certain prescribed medications are linked to sexual problems and diminished sexual pleasure. STIs and other genitourinary infections can cause pain and discomfort. Therefore it is essential that, where possible, a medical assessment takes place by qualified staff.
- ▶ **Ask and give permission:** Not all clients want to discuss sex and sexual pleasure so it's important that providers do not bring up sexual pleasure early on in the discussion. Providers should find out whether clients are willing to discuss this. Service providers can also give permission to clients to speak about their sexual concerns. This helps validate the fact that sexual pleasure is an important issue, enabling clients to acknowledge that their feelings are justified and deserve attention. It is based on the notion that many sexual problems stem from a range of negative emotions, such as anxiety or guilt. Clients might feel inhibited about sex, embarrassed and self-conscious. The provider can often alleviate the client's discomfort by giving permission to the client to continue what s/he is already doing sexually. For example, a client experiencing guilt about masturbation may be given permission to do so, thereby reducing her/his negative feelings.
- ▶ **Listen to each client's concerns, needs and realities:** One of the keys to adopting a sex-positive approach to service provision is communication. By listening to people's concerns, desires, needs and realities, health professionals should provide information that answers the client's direct questions as well as related issues – whether they are raised by the person or not. The provider should not assume what a client means by 'having sex' or that a client knows what the provider means by 'sex': people can have sex together and on their own in many different ways.
- ▶ **Every client is different** and will bring their unique perspectives and experiences. This will affect communication, compliance and therefore outcomes.
- ▶ **Share choices involved in sexual decisions:** The provider's role is to help people be aware of the choices involved in sexual decisions (both the life-enhancing and negative ones) in a non-judgemental way. It is vital to avoid making assumptions based on sexual orientation, sexual practices and/or gender stereotypes.



- ▶ **How to experience and give pleasure:** What is often missing in clients' interactions with health professionals is information about how to have positive sexual relationships, how to experience and give pleasure and how to get the most from intimate relationships. Many people have limited knowledge about their bodies. This prevents them from enjoying their own bodies, communicating with a partner what feels good and knowing how to seek and give pleasure. Providers must understand sexuality and sexual pleasure and be aware of the most common physical and emotional problems faced by their clients of all sexual diversities (both young and adults) in their sexual lives in order to support them to be sexually empowered and enjoy sex.
- ▶ **Respect clients' choices:** To enjoy sexuality, autonomy and individuality are essential. The client may not always make the choice that the provider would make in their position, but the provider should respect their decision. People should walk away from a consultation feeling informed, confident and positive about their choices, rather than ashamed or fearful.



# EXERCISE 1

## Developing a language that works for you



30 minutes

### Materials:

- ▶ Two tables, flipchart papers, marker pens

Introduce the exercise by explaining that it's important that healthcare providers and health promoters develop a language for talking about sex and sexual pleasure that feels comfortable and appropriate within their work context. The words that providers choose to use (or not use) will vary hugely depending on cultural differences and personal preference.

Divide participants into small groups of three to four people. Ask them to brainstorm on each statement below. Alternatively, this could be done individually as a self-reflection and development exercise.

- ▶ All the words you can think of for sex: words that describe sexual activities, behaviours and expressions.
- ▶ All the words you can think of to describe good sex.
- ▶ All the words you can think of to describe bad sex.

Once the groups have completed this activity, together, look at the words on each sheet. Ask participants to circle all the words that they would feel comfortable using with A) friends B) colleagues C) clients. Encourage them to reflect on the differences and difficulties they may have in using some of these words. Ask participants to consider these questions:

- ▶ What is it about them that is difficult/awkward/offensive?
- ▶ Which of these activities and behaviours would you feel comfortable talking about in a counselling session?
- ▶ Which words would you use to describe sexual activities when talking to clients?
- ▶ Would you use different words depending on the client's age, gender, sexuality or socio-economic background?
- ▶ Would you feel confident describing the pleasures and risks of each of these sexual activities to a client, if asked?
- ▶ How might this kind of knowledge be useful to you in counselling sessions? Think about when it might be useful to encourage clients to experiment with new ways of having sex or expressing intimacy, love or desire.
- ▶ On a scale of 1-10, what is your comfort level while doing this activity?

## EXERCISE 2



30 minutes

### Terminology and words to use and avoid - do's and don'ts

#### Materials:

- ▶ Two tables, flipchart papers, marker pens

### Don'ts

- ▶ Boys and girls
- ▶ Promiscuity
- ▶ Virginity/abstinence
- ▶ Sex = penis in vagina/anus
- ▶ Risky behaviour and critical language
- ▶ Assumptions that some sexual acts are weird
- ▶ Prioritize heterosexuality, with sexual diversity as an add-on or omitted
- ▶ Consider sexual behaviour solely in the context of health outcomes
- ▶ Make a distinction between homosexuality and heterosexuality
- ▶ Sexual orientation is about sex
- ▶ Pleasure and orgasm are the same
- ▶ Everyone wants sex
- ▶ Everyone can have the same kind of sexual experiences or bodily functions
- ▶ Make judgemental or sweeping statements about young parents, promiscuity, not having had sex yet, abortion, sexual violence etc.

### Do's

- ▶ People of all genders - try to avoid binary descriptions of gender
- ▶ No value judgement of people's sexual (or lack of) activity
- ▶ Engage in a critical discussion of what these terms mean
- ▶ Celebrate all kinds of sexual activities. These include – but are not limited to – oral sex, penetrative vaginal sex, penetrative anal sex, using a sex toy, masturbation, kissing and sexual contact (touching intimate areas)
- ▶ Non-judgemental, unless it is non-consensual sex
- ▶ Embrace an open, accepting view of people's different identities and preferences
- ▶ Integrate sexual diversity in all lessons on sexuality
- ▶ Include confidence, empowerment and pleasure
- ▶ Recognize the spectrum and fluidity of sexual orientation
- ▶ Make a distinction between attraction and having sex
- ▶ There are many ways to enjoy sexuality without having an orgasm, but people, especially women, need to know how to reach orgasm
- ▶ Some people are asexual – sex is not the same for everyone
- ▶ Be inclusive e.g. people with disabilities
- ▶ Acknowledge and respect that clients may have had these experiences, including sexual violence and abortion.

## EXERCISE 2 CONTINUED...

### Talking points

#### **TIPS** for service providers when talking about sex and sexual pleasure:

- ✓ Be aware of your body language – this should be in line with what you want to say or how you want to respond. Remember that you can convey judgement not only through your words but also in your facial expression and tone of voice.
- ✓ Use neutral language and be careful not to use the word ‘normal’.
- ✓ Use language that is positive, inclusive and respectful. Your language should convey the message that we all have the right to enjoy sex on our own and with a partner, without the risk of harm.
- ✓ Don’t use vague descriptions – be precise.
- ✓ Understand your relationship with your client (consider power, gender and age).
- ✓ Only discuss sex and sexual pleasure when it is appropriate and you have good reason to do so.
- ✓ Talking about sexuality doesn’t just mean talking about behaviour but rather what this means to the person(s) involved.
- ✓ Consider the social context in which sexual behaviours take place.
- ✓ Adopt an inclusive, holistic approach: sexual orientation and gender identity are essential parts of oneself.
- ✓ Talking about sex also entails discussing sexual and gender expression, rights, relationships and families, physical and emotional pleasure and pain, and sexual values and attitudes.
- ✓ Address sexual pleasure as well as sexual abuse.

## EXERCISE 3



30 minutes

### How to be proactive in talking about topics such as sexual pleasure and sexual desire

- ▶ Ask the group to get into pairs. Ask one of them to role play the client and the other one the provider. They need to imagine that they are in a service delivery setting discussing sexual health issues. Together, the pair decides what the situation is, and the client's gender, age and sexual orientation.
- ▶ The provider has five minutes to start the conversation with the client about sexual pleasure.
- ▶ After five minutes, the pair swaps roles.
- ▶ The pair gives each other feedback.
- ▶ Discuss in plenary the challenges and opportunities in discussing sexual pleasure.

#### Notes for facilitator

There is no standard set of questions that providers can ask in a session with their client to open up conversations about sex and support them to develop confidence in their sexuality. Providers need to start by getting to know more about them, finding out what's important to them and how they feel about sex, sexuality and relationships.

There are, however, some simple exploratory questions that can be used in any counselling session when health professionals want to begin a conversation about sex and sexuality. These will help tease out a discussion on sexual enjoyment, pleasure, discomfort and pain. Questions that providers could ask include:

#### Openers: simple, exploratory questions to get started

- ▶ *Have you had any sexual relationships in the last six or twelve months? Is that with men, women, or both?* (The type of sex – anal, oral, vaginal etc – is also important to determine the risk of infection and to provide specific advice on safer sex).
- ▶ *And how's that going?*
- ▶ *Do you have any other sexual partners at the moment?*
- ▶ *How has your sex life changed since your condition started/before your HIV/STI diagnosis/before you got pregnant?*
- ▶ (For sex workers) *How is your work going at the moment? Are you enjoying it?*

## EXERCISE 3 CONTINUED...

As the conversation develops, health professionals can reflect back to the client how they sound as they talk, for example:

### Reflective questions

- ▶ *You sound upset about that?*
- ▶ *You sound ok about that?*
- ▶ *Is that a problem for you and your partner?*
- ▶ *What impact is that having on your sex life?*
- ▶ *You are smiling! Is that something that makes you happy?*

### Other proactive questions

- ▶ *Do you enjoy sex?*
- ▶ *Do you hear other people talking about enjoying sex? What kinds of things do you hear? What were you told about sex when you were younger/before you got married?*
- ▶ *Do you think that people need to have sex for a marriage or relationship to work?*
- ▶ *How does someone/a couple go about having a good sex life? What does this entail?*
- ▶ *What kinds of touch do you enjoy? Are there any intimate or sexual activities that you'd like to do more of/try out with your partner(s)?*

### Other talking points

Numerous factors can have a negative impact on a sexual relationship, ranging from physical and emotional issues to past sexual experiences and communication problems. See page 62 for an example of how providers might discuss pleasurable sex with their clients, by asking them about the issues that hinder and stimulate sexual play and pleasure for them. Providers can then support clients to weigh up these issues and decide how they could increase positive, stimulating experiences and address negative ones.

## How to talk about sexuality

This is an example of the process of communicating about sexuality from WHO's recommendations on 'Brief sexuality-related communication' (BSC). Available at: [http://www.who.int/reproductivehealth/publications/sexual\\_health/sexuality-related-communication/en/](http://www.who.int/reproductivehealth/publications/sexual_health/sexuality-related-communication/en/)

**Attending:** setting up the relationship with the client. While BSC depends on the context and needs of the individual client, there are some typical questions that healthcare providers can use in a socially appropriate manner to introduce the subject of sexual health, such as, "Do you have any questions or concerns about sexual matters?"

**Responding:** asking questions that open up the conversation about sexual health and sexuality, such as, "Are you satisfied with your sex life?"; "Is your sex life going as you'd like?" or "How do you feel in your sexual relationships?"

**Personalizing:** identifying the existence of sexual concerns, difficulties, dysfunctions or disorders and the dynamics between these, such as, "In which ways do you find using condoms difficult?"; "Some people who have had a particular problem (e.g. cancer, hypertension, diabetes or HIV treatment) tell me that they've had sexual problems. How about you?"

**Initiating:** providing information and, with the client, identifying steps that need or could be taken to improve the situation.

## Sexual problems

Here are some specific suggestions for clients experiencing sexual difficulties. These suggestions will, however, only be useful if the provider has obtained a complete and accurate picture of the problem.

### For women and girls

- ▶ In some societies, it is unusual for women to seek help directly. Instead, her partner may seek help on her behalf.

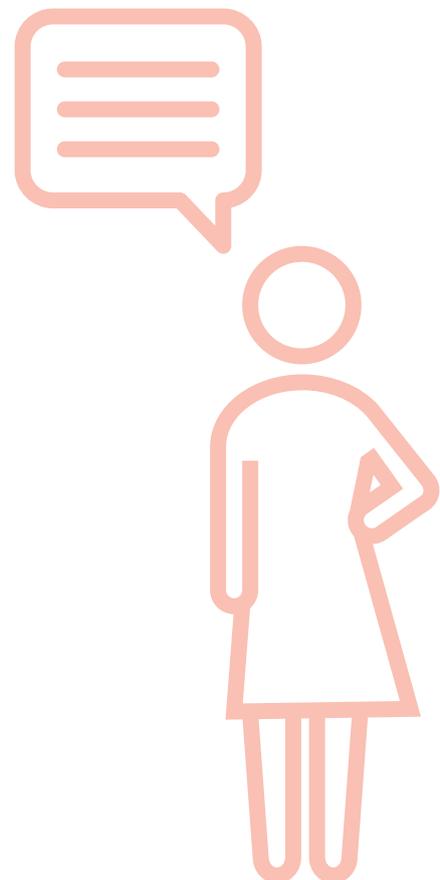
- ▶ Common problems for women are painful intercourse and an inability to reach orgasm. With painful intercourse, it is important to identify the cause of the pain. If it is a physical cause, it should be dealt with immediately.
- ▶ It is essential to know whether the woman/girl is aroused at the time of intercourse or foreplay and, if so, whether she is lubricating sufficiently. If not, the provider could suggest that foreplay is prolonged or that she explores what excites her, regardless of whether she has intercourse or not. This may be difficult to suggest in some cultures where 'dry sex' is prized or where women's pleasure is not valued. Sometimes the speed or position of entry can cause pain. The health professional could advise experimenting and allowing more time for entry.
- ▶ For a woman/girl who has difficulty reaching orgasm, it can be useful to suggest that she examines herself first and clarifies, with the provider, any misconceptions she may have about her body. The provider can then encourage her to touch herself and discover which parts of her body give her pleasure. When she feels ready she can be encouraged to stimulate herself sexually, not necessarily to have an orgasm, but simply with the aim of giving herself pleasure. The provider can explain that while reaching orgasm is important, it may not have to be the focus of her and her partner's sex life. If the woman feels confident, she can then explain to her partner what she enjoys.
- ▶ Outercourse – the sexual act without penetration – can be a way for the couple to have a pleasurable sexual relationship.

### For boys and men

- ▶ Sexual problems in men usually relate to difficulties in getting or keeping an erection, or ejaculation that is too quick/premature or does not happen.
- ▶ In this situation, it is useful to check there are no physical problems, for example a tight foreskin, that can be resolved by qualified medical staff.



- ▶ In most other cases it can be useful to encourage the man to masturbate, if that is acceptable to him. Once he has an erection, he can allow it to subside before he starts stimulating himself again. He can do this several times, so he understands that he can gain and lose an erection during the course of sex with a partner, without it being 'disastrous'. Understanding sexual feelings without having an erection can help him gain confidence in his ability to attune his state of sexual arousal to his partner's. Provided it is acceptable to both partners, the man can be involved once he has gained some confidence in being able to do this alone.
- ▶ The partner can help stimulate the man and try penetration when both people want to. They can start doing this without moving, so the man can get used to the sensation. When both feel confident they can begin to move. The partner needs to take some responsibility for this, until the man has gained confidence, gets used to and appreciates the sensations the interaction can produce for both.



# MODULE 6



## The *Pleasuremeter*: a tool to assess the links between sexual health, sexual rights and sexual pleasure in sexual history taking

Sexual history taking represents an opportunity to evaluate the different links between sexual pleasure, sexual health and sexual rights. In this module, the *Pleasuremeter* is presented as a tool to discuss these links while taking a client's sexual history. The *Pleasuremeter* is not a validated quantitative scale, but rather a tool that serves as a script to guide the process of sexual history taking, using the pleasure approach. Participants can read this module, and a facilitated group discussion can support a better understanding of how to use the *Pleasuremeter*.

### By the end of this module, participants will have:

- ▶ Understood how the *Pleasuremeter* can be used to address the links between sexual health, sexual rights and sexual pleasure in sexual history taking.

6

## Key information

- ▶ Sexual history taking is an essential part of general medical practice and SRH service delivery. Sometimes it is the only window of opportunity to provide counselling on sexuality to clients who seek SRH services. Providers usually focus on obtaining information about the client's risk factors, however, this limits the scope of the counselling and education provided. Some of the most commonly assessed 'sexual risk factors' or 'variables associated to risk' are:
  - Date of last HIV test
  - Number of HIV tests in the last year or two
  - Number of sexual partners
  - Unprotected anal/vaginal intercourse or oral sex
  - History of diagnosed and treated STIs
  - History of violent relationships
  - History of substance use when engaging in sexual relationships
  - History of exchanging sex for drugs or money
  - History of abortion
- ▶ Inquiring exclusively about these variables not only focuses the conversation completely on the risks associated with sexual relationships, but also means that certain forms of sexuality can be stigmatized along the way. A specific identity or behaviour (such as having multiple casual partners) does not determine risk *per se*. Risk is related to behaviours that happen outside the sexual rights framework: when there is a lack of consent, confidence, self-determination, safety, privacy and communication/negotiation in sexual relationships. Providers need to be aware that the stigma surrounding certain types of behaviours and identities influences the ways in which services are delivered to many individuals.
- ▶ The *Pleasuremeter* is based on two motivational interviewing techniques (asking open-ended questions and using scales to assess readiness of change<sup>9</sup>) and the GAB's definition of sexual pleasure. This definition recognizes the physical and psychological dimensions of pleasure and the possibility of experiencing it by oneself or with partners. It also identifies six factors that represent the links between sexual pleasure, sexual health and sexual rights:
  1. Self-determination
  2. Consent
  3. Safety
  4. Privacy
  5. Confidence
  6. Communication/negotiation
- ▶ The *Pleasuremeter* is used to help service providers not only evaluate if an individual is able to experience physical and psychological satisfaction/enjoyment in their erotic practices, but also to assess these six factors as they relate to sexual experiences in the last 12 months. These factors are then used as entry points to discuss ideal sexual experiences in counselling. The *Pleasuremeter* relies on scoring each factor from 1-10 as well as rating the level of psychological and physical satisfaction/enjoyment experienced in sexual relationships. Open-ended questions should be used to spark reflection throughout the counselling session.
- ▶ Implementing the *Pleasuremeter* for sexual history taking does not mean that specific questions about HIV testing, STI symptoms or substance use cannot be asked. Rather, it aims to create a space in which providers can talk to clients about issues connected to sexual pleasure, sexual health and sexual rights in the process of taking their sexual history, and not only about risks and diseases. In the section relating to safety in the *Pleasuremeter*, the provider can raise specific questions related to HIV/STI prevention, as shown on page 67.

- ▶ In clinical settings, the amount of time that SRH service providers have for sexual history taking varies. Depending on how much time the health professional has to provide counselling to the client, the *Pleasuremeter* can be adapted by asking fewer or more questions.

## How to use the *Pleasuremeter* effectively

### 1. Challenge assumptions, stereotypes and stigma

Human beings make assumptions all the time. We think certain things about a person based on how they look, the way they dress and how they talk. These thoughts can determine the way we treat someone. When it comes to providing sexual and reproductive health services, clients should not be judged on any basis. Variables such as their socio-economic status, age, sexual orientation, gender identity, number of sexual partners, race or ethnicity, should not be associated with risk or stereotypes, and should not give rise to service providers' unfriendly attitudes. SRH providers have a responsibility to treat everyone with kindness and in a non-judgmental way.

### 2. Ask about pronouns and sexual identity

Before providers ask questions related to general demographics, such as age, ethnicity, race or medical history, they should ask the client's name and preferred pronouns: he/him, she/her or they/them. This is because gender identity does not necessarily match gender expression: a person might publicly express as a man or woman, but their identity might be different or non-binary.

Afterwards, the counsellor can ask the client the sex that was assigned at birth, their sexual orientation and gender identity. The client should be given the opportunity to say "none" or "other" in these last two categories. Questions include:

- ▶ *What is your sexual orientation? Gay, bisexual, heterosexual, other or none?*

- ▶ *What was your sex assigned at birth?*
- ▶ *What is your gender identity? Male, female, transgender, genderqueer, non-binary, none or other?*

### 3. Evaluate previous sexual experiences with the *Pleasuremeter*

After completing these questions, the *Pleasuremeter* can be explained in the following way:

*"Now I'm going to show you a table that has different factors associated to our sexual health and wellbeing. I want you to think about your sexual encounters in the last 12 months and score each factor from 1 to 10 that corresponds to your actual experiences in that area. After you've rated the factors, we will have a little chat about each of them. Please let me know if you feel uncomfortable about answering something in particular or if you don't understand something."*



| Think about all your sexual relationships in the last 12 months and score the following questions:               |   |  |   |  |   |   |
|--|---|--|---|--|---|---|
| Physical and psychological satisfaction / enjoyment  | Self-determination  | Consent  | Safety  | Privacy  | Confidence  | Communication / negotiation   |
| From 1 to 10, how much did you enjoy/ how satisfied were you with your sexual experiences in the last 12 months? | From 1 to 10, how many of these sexual relationships did you freely choose to have? | From 1 to 10, of all the things you did with your sexual partner(s), how many did you specifically agree to? | From 1 to 10, how safe did you feel in your sexual relationships? | From 1 to 10, how much privacy did you have in all your sexual encounters? | From 1 to 10, how confident did you feel to express yourself with your partner(s) while having sex? | From 1 to 10, how would you rate the quality of your communication and negotiation (of what you wanted and didn't want to do) with your partner(s)? |

After the client has completed the *Pleasuremeter* table, here are some questions that the provider can ask to promote discussion in each area, and to obtain relevant sexual history information in the process:

**Physical and psychological satisfaction/enjoyment:** *Did you have relationships with cisgender males, females or both? With transgender men, women or both? Can you tell me if you had anal, vaginal, oral sex? Approximately how many partners did you have? How do you usually meet your partners? Can you recall any factors or situations that made you lean more towards 1 or 10? Was the satisfaction/enjoyment the same beforehand (when you were planning the encounter or getting ready), during and after sex? Can you think separately of physical and psychological satisfaction/enjoyment in your sexual encounters, or not? Was there anything in particular that made your relationships more or less pleasurable?*

**Self-determination:** *If you select 1 in this section, that would indicate that you were forced to have all your sexual relationships. Conversely, if you select 10, that would mean you chose to engage freely in all of them. Were you forced or did you feel forced to engage in any sexual relationships over the last year?*

**Consent:** *Was it difficult for you to reach consensual agreements about what you wanted and didn't want to do with your sexual partners? Were the consensual agreements specific about what you and your partner wanted to do? Was consent given freely at all times? Did you feel you could change your mind if you wanted to?*

**Safety:** *What made you feel safe or unsafe in your sexual relationships? What was the method of protection you used most often? In which situations did you feel safer? In which situations did you feel less safe? What did you find most difficult about having safe sexual relationships? Did you experience any problems related to STIs that made you feel less safe? What actions did you take afterwards to ensure your safety (such as HIV testing and medical check-ups)? Did substance use influence your safety at some point?*

**Privacy:** *What were your biggest challenges in ensuring privacy? Were there factors that you had no control over when seeking privacy? Did you have privacy in your sexual encounters with your partners and when you masturbated?*

6

It's worth pointing out that some people like to observe their partners during sexual activity or exhibit their sexual activity to their partners. This is only valid, however, when it is consensually agreed and does not violate the rights and privacy of others.

**Confidence:** *Were there things that limited the ways in which you wanted to express yourself during sex? Did a negative thought (for example, concerns about body image) make you feel inhibited in terms of self-expression? Did your partner say or do something that made you feel less confident?*

**Communication/negotiation:** *Were you able to talk to your partners about what you wanted to do in each encounter? Were you able to tell them when something was pleasurable or not? Were you able to propose new things that you wanted to try?*

#### 4. Reflect on how to improve sexual experiences with the *Pleasuremeter*

After discussing each specific factor, the provider should ask the following questions to prompt the client to reflect on ideal sexual experiences at the end of the session:

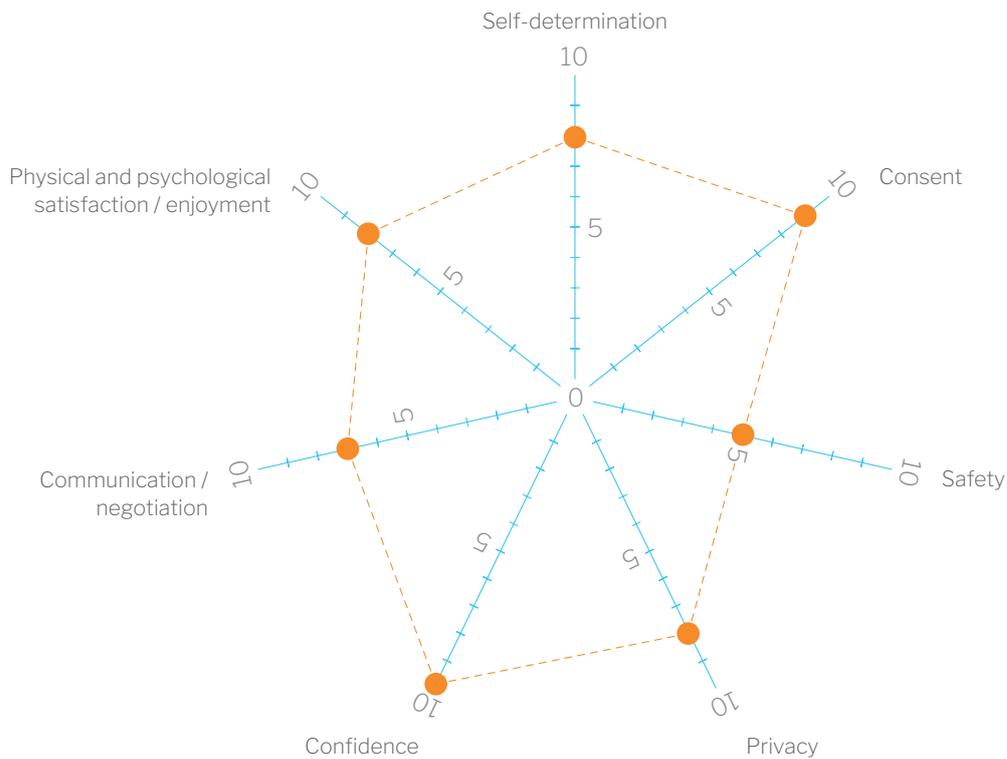
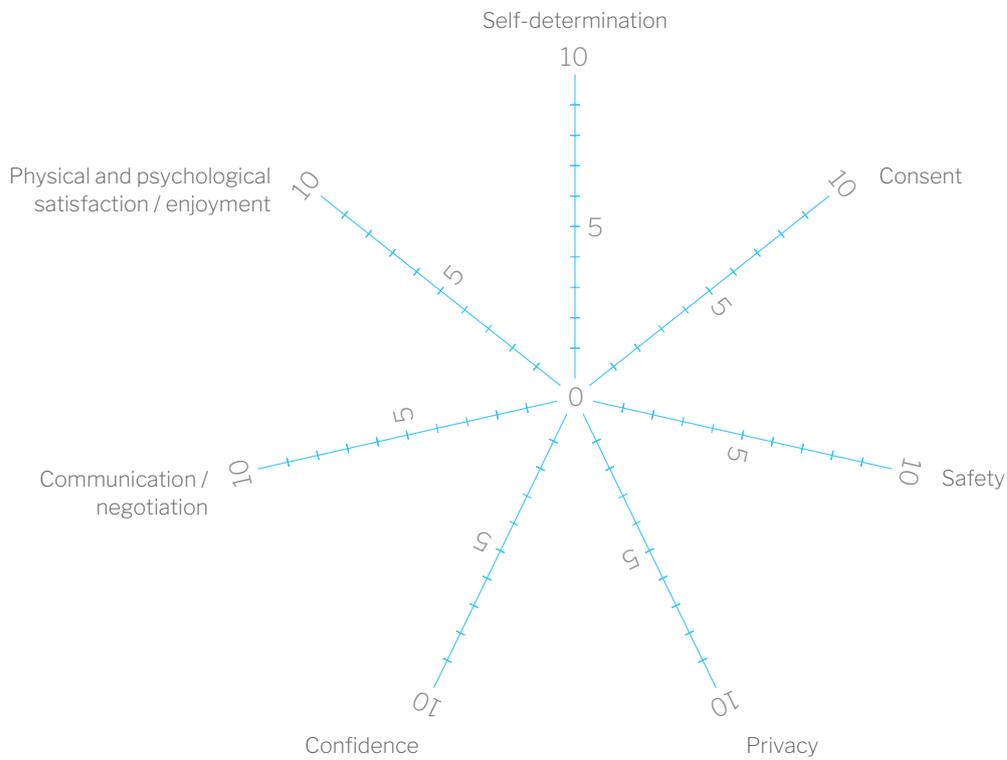
- ▶ *Out of all the factors that we've discussed, let's look at the ones that had the highest scores and the ones with the lowest. What is needed for the factors with the lowest scores to move towards the highest in sexual relationships in the future?*
- ▶ *Of all the factors in the *Pleasuremeter* table, which ones are most important for you to have good sex?*
- ▶ *Are there other factors that we didn't discuss that would enable you to have better sex?*

### TIPS for service providers:

- ✓ An innovative approach to sexual history taking, the *Pleasuremeter* is designed to be used by service providers to explore and obtain a client's subjective view on experiences related to sexual pleasure, sexual health and sexual rights. The results of the *Pleasuremeter* are intended to evaluate the client's sexual experiences, identify gaps, and ultimately contribute to a client-centred plan based on a sex-positive and pleasure approach. The tool is meant to supplement, not replace clinical assessment.
- ✓ It is important to note that the assessment using the *Pleasuremeter* will raise the expectations of the client in addressing issues they may have that inhibit their enjoyment of sex or/and their sexual relationship. Service providers need to be prepared and willing to follow up on these issues and/or be able to refer the clients to others if deemed appropriate.



**Figure 2:** An example of a *Pleasuremeter* diagram that can be used to support the discussion with the client about ideal sexual experiences.



# MODULE 7



## Case studies on implementing the pleasure approach in the provision of sexual and reproductive health counselling

This module introduces case studies to illustrate how to implement the pleasure approach in counselling related to the provision of the following sexual and reproductive health services: prevention of HIV and other STIs; treatment of HIV and other STIs; contraceptives; abortion; perinatal care; and care during the menopause. Each case study features situations that could happen in different parts of the world. It is therefore important to bear in mind the various legal and social contexts where these scenarios could take place.

### By the end of this module, participants will have:

- ▶ Explored the different ways to introduce sexual pleasure and link it with sexual health and sexual rights within the counselling and information provided to clients in the SRH delivery setting.

7

## Key information

- ▶ Various opportunities may arise for SRH service providers to conduct counselling related to these services based on the pleasure approach. For those providers who specialize in HIV/STI testing, for example, the pre- and/or post-test counselling sessions are usually a good time. The same applies to those providers who exclusively offer counselling to women seeking an abortion. Sometimes, if a client is seeking access to contraceptives or condoms, the window of opportunity for counselling might be shorter but nonetheless important. Medical doctors or nurses who see clients for services such as STI diagnosis and treatment, HIV treatment and care, abortions, prenatal care and gynaecological examinations have significant opportunities to provide counselling based on the pleasure approach.
- ▶ In many cases, the opportunity to conduct counselling related to SRH services arises during sexual history taking. The *Pleasuremeter* can be used as a tool to address sexual pleasure and its links to sexual health and sexual rights during this process. See page 64.
- ▶ Providers can be proactive in discussing sexual pleasure with their clients. Many providers feel nervous about this because they are worried about the reaction they will get or because they share their client's feelings of embarrassment about sex. But if providers have built a good rapport with their client and established a safe space it is very unlikely that clients will be offended by their questions. Many clients will feel relieved to finally have an opportunity to talk about an issue that matters to them, and have someone listen to and understand their questions and concerns. If clients don't want to answer providers' questions or talk about sex and sexuality, that's fine – the conversation can move on. Providers may find it useful to share their experiences with colleagues and reflect on what worked and what didn't.
- ▶ There are certain situations in which a SRH service provider might feel that talking about issues of sexual pleasure is not appropriate. For example, when dealing with clients who report being survivors of sexual- or gender-based violence (SGBV), or with women who have undergone female genital mutilation (See Annex 2B, page 115, for issues of sexual pleasure and FGM). Yet discussing sexual wellbeing in consultations with those who have experienced SGBV is an integral part of empowering survivors to make informed, healthy and positive choices about their sexuality: "Choices that are neither born of, nor shaped by, the scars of their past experience, but are informed by the knowledge that it is appropriate to move on with life – indeed, that it is expected that one would do so, and that doing so is their entitlement....There is life after sexual violence."<sup>9</sup> In many cases, SRH providers are the first point of contact for survivors of SGBV, and they should adopt a positive attitude to discussing issues of pleasure in the context of their clients' sexual health and sexual rights. While the vast majority of survivors of SGBV are women, men, children and young people of all genders also experience sexual violence. Transgender populations are particularly at risk of gender-based violence because they challenge traditional gender norms and roles.
- ▶ When a client only wants specific answers to medical or sexual health questions that might not be related to sexual pleasure, the provider might find it difficult to introduce the pleasure approach in the counselling session. Service providers should implement the pleasure approach in line with their client's needs, so if the opportunity does not arise, they should not force it in the conversation.
- ▶ Women often have less access to information about sexual pleasure and wellbeing than men (particularly in low-income countries) so it is essential that medical providers working in maternal and women's health know about women's sexual anatomy, physiology and sexual response, and are able to communicate



this information to their clients. One opportunity to proactively introduce and explain sexual pleasure to women is during gynaecological examinations. See Annex 2A, page 113.

- ▶ Some sexual problems, such as sexual dysfunctions (vaginismus, dyspareunia, erectile dysfunction, premature ejaculation and anorgasmia), compulsive sexual behaviour, and those associated with SGBV, require specialized therapeutic interventions. When providers of SRH services, such as prevention and treatment of HIV and other STIs, family planning, abortion and maternal health, come across clients who are experiencing such difficulties, they should refer them to specialized services, if they are available and needed by the clients.
- ▶ Sexual dysfunctions are very common, and sometimes the physical or psychological pain experienced by people in their sexual relationships is related. Providers should always be ready to listen to any difficulties raised by the client, support them and refer them to available resources or professionals.
- ▶ When providing counselling related to SRH services in challenging legal or social environments, service providers should balance different practical, ethical and legal factors in order to support their clients. See Section III of 'Fulfill! Guidance document for the implementation of young people's sexual rights' (IPPF and WAS, 2016) for more information.

## EXERCISE:



45 minutes

Case studies

### Materials:

- ▶ Handouts with case studies

Divide participants into small groups. They can choose to read and discuss those case studies that are most relevant to their work. We understand that similar situations are often more complex than in the case studies described below but nevertheless hope that participants will find them useful.

For each case study, ask participants to think about and discuss the following:

- ▶ What are the strongest connections between sexual health, sexual rights and sexual pleasure that you can think of?
- ▶ Which questions could you ask the client featured in the case study in order to address these links during counselling related to the service?

We have suggested some questions and points that service providers could use to implement the pleasure approach. Encourage participants to feel free to think of, and discuss, other possibilities.

## CASE STUDY 1

### STI testing and/or condom use

A 20-year-old man comes into a clinic inquiring about a possible symptom of an STI. He tells the counsellor that he is very anxious due to a pimple that has appeared on his penis. He reveals that he has had anal sex with two male partners around his age, and that he did not use condoms all the time.

Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client

#### Entry points to talk about self-determination, consent, safety, privacy, confidence and communication/negotiation for sexual pleasure

*What does good sex mean to you? List some elements related to your ideal sexual relationships. How many have been present in your sexual relationships so far and how many haven't? How could you incorporate the elements that are missing?*

These are good questions to draw out the relevance of self-determination, consent, safety, privacy, confidence and communication/negotiation for sexual pleasure. In this case study, in particular, they are entry points to discuss:

- ▶ The different expectations and assumptions around sex between two men and to explore if these expectations and assumptions shape the quality of the relationships for the client.
- ▶ If the client has felt pressured to have sex in a particular way.
- ▶ If the client has felt pressured not to use a condom.
- ▶ If the client is comfortable talking to his partners about what he likes and doesn't like sexually.
- ▶ If the client is physically and emotionally enjoying his sexual relationships.

#### Integrating the concepts of safer sex and pleasurable sex

*How can safer sex be pleasurable? How can you incorporate condom use in sexy ways?*

These questions can help explore the conversations that have taken place between the client and his partners about condom use. They can lead to a discussion of whether the client feels comfortable or not bringing up the topic and why, and how he can ensure protection and pleasure across a variety of sexual practices (oral sex, anal sex and rubbing). It is also important to discuss with the client options to integrate condom use during foreplay (for example, while rubbing each other's bodies), the different types of condoms that can enhance sexual pleasure (ultra-thin, extra lubricated, scented, flavoured) and the use of lubricants to increase pleasure during anal intercourse.

#### Talking about pleasure in preventing STIs

*How can talking about pleasure prevent STIs? How can exploring our own body and our partners' bodies prevent STIs? How does this relate to other actions that allow us to claim our right to pleasure and our partners' right to pleasure?*

These questions help the client understand the importance of talking to his partners about pleasure as a basis to negotiate protection against STIs, and exploring his body and his partners' bodies for the same purpose. While discussing these questions, the counsellor can mention that STIs sometimes manifest without any symptoms, and that some skin conditions that appear on the genitals are not necessarily symptomatic of an STI, however, the only person who can determine this is a medical doctor.

The provider should say that caring for one's body and seeking pleasure starts with a conversation between the client and his partner about what they want and how they want it, followed by exploring each other's bodies and negotiating protection in each sexual practice (oral, anal sex etc). This is all related to feeling confident and empowered not only sexually but also maintaining adequate care after sex, such as going to regular medical check-ups and testing. The counsellor can also point out that knowing one's HIV status is vital in order to take better care of oneself and one's partners, and to ensure pleasure with protection.

### **Considerations about the context: the impact of homophobic stigma and discrimination**

Homophobic environments and discrimination can affect the ways in which LGBTIQ people make certain decisions about their sexual health and their level of access to services. In countries with repressive legal environments, many gay people and men who have sex with men avoid accessing sexual health services out of fear of being judged or stigmatized for their sexual behaviour. In other situations, homophobia can fuel shame, which is often a barrier to people using protection. In this case study, not enough information has been provided about the country's legal environment, but this has to be taken into consideration when incorporating the pleasure approach in service delivery.

## **CASE STUDY 2**

### **Condom use**

A 19-year-old woman comes into a clinic looking for sexual health counselling. She explains to the medical provider that her boyfriend does not want to keep using condoms because he says he cannot "feel her" that much when they use them. She is concerned because they have only been together for three months and she feels they have not developed enough trust to stop using them. She asks the provider how she can motivate her partner to use condoms.

### **Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client**

#### **Negotiation and consent: key for pleasure and protection**

*Pleasure and protection are a matter for two people: how can you negotiate them with your partner?*

The provider needs to explain to the client that using condoms (or any form of protection) in a sexual relationship is an issue that involves two people. If one person wants to use them and the other doesn't, then this doesn't constitute consent to have sex. The couple must always agree the limits defining their sexual relationship. This means discussing: What is pleasurable for you, what is pleasurable for me and what do we agree to do together? What form of protection do we want to use?

The provider may want to add that if the client's partner is reluctant to use condoms, then it's helpful if she knows a few facts so she can put forward a convincing case for their use.

*How important is it to keep consent in mind when negotiating protection with your partner?*

Everyone has the right to decide what they want to do in their sexual relationships and what they don't want to do. If this client's partner refuses to use protection, the client also has the right to refuse to have sex with him. The provider should emphasize the client's right to consent to having sexual relationships with or without protection: this is related to her right to make decisions about her sexual health and her body.

### **Exploring diverse forms of sexual pleasure for sexual safety**

*Sex beyond penetration can be a lot of fun! How can you explore different types of pleasure together?*

Many people grow up thinking that sex equals vaginal or anal penetration. But sex is much more than that. There are different ways to experience sexual pleasure – from kissing, rubbing in diverse ways, mutual masturbation, oral pleasure and massaging to using sex toys – that can be explored with one's partner. When a male partner says that he can't enjoy sex with a condom, it would be beneficial for the client to talk to him about the variety of ways, beyond penetration, that they can explore pleasure.

*There are different types of condoms, and a variety of sexy ways to use them. How can you explore these different varieties with your partner?*

Some people don't realize that there is a wide range of condoms to explore – with different types of thickness, sizes, shapes, scents and flavours – that can enhance pleasure. Going to a sex shop is a good idea to explore these varieties together. Condoms can also be integrated in sexy ways during foreplay. The client may not have tried female condoms, which are inserted into the vagina or anus, rather than rolled onto a penis. Female condoms can be pleasurable for both of them. This may suit some people who find that male condoms are too restrictive, or affect their sensation. For some women, the female condom provides extra stimulation.

## **CASE STUDY 3**

### **Living with HIV**

A 35-year-old woman who is living with HIV is talking to her medical provider during an annual medical visit. She tells her provider that she has not had sex since her diagnosis two years ago. She has recently met someone she likes a lot. She'd like to have sex with him but doesn't know how to bring up the issue of her HIV status.

[Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client](#)

#### **Considerations about the context: stigma around HIV and restrictive legal/social environments**

*What is the stigma surrounding sexual pleasure and HIV? Where can we see this stigma reflected? Which fears or concerns usually prevent people living with HIV from fully enjoying their sex lives? What is the impact of the legal or social context on stigma?*



The provider should discuss with the client the different layers of stigma that exist around pleasure and HIV. The specific stigma around HIV is connected to the taboo of sexual pleasure, as many people believe that acquiring HIV is a result of ‘shameful’, ‘immoral’ or ‘dirty’ sexual behaviour. This stigma can be present in beliefs, attitudes and discrimination towards people living with HIV and repressive legal environments. Due to the stigma and myths about HIV, the experience of receiving a positive HIV result is often accompanied by overwhelmingly negative feelings towards one’s sexuality. People living with HIV may think “no one will love me now”, “I will feel dirty all my life”, and “I won’t be able to enjoy sex any more”. Talking about these fears will help to overcome them. Human rights are universal: everyone – regardless of HIV status – has the right to enjoy sexual health, including a pleasurable sex life.

Legal contexts with regard to partner notification for people living with HIV vary widely around the world. In some countries, partner notification laws require that when a person tests positive for HIV, the client or service provider has to notify the partners. In other parts of the world, not disclosing one’s HIV status to a partner is criminalized. In this case study, the provider should be aware of the legal context regarding partner notification.

### **Communicating HIV status for sexual protection and pleasure**

*How comfortable would you feel sharing your status with your prospective partner? How important is this for your safety and your partner’s safety?*

Being aware of one’s HIV status is key for prevention. The earlier HIV is detected, the better, because people can access treatment, care and support. If the person living with HIV adheres consistently and correctly to antiretroviral treatment, the virus can become ‘undetectable’ so that the chance of transmitting HIV to someone else becomes practically non-existent.

Everyone has the right and responsibility to ensure their own safety and their partners’ safety when having sexual relationships. The provider in this case study can help the client to evaluate the pros and cons of disclosing her HIV status to her new partner, in accordance with the legal context of the case, and offer support to tell her partner. The provider can also talk to her about what she will do to have pleasurable sex and minimize the possibility of transmission, such as condom use, as well as achieving and maintaining an undetectable viral load. If the client feels ready to share her status, it might be easier for her to negotiate safety and pleasure in a shared way with her partner, and they can consider other prevention options, such as pre-exposure prophylaxis (PrEP) for him, if it is available.

### **Alternative erotic practices as HIV prevention**

*How else can you have a pleasurable sex life when living with HIV?*

Beyond condom use, treatment as prevention and PrEP, non-penetrative sexual activities can always be considered to explore more dimensions of pleasure and minimize the risk of HIV transmission. Rubbing, massaging, mutual masturbation, oral sex and the use of sex toys are all options.



## CASE STUDY 4

### Pre-exposure prophylaxis (PrEP)

A 23-year-old man who is on PrEP goes to a clinic for a medical check-up, where he is routinely tested for HIV and other STIs. The HIV counsellor at the clinic asks him whether he is combining condoms with PrEP. The client states that he's been having anal sex with his boyfriend without a condom. He admits to doubts as to whether his partner is being faithful. The client also mentions that he wants to experiment sexually with other men, but is afraid to discuss this with his boyfriend.

**PrEP** is an antiretroviral (branded drug Truvada or its generic equivalent) taken once a day by HIV negative people before sex to prevent HIV transmission. PrEP is highly effective but does not protect against other STIs. Currently, it is only available in a few countries, such as the US and UK. PrEP is a tool that can be considered by everyone, regardless of gender or age, however, it is most suitable for people who are inconsistent condom users with multiple partners or the partners of someone living with HIV.

Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client

#### Communicating sexual desires and expectations, and establishing limits for sexual pleasure and safety

*How important is it to recognize and communicate our sexual desires to ensure pleasure and safety? What are your sexual expectations and assumptions when it comes to pleasure, PrEP and combination prevention (PrEP and condoms) with different partners? What are your partners' expectations and assumptions?*

For sexual pleasure to contribute to our sexual health, it is important to acknowledge our sexual desires – what we actually want to do (we may have a fantasy, but that does not necessarily mean we want to turn it into reality) – and to communicate this to our partners. We may, for example, fantasize about having sex with other people, but we might not want to do it. But if we do want to do it, it's essential that we find a way to communicate these desires to our partners, negotiate and establish limits accordingly. It is also worth thinking about the assumptions that we make about our partners, and the expectations they might have about us.

In this case study, the client is struggling to talk to his boyfriend about the possibility of having multiple sexual partners or his doubts that his partner might be having sex with other people. These are crucial issues to discuss because the couple might be having anal sex without condoms based on the assumption that both of them are on PrEP and monogamous, when in reality they are not. If one of them has sex with someone else without a condom, there is a chance of acquiring and transmitting an STI. Therefore discussions about sexual expectations, assumptions and desires need to take place within the context of PrEP. Questions that the counsellor could ask in this scenario (where the client has a regular partner and is on PrEP) include:

- ▶ Are you having anal sex with a condom or not? How and why are you making that decision?



- ▶ Are you able to talk about the limits of your relationship? Is it going to be open, monogamous, or will you have a different arrangement?
- ▶ If both of you agree to have sex with other people, how will you approach the issue of combination prevention (PrEP and condoms) with other partners? What will the agreement and expectations be, and what happens if someone breaks it?

### **Consent at all times when negotiating and setting boundaries with a partner**

*How important is it to keep consent in mind when negotiating protection with your partner?*

The issue of consent is crucial in conversations about protection with our partners. The counsellor should emphasize that the client has the right to decide to have sex with protection – he should not feel pressured into having sex without protection if his partner wants to.

## **CASE STUDY 5**

### **Contraceptives**

A young couple come to the clinic to ask for contraceptives. They recently had sex for the first time. Although it was consensual, the girl is very nervous and asks the provider whether it is normal to have pain the first time and whether it will get better.

**Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client**

#### **Exploring the links between consent and pleasure**

*How can you make links between preventing unintended pregnancy and contraceptive choice? How can contraception influence the communication between you and your partner on how to have enjoyable sex? How can you talk to your partner about the use of contraception and sexual pleasure?*

The provider needs to make sure that no force has taken place. The provider also needs to stress the importance of consent at all times during sex: the right that everyone has to protect themselves during sex, and to make informed choices regarding their bodies and their sexual and reproductive health, such as whether to have children or not, when and how many.

#### **Exploring some strategies to minimize pain and enhance sexual pleasure: relaxation, arousal and lubrication**

It is important to mention that pain is not normal during intercourse, and it is not her or his 'fault'. Penetrative sex can be painful at first, and pain during intercourse may be due to a lack of arousal. Not using contraception or condoms might also have played a big part in how comfortable the girl felt having penetrative sex. She needs to be aroused in order to enjoy sex and experience sexual pleasure. She can do this herself or her partner can do it. Women tend to report greater difficulty than men in reaching orgasm. The health professional should explain that sex can still be enjoyable and satisfying without intercourse or an orgasm. The provider should talk to the client about what makes her feel relaxed, and how she and her

partner could initiate sex (solo or together) that focuses on pleasure and intimacy. Most importantly, she needs to discuss this with her partner.

Lubricants are needed during anal sex as the anus does not lubricate. The penis and the vagina, however, naturally produce liquid when someone becomes aroused so in principle lubricants are not necessary for vaginal sex. But some people find that they don't produce enough natural lubrication to make penetrative vaginal sex comfortable and enjoyable. Artificial lubricants can enhance comfort during vaginal sex as well as reduce the risk of bleeding, which helps to limit the risk of infection. If clients are using lubricants with condoms, the provider should remind them to make sure that the lubricant is condom-compatible (i.e. water- or silicon-based). The provider must be careful not to assume that the client likes or does not like 'wet' or 'dry' sex. This can vary between individuals and cultures.<sup>10</sup>

### **Integrating the concepts of safer sex and pleasurable sex**

If a client feels that condoms reduce sensation, the provider and client should discuss the different ways in which sex can be intimate and involve skin-to-skin contact. This includes intimate touching and oral sex as well as all the ways in which people can touch, kiss, stroke and caress different parts of the body.

If a client feels that condom use prevents spontaneity, the provider could encourage the client to use this advance planning as an opportunity to talk to their partner about sex and get in the mood. They could talk about whether or not they might have sex later and what kind of sex they might enjoy having. If using condoms only to prevent unintended pregnancy, they could also explore alternative methods of contraception where no forward planning is required.

### **Addressing clients' concerns about the impact of certain contraceptives on sexual pleasure**

Some people find that using hormonal methods of contraception can reduce their sex drive and cause side-effects, such as frequent bleeding. It's important to take a client's concerns seriously about how their contraceptive method affects their desire and self-esteem rather than focusing purely on how effective each method is at reducing the risk of pregnancy.

### **Considerations about the context: access to contraception for young women**

In many countries, young people, particularly young women, face a great deal of stigma when it comes to accessing contraceptives. Even some healthcare providers or other clinic staff members can be judgemental if a young woman seeks contraceptives. This can be briefly discussed with the client by reminding her that it is a human right to access and use contraception.



## CASE STUDY 6

### Abortion

A young girl comes to the clinic. She is pregnant but doesn't want to continue the pregnancy (abortion is legal in her country). She is very worried that she won't be able to enjoy sex after the abortion.

[Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client](#)

#### Exploring sexual pleasure after an abortion

Women's feelings vary widely with every pregnancy, abortion and birth. It is not the case that all women who abort a pregnancy experience feelings of pain or deep sadness, just as all women who give birth do not experience bliss and perfect joy. There is not a right way to feel.

Apart from the abortion itself, it is important that the provider talks to the client (and her partner, if present) about sex: this includes the sex that led to the pregnancy and the sex that she may have afterwards. The client can become fertile again two weeks after the abortion. She will need to think about whether she wants to have sex again, whether she wants to get pregnant again, how comfortable she feels talking to her partner(s) about these choices, what stops her from acting on her choices and what enables her to act on her choices.

#### Some common concerns and possible responses about sexual pleasure after an abortion

CLIENT:

*I never want to have sex again!*

SERVICE PROVIDER:

*Do you mean penetrative sex or all kinds of sex? Are there other kinds of sex that you would enjoy?*

*Do you think there is anything that you would miss if you never had sex again?*

*What do you enjoy about being with your partner? What do you want from your partner right now? Can you tell him/her/them that?*

*Are there ways in which you can feel close to your partner without having sex? Are there*

*ways in which you and your partner(s) can turn each other on without having penetrative sex?*

*Are there things you'd like to try sexually? Would you be able to ask your partner(s)?*

CLIENT:

*I just want everything to get back to normal.*

SERVICE PROVIDER:

*What does that mean to you – to get back to normal?*

*Does that include having sex?*

*How do you feel about having sex?*

*How could you talk to your partner about how you're feeling?*

*Would you like to use contraception when you start having sex again? What about protection against STIs/HIV?*

CLIENT:

*I shouldn't have been having sex anyway.*

SERVICE PROVIDER:

*What do you mean by 'shouldn't have been having sex'?*

*Can you tell me a bit more about what happened and how you ended up having sex?*

*Did you enjoy the experience?*

*Would you like to have sex again in the future?*

*So, for you, having sex outside of marriage is wrong. Are there ways that you can enjoy yourself on your own or with a partner without having penetrative sex?*

### **Considerations about the context: access to abortion for women**

Abortion can be loaded with stigma. Some countries have very restrictive laws where it is virtually impossible for a woman to access a safe abortion. It is vital that counsellors do not stigmatize abortion and become part of the problem. An abortion is a deeply personal and strong life decision that a woman takes. Supporting her throughout the process will only help her come out of it stronger and healthier. Healthcare providers should also support young women who wish to access a safe abortion by connecting them to organizations that can provide legal advice, if needed.

## **CASE STUDY 7**

### **Perinatal care**

A woman comes to the clinic. She has just found out she is pregnant. She is delighted but very concerned about her relationship because she is scared to have sex in case she loses the baby.

[Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client](#)

### **Implications of pregnancy for sexual pleasure and sexual health**

Pregnancy is different for every woman. All women experience varying levels of sexual desire and sexual pleasure at this time. Many women and couples have questions that providers need to address about whether sex is 'normal' or 'safe' during pregnancy and postpartum. Providers should talk to women about sex before and after the birth. If clients do not introduce the topic, providers can try a simple exploratory question such as:

*Have you thought about what sex is going to be like for you after the birth?*

It can be useful to try and find out what sex means to the client and her partner if she has one. Questions the provider can ask include:

- ▶ *Is sex an important part of your relationship with your partner?*
- ▶ *Has your relationship changed since you got pregnant? Has sex changed for you?*
- ▶ *Have you talked to your partner about what sex is like now that you are pregnant?*
- ▶ *How does your partner feel about everything that's going on?*

Before the birth, health professionals should talk to women about how they plan to feed their baby. They should listen to any concerns or objections that women have about breastfeeding and talk through the benefits for women and children. The hormone released



during breastfeeding (oxytocin) is also released during birth and orgasm. For some women, breastfeeding can feel sensual or sexual. This is normal, and for some women, a highly pleasurable and intimate experience.

### **Self-determination and consent for sexual pleasure throughout the pregnancy**

Most couples experience changes in their intimate and sexual relationships during pregnancy. Many women find that their desire to have sex fluctuates during the different stages of pregnancy. Some partners feel closer and find this a bonding experience, whereas others struggle to reconcile their identity as 'sexual partner' with their partner's new identity as 'expectant mother'.<sup>11</sup>

Health professionals should talk to women and their partners about the pressures and desires they may feel to be or not to be sexual. Some women say that they feel shame and embarrassment for wanting to have sex whilst pregnant. Others say the opposite: that they feel shame and embarrassment for not wanting to have sex. Providers should remind women that they have the right to choose when to have sex and that it is perfectly normal to want – or not to want – to have sex during pregnancy and after the birth. If the client in this case study does not feel comfortable having sex at some point during her pregnancy, she should communicate this to her partner.

### **Talking about postpartum contraception before the birth**

If the provider has started these conversations before the birth it will be easier to pick them up again after the birth – when sex and contraception might be the last thing on the client's mind! The provider should find out whether the woman and her partner would like to use contraception after the birth and discuss the range of options available. Some women report that they feel judged by health professionals for wanting to have lots of children, so the provider should not assume that the client won't want to conceive again postpartum. Questions the provider could ask include:

- ▶ *Have you thought about whether you would like to have any more children after this one?*
- ▶ *Have you thought about what contraception you would like to use after the birth?*
- ▶ *What contraception have you used in the past?*
- ▶ *What about protection against STIs?*



## CASE STUDY 8

### Menopause

A 60-year-old woman comes to the clinic. Her sex life with her male partner had been very good during their 25-year relationship but she now feels that sex during and after the menopause has become less enjoyable, and her sex drive is lower. She is worried it will affect her relationship.

Links between sexual health, sexual rights and sexual pleasure for the service provider to discuss with the client

#### Integrating sexual health with pleasurable sex

*Can you talk to your partner about this? Have you tried other ways of enjoying sex beyond intercourse? Have you tried using lubricants?*

Sex can become less enjoyable for some women during and after the menopause. The natural decline in oestrogen levels can make it uncomfortable. Some women also find their interest in sex wanes. The changes to the body that accompany the ageing process don't help: dry skin, greying hair and middle-age spread can erode self-esteem.

To date, most research on sex after the menopause has focused on negative changes, such as vaginal dryness, decreased libido and less intense orgasms, with very little evidence on positive changes. Yet a shift in research reveals a different picture of how women view changes in their sex life after the menopause. One study found that when they describe sex after the menopause, most women emphasized cultural and social issues, such as the status and quality of their relationship, health and sexual history, rather than menopausal physical changes. There are differences, however, in how women handle problems in sex, based on sexual orientation: lesbian couples often have fewer problems because they are less focused on intercourse.<sup>12</sup>

In men, testosterone production drops and the risk of vascular disease increases, combined with slower erections and longer refractory periods. But, like women, psychological factors can also be significant, such as the belief that the elderly cannot or should not have sex. Masters and Johnson identified two factors that are critical to maintaining sexual capacity in old age: good physical and mental health and "regularity of sexual expression".<sup>13</sup> Other research indicates that all sexual behaviours - including intercourse and masturbation - may continue past the age of 70 or even 80.<sup>14</sup>

#### Exploring new ways to experience sexual pleasure

The provider should reassure the client that having sex less often doesn't mean she doesn't love her partner or enjoy being close to him. The urge for sex might not be as frequent or strong, but that doesn't mean the desire to be with her partner is less. The meaning of sex may change for the client as an individual and in her relationship. It is possible to enjoy sex with one's partner in ways other than vaginal or anal intercourse. Couples may think they don't have the time for sex because of their busy lives, working or as parents or grandparents. But couples who make time for sex rather than making excuses are going to have more active and pleasurable sex lives. Taking time just to have an intimate moment together away from daily life or watching TV may help couples to enjoy each other.



Providers should advise their clients that being open about sex and communicating may make it easier to enjoy a more pleasurable and spontaneous sex life. Although it is not always easy, the client in this case study should share what she likes and dislikes. The provider should encourage the client to be open and explore why she wants less sex and how it makes both partners feel. If one partner has a higher sex drive than the other, they may need support in managing it within the relationship: masturbation might be an option, or perhaps cuddling and kissing may be enough. Some older couples want to be close to each other and share pleasure, but don't feel like having full intercourse. They may be happy to try other things, however, which can increase intimacy.

Although urinary incontinence is common during peri-menopause and beyond, it is not an inevitable result of ageing and should not be considered normal or passively accepted. Urinary leakage during intercourse is estimated to affect up to a quarter of women who suffer from incontinence. This can be embarrassing for women and can cause them to avoid intercourse or worry about leakage to the point that they are unable to relax and enjoy sex.

The service provider can give advice to women who suffer from urinary incontinence. Exercises to train and strengthen the pelvic floor muscles may help. The simple practice of urinating before intercourse can also be helpful, or clients can put something on the mattress to protect it.

### **Sexuality, sexual pleasure and illness**

To enjoy sex – either masturbation or with a partner – you need physical strength and energy. Some illnesses or adverse physical conditions can be challenging. People with a muscular disease, for example, may have trouble with caressing, masturbation or certain movements during intercourse. Other illnesses may cause jerky, unexpected movements that make sex difficult.

A number of illnesses are known to affect sexuality and sexual relationships, including asthma, breast cancer, chronic obstructive pulmonary disease, diabetes, heart disease, renal disease, multiple sclerosis and Parkinson's disease. Other chronic diseases can have an effect, for example, because of pain, stiffness, loss of energy and fatigue. Some medications can have an impact on sexual relationships. Psychological factors, including fear and low self-esteem because of changes in body image, can also cause problems in sexual relationships.

The provider should explain to the client how their illness can influence their sexual life and sexual pleasure. It is important that clients know the provider is happy to discuss this with them at any time.

People with an illness may be limited to specific contraceptives, so the health professional needs to find out how their illness or medication affects the reliability of the contraceptive.

### **Sexuality, sexual pleasure and people with disabilities**

Historically, people with disabilities have often been perceived as either asexual or sexually uninhibited. Supporting people with disabilities to have a satisfying sex life has generally been considered unnecessary or even harmful. Only a few countries have implemented the human rights of people with disabilities, as established by the Convention on the Rights of Persons with Disabilities. Research suggests that disabled people are disproportionately affected by sexual violence and may be more vulnerable to HIV infection (WHO, 2016). Existing information and counselling for (young) people with disabilities often depicts sex as dangerous, echoing perceptions of disabled people's sexuality as problematic (Mall, Swartz, 2014).



People with mental, physical or emotional disabilities are all sexual beings. They have the same rights to enjoy their sexuality within the highest attainable standard of health, including pleasurable and safe sexual experiences that are free from coercion and violence; and to access quality sexuality information and counselling as part of SRH service delivery.

SRH providers who serve people with a disability need to be aware of their own values, misconceptions and lack of knowledge of a disabled client's capacity to experience sexual pleasure on their own and with a partner. They need to be honest about this with their client and seek more information.

## Further reading

- ▶ IPPF/WAS (2016). 'Fulfill! Guidance document for the implementation of young people's sexual rights': <https://www.ippf.org/resource/fulfil-guidance-document-implementation-young-peoples-sexual-rights-ippf-was>
- ▶ IPPF (2015). 'How to talk about abortion: a guide to rights-based messaging': [https://www.ippf.org/sites/default/files/ippf\\_abortion\\_messaging\\_guide\\_web.pdf](https://www.ippf.org/sites/default/files/ippf_abortion_messaging_guide_web.pdf)
- ▶ Scarleteen (2009). 'How to (un)pack for a real discussion about abortion': [http://www.scarleteen.com/blog/heather\\_corinna/2009/06/10/how\\_to\\_unpack\\_for\\_a\\_real\\_discussion\\_about\\_abortion](http://www.scarleteen.com/blog/heather_corinna/2009/06/10/how_to_unpack_for_a_real_discussion_about_abortion)



# MODULE 8



## Overcoming fears and addressing embarrassing questions

Many health professionals avoid talking about sex because they feel uncomfortable and are worried about embarrassing themselves or their clients. It is essential that providers spend some time reflecting on their own sexual values and talking about sex and sexuality.

This module suggests some activities that participants can do on their own or as part of a team to boost their confidence in talking about sex and sexual rights in a positive, analytical way.

### **By the end of this module, participants will have:**

- ▶ Shared their worries and fears about talking to clients about sex and sexual pleasure.
- ▶ Explored differences in approaches and identified shared values and principles.

## Key information

Many healthcare providers feel nervous talking about sex with clients because they are worried about the reaction that they will get. And yet, sex-positive health professionals have found that clients are either receptive and respond well to simple questions about sex or they say they don't want to talk about it and the conversation moves on to another topic.

If providers have built a good rapport with their client and established a safe space, it is very unlikely that the client will react badly to their questions. Many clients will feel relieved to finally have an opportunity to talk about an issue that is important to them. The more positive experiences providers have, the less awkward they will feel. It may be helpful to share experiences with colleagues and reflect on what worked and what didn't, what made them feel embarrassed and what motivated them.

### TIPS for healthcare providers:

- ✓ Talking about sex, sexuality, sexual violence and sexual pleasure can be awkward and embarrassing when you aren't used to it. It's your role to create a safe space to explore these issues by setting clear boundaries and establishing a rapport. As provider, you are probably experienced and good at this already.
- ✓ Steer the client to the topic by asking questions and communicating in a way that clearly demonstrates that you are listening. Some clients can tell you more about their health through story telling than by answering direct questions.
- ✓ Find a language for talking about sex, sexuality, abortion, sexual violence, sexual pleasure, sexual rights and sexual health that works for you. If you feel uncomfortable, then so will your client.
- ✓ Give clients the opportunity to ask questions. Listen carefully and try to answer as best you can. In order to

ask about sensitive, taboo or embarrassing topics, your clients will probably need some help from you. Set the tone by having posters and leaflets available or by introducing sensitive, tricky subjects into the conversation yourself. This will give clients the permission they need to start asking about what they really need to know, but were previously too afraid to ask.

- ✓ Try asking clients some simple exploratory questions about sex, sexual enjoyment, discomfort, confidence and harm. This toolkit includes many examples – try them out and see how clients respond. Clients from diverse cultural backgrounds who speak different languages may be less likely to ask questions and more likely to answer them through narrative than directly. Facilitate client-centred communication by asking open-ended questions whenever possible. Remember you don't have to be a 'sex expert' to provide sex-positive counselling and support.
- ✓ Support your clients to be social activists, set up support groups and lead their own campaigns. Many of the challenges that clients face in claiming their sexual and reproductive health and rights cannot be overcome by individual health professionals, counsellors or clients alone: they relate to gender roles and expectations, social norms, power and privilege. Helping clients to set up support forums or advocate for social or policy changes can empower them to transform their own lives and communities.
- ✓ Try out sex-positive approaches in your work and you will gain confidence. Where possible, shadow your colleagues and support each other, run internal training sessions and work together to confront your fears.

# EXERCISE 1

## Answering difficult questions



30-45 minutes

### Materials:

- ▶ A box and small piece of card

- ▶ Give everyone a small piece of paper or card.
- ▶ On one side of the card, ask everyone to write down a question or statement that they fear being asked during a counselling session. This could be something that participants have been asked in the past or something they worry about being asked if they apply a sex-positive approach and talk to clients about sex, sexual pleasure and enjoyment.
- ▶ Ask everyone to put their questions in a box.
- ▶ Divide participants into small groups of three or four people. Each group takes three or four questions.
- ▶ Ask the group to discuss how they would answer these questions or respond to this statement. Encourage them to think how they can respond in a sex-positive way. Participants will need to talk about what this means.
- ▶ If participants can agree on a response, they should write it on the back of the card.
- ▶ Ask participants to share questions and answers as a whole group. Discuss any particularly challenging areas of work.

## EXERCISE 2

### ALTERNATIVE EXERCISE



30 minutes

#### Understanding your comfort zones

**Materials:**

- ▶ Handouts

Ask participants to read the following scenarios and think how comfortable they would feel counselling someone in this situation:

- ▶ Sex between two 13-year-olds.
- ▶ Sex between a 40-year-old man and a 17-year-old girl.
- ▶ Sex between two men.
- ▶ A pregnant woman who is seeking an abortion after sex with a casual partner. This is her third abortion.
- ▶ A sex worker who doesn't use condoms.
- ▶ Someone who is having an extra-marital affair.

Imagine a line that runs from 1–10, where 1 = I would feel totally relaxed and 10 = I would feel really uncomfortable. Ask participants:

- ▶ Where would you place yourself along this imaginary line?
- ▶ Why?
- ▶ What would help you to feel more comfortable in these scenarios?
- ▶ How could you support people in these situations to have the best sex they can and enjoy their sexuality without harming themselves or others?

# MODULE 9



## Practising the sexual pleasure approach

This module gives participants the opportunity to try out the skills and knowledge gained in the workshop so far. They can decide which situations they want to practise. If participants feel confident enough and the facilitator has sufficient experience, specific scenarios can be introduced as role plays.

### **By the end of this module, participants will have:**

- ▶ Increased their ability to implement the pleasure approach in their work delivering a range of SRH services.

# EXERCISE 1



30 minutes

## Practising the sexual pleasure approach

Split participants into groups of three. One person practises the sexual pleasure approach as a service provider, one is the client and the third one is the observer.

Each group decides which SRH scenario they want to act (it's best to keep it simple). After they have chosen a scenario, the first round starts. The observer can take notes.

After five minutes, all three discuss the exercise and then the group swaps roles. There are three rounds, so each participant has a chance to play each role.

For each role, ask participants to consider the following questions:

### Service provider

Before the role play and as you listen to the client consider these questions:

- ▶ Which messages emphasizing sexual pleasure will you communicate to the client, according to the particular situation?
- ▶ Think of the links between sexual health, sexual rights and sexual pleasure (as they relate to the situation that the client is facing). How can you provide counselling to reinforce these links? Think how issues of consent, safety, communication/negotiation, self-determination, privacy and/or confidence relate to sexual pleasure in each case.

### Client

- ▶ Which issues related to sexual pleasure would you like to discuss in this scenario?
- ▶ What would make you feel more comfortable talking about sexual pleasure in this situation?

### Observer

While observing the role play, consider these questions:

- ▶ What language has the provider used? Was it clear, unbiased and sex-positive?
- ▶ What about body language?
- ▶ How is the client reacting to the pleasure approach?

## EXERCISE 2 CONTINUED...

After each round, consider the following questions for discussion as a group:

1. How did the pleasure approach feel for both the service provider and the client?
2. Which messages reflected the sexual pleasure approach?
3. Which alternative messages could a provider give in order to introduce the pleasure approach into the discussion with the client?
4. How do you think the *Pleasuremeter* would help in this counselling situation?

After the role plays are finished, ask the group to discuss these questions in plenary:

- ▶ What did you find easy in the role plays?
- ▶ What was hard?
- ▶ How do you think you could improve the application of the pleasure approach in service delivery?

If participants feel confident, they can practise some more complex case studies. To do this, however, the facilitator must have extensive experience of role playing.

## Examples of case studies

### Case study 1

A 25-year-old man goes to a local clinic to get tested for HIV (he does this routinely). He is seen by an HIV counsellor, who conducts a rapid HIV test and provides a pre-test counselling session. The client currently has a boyfriend, with whom he has only had sex using condoms, but recently his boyfriend told him that they should do it without a condom because “it feels better”. The client is not sure about that and wants to discuss this issue with the counsellor.

### Case study 2

A 20-year-old woman goes to see her doctor. She says that she’s recently started having sex with her boyfriend. So far, they’ve only had vaginal sex which she hasn’t enjoyed that much. She wants advice from her doctor about how to talk to her boyfriend about this issue and about protection.

### Case study 3

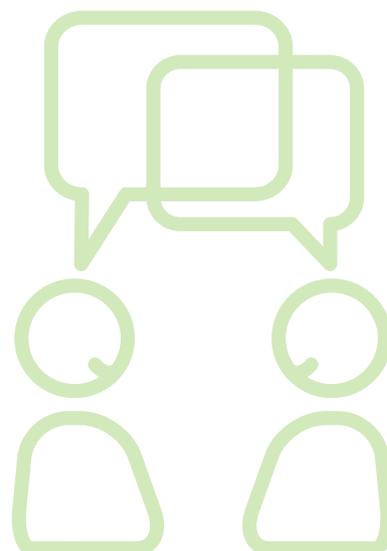
A 32-year-old woman is pregnant and goes for a routine check-up. After she is examined, she tells her gynaecologist that she wants to have sex, but she and her partner are worried about sex during pregnancy. She wants to know how they can avoid harming the baby.

### Case study 4

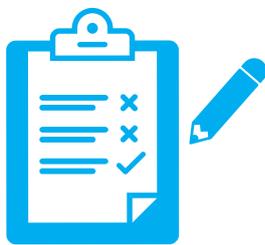
A 35-year-old man who is living with HIV meets his doctor to get the results of his annual check-up. The doctor confirms that he is in excellent health and that the virus remains undetectable, as has been the case for the last five years. The client tells the doctor that he is still using condoms with his partner. They have, however, been talking about not using them any more, as he is undetectable and his partner has told him that he enjoys anal sex without a condom much more. The partner is also considering starting PrEP for added protection. The man wants to talk to his doctor about how to tackle the issue of safety and pleasure with his partner.

**TIPS** for healthcare providers. In order to implement the pleasure approach effectively in counselling related to the provision of SRH services, remember that:

- ✓ As health professional, you need to showcase a positive attitude towards sexuality and the rich diversity of sexual pleasure. Your attitudes towards sexuality are reflected in both verbal and non-verbal messages, such as gestures, looks, tone of voice and expressions.
- ✓ To apply the pleasure approach, active listening is vital. Listen to the language the client uses around sexuality and pleasure. Don't be afraid to use clear and explicit language, according to the client's literacy levels and needs.
- ✓ Practising some key messages and language around sexual pleasure is always useful. The more comfortable you feel using language around sexual pleasure, the more integrated it will be in conversations with clients.
- ✓ Information about biological factors related to sexuality or the negative consequences of sex doesn't have to be excluded. The pleasure approach requires a shift in messaging and attitudes towards human sexuality: instead of reinforcing fear and shame, it promotes sexual happiness, fulfilment and satisfaction.
- ✓ The GAB's definition of sexual pleasure and the *Pleasuremeter* provide a framework to implement the pleasure approach. They indicate key elements where sexual health, sexual rights and sexual pleasure are linked, and suggest some questions that can be asked in order to address these links in counselling for SRH services. But it's up to you, as provider, to be creative and think of other connections between these three concepts and ways to address them in the counselling you give to clients.



## SECTION 2. TRAINING MODULES



### C. Looking to the future and thinking about evaluation

This section looks at how participants can put into practice what they have learned in the training/workshop. It also addresses the changes that need to take place in their personal and professional life in order for them to continue feeling comfortable discussing sexuality and sexual pleasure. Finally, some activities are outlined to monitor and evaluate the process and outcomes of the training.

Objectives:

- ✓ To explore the value of including sexual pleasure within counselling and communication in SRH service delivery and plan key changes that need to occur.
- ✓ To evaluate the process and outcomes of the training/workshop.

# MODULE 10



## Planning ahead and evaluation

This session looks at the most important points participants have learned and how they can apply this learning in the future.

### **By the end of this module, participants will have:**

- ▶ Identified the most important issues they have learned during the workshop.
- ▶ Planned how they can start to put this learning into practice.
- ▶ Evaluated the workshop.

## A. Planning the future

### Key information

- ▶ At the end of the training/workshop, encourage participants to reflect on how they can use their new skills and knowledge in their personal and professional life.
- ▶ It is important to be realistic: participants need to think what they can achieve in the short-term.
- ▶ The planning should preferably be based on learning from the workshop.

### EXERCISE 1

#### Looking to the future



15 minutes

#### Materials:

- ▶ A card for each participant

- ▶ Summarize each of the workshop's modules. Explain the objectives, content and intended outcomes; show the importance of the process and dynamic of the workshop.
- ▶ Ask participants to write their name and email address on the card.
- ▶ Ask them to write down and answer the following three questions:
  1. What have you learned during the workshop?
  2. What is your key takeaway from the workshop – something you don't want to forget?
  3. What will your first steps be to implement what you've learned?
- ▶ Ask participants to read out loud what they wrote on the card.
- ▶ Collect the cards and either post them or email them back to participants in a month's time.

## EXERCISE 2



30 minutes

### Planting a tree for the future

**Materials:**

- ▶ Paper and pencils

- ▶ Ask participants to draw a tree. Give an example on a flipchart.
- ▶ Introduce the exercise as above.
- ▶ At the roots of the tree, ask participants to write down these words: sexual health, sexual rights and sexual pleasure. These roots will nourish the tree.
- ▶ In the branches, ask participants to write down these words: personal life, professional life, education, working with colleagues etc.
- ▶ The leaves of the tree represent the activities that can be carried out in the short term.
- ▶ The flowers symbolize the vision: what participants ideally want to achieve.
- ▶ Ask participants – based on what they have learned during the workshop – to start with the flowers in the branches (where they want to be ideally); and then describe the leaves (the steps needed to get there).
- ▶ Ask participants to share and explain their trees to one or two other participants.

## Example: planting a tree for the future



## B. Evaluating the workshop

### Key information

- ▶ Most evaluations only focus on participants' reactions and what they have learned. But it can also be useful for the facilitator to obtain feedback on the process and methodology of learning.
- ▶ It may be more challenging to evaluate the impact or results of the workshop. You may need to arrange for the participants to reflect on this three to six months after the workshop.
- ▶ To elicit insightful feedback, ask the participants open-ended questions, such as:
  - What really struck you as interesting, new, provocative or meaningful during this workshop?
  - Give an example of one change that you will make in your work or one idea that you will put into practice as a result of this workshop?
  - Which part of the workshop did you find most useful for your work?
  - Which part of the workshop do you think should be changed to enhance learning?
- ▶ As facilitator, you can evaluate the workshop in different ways:
  1. During the workshop, after each session/module/day, ask participants:
    - What was your light bulb moment?
    - What did you learn that was new and you don't want to forget?
    - What do you need to know more about?
  2. At the end of the workshop, you could conduct one of the following exercises to obtain oral and/or written feedback.

#### TIP



When carrying out oral and written evaluation, always start with the written part.

### EXERCISE 1

#### Oral feedback



10-15 minutes

#### Materials:

- ▶ Two chairs

- ▶ Place two chairs in the middle of the room: one is a 'positive chair' and the other an 'improvement chair'.
- ▶ Ask participants to sit on both chairs and share what they liked (positive chair) and what could have been better (improvement chair).

## EXERCISE 2



10-15 minutes

### Written feedback

#### Materials:

- ▶ Cards and pens

- ▶ At the end of the workshop, give each participant a card. Ask them to write down their name and email address. On the card, each participant has to answer the following questions:
  - What have you learned during the workshop (maximum three things)?
  - What is the most important thing that you don't want to forget?
  - What do you most want to apply in your work?
- ▶ After participants have filled in the card, they can share it with others and/or in plenary.
- ▶ Keep the cards and email them to the participants one or two months later.



## EXERCISE 3



10-15 minutes

### Materials:

- ▶ Handouts and pens

Hand out two sheets listing questions about:

1. Agenda/content
2. Logistics

Include questions on each sheet that can be answered on a scale from 1 (very unsatisfactory) to 4 (excellent).

▶ Questions for **1.** could include:

- Was the content relevant to your work?
- Did you get an opportunity to share your experiences and knowledge?
- What did you think of the way the workshop was facilitated overall?
- What did you think of the quality of the materials distributed?
- Were the overall objectives of the workshop met?

You can add open-ended questions, such as:

- What was the most useful session of the workshop? Why?
- What didn't work so well? Why?
- Have you identified any areas where you need more training and technical support?
- Do you have any other comments or suggestions?

▶ Questions for **2.** could include:

- What did you think of the meeting arrangements?
- Were you happy with the coffee/lunch breaks?
- What about the travel/accommodation arrangements (if applicable)?

For other examples, please see Annex 1, page 104.

## SECTION 3. CONCLUSIONS

The workshop programme incorporates a range of different methodologies, a mixture of reflective exercises, participatory activities, and large and small group discussions.

We understand that your own context may not allow for the same amount of time required for this training programme. In that case, we encourage you to adapt the programme and create workshops that are suitable for the context of your own target group.

We hope that we have made a strong case for your investment in incorporating sexual wellbeing and pleasure in the delivery of sexual and reproductive health services. As you have seen, ample opportunities arise to integrate the pleasure approach in SRH service delivery. This begins with you: bringing your colleagues, students, teachers, lecturers and practitioners together to identify the synergies and connections that will enable the pleasure approach to be implemented in a variety of ways across programmes and interventions. Opening up a dialogue about sexual pleasure – within the framework of sexual rights and sexual health – can empower individuals and unlock many benefits for couples and communities.

# ANNEXES



# Annex 1: Handouts and exercises for the modules

## Module 2: Unpacking sexuality, sexual health, sexual rights and sexual pleasure

### 1. Introduction to working definitions

**Sexuality** is “a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.” (WHO, 2006)

**Sexual health** is “a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

**Sexual rights:** “The fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled. Sexual rights embrace certain human rights that are already recognized in international and regional human rights documents and other consensus documents and in national laws. Rights critical to the realization of sexual health include:

- ▶ the rights to equality and non-discrimination
- ▶ the right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- ▶ the right to privacy
- ▶ the rights to the highest attainable standard of health (including sexual health) and social security
- ▶ the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- ▶ the right to decide the number and spacing of one’s children
- ▶ the rights to information, as well as education
- ▶ the rights to freedom of opinion and expression, and
- ▶ the right to an effective remedy for violations of fundamental rights.

The responsible exercise of human rights requires that all persons respect the rights of others. The application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people’s rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination.” (WHO, 2006, updated 2010)

**Sexual pleasure:** “Sexual pleasure is the physical and/or psychological satisfaction and enjoyment derived from solitary or shared erotic experiences, including thoughts, dreams and autoeroticism. Self-determination, consent, safety, privacy, confidence and the ability to communicate and negotiate sexual relations are key enabling factors for pleasure to contribute to sexual health and wellbeing. Sexual pleasure should be exercised within the context of sexual rights, particularly the rights to equality and non-discrimination, autonomy

and bodily integrity, the right to the highest attainable standard of health and freedom of expression. The experiences of human sexual pleasure are diverse and sexual rights ensure that pleasure is a positive experience for all concerned and not obtained by violating other people's human rights and wellbeing." (GAB, 2016)

## Module 3: Personal and professional reflections: attitudes, values and ideas

### Statements:

- ▶ It is easier for men to experience sexual pleasure than women
- ▶ Good sex is spontaneous
- ▶ Good sex should end in an orgasm
- ▶ Sex = intercourse
- ▶ Penis size matters in giving and receiving sexual pleasure
- ▶ Men need an erection to have sex
- ▶ Men want more sex than women
- ▶ Sexual relationships should be controlled, for example, young people shouldn't have sex before marriage
- ▶ Gay men have more sexual partners than heterosexual men
- ▶ Having more sexual partners implies that the person is 'high-risk'
- ▶ Sex is a voluntary action between adults
- ▶ When you have a good sexual relationship, you should not masturbate.

## Module 4: Risk-based approach vs pleasure approach in sexual health promotion

### Exercise 1: Questions for discussion after videos

- ▶ In which video was the pleasure approach most apparent? In which one was the risk-based approach most apparent? Why?
- ▶ Which video was difficult to locate on one side of the risk/pleasure spectrum? Why?
- ▶ Which elements of the risk-based approach did you see in the videos that ranked lowest?
- ▶ Which elements of the pleasure approach did you see in the videos that ranked highest?
- ▶ What is more important as a message – pleasurable sex or safer sex? Or both?

### Exercise 2: Framing messages based on both approaches

- ▶ Each team develops between three and five bullet point messages using both the risk-based approach and pleasure approach for a topic that is randomly assigned. Some of the topics that can be used for this exercise are:
  - Condom use
  - Sexual diversity
  - Sexual relationships in adolescence
  - Sexual violence
  - Contraception
- ▶ Each team presents their messages, followed by a plenary discussion.

## Module 5: Basics in language and messaging

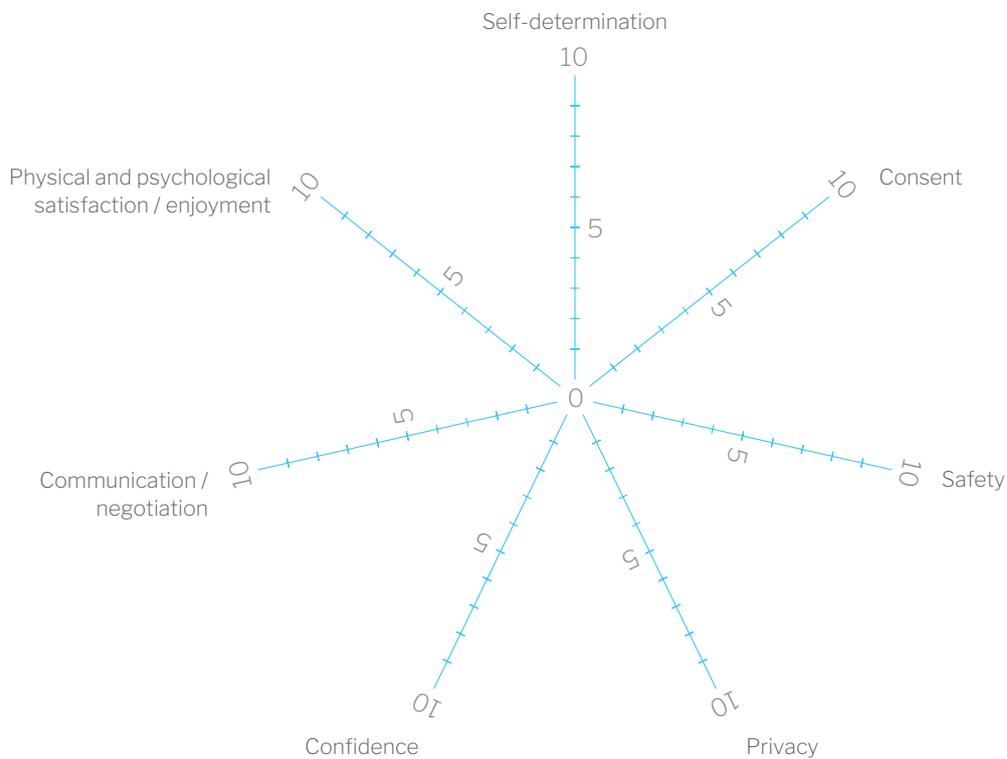
### Exercise 2: Do's and don'ts

Fill in:

| Don'ts                                      | Do's   |
|---|--|
| Boys and girls                              | People of all genders - try to avoid binary descriptions of gender               |
| Promiscuity                                 |  |
| Virginity/abstinence                        |  |
| Sex = penis in vagina/anus                  |  |
| Risky behaviour and critical language       |  |
| Assumptions that some sexual acts are weird | Embrace an open, accepting view of people's different identities and preferences |
|   |  |
|   |  |
|   |  |
|   |  |

## Module 6: The Pleasurimeter

| Think about all your sexual relationships in the last 12 months and score the following questions:               |   |  |   |  |   |   |
|--|---|--|---|--|---|---|
| Physical and psychological satisfaction / enjoyment  | Self-determination  | Consent  | Safety  | Privacy  | Confidence  | Communication / negotiation   |
| From 1 to 10, how much did you enjoy/ how satisfied were you with your sexual experiences in the last 12 months? | From 1 to 10, how many of these sexual relationships did you freely choose to have? | From 1 to 10, of all the things you did with your sexual partner(s), how many did you specifically agree to? | From 1 to 10, how safe did you feel in your sexual relationships? | From 1 to 10, how much privacy did you have in all your sexual encounters? | From 1 to 10, how confident did you feel to express yourself with your partner(s) while having sex? | From 1 to 10, how would you rate the quality of your communication and negotiation (of what you wanted and didn't want to do) with your partner(s)? |



## Module 7: Case studies on implementing the pleasure approach in SRH counselling

For each case study that you read, think about and discuss the following:

- ▶ What are the strongest connections between sexual health, sexual rights and sexual pleasure that you can think of?
- ▶ Which questions could you ask the client featured in the case study in order to address these links during counselling related to the service?

### 1. Case study: STI testing and/or condom use

A 20-year-old man comes into a clinic inquiring about a possible symptom of an STI. He tells the counsellor that he is very anxious due to a pimple that has appeared on his penis. He reveals that he has had anal sex with two male partners around his age, and that he did not use condoms all the time.

### 2. Case study: Condom use

A 19-year-old woman comes into a clinic looking for sexual health counselling. She explains to the medical provider that her boyfriend does not want to keep using condoms because he says he cannot “feel her” that much when they use them. She is concerned because they have only been together for three months and she feels they have not developed enough trust to stop using them. She asks the provider how she can motivate her partner to use condoms.

### 3. Case study: Living with HIV

A 35-year-old woman who is living with HIV is talking to her medical provider during an annual medical visit. She tells her provider that she has not had sex since her diagnosis two years ago. She has recently met someone she likes a lot. She'd like to have sex with him but doesn't know how to bring up the issue of her HIV status.

### 4. Case study: Pre-exposure prophylaxis (PrEP)

A 23-year-old man who is on PrEP goes to a clinic for a medical check-up, where he is routinely tested for HIV and other STIs. The HIV counsellor at the clinic asks him whether he is combining condoms with PrEP. The client states that he's been having anal sex with his boyfriend without a condom. He admits to doubts as to whether his partner is being faithful. The client also mentions that he wants to experiment sexually with other men, but is afraid to discuss this with his boyfriend.

### 5. Case study: Contraceptives

A young couple come to the clinic to ask for contraceptives. They recently had sex for the first time. Although it was consensual, the girl is very nervous and asks the provider whether it is normal to have pain the first time and whether it will get better.

### 6. Case study: Abortion

A young girl comes to the clinic. She is pregnant but doesn't want to continue the pregnancy (abortion is legal in her country). She is very worried that she won't be able to enjoy sex after the abortion.

### 7. Case study: Perinatal care

A woman comes to the clinic. She has just found out she is pregnant. She is delighted but very concerned about her relationship because she is scared to have sex in case she loses the baby.

### 8. Case study: Menopause

A 60-year-old woman comes to the clinic. Her sex life with her male partner had been very good during their 25-year relationship but she now feels that sex during and after the menopause has become less enjoyable, and her sex drive is lower. She is worried it will affect her relationship.

## Module 8: Overcoming fears and addressing embarrassing questions

### Exercise 2: Understanding your comfort zones

Read the following situations and think how comfortable you would feel counselling someone in this situation:

- ▶ Sex between two 13-year olds.
- ▶ Sex between a 40-year-old man and a 17-year-old girl.
- ▶ Sex between two men.
- ▶ A pregnant woman who is seeking an abortion after sex with a casual partner. This is her third abortion.
- ▶ A sex worker who doesn't use condoms.
- ▶ Someone who is having an extra-marital affair.

Imagine a line that runs from 1 – 10, where 1 = I would feel totally relaxed and 10 = I would feel really uncomfortable. Where would you place yourself along this imaginary line?



Think about the following questions:

- ▶ Why did you place yourself there?
- ▶ What would you help you to feel more comfortable in these scenarios?
- ▶ How could you support people in these situations to have the best sex they can and enjoy their sexuality without harming themselves or others?

## Module 9: Practising the sexual pleasure approach

### Exercise 1: Practising the approach

Split into groups of three. For each round, one person tries out the approach as service provider, another one as the client and a third one as the observer.

For each role consider the following questions:

#### ▶ Service provider

- Which messages emphasizing sexual pleasure will you communicate to the client, according to the particular situation?
- Think of the links between sexual health, sexual rights and sexual pleasure (as they relate to the situation that the client is facing). How can you provide counselling to reinforce these links? Think how issues of consent, safety, communication/negotiation, self-determination, privacy and/or confidence relate to sexual pleasure in each case.

#### ▶ Client

- Which issues related to sexual pleasure would you like to discuss in this scenario?
- What would make you feel more comfortable talking about sexual pleasure in this situation?

#### ▶ Observer

While observing the role play, consider:

- What language has the provider used? Was it clear, unbiased and sex-positive?
- What about body language?
- How is the client reacting to the pleasure approach?

## Examples of case studies

### Case study 1

A 25-year-old man goes to a local clinic to get tested for HIV (he does this routinely). He is seen by an HIV counsellor, who conducts a rapid HIV test and provides a pre-test counselling session. The client currently has a boyfriend, with whom he has only had sex using condoms, but recently his boyfriend told him that they should do it without a condom because “it feels better”. The client is not sure about that and wants to discuss this issue with the counsellor.

### Case study 2

A 20-year-old woman goes to see her doctor. She says that she’s recently started having sex with her boyfriend. So far, they’ve only had vaginal sex which she hasn’t enjoyed that much. She wants advice from her doctor about how to talk to her boyfriend about this issue and about protection.

### Case study 3

A 32-year-old woman is pregnant and goes for a routine check-up. After she is examined, she tells her gynaecologist that she wants to have sex, but she and her partner are worried about sex during pregnancy. She wants to know how they can avoid harming the baby.

### Case study 4

A 35-year-old man who is living with HIV meets his doctor to get the results of his annual check-up. The doctor confirms that he is in excellent health and that the virus remains undetectable, as has been the case for the last five years. The client tells the doctor that he is still using condoms with his partner. They have, however, been talking about not using them any more, as he is undetectable and his partner has told him that he enjoys anal sex without a condom much more. The partner is also considering starting PrEP for added protection. The man wants to talk to his doctor about how to tackle the issue of safety and pleasure with his partner.

## Module 10: Planning ahead and evaluation

### Exercise 1: Looking to the future

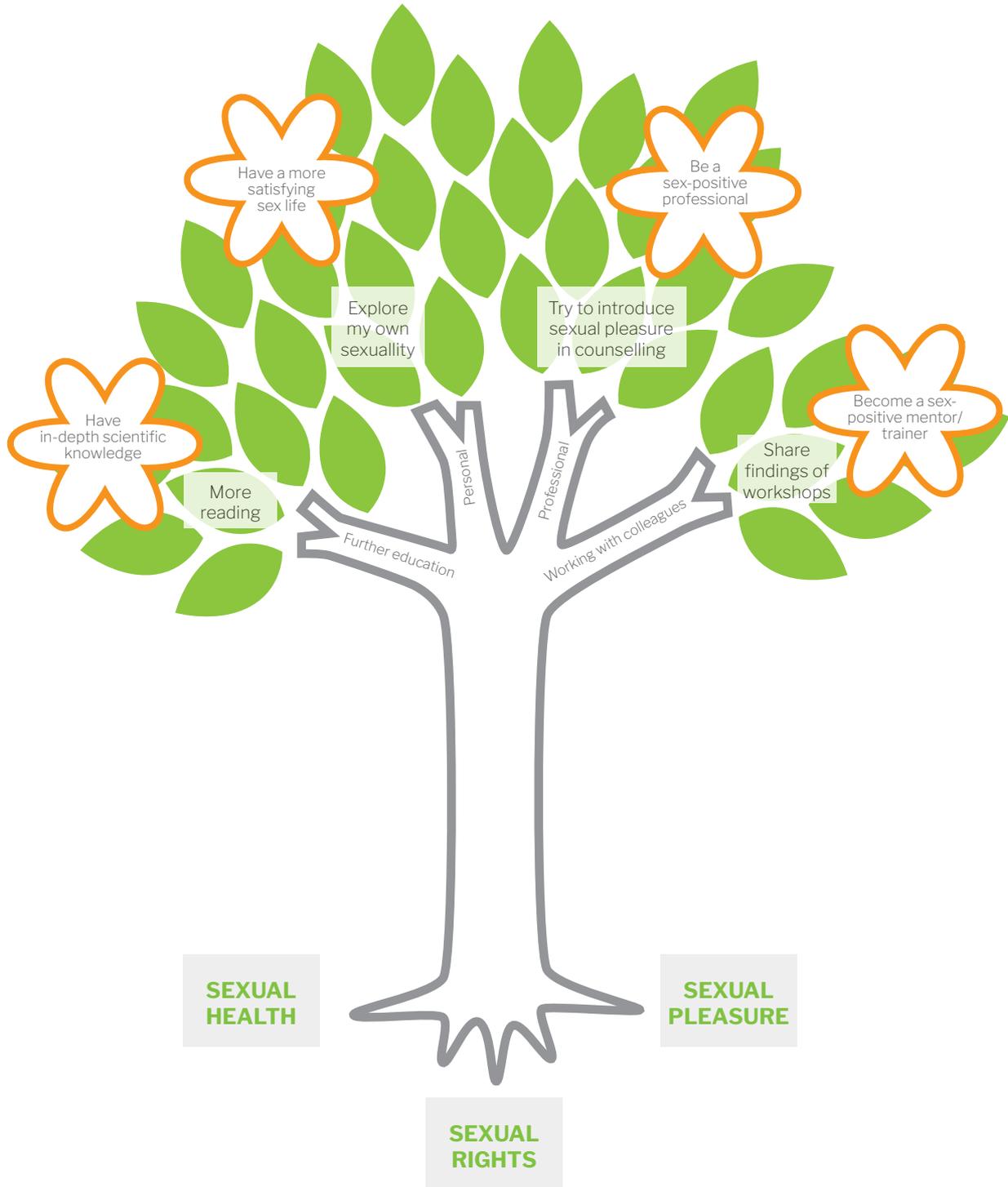
Questions:

1. What have you learned during the workshop?
2. What is your key takeaway from the workshop – something you don’t want to forget?
3. What will your first steps be to implement what you’ve learned?

### Exercise 2: Planting a tree for the future

- ▶ Draw a tree.
- ▶ At the roots of the tree, write down these words: sexual health, sexual rights and sexual pleasure. These roots will nourish the tree.
- ▶ In the branches, write down these words: personal life, professional life, education, working with colleagues etc.
- ▶ The leaves of the tree represent the activities that can be carried out in the short term.
- ▶ The flowers symbolize the vision: what you ideally want to achieve.

## Example: planting a tree for the future



### **Exercise 3: Evaluation**

Include questions on each sheet that can be answered on a scale from 1 (very unsatisfactory) to 4 (excellent).

- ▶ Was the content relevant to your work?

1.                      2.                      3.                      4.

- ▶ Did you get an opportunity to share your experiences and knowledge?

1.                      2.                      3.                      4.

- ▶ What did you think of the way the workshop was facilitated overall?

1.                      2.                      3.                      4.

- ▶ What did you think of the quality of the materials distributed?

1.                      2.                      3.                      4.

- ▶ Were the overall objectives of the workshop met?

1.                      2.                      3.                      4.

## Annex 2A: Talking about sexual pleasure to women during gynaecological examinations

Talking to clients about sex is a normal part of a gynaecological examination or consultation. Conducting examinations of women's breasts or pelvic areas can provide an opportunity for women to learn about their bodies and discuss any concerns that they may have. See the example below for guidance in conducting examinations.

The use of mirrors in consultations can help educate women about their bodies. For women who have had pelvic or genital surgery, it can help them re-connect with their bodies in a safe space.

Any condition that affects the breasts or pelvic area can affect a woman's sense of sexual self, her feelings about her body and her relationships.

Not every woman seeking gynaecological counselling will want to talk about sex. But healthcare providers should ask about sex and be prepared to talk about it if the client wants to. Once the topic has been broached, some women may respond; others may not.

When working with women with possible or diagnosed gynaecological conditions, the provider's role is to help manage the physical symptoms of her condition and how this might affect her psychological wellbeing and her relationship (including sexual relationship, if appropriate).

### Questions to ask the client

- ▶ Talking about sex during the examination can help providers identify areas of pain and discomfort that the woman feels. It also enables the client to access the holistic care, treatment and support

that she needs. Questions that health professionals could ask include:

- *Are you in a sexual relationship at the moment? How are you finding that?*
- *Are you having any difficulties in your relationship at the moment – physical or emotional?*
- *Do you have any pain during sex? Tell the client that physical pain can cause emotional or psychological pain.*
- *If so, what impact is that having on your sex life?*
- *How was your sex life before your condition started?*
- ▶ The provider can try reflecting back to the client how she sounds about her physical symptoms, for example: *You sound really sad about that? You sound OK about that? Is that a problem for you and your partner?*
- ▶ When clients book an appointment, the provider may want to suggest that they write down any questions that they want to ask, including questions that may feel difficult or embarrassing to say out loud. Some – but not all – women may find this easier.
- ▶ Clients may feel uncomfortable talking about sex and any problems they are experiencing. Providers can try to put them at ease by asking simple questions that introduce the topic of sex, such as:
  - *Have you got any questions you'd like to ask? You can ask me anything you like! Even if it seems a bit silly or as if it has nothing to do with your condition.*
  - *Don't be embarrassed – I hear all kinds of things in my job. Also, it's my job to talk to people about bodies, relationships, sex and things like that.*

### For symptomatic clients and women undergoing treatment

- ▶ Knowing the sexual side effects of particular conditions and treatments can help women to understand what is happening in their bodies and feel more in control.
- ▶ Providers can help by offering women information (leaflets, websites and support groups) and creating opportunities for them to ask questions.

#### TIPS for health professionals:

- ✓ Encourage your client to talk to her partner. She should let her partner know how she feels and how he/she can help her manage the changes she is experiencing. There may be simple things that they can try together, such as using lubricants to ease vaginal dryness and improve sensation, or changing position to make sex more comfortable and enjoyable.
- ✓ Encourage your client to explore new ways to be intimate with her partner. If penetrative sex is uncomfortable for her, then she could try other ways to be intimate, turn each other on or reach orgasm. These include massage, cuddling, kissing, talking, stroking, playing with the senses (sight, taste and sound) or masturbating on her own or with a partner.

### Conducting examinations

- ▶ A mirror can be used during gynaecological examinations. While the provider is looking directly at the vulva and the vagina, the client is holding the mirror and looking at the reflection. This means that neither healthcare provider nor client are looking at each other, which can help make the client more comfortable.

- ▶ While performing the examination, the provider can point out the different anatomical parts to the client, such as the labia majora and minora, the clitoral hood and clitoral body. Explain that the sole function of the clitoris is to provide pleasure and that it contains around 8,000 nerve endings.
- ▶ Next, the provider could indicate the urethral orifice, the introitus, and the opening to the vagina. Explain that secretory glands in the introitus are a secondary source of lubrication and that lubrication primarily comes from inside the vagina.
- ▶ The provider could tell the client to visualize the vagina as a mouth. As she puts her finger on the vaginal floor, the provider can compare it to the tongue of the mouth. Then she can move her finger to the side wall, which can be compared to the inside of the cheek. Finally, she could touch the anterior fornix, which can be compared to the roof of the mouth.
- ▶ This way the client will become much more familiar with her vagina and it may help her to explore herself or together with her partner. Having images available of genitalia will enable the woman to see what the provider is examining. Or use a mirror!

### Further reading

Scarleteen 'Innies & outies: The vagina, clitoris, uterus and more'.

[http://www.scarleteen.com/article/bodies/innies\\_outies\\_the\\_vagina\\_clitoris\\_uterus\\_and\\_more](http://www.scarleteen.com/article/bodies/innies_outies_the_vagina_clitoris_uterus_and_more)

Information and images for the vaginal corona that may be useful when discussing virginity with clients:

[http://www.rfsu.se/Bildbank/Dokument/Praktikor/praktika-Vaginal\\_corona2009.pdf](http://www.rfsu.se/Bildbank/Dokument/Praktikor/praktika-Vaginal_corona2009.pdf)

## Annex 2B: Responding to clients' concerns about female genital mutilation and pleasure

- ▶ A wide range of female genital mutilation (FGM) practices exists, with a variety of meanings attached in different cultures and communities.<sup>15</sup> Most procedures leave some degree of scar tissue, which can make sex uncomfortable and painful for some women. Infibulation (type three FGM) greatly restricts the vaginal opening. This can cause significant pain for some women during sexual intercourse. Some women also feel depressed or traumatized by the experience and may not want anyone – a health professional or partner – to look at or touch the scarred area. It might be helpful to talk about pleasure for women who have been cut. It can be hard for them to enjoy sex, as the opening that remains is too small for a penis to enter without pain. Nevertheless, some women report having an enjoyable sex life even with this kind of cut.
- ▶ For other FGM categories, women will find it harder to reach orgasm than women who haven't been cut because many women can do so most easily by stimulating the clitoris. But this doesn't mean that if a woman's external clitoris has been removed, she won't be able to have an orgasm: the outer part of the clitoris is only a small part of a much bigger organ. With an understanding and patient partner, women should be able to reach orgasm. It's a matter of experimenting to see what feels good.
- ▶ Research into women who have experienced FGM suggests that some women believe that being cut increases their own and their (male) partner's enjoyment of sex.<sup>16</sup> In small studies of migrant women from Somalia<sup>17</sup> and the Horn of Africa<sup>18</sup> most women report that they find penetrative sex pleasurable and are able to experience orgasm. Other research with Somali and Sudanese migrant women living in the UK suggests that women do not enjoy penetrative sex but experience pleasure from kissing, cuddling and having erogenous zones such as thighs, breasts and lips stimulated.<sup>19</sup>
- ▶ Studies showing that women who have undergone FGM can and do experience pleasure during sex can be puzzling for cultures that do not endorse such practices. For counsellors working with women who have experienced FGM this means starting by trying to understand how a woman feels about her body and her sexual relationships, and how she reflects on and makes sense of her experience of being cut.
- ▶ If the client says that having sex is difficult and triggers negative memories and responses, and yet wants to be intimate with her partner, the provider could ask:
  - *Have you spoken to your partner about this? What does s/he say?*
  - *When do you get these feelings? Are they connected to a particular feeling or act?*
  - *What do you and your partner do to show each other love and affection in ways that aren't sexual?*
  - *We've talked a lot about sexual experiences that have been abusive and painful for you. I wondered if you have also had sexual experiences that you've enjoyed?*
- ▶ It can sometimes be difficult for women who have been through FGM to think about having sex. Women may be worried that it will be painful because of the scar or that they may not have an orgasm if the external part of their clitoris has been removed. It may help to explain that it is impossible to completely remove the clitoris. The part of the clitoris that we can see in women who have not been

cut is only a small part of the organ that continues up into the body. Some women (those who have and haven't been cut) find that stimulating the area around the clitoris, the outer labia or inside the vagina can be very pleasurable. Providers may find it useful to use diagrams or draw a rough sketch as they talk.

- ▶ Clients may find it useful to discuss ways of touching and being intimate that they enjoy, and explore whether they would feel comfortable seeing what feels good by touching themselves, or involving a partner. Survivors of FGM may find it useful to speak to or read the stories of other women who have been cut in order to understand a range of sexual experiences.



## Endnotes

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