Family Planning Providers' Perspectives On Dual Protection

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CONTEXT: *Family planning providers can play an important role in helping women to identify their risk of HIV and other sexually transmitted diseases (STDs) and to adopt preventive measures. In-depth investigation of providers' attitudes about approaches to STD risk assessment, contraceptive counseling and dual protection—concurrent protection from STDs and unintended pregnancy—has been limited.*

METHODS: *In semistructured interviews conducted in 1998, 22 health care providers from a large New York City agency offering contraceptive and STD services described how they balanced STD and pregnancy concerns, viewed risk assessment and assessed various contraceptive methods.*

RESULTS: *STD prevention was seen as an integral part of family planning counseling, and most providers believed that risk assessment should be conducted universally. Providers viewed dual protection as use of condoms along with an effective contraceptive; few advocated use of the male or female condom alone. The female condom was believed to be a disease prevention method of last resort and was considered appropriate only for specific groups of women. Although providers lacked understanding about the effectiveness of the female condom and how to counsel clients concerning its use, they expressed interest in learning more.*

CONCLUSIONS: *Training is needed to reduce providers' negative perceptions of the female condom and to reinforce the importance of individualized counseling tailored to women's specific circumstances. Studies are needed on how to encourage family planning providers to promote male and female condoms as effective contraceptive methods.*

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The landmark 1994 Cairo International Conference on Population and Development,[1] the 1995 Beijing Conference on Women[2] and the five-year review of the Cairo conference[3] provided the impetus for family planning programs worldwide to shift their focus from fertility control to the broader concept of reproductive health.[4] In the United States, this was accomplished through changes in the federal Title X program,[5] which encouraged family planning agencies to offer services related to sexually transmitted diseases (STDs), including HIV.[6] In most parts of the world, including the United States, family planning and STD services have been separate administratively and conceptually.[7] Traditionally, family planning services have addressed women's need for contraception without considering women's or their partners' STD risk; meanwhile, STD services have been heavily slanted toward men, ignoring the contraceptive needs of men and their partners.

In communities in the United States and elsewhere, many women are at significant risk for unintended pregnancy and STDs, including HIV. Yet the separation of services means that many women in family planning clinics receive contraceptive services with little or no evaluation of whether they need dual protection–that is, concurrent protection from STDs and unintended pregnancy. Because family planning clinics serve large numbers of women of childbearing age, this lack of integration of services represents a missed opportunity to identify many at-risk women and to offer them counseling on dual protection.

THE DUAL-PROTECTION DILEMMA

Dual protection can be achieved in three ways: by use of a male or female condom alone, by use of a condom along with a nonbarrier contraceptive, or by use of effective contraception in the context of long-term mutual monogamy (although this option may be unfeasible in many settings). Because barrier methods are not the most effective means of fertility control, the family planning field traditionally has been reluctant to recommend these methods alone for dual protection. Yet numerous empirical studies have shown that the more effective the primary method is at pregnancy prevention, the less likely women and their partners are to use, or to intend to use, male condoms consistently.[8] Unfortunately, the most effective pregnancy prevention methods–sterilization, hormonal methods and IUDs–do not protect against STDs.

Dual-method use protects against STDs and pregnancy. However, sexually active persons may be unwilling to use two methods or may be dissuaded from using condoms because of the perception that condoms are associated with STDs; in addition, use-effectiveness may be compromised because as a person begins to use a second method, he or she may become less consistent in using the first method.[9]

Reported rates of dual-method use have ranged from 3% to 42%, depending on study design, country, combination of methods used, period of assessment, users' characteristics, and characteristics of the partner and the relationship.[10] Dual-method use has been correlated with being younger,[11] having higher education, being black,[12] having received instruction in condom use or education about HIV,[13] using the pill,[14] having an elevated STD risk,[15] being in shorter-term or less-committed relationships,[16] and making shared decisions about contraceptives.[17]

Because of incorrect and inconsistent use, the one-method approach to dual protection can yield a higher annual pregnancy rate (14%, adjusted for underreporting of abortion) than hormonal methods, sterilization and the IUD in typical use.[18] Some researchers have suggested that the contraceptive use-effectiveness of the condom alone can be increased by promoting emergency contraception as a backup in the event of condom failure,[19] but such an effect has yet to be demonstrated empirically. Weaknesses in previous studies (including self-selected samples, inadequate statistical power and reliance on self-reported outcomes) make it impossible to conclude that a two-method strategy for dual protection is more appropriate to promote than a one-method approach.[20]

In the study described in this article, we explored how providers viewed contraceptive methods, how they assessed clients' risk for STDs and, on the basis of their assessment, how they counseled clients about options for the prevention of disease and unwanted pregnancy. This investigation was the first phase in a larger provider-delivered intervention designed to promote dual protection to family planning clients.

METHODS

Setting and Sample

We selected the clinics of Community Healthcare Network (CHN), a large primary health care organization in New York City, as the sites for this study. Since 1996, CHN has had policies of integrating STD prevention and treatment into its family planning services and of promoting dual protection through dual-method use. The agency offers voluntary STD counseling and testing (including STD risk assessment), and promotes use of male condoms for dual protection. At the time of the study, CHN had eight freestanding clinics and two mobile units serving underserved communities.

In 1998, the year our study was conducted, the majority of CHN family planning clients (more than 80%) were black or Hispanic. Of the 10,314 family planning clients seen at CHN clinics during that year, approximately half (51%) were new clients. Most clients (85%) were adults (aged 18 or older). The most common source of payment for family planning visits was Medicaid (38%), followed by clients' partial payment (27%). Nearly two-fifths of clients (37%) came to the clinic using no method of protection, primarily because they were postpartum (42%). Among those currently using a contraceptive, the most frequently reported methods were male condoms (54%), the pill (22%), spermicide plus a condom (8%), an injectable (7%) and sterilization (6%).[21]

Family planning clients served at CHN clinics in 1998 were at relatively low risk for STDs: Of the 5,280 HIV tests performed that year, 10 had positive results and 44 were inconclusive; of the 7,173 chlamydia tests, 1% had positive, suspicious or abnormal results.

We interviewed 22 of the 23 frontline family planning service providers at seven of the eight freestanding CHN clinics operating in 1998; at one clinic, the manager denied us permission to interview staff. Although we also interviewed the clinic managers at all eight sites, these interviews did not address client-counseling practices and are therefore excluded from the analysis.

The sample comprised 10 nurses, three physicians, four physician extenders (nurse practitioners and physician assistants) and five social workers; all but two of the providers were women. The one provider not interviewed was a physician who reported having insufficient time to participate. The median age category of the sample was 40–44 years. Most of the providers (96%) had a college education or higher. Their median duration of employment was 9–10 years in the health care industry and 3–5 years in the family planning field.

Data Collection and Analysis

We visited each clinic and initially interviewed the clinic managers, who informed their clinical staff about the study and assisted us in scheduling appointments with the providers. The providers gave informed consent to participate. Three of us conducted the semistructured interviews, which took place between March and December 1998. We were interested primarily in understanding the range of views expressed and identifying common themes, instead of generalizing findings to other populations[22] or quantifying the proportion of our small sample expressing a particular viewpoint. To elicit participants' candid, thoughtful responses, we used open-ended questions with probes. We informed participants that there were no right or wrong answers.

The interviews, lasting 45–75 minutes, covered provider training and experience in family planning, perceptions of the challenges and rewards of working with clients, and perceptions of clients' STD and pregnancy risk. Providers also described how they typically assessed risk and counseled clients about contraceptives, their perception of the strengths and limitations of different contraceptives, and their views on dual-protection approaches. Furthermore, they were asked to describe the characteristics of good candidates for each method. We recorded responses manually and audiotaped the interviews for backup.

To map the range, variability and patterns of participants' perspectives, we sorted responses into a matrix. Using the questions that guided the interviews, we developed a coding scheme that helped us identify concepts represented in the data.

For the lead question on each topic, we developed categories of responses and then classified and tabulated the frequency of responses in each category. For example, for the question "Who do you think is a good candidate for the female condom?" we agreed on three main categories of responses: all women, some women and no women. Two of us then independently coded the responses. The independent coding of the textual responses, followed by a discussion and resolution of differences between the two coders, ensured that codes were applied consistently. We then counted the responses in each category to assess the variation.[23] The quotes presented here represent the richness and range of participants' responses.[24]

RESULTS

STD and Pregnancy Risk Assessment

The providers perceived STD risk assessment and counseling as being integral to their role. They thought that the risk for STDs among most new clients was moderate to high, but they also noted that these clients often seemed unaware of their risk status. The providers used the New York State Department of Health's HIV risk assessment form to evaluate clients' risk behaviors; the form yields yes-no responses, and some providers did not routinely probe clients about the context of reported behaviors.

The assessment of clients' risk for unintended pregnancy and the review of contraceptive options were frequently described as being separate from STD risk assessment and counseling. To assess disease risk, providers indicated that they typically consulted a checklist developed by the New York State Department of Health. The providers indicated that they then went on to talk to the client about contraception, as part of a separate component of the client interview.

Eighteen providers believed that risk assessment should be conducted universally; however, four providers thought that risk assessment should be conducted only at a client's first visit or when a client indicates being at risk. Among those who believed that all women should be assessed for STD risk, a common explanation was that providers and clients often are unaware of the clients' vulnerability to STDs:

"I think we should do it for all, because some people are at risk and they don't know; they never thought about it." –*Nurse*

One provider noted that clinic visits provide an excellent opportunity to educate clients about sexual protection, even if they are not sexually active:

"Every single visit, even if they say they [have been] abstinent for 10 years,...talk to them about what would be safe sex."–*Nurse*

A physician assistant noted, "I always discuss STD issues with them. Some people may be embarrassed, but we speak freely in the room."

Among those who thought that certain clients should be targeted for STD risk assessment, one physician reported using information gathered from the clients' general history (for example, age and marital status) to determine whether an STD risk assessment would be necessary. This physician targeted teenagers and unmarried women for risk assessment.

The depth and quality of risk assessments varied widely. Some providers described risk assessment as a perfunctory review, while others reported in-depth probing of clients' and their partners' risk behaviors.

Counseling Focus: Balancing Pregnancy and STD Issues

Providers' comments about how they balanced issues related to pregnancy versus STD prevention in counseling reflected four patterns: The majority of providers gave equal attention to pregnancy and STDs, some gave greater priority to STDs, some tailored their counseling on the basis of clients' circumstances and one assigned a higher priority to pregnancy matters.

Thirteen providers believed that equal weight should be given to clients' pregnancy- and STD-related needs:

"About equal. The same way you get pregnant, the same way you get HIV, the same way you get STDs—so I put them in the same balance."–*Nurse*

"I think I like what the agency is doing: A pregnancy test is free, and it's advertised [that] this is a place [where] you get free pregnancy testing; but...everyone who gets a pregnancy test gets...standard HIV counseling and a chance to be tested."–*Social worker*

Four providers believed that STDs should receive greater attention than pregnancy issues in counseling. One nurse justified this emphasis by pointing to the prevalence of STDs among the clinic's adolescent clients; a physician noted that HIV infection is "a matter of life and death."

Four providers mentioned that they tailored their counseling on the basis of the client's age, type of sexual partner (regular or casual), lifestyle and priorities:

"I had a young woman who said she had anal, oral and vaginal sex with a much, much older partner. Therefore, a lot of the focus had to be on risk reduction, potential for abuse in a relationship like this and then [how] to protect herself."–*Social worker*

"It depends on the age-group you are dealing with. Teenagers are so active, relationships are so important to them—enforce both methods. But when you get somebody in a monogamous relationship, maybe just the pregnancy prevention becomes the major issue."–*Physician*

A physician assistant, the one provider who prioritized pregnancy over STD prevention as the focus of counseling, remarked, "[With] the clients I see here, I would say it is 50–50—well, more pregnancy than STD. The biggest concern is really pregnancy; STDs can be cured....With 15-year-olds getting pregnant, they can have a termination; but many stop school."

Regardless of their counseling focus, several providers framed their rationale from a dual-protection perspective and indicated that pregnancy and STDs are consequences of the same behavior:

"If you counsel on HIV and STDs, you are counseling on protection, so pregnancy will not be happening either." –*Nurse*

"The same way you get pregnant,...the same way you get STDs—so I put them in the same balance." —Nurse

Barrier Methods

• *Male condom.* We asked providers under what circumstances and to whom they would suggest use of the male condom. Sixteen believed that all women should be encouraged to have their partners use a condom. One nurse reported, "I tell all women to get their male partner to use condoms, even older women. I say, 'You never know.'" The remaining six mentioned specific groups of women who should be counseled about condom use—women who have sex infrequently, do not like hormonal methods, have a cooperative partner, want to prevent pregnancy and disease, or have multiple partners. Providers reported that they would not recommend the male condom to women in a long-term marriage; to those with latex allergies; and to those with a partner who may be uncooperative, accuse them of cheating or threaten abuse.

"I know very few women using [the female condom]....We don't promote it as much as we should."
—Physician

Although most providers would recommend a male condom to all women, only seven would recommend it as a primary method of contraception; 11 would recommend male condoms only in combination with a spermicide. The remaining three providers who commented on this subject said they would never recommend male condoms as the primary method.

Providers recognized that many women lack control over male condom use. One nurse practitioner noted, "We see a lot of women who say their partner will use a condom, but he doesn't." Providers' reluctance to recommend using the male condom was also based on their concerns about its effectiveness in preventing pregnancy. All but one provider agreed that promoting male condoms instead of hormonal methods would increase women's risk of unintended pregnancy.

Another major concern about male condom use was related to typical-use conditions—slippage and breakage, as well as incorrect and inconsistent use:

"Condoms are good only when used. It only takes one time to get pregnant."—*Physician assistant*

"[It] leaves them wide open for unintended pregnancy. Men don't put it on properly; [they] poke holes."—*Social worker*

• *Female condom.* Twelve providers believed that the female condom was an appropriate choice for some women. Only three thought that all women were good candidates; another three thought no client could be a good candidate, and the remaining four expressed no opinion. The providers who believed the female condom was an appropriate method for some women typically mentioned as potentially good candidates women with no other options because their male partners refuse condom use, sex workers, women who are HIV-positive, women who are self-assertive and want to be in control, and women who are comfortable with their bodies.

When asked if they would recommend the female condom as a primary contraceptive method, eight providers indicated that they would, but with certain caveats—for example, only if a woman lacks other options or has a male partner who is unwilling to use a condom.

Fourteen providers believed that promoting the female condom instead of hormonal methods would increase women's risk of unintended pregnancy. These providers typically reported that their female clients did not want or know how to use the female condom or that the method was technically difficult to use.

"It's so rarely used. It isn't so popular. Women may not know how to use it, so it may sit at home."—*Physician*

"Something could always go wrong....The man could put his penis to the side, or sometimes the condom could get misplaced during the action."—*Nurse*

When asked what they had heard about the female condom, providers offered an array of negative responses related to its physical characteristics—the noise, awkwardness, slipperiness, discomfort on insertion and aesthetics:

"It's disgusting....I wouldn't even try [it]. It slips, twists, [you] have to hold it—[it's] a lot of work."—*Nurse*

"It's visible externally...part of it [hangs] out....Yuck—don't want it."—*Nurse*

"Hard to put in; seems...noisy."—*Physician assistant*

However, only one provider's negative assessment of the female condom was based on personal use:

"I tried it. Sex feels worse."—*Nurse*

Providers' negative responses often were framed in terms of their clients' experience with the female condom:

"I guess my bias comes from patients who have negative reactions....99.5% of women shown the female condom are repulsed by it."—*Nurse*

"It's not popular. No one seems interested. We show it, but it seldom gets a yes."—*Social worker*

"I show it; usually all I get is a laugh."—*Social worker*

One nurse practitioner admitted, "My own bias is it's easier for a man to use a condom; [the female condom] seems so awkward." This comment seemed surprising, given that providers frequently mentioned difficulties in getting men to use condoms.

Several providers acknowledged their ignorance about the effectiveness of the female condom and how to insert it. Two suggested that this influenced whether they promoted the method to clients:

"I'm more reluctant to recommend it because I'm not sure how it's inserted."—*Social worker*

"I know very few women using it. It has to do with our own ignorance. We don't promote it as much as we should."—*Physician*

Several program-related barriers to promoting female condoms were mentioned. The following comments were typical:

"Female condoms are not free here, but if [clients] have Medicaid, they can get a prescription for them."*—*Physician assistant*

"We don't have that many to distribute because of the price."—*Social worker*

Despite these reservations, several providers indicated the need for more information about the female condom:

*The female condom is an over-the-counter product (i.e., no prescription is required). In New York State, however, it is reimbursable by Medicaid with a physician's written order.

"We need to know more about it—and how to use it." —*Nurse*

"We need more education."—*Social worker*

• *Diaphragm.* When asked who they thought would be a good candidate for diaphragm use, 21 providers responded that this method was appropriate for certain types of women; one said the method was not appropriate for any woman, and none thought it was appropriate for all women. Providers described the ideal diaphragm user as being someone responsible, with good self-control and confidence in inserting the diaphragm (i.e., someone who is comfortable touching her body). For example, one nurse thought the ideal candidate would be "someone who can stop and [insert] it in the heat of the moment." Other characteristics used to describe good candidates for diaphragm use were lack of interest in or ability to use hormonal methods and partners' dislike of or refusal to use condoms.

Providers were not enthusiastic about the diaphragm, however. They reported that it was not popular with women and that they rarely recommended it. One social worker candidly admitted, "I show it, but my bias is against it because my friend got pregnant [despite using it]."

• *Spermicides.* Fourteen providers believed that use of a spermicide (nonoxynol-9) alone for contraception was ineffective and thought that spermicide should be used only with condoms—particularly as a backup method in case a condom fails. The remaining eight, who believed that a spermicide could be used alone, viewed this method in the context of a harm reduction approach—that is, when a highly effective method is not used, use of a less-effective method is desirable if it reduces the risk of unprotected sex. Scenarios of this type mentioned by the providers involved women whose partner refuses to use a condom, women who do not like hormonal methods or for whom they are contraindicated and women with low fertility. Although information about the possible disease prevention effects of spermicides was not widely available at the time of our interviews,* no one mentioned this potential benefit.

Hormonal Methods

Providers were more positive about hormonal contraceptives than they were about male or female condoms for pregnancy prevention. Thirteen providers indicated that they would recommend the injectable depot medroxyprogesterone acetate, while 14 said they would recommend the pill unless it was medically contraindicated. Providers cited specific factors that they thought could make pill use a health threat to the user; these contraindications included a high risk for HIV or ovarian cancer, obesity, diabetes, heart problems, varicose veins, seizures, irregular bleeding and smoking.

Views varied on who was most appropriate for each type of hormonal method. Five providers thought that not recommending the pill was justified if the client seemed forgetful or irresponsible, if she had intercourse infrequently or if she was an adolescent. In contrast, five mentioned positive features making the injectable an attractive option to recommend. Specifically, they noted that it is a long-term contraceptive; its use can be hidden (from parents and partners); and it is less susceptible to user failure than the pill is, because women do not have to remember to take it. However, two providers would not recommend the injectable to adolescents because it causes irregular bleeding.

Emergency Contraception

Although 11 providers believed that emergency contraception was appropriate for all women, 10 others described it as appropriate only in specific situations—after a one-night stand, when a condom breaks or for HIV-positive women. One social worker reported being unfamiliar with emergency contraception. When asked directly, 18 providers asserted that there should be limits on the use of emergency contraception; 12 of these thought that emergency contraception should be readily available but not used regularly for birth control. A nurse noted, "If you see a person is doing it regularly, then it's getting to be a trend....I wouldn't recommend it for them."

Counseling was recommended to help frequent users of emergency contraception choose a regular contraceptive method:

"Reinforce [that] they should be on birth control, and let them realize they are at risk [because of] what they put into their bodies."—*Nurse*

Some providers expressed concern that continued use might harm the body—for example, by damaging the uterus. None mentioned that emergency contraception could serve as a backup method in the case of condom failure; however, this issue was not raised systematically.

Dual Protection

When asked how they would counsel women who needed both pregnancy and disease protection, most providers equated dual protection with use of two methods. Providers did not trust condom use alone as a strategy for dual protection:

"The only method that protects [against] both things is the pill [in combination with a] condom."—*Physician assistant*

"We stress pregnancy prevention plus condoms. If the client doesn't want to get pregnant, generally I don't recommend condoms unless [she] is highly motivated and [her] partner willing."—*Nurse*

Half the providers recommended dual-method use for all women, while the other half considered it necessary only for certain types of women—for example, women with multiple partners or with unfaithful partners, sexually active youth and HIV-infected women. Four providers said they would not recommend dual-method use for women in a monogamous relationship.

*In 2000, results of a trial involving female sex workers in South Africa, Benin, Côte d'Ivoire and Thailand showed that nonoxynol-9 is ineffective for prevention of HIV transmission (source: Van Damme L et al., 2002, reference 34). In fact, the study showed that for women who used the microbicide gel frequently (application more than 3.5 times daily) and who had genital lesions, the risk of HIV infection was increased compared with that for women who used a placebo. Moreover, a review of nine nonoxynol-9 trials involving 5,096 women, primarily sex workers, found no evidence of a protective effect against HIV infection or other STDs (source: Wilkinson D et al., 2002, reference 34).

All family planning providers should be trained in sexual risk assessment and counseling on barrier methods.

DISCUSSION

The setting of this study, CHN, is one in which great strides have been taken to integrate family planning and STD services and to promote condom use. Almost all providers demonstrated an awareness that large numbers of their clients are at risk for STDs yet use condoms inconsistently. Most providers believed in universal STD risk assessment.

Providers encouraged dual protection through condom use for disease prevention combined with hormonal method use for contraception. However, because providers noted that they typically discussed STD risk and pregnancy risk separately with clients, their counseling did not help clients to think about the two concepts together. Although not all family planning clients will need dual protection (e.g., those who are pregnant or who have had a tubal ligation), a concurrent pregnancy and STD risk assessment can help to individualize the counseling session, increase women's awareness of dual-protection options and identify the context in which women must make choices. It can also help to make optimal use of the limited provider time for family planning visits.

The standard of care in the family planning field is to present the array of available contraceptive methods and let the clients choose. However, we found that views about contraceptive methods among the providers we interviewed often were based on providers' perceptions of their clients' social categories—for example, whether they were single or married, young or old—instead of their individual circumstances and the methods' effectiveness in preventing disease or pregnancy. Other studies have reported that when providers evaluate the appropriateness of contraceptive methods for individual clients, they base their decision on factors such as the age of the client.[25]

Both the diaphragm and the female condom require a woman to touch her body and to practice inserting the device in the vagina, but providers viewed these methods differently. No provider defined the diaphragm as a method of last resort. Meanwhile, no provider said that older, more mature women, or women who have a steady partner and have planned sex, would be good candidates for the female condom. These differences may reflect perceptions of the diaphragm as a method for family planning and the female condom as a method for disease prevention.

Despite the proven effectiveness of the female condom, almost all the providers in this study viewed it as a method of last resort, suitable for women with no other options or for women at high risk, rather than as an option for all women needing disease protection. This was true even though many providers spoke about the difficulties women faced in getting their partners to use the male condom. Even providers who viewed the female condom as an appropriate method for some women expressed negative attitudes toward it. Providers lacked an understanding of how the female condom is used and, more important, how to address clients' initial negative responses and counsel those who would consider trying it. Nonetheless, they wanted to learn more about this method. Given that women's health advocates were a driving force in accelerating Food and Drug Administration approval (in 1993) of the female condom and in promoting the benefits of its use, it is somewhat surprising that family planning providers, many of whom advocate women's controlling matters of their own sexual health, did not view the female condom more favorably.

Our findings regarding providers' negative views of the female condom are consistent with findings in previous studies.[26] In another study of ours, conducted among New York City providers from five health care settings, many providers were negative about the female condom, mainly because they thought it was difficult to use and unappealing visually.[27]

Nevertheless, some research results allow room for optimism. Several studies have shown that when given comprehensive training on use of the female condom, providers develop more positive attitudes about the method and increasingly incorporate discussions of it in their counseling.[28] In a study of family planning providers in South Africa, participants reported greater comfort with using the female condom after they received training and gained experience in using it.[29] Other research has shown that training can improve providers' knowledge and counseling skills regarding STDs.[30] A study of the acceptability of the diaphragm in three countries (Colombia, Turkey and the Philippines) reported that providers' negative views diminished as they learned that this method has fewer side effects and is safer than hormonal methods.[31]

Although these family planning providers expressed strong support for male condom use—"always use condoms" was a clinic mantra—most did not view either the male or the female condom by itself as a viable method for pregnancy prevention or dual protection. Consistent with their agency's stated policy of promoting dual-method use, most providers in our study voiced serious reservations about the contraceptive use-effectiveness of the male or female condom. Until evidence demonstrates clearly the benefits of the one-method versus two-method approach to dual protection, the family planning field should promote a counseling approach that reviews each woman's situation and tailors counseling and prevention alternatives accordingly. This approach would include informing women that the male or female condom can be used as a contraceptive. As family planning providers learn more about emergency contraception, and thus develop more positive views about it, the possibility of using this option, when necessary, may allay their fears of an increased pregnancy risk from use of a condom alone. However, whether clients' use of emergency contraception will reduce rates of condom use, as use of other hormonal methods does, remains unknown.

Research may help identify circumstances in which the one-method approach or the dual-method approach to dual protection is more appropriate. Several factors should be considered: the likelihood of exposure to infection compared with concern of unintended pregnancy, perceived consequences of the outcomes and clients' motivations.[32]

Our study is limited by the use of data that relied on

family planning providers' reports; actual counseling practices were not assessed. Because we did not observe provider-client interactions or interview clients, the impact of providers' beliefs and attitudes on clients' behaviors is unknown. Moreover, our results cannot be generalized to other reproductive health service providers, because our participants' views may not represent the views of all providers.

Future Directions

Our findings strongly suggest that all family planning providers should be trained in sexual risk assessment and counseling on barrier methods—critical components of effective STD prevention. Several strategic areas require strengthening. First, providers need training to move beyond assessments of clients' sexual risk behavior that use questions requiring only yes-no responses. Critical to the tailoring of client-centered dual-protection counseling is providers' ability to elicit detailed information about the STD risks of clients and their partners.[33]

Second, providers need training in how to help women talk to their partners about risk and protective behaviors, and how to probe so that they can be reasonably assured that their partners respond candidly.

Third, training exercises in clarifying providers' values can help providers to identify their own biases about barrier contraceptives. This is especially important because clients may depend on providers for information and advice about newer methods, such as the female condom. Providers should be trained to routinely offer the female condom as an option for clients who are at risk for STDs.

Fourth, as a consequence of more conclusive evidence regarding the ineffectiveness of nonoxynol-9 in preventing STDs,[34] providers need to be updated as new microbicidal products are developed. Finally, providers need training in how to implement specific dual-protection counseling approaches for different types of clients and situations. However, because providers do not always conduct risk assessments and deliver dual-protection messages that they have learned,[35] training alone will probably be insufficient. Mechanisms for monitoring the impact of training, along with continual reinforcement of newly acquired skills, must be put in place. Reinforcement increases family planning providers' skills in client-centered counseling and, therefore, clients' satisfaction with the counseling.[36]

Conclusion

In the United States, the introduction of the pill in the 1960s revolutionized the field of family planning, providing women with the ability to control contraceptive use and prevent pregnancy by using a highly reliable method. The AIDS pandemic has prompted calls for a wider range of female-initiated methods for STD prevention. User acceptability and increased uptake of these methods will probably depend in part on the family planning field's initiative to promote these methods, as well as the concept of dual protection, consistently.

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