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"When I Talk About Sexuality, I Use Myself as an Example": Sexuality Counseling and Family Planning in Colombia

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For a long time, it was a joke in the reproductive health field that most family planning services operated as though contraceptive use had nothing to do with sex. Evidence from around the world has brought to light how profoundly the power dynamics in sexual relations restrict women's use and choice of contraceptive methods, or force them to use methods secretively. The onset of the HIV/AIDS epidemic and rising consciousness about sexually transmitted infections (STIs) and reproductive tract infections (RTIs) have provided additional and urgent reasons to put promotion of sexual health on the agenda of all family planning agencies.

This increasing awareness has led to specific operational challenges. How can personnel at all levels be trained to address sexual health in ways that are respectful of diverse service users when the surrounding culture inculcates lack of respect? How can they deal with gender-based power dynamics that determine women's ability to protect themselves from STIs, sexual coercion, or violence? This case study of institutional change describes how one family planning organization—Profamilia in Colombia—confronted these challenges and expanded its mission and services by adopting a sexual and reproductive health approach.[1]

THE EVOLUTION OF PROFAMILIA

As a family planning organization, Profamilia is an often-cited success story. Founded in 1965 by Fernando Tamayo as a nonprofit, nongovernmental organization, Profamilia is Colombia's International Planned Parenthood Federation (IPPF) affiliate, one of the largest in IPPF's worldwide network. With 35 clinics in 31 cities and almost three-quarters of a million client visits each year, Profamilia is a major service provider in Colombia, delivering approximately 60 percent of all family planning services in the country.[2]

Although Profamilia originally focused exclusively on contraceptive delivery, in 1967 it began to diversify. It expanded its services, first by providing Pap smears and, later, gynecologic services and some pediatric and general medical care. By the mid-1980s, Profamilia had broadened its mandate beyond women's medical services, and over the next ten years (1985–94) it gradually launched an impressive range of new services. First the agency opened men's clinics in Bogotá and Medellín; while vasectomy provision was perhaps the driving force for opening these clinics, many men came for treatment of STIs and urologic problems. Next, it began to provide legal services for women and opened youth centers. Profamilia continued to expand its sexual and reproductive health services by conducting a workshop for clinic directors on gender issues and reproductive rights, undertaking an AIDS prevention campaign, and establishing an advisory office for issues related to sexual and reproductive rights and gender. In 1995, María Isabel Plata, a cofounder of Profamilia's legal services for women and a lawyer internationally recognized for her work on women's rights, became Profamilia's executive director.

In the midst of this expansion, foreign donors, most notably the U.S. Agency for International Development (USAID), began withdrawing support from Colombia. In 1995 the Colombian government implemented health-sector reform through Law 100. Law 100 is notable for its progressive commitment to equity and universal access in the health care system, its coverage of a range of family planning and sexual and reproductive health services, and its support for community-based health promotion. The opportunity for financial reimbursement from the government created by Law 100 induced many public and private institutions to begin offering reproductive and sexual health services. While the law's passage resulted in the loss of Profamilia's "monopoly" as the national provider of private-sector family planning and reproductive health services, it also gave the organization additional opportunities for attaining financial sustainability (Profamilia and AVSC International 1996).

TURNING CHALLENGES INTO OPPORTUNITIES

By the early 1990s, Profamilia found itself with a shrinking donor base and a deepening philosophical commitment to diversifying services. Rather than retreat in the face of uncertain finances, the organization invested further in a holistic approach to reproductive health, sexual and reproductive rights, and gender equity—programmatic steps that would resonate with the principles of the 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 World Conference on Women in Beijing. The organization opted to emphasize increased quality and

diversity of services, enhance responsiveness to users' concerns and rights, and expand sexual health services beyond the confines of the male clinics. What had been a slow but steady process of diversification accelerated.

Financing the growing range of services was a daunting task. Because neither legal nor psychological services were covered by Law 100, Profamilia had to increase its fees for these services. On the other hand, many of its reproductive health services—including educational activities such as talks on violence or sexuality in the community and schools—became universally reimbursable for the first time, giving Profamilia the potential to achieve greater financial self-sufficiency in the process of implementing ICPD principles.

Plata explains the synergy generated by these strategic challenges as Profamilia adapted to the new situation:

> *Diversification of services and involvement in women's rights, adolescent programs, and men's services has caused more youth, women, and men to come to Profamilia. When we give talks on these topics, it opens the doors to other institutions [with which Profamilia gains contracts]. For example, the talks on rights and self-esteem opened the door to collaboration with Family Welfare [a major government agency]. . . . Thus, implementing the principles of holistic care, gender equity, and sexual and reproductive rights prepared Profamilia for the changes brought by Law 100. . . . If we had not taken advantage of the principles approved in Cairo and Beijing, we would not have had success under Law 100. Everything acted in concert: our financial needs, the changes in the health sector, the withdrawal of USAID, and our adoption of these principles.*

Indeed, Profamilia's experience has shown that far from being too costly and complicated, providing expanded sexual and reproductive health services has been financially beneficial. Because the new clinical and community education services are reimbursed through the government's health insurance scheme, incorporating the ICPD principles of sexual and reproductive health has been key to Profamilia's financial sustainability. As of December 1998, service fees and product sales covered 74 percent of Profamilia's budget, up from 35 percent in 1989.

The organization underwent a number of administrative and programmatic changes in diversifying services as part of its larger goal of incorporating sexual and reproductive health principles. This chapter highlights one important aspect of the diversification: the incorporation of sexual health into Profamilia's services, and how the organization's broader commitment to holistic approaches, gender equity, and sexual and reproductive rights enhanced promotion of sexual health. Box 1 illustrates why the commitment to sexual health must be addressed within this broader framework of institutional change.

Box 1. Sexual health: Confronting stereotypes

According to covenants of the World Health Organization and the United Nations, sexual health involves a state of comprehensive physical, emotional, and social well-being related to one's sexuality. Promoting sexual health involves much more than prevention of disease, and doing so runs up against a host of powerful cultural and political obstacles related to interpersonal relations and communication, gender, and involvement of men. While contexts vary enormously both among and within countries, recent research on sexuality shows common patterns within or across many cultures that force much sexual behavior into hiding and add tremendous complexity to the task of promoting sexual health. These include:

- Taboos on speaking about sex;
- Acceptance of male domination in heterosexual relationships;
- Double standards for men and women regarding monogamy in sexual relationships;
- Condemnation of diverse sexual practices and nonheterosexual orientations;
- Culturally imposed sanctions on the exercise of sexuality by adolescents (particularly girls), by women, and outside of marriage;
- Tendencies to blame the victims of sexual coercion and violence, especially if they are adult and female, and to excuse male perpetrators;
- Sexual stereotyping of low-income groups and ethnic minorities; and
- Norms of masculinity that emphasize sexual conquests and risk-taking.

Confronting these patterns is the central challenge for any agency developing sexual health programs. Even staff who are normally respectful, understanding, and adequate listeners may behave differently when confronted with thorny issues of sexuality and gender. Deep-seated discriminatory attitudes related to gender, class, and ethnicity, all of which tend to have sexual components, interfere with providers' ability to counsel clients adequately. Many providers suffer from sexual traumas or problems that make it difficult for them to be unbiased listeners. Providers at all levels must hone their skills at listening, responding nonjudgmentally, and demonstrating respect for all clients regardless of their age, sex, marital status, income level, or ethnic background. Perhaps the most difficult part of this process is self-criticism—providers must learn to recognize and eradicate their own unexamined discriminatory attitudes and behavior. Adding sexual health services, therefore, entails addressing these complex sociocultural issues. Efforts to incorporate sexual health services must be linked to broader efforts to humanize provider–client relations, promote clients' rights, sensitize providers to discrimination, involve men as supportive partners, and help staff deal with their own concerns.

A COMMITMENT AT THE TOP TO A FOCUS ON SEXUAL HEALTH

Although some professional and counseling staff in Colombia's large cities had received training in reproductive health and gender as early as the late 1980s, the full-scale incorporation of sexual health into Profamilia's work began in the early 1990s. In a workshop devoted to gender issues held in 1991, all clinic directors received training from feminist health leaders from other Latin American countries. By this time, Profamilia had learned—from its experiences with the men's clinic, legal services, youth programs, and AIDS campaigns—that incorporating a sexual health framework into services and into the institutional concept of quality would require a multifaceted strategy that addressed gender and rights issues and reached all levels of the organization.

Profamilia identified the following mechanisms for change within the organization:

- Training in counseling for personnel at all levels, using both in-house and outside trainers, so that the dominant cultural attitudes on sexuality and gender would not translate into judgmental approaches with users on sexual health issues.
- New pamphlets and information, education, and communication materials aimed at both men and women on STIs and AIDS, sexual and reproductive rights, sexual dysfunction, sexual violence, adolescence and sexuality, and genital and reproductive tract infections.
- New evaluation tools, including a pilot evaluation that involved gender issues[3] such as domestic and sexual violence, and indicators that included sexual health concerns.
- Quality-of-care and ethics committees, to deal with new quality and ethical issues as reproductive and sexual health services diversified.
- Ongoing internal reinforcement through informal face-to-face and written communication (e.g., encouraging doctors and midwives to invite increased male participation, and internal discussions about ethical and rights issues that staff confront in their daily work).

A FOCUS ON COUNSELING

Because Profamilia was expanding into an area so dependent on provider–client interaction, the linchpin strategy for promoting sexual health was to improve the quality of counseling. Before the initiative, the organization's counselors were responsible for talking with users about issues specific to the services they were seeking (e.g., contraception, Pap smears, and pregnancy testing) and gave talks on reproductive health topics in workplaces, schools, and other municipal locations. They needed additional training in order to be able to discuss sensitive topics related to sexuality.

Headquarters training staff interviewed both users and staff about the quality of counseling services. Although Profamilia has always had a strong commitment to high quality, comments from users and staff made it clear that there was room for improvement.

Users' comments included:

When I came here two years ago, the woman who counseled me was quite irritable.

When I had my little girl, they treated me so badly that I didn't come back.

Staff also raised concerns:

There was a tendency to treat the person as their method ("the IUD") or as their symptom ("the vaginal infection").

Sometimes a person came for a gynecologic exam and we exhausted ourselves talking about family planning. . . . When we talked about absolutely everything, sometimes the person left more confused than when she had arrived.

Men were rarely included or invited to the women's clinics, which were completely oriented toward serving female users.

People thought of Profamilia as "tube tying, tube tying, tube tying."

Profamilia's youth clinics, which had already succeeded in adopting a more client-centered, sexual health–oriented approach, helped facilitate the incorporation of sexuality into education and counseling institutionwide. Adolescents who had "graduated" to become users of the adult centers returned to their former counselors complaining about rapid and perfunctory attention. As one trainer explained, "If we can do this with young people, we can do it with adults."

Developing Staff Skills

Sexual health workshops for counselors from all Profamilia clinics were held in 1993–94, with funding from the Canadian Planned Parenthood Federation. Evaluations of these early efforts indicated that prejudices related to homosexuality and adolescent sexuality remained deeply entrenched among family planning counselors, even after the workshops. Furthermore, staff at headquarters realized that the "internal clients"—the staff—needed as much assistance on sexual health issues in their own lives as external clients did. Accordingly, the Profamilia trainers began to use more participatory methods and to provide more opportunity in workshops for personal reflection. Germán Lopez, a Profamilia senior staff member, described the need for more intensive training and guidance in this way:

The focus groups with counselors at the beginning of the project showed that former workshops to introduce counselors to the sexual health focus had not been participatory enough. There were many prejudices and stereotypes evident. . . . The discussions . . . demonstrated that . . . the counselors had disdainful and punitive attitudes toward the sexual experiences of women and adolescents [and] they did not perceive the need to incorporate sexual partners.

Furthermore, there was a growing consensus, not only at the agency but also in the field at large, that a necessary first step toward gender equity and sexual health was for women to view themselves as worthy of respect and as having rights. To achieve these goals, Profamilia recognized that it would be crucial for the counselors to boost a woman's self-confidence so that she could begin to make and implement decisions in her own interest. In 1994, with support from the Ford Foundation, Profamilia held a

workshop for family planning counselors nationwide on gender issues, sexual health, and rights. As Lopez explains, "We decided to upset completely the counselors' ideas about sexuality and sexual and reproductive health, confronting their values, myths, and prejudices." However, this training would not have been sufficient to effect needed changes in practice, even when combined with other measures such as new client education materials and other incentives from management. Profamilia had to link changes in personal attitudes to the counselors' need for day-to-day guidance and reference materials. To respond to this need, Profamilia used the workshop to solicit counselors' ideas for the basic content of a reference manual. In general, the counselors responded favorably to the chance to combine exercises that encouraged their personal development with participation in the development of a manual of protocols for their own use.

Developing Counseling Tools

Entitled "How to Incorporate Sexual and Reproductive Health in Family Planning Services and Programs with a Gender Perspective," the manual offered standard protocols for providing counseling on family planning, gynecology, infertility, pregnancy testing, cervico-uterine cancer screening, and testing for RTIs and STIs, with an explicit emphasis on connections to gender issues, rights, and sexuality.[4]

Profamilia appointed a team of three staff members (two national program coordinators and the director of the Bogotá youth center) to develop the first draft of the manual. To ensure that the manual responded to counselors' needs and to give staff a sense of ownership in the manual, the team used the ideas solicited from counselors at the workshop and conducted five focus-group discussions with counselors. Staff input was complemented with information gathered through visits to sexual health programs in Peru and Chile.

The team distributed the draft manual to all counselors for review and then, in January–April 1996, ran five three-day training workshops in four cities for counselors from all Profamilia clinics so that they could be involved in refining the protocols (see Box 2 for a list of workshop exercises).

Participants found that discussion of sexual health counseling required reflecting on and questioning their own values about gender and sexuality. Their remarks affirmed that the process of developing the manual was extremely valuable:

> *The experience with the manual [workshops] was wonderful. We [the counselors] practically developed it. . . . Although we talk about the same things, there can be deficiencies in the way we counsel people. . . . It was very personal. When one arrives at an institution like this, one changes. The change begins with us as the "internal client."*

Box 2. Workshop exercises

- Review of concepts: sexual and reproductive health and gender
- Review of one's own experiences regarding sexuality
- Reading and discussion on pleasure and relationships
- Review of one's own reproductive health concerns
- Analysis of the relationship between personal experiences and work (a communications exercise)
- Review of basic elements of counseling
- Working group review of and suggestions for improving counseling protocols
- Practice in administering protocols
- Planning session on how to implement protocols in the workplace

And we have to change, because if we don't, then we can't change the external client either. In the workshops [however] there are still counselors who hold prejudices, and when the training ends, you don't see the changes immediately.

It was a very intensive week, very participatory, with group exercises that helped us a lot. They taught us to know ourselves better; this helps in personal life and also on the job.

Volume I of the two-volume manual includes 30 protocols organized according to key variables such as service requested, client age, prior use of family planning, whether or not pregnancy is desired, and whether or not the client is sexually active. The organization of the manual helps the counselor determine the issues that should be addressed with different types of clients. Because many topics are included in the 30 protocols, the protocols use standardized language to discuss the couple's relationship, self-care, and information on contraceptive methods. For example, all of the protocols (except the one for clients who are not sexually active) direct the counselor to address the couple's relationship and ask many of the same sorts of questions (see Box 3). The protocols having to do with a couple's relationship open up the topic of the quality of the sexual relationship. Value judgments are evident in this text, however, that might cause users with multiple partners to feel devalued and criticized by the counselor.

Almost all of the protocols include some interview questions that vary with the user's situation. Hence, the protocol for sexually active adolescents starts with questions about the coercive versus voluntary nature of sexual activity, while the protocol for adult clients seeking Pap smears begins with general questions about the couple's relationship. While the adult protocols neither explicitly prompt the counselor to probe for violent or coercive relationships nor include an invitation to involve the sexual partner in counseling, interviews with counselors suggest that in large clinics in 1998, they were doing both in practice with female clients.

Box 3. Counseling manual's standard section on couple relationships

(Excerpt from the module for a sexually active adult who is a first-time user of family planning.)

The counselor should assume that the client coming for information on contraception either plans to have sexual relations or is currently doing so.

If the client has a stable partner, find out whether the partner supports the decision to adopt a method, and in what way he or she is supporting the decision.

Ask about the level of communication with the sexual partner, the client's knowledge of the sexual life of the partner, the client's opinion of the importance of mutual fidelity, and how long the client has been in this relationship. This information is necessary for the following reasons:

- To determine risk behaviors: whether the client has sexual relations indiscriminately without using condoms or, if the client has only one partner, whether the client is confident of the partner's fidelity and has been for a long time.
- To be used as an opening to discuss condom use in addition to use of another contraceptive method, and to ascertain whether the partner would be in agreement. The counselor could suggest communication strategies to persuade the partner if he is reluctant to use a condom (see article in Volume II on safe sex).
- To emphasize the client's responsibility for caring for her or his own body and health as well as that of her or his sexual partner (see section on self-care).

Volume II of the manual gives complementary readings on key subjects, including sexuality, human sexual response, menopause, myths and prejudices about sexual relations, self-esteem, safe sex, STIs, quality of care in services, personalized counseling for women with unwanted pregnancies, and Pap smears. Written by Profamilia staff and other Latin American authors, the readings were compiled to provide relevant background information for staff on these topics and their relationship to sexuality.

Participants in the workshops were expected to return to their clinics and replicate the training with other staff involved in service provision. As can be expected, this strategy had mixed results. Some reported that high turnover among doctors made their involvement in training difficult; others, however, ran successful workshops with all levels of staff, including doctors.

PROGRESS

Sexual and reproductive health counseling has taken a huge leap forward at Profamilia. In a six-month post-training evaluation that began in late 1996, counselors reported many successes and changes in their clinics, including incorporation of the new topics into counseling, increased user satisfaction, increased use of services other than family planning, and remodeling of clinics to provide more privacy for counseling. In interviews conducted in 1998, counselors reported feeling comfortable asking a very general question, often related to whether or not a spouse was in agreement with the use of family planning or the quality of the couple's relationship, that left an opening for

a conversation on relationships and sexuality.[5] Others described greater ease in discussing issues of sexuality: "When I talk about sexuality, I include myself. . . . Eight years ago it would not have been possible to talk about sexuality—now we plunge into these topics without worries or fears." Counselors also expressed confidence that they could refer users to the psychologist when faced with concerns they could not handle.

Staff psychologists have emerged as key figures in the incorporation of sexuality into Profamilia's work. As the counseling sessions began identifying a greater number of women with emotional concerns, the psychologists (who had originally been hired to work in the youth centers but had taken on some adult clients) expanded their duties. Clinic-based psychologists now regularly counsel women who are victims of domestic or sexual violence, as well as couples with infertility and sexual problems. They also serve as a mental health referral agent whenever an adult client demonstrates to a counselor or other clinician the need for more sophisticated psychological support and intervention than counselors can provide. For example, user concerns about orgasm or communication with sexual partners can usually be handled by the counselors, but a client suffering from physical abuse will be referred to a psychologist for more extensive counseling and assistance. Some psychologists also accompany those counselors who feel the need for extra support when they give community talks on sexuality.

Analysis of comments from client focus groups suggests that counseling has improved as a result of the ongoing internal examination and training.

> *This time when I was in counseling, the young woman was very nice and told me that the information I had received [two years earlier] was not correct.*

> *I came two years ago, but now the counselors explain things much better, they are more concrete . . . and they spend more time explaining each method.*

REMAINING CHALLENGES

Profamilia is justifiably proud of its progress in incorporating sexual health into its services. But change does not come without some institutional upheaval. A number of remaining challenges were identified during this case study of institutional change at Profamilia.

Persistent Ambivalence About Sexuality Counseling

The emphasis on expanded counseling generated some ambivalence at the managerial level regarding what a counselor can and should handle. Contrary to the picture painted by the counselors, one administrator felt that "women don't like us to talk about sexuality, and the gynecologists don't want to ask about it. It seems very intrusive."

However, in focus groups female users acknowledged that they lack information about self-care, STIs, and HIV/AIDS prevention, and stated that they are completely uninformed about sexual and reproductive rights, women's rights, and users' rights. Many indicated that they would be willing to stay in the counseling sessions for a longer period of time in order to gain this information. Believing that women want this information does not, however, solve the problem. As another administrator stated, "The users can become very distressed and talk so much that the counselors can't handle it" [in the time allotted for the session].

Counselors themselves worry that they lack the skills necessary to deal with situations that are difficult but not rare—for example, women experiencing sexual violence, unwanted pregnancy, and problems with gender identity and sexual response or dysfunction. As one youth center staff member commented, "Some of the situations covered in the manual are still difficult for me to deal with at times, such as rape, unwanted pregnancies, and lack of self-esteem." Executive staff recognize that for sexual and reproductive health to be definitively incorporated into counseling services, continuing staff training will always be needed owing to normal staff turnover and the lack of a psychologist in smaller clinics.

The incorporation of sexuality and gender issues into counseling at the men's clinic has also been uneven. The vasectomy service has a counselor/coordinator, and vasectomy counseling now addresses sexuality, particularly users' fears and myths about sexual pleasure and performance following the procedure. As one satisfied user reported after the counselor applied the new protocols, "I never imagined that vasectomy would raise so many issues. Now I am less worried." However, the vast majority of clients (87 percent in one study[6]) come to the men's clinic with other concerns (primarily related to urologic problems and screening for STIs), and it is unclear whether the male counselors are comfortable discussing sexual health outside the context of vasectomy counseling. None of the counselors interviewed in 1998 spontaneously referred to counseling clients who came for STI and HIV/AIDS screening, and they had little to say in response to direct questions. The clinics prominently advertised the availability of Viagra, although one counselor said that there had been little demand for it. Counselors reported that women tend to be the more talkative members of couples, and that the counselor often needed to encourage men to speak.

Gender Bias in Sexuality Counseling

The quality of counseling for male and female clients has improved, but gender bias remains. Women are asked about patterns of sexual coercion or violence on the part of their male partners, but they are not encouraged to delve into issues of their own

sexual satisfaction and pleasure. Men are encouraged to discuss their concerns about pleasure and performance, but they are not asked questions that might reveal violence or sexually coercive patterns on their part. While these may be the concerns that users present, counselors may also be reinforcing gender stereotypes accepted by the culture (e.g., that a "real man" must always be ready for sex and that women should not be concerned with pleasure and satisfaction), thus shortchanging both male and female clients in important ways.

Approaching Sexual Partners Appropriately

Most counselors and clinic directors stated that a client is routinely asked to invite his or her sexual partner, and that they counsel more couples now than they did before. When working with a couple, counselors pay attention to the couple's interactions and to the rights of the person who is about to adopt a contraceptive method or undergo a medical procedure. Sometimes, however, involvement of partners can be taken too far; after the training there were a few reports of counselors who demanded rather than invited the presence of the partner, possibly pressuring the client to bring a partner when he or she did not want to. The best routine question might be, "Do you have a sexual partner you would like to invite to the next visit?" Most counselors interviewed already seemed to have incorporated this practice.

Time Constraints

Counselors also feel time pressures when sessions involve discussion of relationships and sexuality. While the average counseling session is 15–20 minutes long, sessions with clients who have a pressing problem can last up to an hour. Post-training evaluations from different sites in late 1996 found that the lack of time and personnel had become a critical issue in some clinics.

Staff responded in several ways. Counselors made it a point to inquire about a client's primary concerns at the beginning of the session so that they could focus on these points of interest and leave time at the end to broach new topics having to do with sexual and reproductive health. Difficult cases were often referred to the psychologist, and, in cases of sexual or physical violence, also to legal services. Clinic directors also began placing new information materials related to sexual and reproductive health in all waiting rooms.

In the last few years, the larger clinics have dealt with the lack of time by training all staff to deal with sexuality issues to some extent. Doing so serves multiple purposes: It provides extra capacity for dealing with clients, and it creates an environment that is more understanding of sexuality concerns and a staff that works better as a team. This

strategy was facilitated by the organization's historical commitment to training staff at all levels in sexual and reproductive health. At the Cali clinic, for example, the cashiers design the monthly poster display, and an accountant had read the entire counseling manual. In all three cities there are training events that include all levels of personnel. One counselor in a male clinic commented:

> *It is so important to train everybody, because when an interview turns into a lengthy one, the nurses or the receptionists have to give at least a minimal level of counseling, and they are trained to do so. Everyone here fills more than one function. The administrative staff also attends to the public. . . . Even the security guards know how to give basic information on the services we provide.*

Training all staff also makes it possible for administrative staff to climb the career ladder and become counselors.

Lack of Privacy

Both executive staff and counselors highlighted lack of privacy in the physical infrastructure of some clinics as a major obstacle to offering counseling on sensitive topics such as sexuality. As noted earlier, several clinics nationwide have made remodeling the counseling space a high priority.

Evaluation

While Profamilia has conducted pilot evaluations of incorporating sexual health and gender issues into the services it provides, there is no evidence that these issues have been incorporated into the routine monitoring and evaluation of quality of care. This situation is not unique to Profamilia. It reflects one of the major challenges to providers of sexual and reproductive health services worldwide. The preoccupation with "indicators" in the donor and NGO communities in this field is indicative of the difficulty of evaluating progress on sexual health and gender issues through routinely gathered measures.

INCORPORATING SEXUAL HEALTH INTO SERVICES: A MATTER OF INSTITUTIONAL AND CULTURAL CHANGE

Profamilia's experience illustrates that transforming provider–client interaction is not a simple before-and-after story. Profamilia's executive director, María Isabel Plata, explains that incorporating sexual health into services in any institution is necessarily "both an institutional and a cultural process. It takes time." Precisely because the cultural barriers to the promotion of sexual health in most societies are numerous and deeply rooted, the process requires ongoing investment. Still, despite uneven achieve-

ments, Profamilia staff agree on the basic philosophy underlying counseling. As one staff member explained:

> *The most important aspect of learning to do individual counseling is to learn to listen to the person facing us before giving any information.*

In incorporating sexual health into its services, Profamilia had much to build on and many subsequent opportunities to reinforce the gains achieved through the early training and the development of the manual of counseling protocols. Before 1994 the organization had positioned itself to incorporate the principles of the Cairo conference through a historical commitment to quality of care and good management practices; development of superior evaluation systems; the presence of feminists in leadership positions; long-standing civic involvement in policy dialogues on sexual, reproductive, and women's rights; recognition of the importance of staff training; and a spirit of innovation.

In the four years following its initial counselor training, Profamilia adopted two main strategies to consolidate its progress, as follows:

- *Standardized incorporation of sexual health issues into education and services.* Examples include incorporating sexual health themes into its curriculum for sex education in the schools, and adding questions to the clinical record form used nationwide that relate to sexuality (pleasure and risks), violence (physical, psychological, and sexual), and negotiation between couples.
- *In-service training opportunities that focus on sexual health and gender.* Recent examples include conferences on sexuality for Bogotá clinic staff, research on adolescent sexuality supported by WHO, and an internal study group on masculinity. In 2001, Profamilia's Gender and Rights office coordinated an effort with the youth centers of the largest nine clinics to strengthen their approach to sexuality and sexual rights. The program, entitled "Constructing Bridges of Respect for Difference," involves center directors, staff, and peer educators in addressing homophobia and other prejudices.

CONCLUSION

How transferable is Profamilia's experience? Undoubtedly, several factors enhanced the sexual health initiative. Profamilia has a reputation for being well-managed and innovative, with an ability to adapt to changing circumstances, be forward-looking, and institutionalize principles of quality of care. The growing presence of women's rights advocates in leadership positions has greatly strengthened the organization's commitment to holistic approaches, gender equity, and sexual and reproductive rights. Finally, the progressive aspects of Colombia's health system reform enabled Profamilia to implement these commitments while achieving greater financial sustainability.

Although these internal and external factors served as important building blocks for the sexual health initiative, the challenges faced by Profamilia are still comparable to those faced by all other service organizations whose historical focus has been family planning.

The deep cultural roots of attitudes about sexuality demand that providers undergo a "shake-up" of their attitudes, to enable them to counsel users on sensitive sexual health issues without being judgmental or punitive. Most counseling and medical staff need to examine these issues in their own lives. The participatory education and training methods used by Profamilia stimulated both personal reflection and attitudinal change among the counselors and involved them in developing their own counseling guidelines. While such training is necessary, it is not sufficient. Profamilia uses many strategies to complement the counselor training and reference manual, including training medical and administrative staff, producing new client educational materials, developing new evaluation strategies, participating in national and municipal campaigns on AIDS, and taking out subscriptions to key journals to which staff have access. The key to having staff take institutional initiatives seriously is to promote guiding principles consistently over time through a range of synergistic strategies, rather than to rely on one-shot interventions with no follow-up.

In the process, Profamilia discovered that it must draw on skills and validation from a variety of in-house resources and community partners. The adolescent program fostered an openness to matters of sexuality that the staff had resisted earlier. This was a surprise, but an important lesson. Feminist health advocates provided information and experience that were valuable in framing the curriculum and getting a sense of women's needs. Legal services staff contributed their expertise by dealing with issues of rights and gender, such as violence against women. Psychologists, once involved, added professional credibility to the counseling sessions, made sensitive subjects discussable, and connected them to health in a formal way. There was a surprising openness among all staff, and even inexperienced staff contributed to the development of written materials and manuals. Indeed, sexuality is a subject that people at all levels need to explore more fully.

Acknowledgments

Special thanks to the staff at Profamilia for their generosity with their time, insights, and institutional information. María Isabel Plata, Patricia Ospina, Gabriel Ojeda, Germán Lopez, Ana Cristina Gonzalez, and Maria Cristina Calderón at headquarters gave me an institutional overview, while the directors and counselors at the clinics in Bogotá, Cali, Ciudad Kennedy, and Medellín provided valuable insight on how institutionwide initiatives translate into changes in services. The writing of this chapter was made possible by generous support from the Ford Foundation and the David Rockefeller Center for Latin American Studies at Harvard University.

Notes

1 This case study is based on data from a project supported by the Ford Foundation from 1994–96, and on data collected during two weeks in October 1998 during site visits to Profamilia clinics in Bogotá, Cali, Ciudad Kennedy (in the urban periphery of Bogotá), and Medellín. During these visits, I collected additional documents and interviewed key informants, including executive staff at headquarters, clinic directors, one or two counselors in male and female clinics, and psychologists from the youth centers. Given the limitations of the data and the sample, this case does not necessarily represent the situation of Profamilia services in other cities and in rural areas, nor can it approach the validity of a full evaluation.

2 Before 1995, when a new health insurance law took effect, Profamilia provided 70 percent of the country's family planning services. See Galvis 1995 for details.

3 IPPF/Western Hemisphere Region involved Profamilia and two other Latin American IPPF affiliates in a four-year effort to develop an evaluation manual that incorporates gender issues. The manual was published in English and Spanish (IPPF/WHR 2000).

4 Urology and antenatal services were not included in the protocols because of low client volume, and because most urology and antenatal clients use one of the other services included in the protocols.

5 The counselors were aware that they should have been incorporating sexual health topics into their counseling. Therefore, the interviews cannot serve as evidence of consistent behavior in counseling, but they demonstrate new internalized norms and experiences of implementing them.

6 From a 1997 quality-of-care study in the Bogotá men's clinic (Barker 1998).

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