Family Planning–Integrated Antiretroviral Therapy: A Curriculum

Trainer's Manual

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Acknowledgments

This manual is intended for providers of HIV care and treatment services, supervisors, field officers, and community outreach and communications personnel. It was drafted in 2006 for use in Uganda, and was later revised and updated by the ACQUIRE Project.

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Abbreviations and Acronyms

AIDS	acquired immuneodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
BCC	behavior change communications
CD4	cluster of differentiation 4
CHW	community health worker
COC	combined oral contraceptive
DMPA	depot-medroxyprogesterone acetate (marketed as Depo Provera)
DMU	dual method use
ECP	emergency contraceptive pills
FHI	Family Health International
HIV	human immunodeficiency virus
HMIS	health management information system
IEC	information, education, and communication
IUD	intrauterine device
LAM	lactational amenorrhea method
LMP	last menstrual period
MCH	maternal and child health
MEC	Medical Eligibility Criteria
MOH	Ministry of Health
MTCT	mother-to-child transmission
NVP	nevirapine
OI	opportunistic infection
PHA	public health authorities
PID	pelvic inflammatory disease
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
PNA	performance needs assessment
PNC	postnatal care
POP	progestin-only pill
RH	reproductive health
SDM	Standard Days Method
SOAP	Subjective/Objective Assessment Plan
SRH	sexual and reproductive health
STI	sexually transmitted infection
TASO	The AIDS Support Organization
TB	tuberculosis
UNFPA	United Nations Population Fund
VCT	voluntary counseling and testing
WHO	World Health Organization

Introduction for the Trainers

Introduction

As HIV prevention, care, and treatment services increase both the availability of antiretroviral therapy (ART) and people's access to it, many more people living with HIV (PLHIV) are living longer, higher quality lives. This results in a growing unmet need for family planning (FP) and reproductive health (RH) services among PLHIV. Until recently, the FP needs of PLHIV have largely been overlooked. Health personnel generally lack the knowledge and skills needed to help men and women to make free and informed decisions regarding their reproductive and contraceptive options and are less equipped to support women who are taking antiretroviral (ARV) medications.

As part of the ACQUIRE Project's systems approach to integrating FP with HIV care and treatment services, training is a system needing interventions to help build capacity among health care personnel so they can operationalize integrated services. To further support training, this manual discusses:

- Levels of integrating FP into HIV services for on-site provision of contraceptive information, counseling, and methods options
- Functioning of facility-based and community outreach service-delivery cadres in FP-HIV integrated services

What Is Integration?

Integration is an approach in which health care providers use a health encounter to help a client address broader health and social needs than those prompting the initial encounter. Integration provides anticipatory assessment and plans and evaluates services relevant to the clients' desires, needs, and/or risks. When this approach is applied to FP and HIV services, the goal is to offer comprehensive HIV prevention, counseling and testing, and treatment in which FP is integral to care. As a result, the FP component of care will reflect HIV-positive individuals' unique needs to improve their sexual and reproductive health (SRH) outcomes—e.g., fertility decision making, FP options in relation to HIV status, and use of ARV drugs or drugs to treat opportunistic infections (OIs).

Very often, the term "integrated services" creates an image of a facility where a client could have all of her/his health needs met in one encounter, but this may not be feasible or appropriate, depending on the service's capacity. FP-integrated HIV services may be offered at the same facility or location during the same operating hours. FP-integrated HIV services may also be offered by the same provider in one visit, or "the provider of one service would actively encourage the client to consider using the other service during that same visit," if the needed services are beyond the capacity of the facility or the skills set of the attending provider.[1] For integration to be effective, though, an effective referral system *must* be in place to ensure that coordinated care is accessible and affordable.

[1] Foreit, K., et al. 2002. When does it make sense to consider integrating STI and HIV services with family planning services? *International Family Planning Perspectives* 28(2):105–107.

In terms of integration, potential points at which client-tailored information and services can be provided or recommended emerge along a continuum of care. An integrated approach engages the client in addressing her/his broader health and or social needs besides those that prompted the health encounter. On the facing page is a program model chart of five possible levels for integrating FP with HIV services. Though these levels of integrated care can be offered as facility-based services, they also could be offered through mobile service mechanisms: Levels A through C could be offered by community- and/or home-based personnel.

This manual should be used to set the context for training based on the results of needs assessments that have identified the service delivery system's capacity to integrate FP into HIV and ARV therapy (ART) services and to offer examples of the FP-integrated practices that various cadres of providers can perform, based on the intended level of integration.

The Fundamentals of Care

If efforts to expand access to quality RH/FP services as an integral component of HIV care and treatment are to be successful, programs must pay sustained attention to the fundamentals of care. These fundamentals consist of three main elements:

1. Ensuring informed and voluntary decision making
2. Assuring the safety of clinical techniques and procedures
3. Providing a mechanism for ongoing quality assurance and management

As part of the process of integrating FP services with HIV care and treatment services, facilitative supervision is one of the key mechanisms for institutionalizing continuous quality assurance. It is the primary means for maintaining a focus on the other two fundamentals of care to sustain service quality.

Goals and Objectives

The goal of this training is to equip ART center staff, community outreach workers, and personnel providing home-based services with knowledge and skills and to promote the accepting attitudes that they need to provide FP services as a component of comprehensive HIV care and treatment.

General Training Objectives

By the end of the training, ART center staff, community outreach workers, and personnel providing home-based services should be able to:

- Provide accurate FP messages and method-related information during health talks and counseling
- Address sensitive issues about sexuality in a confident manner that enables clients to discuss their sexual issues while protecting their sexual and reproductive rights
- Explore with clients their fertility desires, risks for unintended pregnancy, and risks for infection

Levels of Integrating FP into HIV Services for On-Site Provision of FP Information, Counseling, and Methods Options

Level A	Level B	Level C	Level D	Level E
Provides all of the following functions: • Provides FP information to clients accessing ART, PMTCT, STI, VCT, and tuberculosis services. • Performs risk/intention assessment for pregnancy or spacing. • Counsels on FP methods, methods' ability to prevent STI and HIV infection, method choices available and where to access, dual protection, and potential drug interactions with hormonal methods. • Provides condoms, with instructions for and demonstrations on correct use. • Provides emergency contraceptive pills (ECPs).* • Refers for other methods not offered on-site.	***Provides all Level A functions plus:*** • Provides combined oral contraceptives (COCs)* with instructions for use. • Provides follow-up or refers for follow-up. • Counsels on potential drug interactions with COCs.	***Provides all Level B functions plus:*** • Provides injectable hormones with instructions for use, and cautions to return on schedule for reinjection without delay. • Provides follow-up or refers for follow-up.	***Provides all Level C functions plus:*** • Provides intrauterine device (IUD) with instructions for use. • Provide implants with instructions for use. • Provides follow-up or refers for follow-up.	***Provides all Level D functions plus:*** • Provides surgical contraceptive methods, with instructions for self-care, and provides follow-up.

*If facilities or programs providing Level A functions are not *immediately* prepared to provide oral contraceptives for ongoing uses, they may provide ECP with referral for ongoing family planning management. If the facility or program already provides oral contraceptives (Level B), it can also offer ECP.

- Provide FP method information, including information related to dual protection and condom negotiation, during counseling
- Provide condoms (male and female, where available), combined oral contraceptives (COCs), injectables such as depot medroxyprogesterone acetate (DMPA, marketed as Depo Provera), and emergency contraceptive pills (ECPs) for clients using an ART facility, and be able to refer them for methods not provided on-site
- Manage common side effects of COCs, DMPA, and ECPs
- Maintain the logistics and record keeping systems for FP-integrated service delivery

Specific Training Objectives

During the training, ART center staff, community outreach workers, and personnel providing home-based services will do the following:

- Explore their attitudes and biases related to the provision of RH/FP services to PLHIV
- Discuss the RH rights of women and men who are HIV-positive, including their right to make free, informed choices about the number, spacing, and timing of their births
- Explain the importance of FP's role in HIV prevention and in HIV care and treatment
- Use updated method-specific information in health talks, counseling, case study exercises, and practicum learning experiences
- Explain the theoretical interaction between first-line ARV drugs and hormonal FP methods; interactions between tuberculosis (TB) treatment drugs and hormonal FP methods; and contraindications for the use of certain ARV drugs during pregnancy
- Practice using institutional logistics protocols for ensuring reliable supplies of FP commodities
- Practice completing standardized health management information system (HMIS) forms to monitor FP activities and use in decision making about services
- Develop a plan for modifying services to integrate the provision of FP based on needs assessment findings and on insights from this training

About This Curriculum

Who Is This Curriculum for?

This training manual was developed to prepare HIV care and treatment providers and counselors—either facility- or community-based—to explore the fertility desires of PLHIV and to offer them counseling on reproductive considerations and on FP methods, including provision of selected methods and referral for those methods not available on-site.

This is a standardized curriculum for facilitating the integration of FP with HIV care and treatment services. This curriculum should be adapted to address the needs of a specific country or program.

The curriculum is designed so that units can be used separately—for example, for continuing education or during orientation workshops or meetings to present different

issues related to supervision, leadership, and improvement of quality of services and providers' performance. A sample agenda is included with this manual (see page xxii).

Course Trainers and Participants

This curriculum is designed to be used by skilled and experienced *trainers.* It is assumed that the trainers understand adult learning concepts, employ a variety of participatory training methods and techniques, and know how to adapt materials to meet the program's and the participants' needs. (For more information, see "Before the Training Course," p. xv.) It is also assumed that the trainers have a deep knowledge of the fundamentals of care, FP, HIV prevention, care, and treatment, and counseling, including performance improvement approaches and tools. The trainers should know how the local supervisory system operates and the roles and functions of supervisors at different levels for supporting integration. The trainers should also have experience working with the target audience—clinicians, counselors, and outreach or community-based personnel. It is assumed that the trainers are well-informed about the results of and experiences with applying the systems approach to FP integration.

A team of two trainers is needed to conduct this intensive and interactive course. The work of well-coordinated co-trainers increases the effectiveness of the training and allows the participants to benefit from the skills and expertise of both trainers.

The *participants* in this course can be clinicians, counselors, and outreach or community-based personnel. To support integration, content can be adapted for use to orient on-site and off-site supervisors. Careful selection of participants helps to facilitate the learning process. The goals and objectives of the course define the criteria for participant selection. Prior FP experience is beneficial.

Training Approach

The curriculum has been developed with adult learning principles in focus and using participatory approaches. All concepts are conveyed through interactive exercises and case studies. Use of different training techniques and activities helps the participants achieve the curriculum's objectives for knowledge, attitudes, and skills. The course activities encourage the participants to apply their knowledge and experiences during the training sessions, become actively engaged in the learning process, reinforce new information, model behavior, demonstrate skills, and create opportunities to practice their skills during the sessions and a field visit, to verify that these are being applied correctly.

Curriculum Design

The curriculum has been developed in a user-friendly, flexible format. It is intended to be adapted as needed, so the training can be tailored to meet the participants' needs and to accommodate time constraints. A detailed, step-by-step description is provided for each session, following a standardized format:

- Essential ideas to convey
- Session purpose and objectives
- Time
- Materials

- Advance preparation
- Flipchart text
- Detailed steps
- Training tips
- Participant handouts
- Trainer's resources

Sessions are grouped within units, which trainers can modify according to the needs of the audience and the time available. The sample agenda presented on page xxii can help the trainers with this task. Trainers are encouraged to adapt the training to make it most suitable to the needs of the participants. Different training methods can be used to fit within time constraints. For example, an interactive exercise might be replaced with a presentation, which may take less time. However, to the extent possible, the trainers should use participatory training techniques, as these have proven to be most effective for adult learning.

The training units also can be used separately for the purpose of continuing education for staff and supervisors. Because of that, the PowerPoint presentations include some repeated slides that serve as an introduction to the topic. During the training course, these slides serve the purpose of reinforcing messages to promote information retention. *Note:* Unit 4 has more than 70 slides that can be used as a resource for this unit. Go through the slides and select those identified for use in the "Materials" section; decide on additional slides that you think will enhance learning. *All of the slides do not need to be used*; select slides based on the participants' background, the time involved, and your identification of "must know" content to support posttraining functions.

Essential ideas to convey are presented at the beginning of each unit or session. The objectives listed for a session are the concrete, measurable behaviors that the participants should have adopted by its end (or by the end of the course). These define what questions need to be considered for the precourse and midcourse assessments, for evaluation of the course, and for follow-up assessments. Use the pretest (see pages 10–19) to provide last-minute adjustments to the training, to identify areas in which knowledge or skills are lacking, and to compare progress in what has been learned from the beginning to the end of training.

While an increase in knowledge is expected as a result of the training, for participants to demonstrate a knowledge level consistent with safe practice, *the FP content postassessment score should be* ***no less than 85%.*** Participants not achieving this level of knowledge of FP content will require additional support during their work time, with close posttraining follow-up until satisfactory learning has been achieved and documented. The midcourse assessment should be scheduled at the end of the first training week; this will allow time to identify remaining areas where knowledge is needed and will guide study before retesting at the end of training.

A time is suggested for each session. The session plans give detailed instructions for conducting each activity and time estimates for each activity.

The materials section describes all of the materials needed to conduct a session: handouts, reference materials, flipcharts, index cards, masking tape, markers, and other supplies. Advance preparation lists the tasks that the trainer needs to complete before the training and provides texts for the flipcharts and other training aids. Some sessions require an LCD projector. If electricity is unavailable, hard copies of the PowerPoint presentations can be used to create a participant handbook and/or handouts during the training. This manual does not include content separated out to create a participant handbook. Training teams can create a participant handbook if they choose to by copying and pasting the technical content into a separate folder. To support training and enhance interactive learning, trainers should give the technical content as a reading assignment to the participants before each session.

Optional exercises and study guides are cited in the agenda and can be found in the relevant units. Answer keys accompany each study guide. Skills checklists for COC and DMPA initiation and follow-up are located in Appendix D; these checklists are for use during simulation exercises and during the clinical and counseling practicum. Job aids and a sample provider/counselor job aid can also be found in Appendix E. For use during Unit 4, a graphic for "Dual Protection" and "Dual Method Use" is also provided.

Each session contains training tips that provide additional information or explanation on content or the training methodology.

Before the Training Course

Three to six weeks before the training, the trainers should carefully read the entire manual and all of the reference materials, paying special attention to the items under Advance Preparation. Prepare folders for each day of the training to hold the needed materials. Plan ahead well enough to have the advance materials ready *before* the training begins. The trainers must prepare in advance all handouts, flipcharts, cards for dividing the participants into small groups, cards for case studies and other exercises, and other materials and supplies needed to conduct the sessions. All materials should be organized by day of training and should be put into an order that follows the order of the sessions. This will save time during the training course.

One week before the training, the trainers should review the daily session folders to verify that all required resources are in place for use during each day of training. The trainers will need to consider the flow of topics, the structure of the course, and the training methodology of each activity, so they know well how they will conduct a session, what they need for each activity, what the key messages are to convey, etc. The session plan will help the trainers organize their work and will facilitate the learning process.

Before the trainers start preparing to conduct the course, they need to contact representatives from the institution that requested the training, to clarify their needs and to discuss the selection of the participants, so as to tailor the course accordingly. The trainers should also discuss logistics and the responsibilities assigned between the trainers

and program institution/organizers. The trainers should discuss the requirements for a training venue, to make sure that the venue suits the training activities. They also need to identify who from the institution that requested the training will attend the opening and closing of the course. In addition, the institution should provide the trainers with the finalized list of participants.

The trainers need to be familiar with the country/regional/district supervision and other support systems that are involved in service provision in that area.

Texts of case studies and exercises should be adjusted to use local names and situations common in the participants' practice. If important issues are missing from the local protocols or if the standards are not up to date, the trainers must discuss with their counterparts the need to initiate the change.

The co-trainers should communicate and work together on preparation. Working effectively in teams requires that the co-trainers establish and maintain respectful, collaborative working relationships and that they enter into new training courses with clearly defined roles and shared expectations about how to conduct training and resolve difficult situations that may arise during training. To ensure that co-training is most effective, training teams should:

- Decide before the course how they will manage potentially disruptive situations, including:
  - How to intervene if a trainer forgets an important point during an exercise
  - How to manage participants who dominate discussions
  - How to respond to participants who upset others by making negative comments
  - How to warn each other if the pace of training is too fast or too slow
  - How to alert each other when a presentation or exercise is running over its scheduled time
- Give the current training their full attention, even when they are not facilitating it. It is disruptive for both the trainers and the participants when a co-trainer engages in distracting behavior, such as writing, whispering, or leaving the training room during a session.
- Set aside time at the end of each day to discuss any issues or concerns that arose during the training sessions and make necessary adjustments to the next day's agenda.

(*Note:* The above points are adapted from de Bruyn, M., & France, N. 2001. *Gender or sex: Who cares? Skills-building resource pack on gender and reproductive health for adolescents and youth workers with special emphasis on violence, HIV/STIs, unwanted pregnancy and unsafe abortion.* Chapel Hill, NC: Ipas.)

During the Workshop

Creating a Positive Learning Environment

Many factors contribute to and affect the learning process. The trainers' behavior is a key factor, because through their behavior and communication style, trainers create a positive,

nonthreatening environment. Carefully applying principles of adult learning to the design and conduct of the course is crucial to facilitating the learning process successfully.

How can the trainers build trust and create a positive learning environment? The trainers should:

- **Create and maintain a nonthreatening environment**:
  - Treat the participants with **respect** and as equals, and make sure that the participants also treat each other with respect and equality.
  - Maintain **confidentiality** if the participants share private information with the trainer.
  - Make sure that the physical environment helps to create a positive learning environment (through proper seating arrangements, comfortable temperature and air ventilation in the room, light, scheduling of breaks, and other arrangements).
- **Pay careful attention to communication**: The flow of **information** is important. When people are kept informed, they feel valued and an integral part of the team; when there is secrecy, they feel threatened. Communication should be as complete as possible and should transmit positive messages of trust. Other tips to follow:
  - Use icebreaker activities in the beginning of the course and warm-up exercises after breaks to encourage team-building and increase comfort.
  - Read the body language of the participants.
  - Listen to everyone's ideas.
  - Acknowledge and praise ideas that the participants contribute.
  - When possible, turn questions people ask you back to the participants so they can use their expertise to respond.
  - Provide positive reinforcement and constructive feedback to individuals and the group, when appropriate.
  - Arrange activities so that the participants can share with the group their knowledge and experiences and can apply them through the activities.
  - Avoid being judgmental about the participants and their comments.
  - Acknowledge that it is normal to feel nervous, anxious, or uncomfortable in new and unfamiliar situations.
  - Share your own experiences, including situations in which you were and were not successful.
  - Show the group that you enjoy working with them.
  - Spend time with the participants during breaks and meals, so that you can have informal time with them.
  - Learn and use the participants' names.
- Model correct behavior by showing trust in others and being reliable yourself. Remember that your actions are as important as your words. Make sure that there is consistency between your words and actions.
- Practice appropriate self-disclosure: When the trainers share what they are thinking, the participants are more likely to trust them because they understand them. However,

The co-trainers should hold daily debriefings. Such debriefings provide the trainers with an opportunity to discuss aspects of the training that need improvement and to adjust the training agenda or the training style. They can discuss the following questions at the end of the day:

1. How well did we meet the goals of our course sessions today?
2. What did we do today that was not effective?
3. What did we do today that was effective?
4. How well did we handle problems that arose during the sessions today?
5. How well are we working together as cotrainers? Is there anything that we need to improve?
6. Is there anything we would like feedback on during the sessions tomorrow?

(*Note:* The above points are adapted from: Wegs, C., Turner, K., and Randall-David, B. 2003. *Effective training in reproductive health: Course design and delivery. Reference Manual.* Chapel Hill, NC: Ipas.)

Observing Clients' Rights

The participants will have direct contact with clients during this FP-HIV integration training course. As with any clinical service, the clients' rights are paramount and should be considered at all times throughout the training course. Each client's permission must be obtained before training participants can observe or assist with any aspect of client care. A client who refuses to grant permission to have participants present when a procedure is performed should not be denied services, nor should the client's procedure be postponed.

Maintaining Privacy and Confidentiality

It is the trainer's responsibility to ensure that a safe environment exists for learning to take place. Ground rules should clearly state that discussions and sharing of thoughts, opinions, and feelings will not be ridiculed or discussed outside of the learning space.

Monitoring Learning Progress

It is important that the trainers monitor the participants' learning process and the progress that the participants make or do not make. At the beginning of the course, the trainers need to understand the knowledge, skills, and attitudes that the participants start the training with, so that at the end of the course, the trainers can evaluate and compare the results of the assessments. For that reason, precourse and midcourse knowledge assessments are useful (as well as a postcourse knowledge assessment, if needed). The knowledge assessment tools are included on pages 10–19, as is an answer key (immediately following the tools).

The trainers should evaluate knowledge and skills (see skills checklists in Appendix D) during the practice sessions, small-group work, exercises, role-plays, and discussions. They should be sensitive to the atmosphere in the training room: They must be able to read the signals that the participants send through their body language. At the end of each day, various forms can be used to collect reflections on the day's events. These forms should be simple and should not require too much time to fill out or be conducted. The participants can provide valuable information about the training process through the use of daily written or exercise reflections. Sample Reflection on the Day forms can be found in Appendix A.

At the end of the course, it is important to reflect on and determine outputs of the training program: What were the postcourse results? What was the overall reaction to the course? Did the trainers achieve the objectives? Did the participants think that they would apply their new knowledge and skills in their everyday work? For those reasons, and as an addition to a midcourse/postcourse assessment, the trainers can use a course evaluation form, which allows the participants to share their experience during the training and their opinions about the usefulness of the training, of the materials distributed, of the training techniques used, of the logistics of the training, and of the trainers' performance.

After the Training Course

An important part of the trainers' and the programs' tasks is monitoring and evaluating the participants' performance after the training, after they have returned to their work places. Developing evaluation strategies and making evaluation plans are essential first steps that should be discussed with an institution's supervisors before the course. The participants should be informed how their performance will be monitored when they apply newly acquired knowledge and skills, who will conduct follow-up, and how this follow-up will be handled.

The follow-up mechanism includes visiting the participants at their facilities, observing the participants' performance, reviewing the progress that the participants have made on their action plans, collecting and analyzing service statistics, establishing a peer-support network, and problem solving with the participants.

The following pages show a detailed breakdown of the functions of a range of facility-based and community outreach personnel at different levels of facilities offering family planning–HIV integrated services. The trainers should keep this breakdown in mind when evaluating the participants, and they should make efforts to refer to and distribute this graphic to the participants during the training.

Posttraining Functions

Facility-Based and Community Outreach Service-Delivery Cadres' Functions in Family Planning-HIV Integrated Services

Level of Integration	Cadre	Provider Tasks by Cadre
A	• Community outreach personnel • Communications personnel—messages and information dissemination • Service providers	• Conduct FP "health education" sessions in service settings offering ART, PMTCT, STI, VCT and tuberculosis services • Conduct pregnancy risk/intention assessment • Provide basic information on each available FP method, including each method's ability to protect against HIV and STI • Include dual protection information during counseling • Provide condoms and instructions for correct use, including demonstration/return demonstration • Provide ECPs, as indicated • Refer the client for his/her selected methods not offered on-site • Document services given
B	• Community outreach personnel • Communications personnel—messages and information dissemination • Service providers	Tasks of "A" plus: • Conduct counseling on available FP methods, including potential drug interactions with COCs • Include information regarding oral contraceptives' ability to protect against HIV and STI; counsel for dual method use • Screen, counsel, and provide COCs • Provide instructions for correct use of COCs; for HIV-positive clients, give tailored instructions for use of COCs if taking ARVs • Document services given

Facility-Based and Community Outreach Service-Delivery Cadres' Functions in Family Planning–HIV Integrated Services (*cont.*)

Level of Integration	Cadre	Provider Tasks by Cadre
C	• Community outreach personnel, including referral to service site • Communications personnel—messages and information dissemination • Service providers	Tasks of "B" plus: • Conduct counseling on available FP methods, including potential drug interactions with hormonal injectables and/or implant • Include information regarding injectables' ability to protect against HIV and STIs; counseling for dual method use • Screen, counsel, and provide injectables • Provide instructions for use of injectable; if HIV-positive client, give tailored instructions for use of injectable if taking ARV drugs • Carry out infection prevention, safe injection practices • Document services given
D	• Community outreach personnel, including referral to service site • Communications personnel—messages and information dissemination • Service providers	Tasks of "C" plus: • Counsel on available FP methods, including the IUD's and/or implant's ability to protect against HIV and STIs; counsel for dual method use • Screen, counsel, and provide the IUD or implant • Carry out infection-prevention practices for IUD or implant insertion and removal • Provide instructions for use of the IUD or implant, including date of removal • Document services given
E	• Community outreach personnel—referral to service site • Communications personnel—messages and information • Service providers (physicians for procedure; nurses, midwives for pre-/postprocedure counseling, instructions, and client support [if it is minilaparotomy under local anesthesia], and postoperative client monitoring.)	Tasks of "D" plus: • Counsel on available FP methods • Inform client of voluntary sterilization's inability to protect against HIV and STIs; counsel for dual method use • Counsel for informed decision making and obtain informed consent for permanent methods • Provide voluntary sterilization • Provide pre-/postprocedure self-care instructions • Provide instructions to men regarding the need to rely on condoms and/or another contraceptive during the first three months following the procedure

Sample Training Schedule

Time	Day 1	Day 2	Day 3	Day 4	Day 5
Week One: Theory and Simulation Practice					
8:00–9:15 AM	• Registration* • Introductions • Participant Expectations • Training Objectives • Logistics	Unit 4: FP Update and FP Use by HIV-Positive Individuals Basics of COCs, DMPA, and ECPs	Unit 5: Health Talks and Integrated RH Counseling Counseling Simulation Practice	Case Studies for FP	Side Effects Management Case Studies (*cont.*)
9:15–10:30 AM	• Pretraining Knowledge Assessment • Overview of HIV Pandemic	Basics of COCs, DMPA, and ECPs (*cont.*)	Counseling Simulation Practice		
10:30	BREAK				
10:45–12:15	Unit 1: Values & Rights (90 minutes)	FP Update and FP Use by HIV-Positive Individuals: COCs, DMPA, ECP, and Condoms	Counseling Simulation Practice		Unit 7.1: Logistics for FP
12:15–1:00 PM	Unit 2: Family Planning's Role in HIV Prevention, Care, and Treatment (30 min.)				Unit 7.2: Record-Keeping for FP
1:00 PM	LUNCH				
2:00–2:30 PM	Unit 2: Family Planning's Role in HIV Prevention, Care, and Treatment (*cont.*) (30 min.)	FP Update/FP Use by HIV-Positive Individuals: Condom Use/Negotiation Skills	Counseling Simulation Practice (cont.)	Unit 6: Management of Selected FP Method Side Effects Side Effects Management Case Studies	• Next Steps for Implementing Integration On-Site
2:30–4:30 PM	Unit 3: Reproductive Anatomy, Menstrual Cycle, Conception (2 hours)	Review of Counseling Principles and Skills			• Midtraining Knowledge Assessment
4:30–5:00 PM	Closing (30 min.)				Preparation and instructions for clinical practice week
Assignments	Reading: FP Methods—COCs, DMPA, and ECPs	Study Guides: FP Methods, Use with ARV and TB Drugs, Dual Protection/Dual Method Use; Helping Clients Communicate	Reading: FP Method Side Effects and Their Management	Exercise: Did You Know?	Exercise: FP Methods Follow-Up Schedule

Sample Training Schedule (*cont.*)

Week Two: Clinical and Counseling Practicum					
Time	Day 6	Day 7	Day 8	Day 9	Day 10
8:00 AM	Preclinical Meeting	Preclinical Meeting	Preclinical Meeting	Preclinical Meeting	Preclinical Meeting
8:30–?	FP Clinical Practice	FP Clinical Practice	FP Clinical Practice	FP Clinical Practice	FP Clinical Practice
3:00–4:00	Postclinical Meeting	Postclinical Meeting	Postclinical Meeting	Postclinical Meeting	Postclinical Meeting
4:00–5:00	Reflections	Reflections	Reflections	Reflections	Posttraining Knowledge Assessment Training Course Evaluation Closing
Assignments	Exercise: Study Guide No. 1: COCs	Exercise: Study Guide No. 2: DMPA	Exercise: Study Guide No. 3: IUD, Implants, LAM, SDM, and Permanent Methods		

Unit 1: HIV Overview

Unit 1: HIV Overview

Session 1.1: Introduction and Overview

Essential Ideas to Convey

- In Africa, reported HIV cases are more common in urban areas than in rural areas. This pattern has been stable since the beginning of the pandemic. The explanation for this is not clear, although it is probably *not* true that people living in rural areas have sex less frequently or have fewer concurrent sexual partners than do their urban counterparts.
- Marriage per se does *not* protect people from HIV infection. In both Kenya and Tanzania, for example, HIV prevalence among adults who are "currently in union" is about double the prevalence of those who have "never been in union."
- Often, women's *only* risk factor for HIV is that they have had unprotected sexual intercourse with their husbands.
- Having *concurrent* sexual partners appears to carry a greater risk of contracting HIV than having *serial* sexual partners. Having more than one concurrent sexual partner is a behavior that continues throughout adult life. It does *not* stop the day one gets married or turns 50.

Note: Trainers should consider incorporating information about HIV here that is specific to the area were the training is being conducted.

Session Purpose and Objectives

The purpose of this session is to update the participants' knowledge of HIV and to introduce the role of family planning (FP) as a strategy for preventing HIV transmission and for supporting the quality of life of people living with HIV (PLHIV). By the end of the session, the participants will be able to:

- Explain the HIV situation around the world
- Explain how FP can serve as an HIV prevention strategy.

Time

30 minutes

Materials

- Participant Handout 1.1a: Pretest/Posttest Assessment Tool for Clinicians/ Providers
- Participant Handout 1.1b: Pretest/Posttest Assessment Tool for Counselors
- LCD projector
- Laptop computer

- Screen (or other surface on which to project slides)
- PowerPoint slide presentation (Session 1)
- A handout for participants reflecting the content of the PowerPoint presentation

Advance Preparation

1. Make enough copies of Participant Handout 1.1a or 1.1b (choose the version of the questionnaire most appropriate to the members of the training group) to distribute to all members of the group.
2. Review the PowerPoint slides and choose slides appropriate to the discussion in this session; feel free to prepare supplementary slides representing the situation in the country or locality where the training is taking place.
3. Make a copy of the final set of slides, and make enough copies of the slides to serve as a handout for the participants. Be sure that the material includes the latest statistics on HIV and describes the current status of antiretroviral therapy (ART) service

Training Steps

1. Distribute Participant Handout 1.1a or 1.1b to the group and allow *10 minutes* for the participants to complete all of the questions. Collect the completed handouts and, after the training day is completed, score the completed handouts against the answer key in Trainer's Resource 1.1.
2. Distribute the prepared handout to the group, and briefly review the current situation regarding HIV and ART services.
3. Present the PowerPoint slides for this session.
4. Lead a discussion by asking the participants to
   - Define "family planning"
   - Explain their ideas about FP's value in HIV prevention, care, and treatment
   - Describe FP's role in HIV care and treatment

Unit 1: HIV Overview

Session 1.2: Sexual and Reproductive Health and Rights of HIV-Positive Women and Men

Essential Ideas to Convey

- It is important for health workers to be aware of their feelings, beliefs, and attitudes about HIV and AIDS, sexual behavior, pregnancy, and FP. If they do not address their personal reactions and emotions, they may unintentionally treat HIV-positive clients differently than clients are treated in general, thereby diminishing the quality of care that they provide.
- Beliefs and attitudes about sexuality, pregnancy, and HIV are often difficult for clients to express, particularly to strangers. Health workers have a professional obligation to remain objective and nonjudgmental and to avoid letting their personal beliefs and attitudes become barriers to communication with clients.
- By exploring and becoming aware of their beliefs about sensitive topics before raising them with clients, health workers can learn how to remain neutral during counseling sessions.
- **Health workers cannot make decisions for their clients**. Clients' rights to make decisions must be respected, even if the provider does not personally agree with their choices or does not personally condone their behavior.

Session Purpose and Objectives

The purpose of this session is to help the participants explore their feelings related to sexual and reproductive health (SRH) rights of PLHIV, to more effectively provide services with a caring and sensitive attitude. By the end of the session, the participants will be able to

- Explore their feelings and values about the SRH rights of HIV-positive women and men
- Demonstrate respect for the diversity of opinions within the group, among health workers, and for PLHIV regarding sexuality and fertility desires
- Examine their own values and attitudes regarding sensitive issues, to remain effective when counseling HIV-positive women and men about sexual activity, pregnancy, and contraception
- List clients' rights regarding reproductive health (RH)

Time

1 hour, 30 minutes

Materials

- Paper, pens, or pencils for participants
- Flipchart paper, markers, tape
- Participant Handout 1.2: My Personal Feelings about Sex, Pregnancy, Family Planning, and Being HIV-Positive

Advance Preparation

Part 1

1. Print enough copies of Participant Handout 1.2 to distribute to the group.

Part 2

1. Prepare three sheets of paper labeled "Agree," "Disagree," and "In Between." Post the signs along a wall, spaced a few body lengths apart.
2. Select the values statements to be used during the session (see Trainer's Resource 1.2: Values Clarification Statements).
3. Arrange the training room to allow adequate open space for the participants to assemble around each sign.

Part 3

1. Collect flipchart paper, markers, and tape.
2. Prepare a flipchart like the one on page 7.

Training Steps

Part 1 (45 minutes)

1. Distribute one copy of Participant Handout 1.2 to each participant. Ensure that the participants have pens or pencils and writing paper.
2. Instruct the participants to write short personal responses to the questions. Their comments are their private thoughts; they should therefore keep their papers to themselves.
3. Ask for volunteers to share their responses to the first question. If the group is hesitant to begin, the trainers should share their own thoughts to get them started.
4. Lead a large-group discussion based on the following questions:
   - ✳ Which questions were the most difficult to answer, and why?
   - ✳ How can thinking about these issues help us become better counselors?
   - ✳ How can our own attitudes and personal experiences with HIV and AIDS affect our work as counselors?
   - ✳ How can we confront and overcome our own concerns and fears about talking with HIV-positive women and men about sex, sexuality, pregnancy, and contraception?

Reproductive Health Rights of Women and Couples

- **Information**
  To receive clear, accurate, complete information so as to learn about the availability and benefits of family planning (FP) as a part of antiretroviral treatment (ART) services.

- **Access**
  To obtain FP services as an integral part of ART services, regardless of age, marital status, socioeconomic class, and HIV status.

- **Choice**
  To decide and plan family size, choose an FP method that best meets their needs, and receive FP services as a part of ART services.

- **Safety**
  To receive all services related to maternal and child health (MCH) and prevention of mother-to-child transmission (PMTCT), and to receive FP information that will prevent unwanted pregnancies and will help HIV-negative women/couples stay free of HIV infection and HIV-positive women/couples prevent HIV reinfection.

- **Privacy**
  To have both visual and audio privacy during FP counseling and service delivery.

- **Confidentiality**
  To be assured that any personal information will not be shared in public.

- **Dignity**
  To be treated with courtesy, enthusiasm, attentiveness, and respect, regardless of socioeconomic status, HIV status, ethnicity, age, or sex.

- **Comfort**
  To ensure physical and emotional comfort while receiving FP-integrated ART services.

- **Continuity**
  To receive ongoing, appropriate FP-integrated ART services for as long as is needed.

- **Opinion**
  To express opinions about the services received without fear and with confidence that the opinions will be considered.

Note: The above information may need to be presented on several pieces of flipchart paper. The key is to ensure that all points will be visible to the participants.

Part 2 (25 minutes)

1. Explain that this exercise will help the participants to understand viewpoints that differ from their own and to consider how these differences influence their effectiveness as counselors. State that there are no "right" or "wrong" answers and that all are entitled to their own opinions. However, providers must be responsible in examining how their attitudes and opinions can potentially undermine quality client-centered care and services.
2. Ask the participants to gather in the center of the open area. Direct their attention to the "Agree," "Disagree," and "In Between" signs.
3. Explain that you will read a series of values statements. After a statement is read aloud, the participants will decide whether they "agree" or "disagree" with that statement or if they are unsure of their response. Those who agree are to stand by the "Agree" sign. Those who disagree are to stand by the "Disagree" sign. Those who are unsure are to stand under the "In Between" sign. Let the participants know that if during subsequent discussions they hear something that causes them to change their opinion during the activity, they are free to move from one sign to another.
4. Read a statement aloud. Ask the participants to move to the appropriate area of the room, according to their opinion. Invite comments from one or two participants from each location ("Agree," "Disagree," "In Between") to explain why they have chosen to stand where they are. The trainers must remain neutral, but you can share factual information to clarify matters, as needed. After hearing a representative from each position, give the participants the option of switching positions if they wish. When participants move, ask them what prompted their decision to change position.
5. Repeat this process until you have posed all of the statements that you wish the group to consider.
6. Ask the participants to return to their seats for a group discussion. Facilitate a discussion based on the following questions:
   - ✳ Which statements were the most controversial, and why?
   - ✳ How did you feel when other people expressed values and beliefs that differed from yours?
   - ✳ How did it feel to hold a minority opinion?
   - ✳ How did it feel to hold a majority opinion?
   - ✳ What differences would you expect to find between the values of health workers and those of HIV-positive women and men?
   - ✳ How do such differences affect our work when counseling clients?
   - ✳ How can providers help clients to make difficult decisions when they disagree about fundamental values?
   - ✳ How can we prevent our personal values from influencing our counseling in a negative way?

Trainers' Tips

It is important for the trainers to remain neutral throughout this exercise and to maintain a balance among the different viewpoints expressed.

To explore a range of issues, you may need to limit discussion of each statement to comments from one or two participants representing each position.

Do not clarify the meaning of the statements, as this may influence the results. If participants ask for clarification, simply read the statement again.

If everyone moves to one side of the room (e.g., everyone "agrees" with the statement), you can ask the group how a person with the opposite opinion might defend his or her position. Alternatively, one of the trainers can step into that spot and speak out on that position, clarifying to the group that they are just stating the rationale for that position in a direct and straightforward manner.

Part 3 (20 minutes)

1. Ask the participants to list what RH rights they believe PLHIV have.
2. Write the participants' responses on a blank sheet of flipchart paper.
3. Display the prewritten flipchart with the complete clients' rights listed.
4. Ask the participants to give an FP-integrated ART example for each client's right.
5. Explain to the participants that in the next unit, they will look specifically at a statement from the United Nations Population Fund (UNFPA) and World Health Organization (WHO) on the *sexual and reproductive health rights of women living with HIV*.

Participant Handout 1.1a

Pretest/Posttest Assessment Tool for Clinicians/Providers

Name: _____

Date: _____

Part 1

Instructions: Check (✓) one response for each of the questions below. There is no right or wrong answer to these questions.

1. **I believe that telling HIV-positive women and men that certain behaviors put them at risk for unintended pregnancies and for infection or reinfection with HIV or other sexually transmitted infections (STIs) is generally enough to cause them to change their behavior.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

2. **I am comfortable providing health services to HIV-positive women and men.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

3. **I believe that I am at high risk of becoming infected with HIV while working at my clinic.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

4. **I believe that it is important to counsel every woman and man living with HIV about their sexual and reproductive health and rights.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

5. **I believe that people who have sex with members of the same sex have a right to access the highest-quality health services at my facility.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

6. **I believe that providing family planning (FP) to HIV-positive women will encourage them to have sex and to become pregnant.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

PART 2

Instructions: For each of the following statements, circle either "true" if you agree with the statement or "false" if you disagree.

7. **HIV-positive women and men have the same sexual and reproductive rights as those who are HIV-negative.**

   True/False

8. **HIV-positive women and men have the right to have another child if they want one.**

   True/False

9. **The only FP methods that HIV-positive women and men should use are abstinence or condoms.**

   True/False

10. **Pregnant HIV-positive women should be advised to have a tubal ligation after they have delivered their baby.**

    True/False

11. **If a woman with an intrauterine device (IUD) becomes HIV-positive, she should have the IUD removed.**

    True/False

12. **Prior to starting antiretroviral therapy (ART), women should be asked to sign a written statement that they will not get pregnant while they are taking antiretroviral (ARV) drugs.**

    True/False

13. **Women who are taking ARV drugs should not use injectables (e.g., depot medroxyprogesterone acetate [DMPA], marketed as Depo Provera).**

    True/False

14. **IUDs are a safe contraceptive method for most HIV-positive women.**

    True/False

PART 3

Instructions: Circle the **letter** of the **right answer(s)**.

15. A common side effect that some women experience when using DMPA is irregular bleeding. The recommended management is:

a. Double the dose of the DMPA injection.

b. Assess for other possible causes and, if there are no other causes, reassure the client that the irregular bleeding will improve over time.

c. Assess for other possible causes and, if there are no other causes, offer the client combined oral contraceptives (COCs) for five days or one cycle, or ibuprofen, 800 mg, every eight hours for three days; inform the woman that the irregular bleeding *may* return.

d. Change the method immediately.

16. Women with HIV who are on ART benefit from using contraception because:

a. They can focus more on their ART and other demands related to HIV disease when their risk of unintended pregnancy is reduced.

b. It allows them to avoid a potentially complicated pregnancy (i.e., ARV drugs can aggravate anaemia and insulin resistance that are common during pregnancy).

c. All ARV drugs are contraindicated during pregnancy.

d. A wider range of ARV drugs is available to women who are not at risk of pregnancy.

17. There are several theoretical concerns related to the use of hormonal contraception among women with HIV who are taking ARV drugs. The following statements accurately describe these issues and theoretical concerns:

a. Research has proven that COCs do not affect the efficacy of ARV drugs.

b. Some ARV drugs reduce blood levels of contraceptive hormones; lower concentrations could reduce the effectiveness of hormonal contraceptives.

c. Some ARV drugs can increase blood levels of contraceptive hormones; higher concentrations could increase hormone-related side effects.

d. Evidence from available research on ARV drugs and hormonal contraception is sufficient to warrant more restrictive changes to existing clinical practices.

18. What particular issues should providers discuss when counseling women with HIV who are considering pregnancy?

a. That pregnancy accelerates HIV disease

b. Risks and rates of mother-to-child transmission of HIV

c. That ARV drugs administered around the time of delivery reduce HIV transmission to the child

d. That combining breastfeeding and artificial feeding (mixed) is best for reducing postpartum HIV transmission

e. The implications of rearing a child with HIV

f. The availability of family support

g. The location and logistics of available care and treatment

19. What particular issues should health workers discuss when counseling HIV-positive clients who are considering contraception, including hormonal contraception, while taking ARV drugs?

a. The advisability for couples with HIV to abstain from sexual intercourse

b. The characteristics of contraceptive methods, including possible side effects and complications

c. The ability to use a method correctly (e.g., take pills on schedule, especially if taking ARV drugs)

d. Less need to consider method effectiveness due to reduced fertility caused by HIV

e. Drug interactions between hormonal contraceptives, ARV drugs, rifampicin, and griseofulvin

f. The limitations of FP methods with regard to preventing pregnancy and STI/HIV infection or reinfection

g. The advantages of dual protection, including dual method use

h. A partner's willingness to use condoms, and condom negotiation strategies

i. When to return for questions, problems, and resupply of the contraceptive method

j. The need to return for frequent follow-up, even if problems do not arise, because of the client's HIV status

20. In addition to information specific to pregnancy or contraception, what other topics should providers discuss while counseling HIV-positive clients?

a. The importance of knowing a partner's HIV status, including encouraging partner testing if his or her status is unknown

b. The fact that it is not necessary to use condoms if both partners are HIV-positive

c. Considerations in disclosing HIV status, including the risk of abandonment, violence, or loss of financial support

d. The requirement to bring one's partner for testing

e. The requirement to disclose one's own status to the partner

f. Referrals to other reproductive health services, as needed (e.g., STI management and treatment; postpartum, postabortion, and antenatal care; and HIV care and treatment)

g. The availability of support systems (e.g., family, community, social, legal, nutritional, or child health services)

Participant Handout 1.1b

Pretest/Posttest Assessment Tool for Counselors

Name: _____

Date: _____

PART I

Instructions: Check (✓) one response for each of the questions below. There is no right or wrong answer to these questions.

1. **I believe that telling HIV-positive women and men that certain behaviors put them at risk for unintended pregnancies and for infection or reinfection with HIV or other sexually transmitted infections (STIs) is generally enough to cause them to change their behavior.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

2. **I am comfortable providing health information or services to HIV-positive women and men.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

3. **I believe that I am at high risk of becoming infected with HIV while working at my clinic.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

4. **I believe that it is important to counsel every woman and man living with HIV about their sexual and reproductive health and rights.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

5. **I believe that people who have sex with members of the same sex have a right to access the highest-quality health services at my facility.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

6. **I believe that providing family planning (FP) to HIV-positive women will encourage them to have sex and to become pregnant.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

PART 2

Instructions: For each of the following statements, circle either "true" if you agree with the statement or "false" if you disagree.

7. **HIV-positive women and men have the same sexual and reproductive rights as those who are HIV-negative.**

   True/False

8. **HIV-positive women and men have the right to have another child if they want one.**

   True/False

9. **The only FP methods that HIV-positive women and men should use are abstinence or condoms.**

   True/False

10. **Pregnant HIV-positive women should be advised to have a tubal ligation after they have delivered their baby.**

    True/False

11. **If a woman with an intrauterine device (IUD) becomes HIV-positive, she should have the IUD removed.**

    True/False

12. **Prior to starting antiretroviral therapy (ART), women should be asked to sign a written statement that they will not get pregnant while they are taking antiretroviral (ARV) drugs.**

    True/False

13. **Women who are taking ARV drugs should not use injectables (e.g., depot medroxyprogesterone acetate [DMPA], marketed as Depo Provera).**

    True/False

14. **IUDs are a safe contraceptive method for most HIV-positive women.**

    True/False

PART 3

Instructions: Circle the **letter** of the **right answer(s)**.

15. A common side effect that some women experience when using DMPA is irregular bleeding. The recommended management is:

a. Double the dose of the DMPA injection.

b. Assess for other possible causes and, if there are no other causes, reassure the client that the irregular bleeding will improve over time.

c. Assess for other possible causes and, if there are no other causes, offer the client combined oral contraceptives (COCs) for five days or one cycle, or ibuprofen, 800 mg, every eight hours for three days; inform the woman that the irregular bleeding *may* return.

d. Change the method immediately.

16. Women with HIV who are on ART benefit from using contraception because:

a. They can focus more on their ART and other demands related to HIV disease when their risk of unintended pregnancy is reduced.

b. It allows them to avoid a potentially complicated pregnancy (i.e., ARV drugs can aggravate anaemia and insulin resistance that are common during pregnancy).

c. All ARV drugs are contraindicated during pregnancy.

d. A wider range of ARV drugs is available to women who are not at risk of pregnancy.

17. There are several theoretical concerns related to the use of hormonal contraception among women with HIV who are taking ARV drugs. The following statements accurately describe these issues and theoretical concerns:

a. Research has proven that COCs do not affect the efficacy of ARV drugs.

b. Some ARV drugs reduce blood levels of contraceptive hormones; lower concentrations could reduce the effectiveness of hormonal contraceptives.

c. Some ARV drugs can increase blood levels of contraceptive hormones; higher concentrations could increase hormone-related side effects.

d. Evidence from available research on ARV drugs and hormonal contraception is sufficient to warrant more restrictive changes to existing clinical practices.

18. What particular issues should providers discuss when counseling women with HIV who are considering pregnancy?

a. That pregnancy accelerates HIV disease

b. Risks and rates of mother-to-child transmission of HIV

c. That ARV drugs administered around the time of delivery reduce HIV transmission to the child

d. That combining breastfeeding and artificial feeding (mixed) is best for reducing postpartum HIV transmission

e. The implications of rearing a child with HIV

f. The availability of family support

g. The location and logistics of available care and treatment

19. What particular issues should health workers discuss when counseling HIV-positive clients who are considering contraception, including hormonal contraception, while taking ARV drugs?

a. The advisability for couples with HIV to abstain from sexual intercourse

b. The characteristics of contraceptive methods, including possible side effects and complications

c. The ability to use a method correctly (e.g., take pills on schedule, especially if taking ARV drugs)

d. Less need to consider method effectiveness due to reduced fertility caused by HIV

e. Drug interactions between hormonal contraceptives, ARV drugs, rifampicin, and griseofulvin

f. The limitations of FP methods with regard to preventing pregnancy and STI/HIV infection or reinfection

g. The advantages of dual protection, including dual method use

h. A partner's willingness to use condoms, and condom negotiation strategies

i. When to return for questions, problems, and resupply of the contraceptive method

j. The need to return for frequent follow-up, even if problems do not arise, because of the client's HIV status

20. In addition to information specific to pregnancy or contraception, what other topics should providers discuss while counseling HIV-positive clients?

a. The importance of knowing a partner's HIV status, including encouraging partner testing if his or her status is unknown

b. The fact that it is not necessary to use condoms if both partners are HIV-positive

c. Considerations in disclosing HIV status, including the risk of abandonment, violence, or loss of financial support

d. The requirement to bring one's partner for testing

e. The requirement to disclose one's own status to the partner

f. Referrals to other reproductive health services, as needed (e.g., STI management and treatment; postpartum, postabortion, and antenatal care; and HIV care and treatment)

g. The availability of support systems (e.g., family, community, social, legal, nutritional, or child health services)

Participant Handout 1.2

My Personal Feelings about Sex, Pregnancy, FP, and Being HIV-Positive

What if you had HIV or AIDS?

- If you were told that you had HIV, in what ways would this change your life?

- What do you think would be the most difficult part about being HIV-positive?

- How would you feel about having sex if you were HIV-positive?

- Would you tell your sexual partner/partners that you have HIV? *Every* sexual partner? Why or why not? How and when would you be likely to tell them?

- If you had HIV, whom would you ***not*** tell? Why would you want to keep the information secret from them?

My Personal Feelings about Sex, Pregnancy, FP, and Being HIV-Positive

What if you had HIV or AIDS?

- How would you feel about having a child (or another child) if you had HIV? Why?

- What factors might make you want to have a (or another) child?

- If you were trying to decide about having a child, with whom would you discuss this? Why? With whom would you ***not*** discuss this? Why?

- If you had HIV, how would you want to be treated in a health clinic?

- Would you feel comfortable talking with someone at ***your facility*** about having sex, about having another child, about FP, or about FP methods? Why or why not?

Trainer's Resource 1.1

Answer Key for Pretest/Posttest Assessment Tool

Part 1

Values questions do not have correct or incorrect answers. Record results in table format to illustrate any changes in participants' attitudes that have occurred during the course.

	Agree	Somewhat agree	Somewhat disagree	Disagree
Pretest				
Posttest				

Instructions: Check (✓) one response for each of the questions below. There is no right or wrong answer to these questions.

1. **I believe that telling HIV-positive women and men that certain behaviors put them at risk for unintended pregnancies and for infection or reinfection with HIV or other sexually transmitted infections (STIs) is generally enough to cause them to change their behavior.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

2. **I am comfortable providing health services to HIV-positive women and men.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

3. **I believe that I am at high risk of becoming infected with HIV while working at my clinic.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

4. **I believe that it is important to counsel every woman and man living with HIV about their sexual and reproductive health and rights.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

5. **I believe that people who have sex with members of the same sex have a right to access the highest-quality health services at my facility.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

6. **I believe that providing family planning (FP) to HIV-positive women will encourage them to have sex and to become pregnant.**

□ Agree □ Somewhat agree □ Somewhat disagree □ Disagree

PART 2

Instructions: For each of the following statements, circle either "true" if you agree with the statement or "false" if you disagree.

7. **HIV-positive women and men have the same sexual and reproductive rights as those who are HIV-negative.**

   True/False

8. **HIV-positive women and men have the right to have another child if they want one.**

   True/False

9. **The only FP methods that HIV-positive women and men should use are abstinence or condoms.**

   True/**False**

10. **Pregnant HIV-positive women should be advised to have a tubal ligation after they have delivered their baby.**

    True/**False**

11. **If a woman with an intrauterine device (IUD) becomes HIV-positive, she should have the IUD removed.**

    True/**False**

12. **Prior to starting antiretroviral therapy (ART), women should be asked to sign a written statement that they will not get pregnant while they are taking antiretroviral (ARV) drugs.**

    True/**False**

13. Women who are taking ARV drugs should not use injectables (e.g., depot medroxyprogesterone acetate [DMPA], marketed as Depo Provera).

True/**False**

14. IUDs are a safe contraceptive method for most HIV-positive women.
True/False

PART 3
Instructions: Circle the **letter** of the **right answer(s)**.

15. A common side effect that some women experience when using DMPA is irregular bleeding. The recommended management is:

a. Double the dose of the DMPA injection.

b. Assess for other possible causes and, if there are no other causes, reassure the client that the irregular bleeding will improve over time.

c. **Assess for other possible causes and, if there are no other causes, offer the client combined oral contraceptives (COCs) for five days or one cycle, or ibuprofen, 800 mg, every eight hours for three days; inform the woman that the irregular bleeding *may* return**.

d. Change the method immediately.

16. Women with HIV who are on ART benefit from using contraception because:

a. **They can focus more on their ART and other demands related to HIV disease when their risk of unintended pregnancy is reduced.**

b. **It allows them to avoid a potentially complicated pregnancy (i.e., ARV drugs can aggravate anaemia and insulin resistance that are common during pregnancy)**.

c. All ARV drugs are contraindicated during pregnancy.

d. **A wider range of ARV drugs is available to women who are not at risk of pregnancy**

17. There are several theoretical concerns related to the use of hormonal contraception among women with HIV who are taking ARV drugs. The following statements accurately describe these issues and theoretical concerns:

a. Research has proven that COCs do not affect the efficacy of ARV drugs.

b. **Some ARV drugs reduce blood levels of contraceptive hormones; lower concentrations could reduce the effectiveness of hormonal contraceptives.**

c. **Some ARV drugs can increase blood levels of contraceptive hormones; higher concentrations could increase hormone-related side effects.**

d. Evidence from available research on ARV drugs and hormonal contraception is sufficient to warrant more restrictive changes to existing clinical practices.

18. **What particular issues should providers discuss when counseling women with HIV who are considering pregnancy?**
    a. That pregnancy accelerates HIV disease
    b. **Risks and rates of mother-to-child transmission of HIV**
    c. **That ARV drugs administered around the time of delivery reduce HIV transmission to the child**
    d. That combining breastfeeding and artificial feeding (mixed) is best for reducing postpartum HIV transmission
    e. **The implications of rearing a child with HIV**
    f. **The availability of family support**
    g. **The location and logistics of available care and treatment**

19. **What particular issues should health workers discuss when counseling HIV-positive clients who are considering contraception, including hormonal contraception, while taking ARV drugs?**
    a. The advisability for couples with HIV to abstain from sexual intercourse
    b. **The characteristics of contraceptive methods, including possible side effects and complications**
    c. **The ability to use a method correctly (e.g., take pills on schedule, especially if taking ARV drugs)**
    d. Less need to consider method effectiveness due to reduced fertility caused by HIV
    e. **Drug interactions between hormonal contraceptives, ARV drugs, rifampicin, and griseofulvin**
    f. **The limitations of FP methods with regard to preventing pregnancy and STI/HIV infection or reinfection**
    g. **The advantages of dual protection, including dual method use**
    h. **A partner's willingness to use condoms, and condom negotiation strategies**
    i. **When to return for questions, problems, and resupply of the contraceptive method**
    j. The need to return for frequent follow-up, even if problems do not arise, because of the client's HIV status

20. **In addition to information specific to pregnancy or contraception, what other topics should providers discuss while counseling HIV-positive clients?**
    a. **The importance of knowing a partner's HIV status, including encouraging partner testing if his or her status is unknown**

b. The fact that it is not necessary to use condoms if both partners are HIV-positive

c. **Considerations in disclosing HIV status, including the risk of abandonment, violence, or loss of financial support**

d. The requirement to bring one's partner for testing

e. The requirement to disclose one's own status to the partner

f. **Referrals to other reproductive health services, as needed (e.g., STI management and treatment; postpartum, postabortion, and antenatal care; and HIV care and treatment).**

g. **The availability of support systems (e.g., family, community, social, legal, nutritional, or child health services)**

Trainer's Resource 1.2

Values Clarification Statements

(DO NOT DISTRIBUTE TO THE PARTICIPANTS**)**

Gender

- The average woman wants sex less often than the average man.
- If a woman never experiences childbirth, she is less of a woman.
- A man is more of a man once he has fathered a child.
- Pregnant women should not have sex.

HIV and AIDS

- Most people who get HIV are promiscuous.
- An HIV-positive person has the right to have sex if he or she wants to.
- It is a crime for HIV-positive people to have sexual relations without informing their partner about their HIV status.
- An HIV-positive person has a right to have another child if he or she wants to.

Sexuality

- Sex without intercourse is not real sex.
- If people go too long without sex, it is bad for them.
- A person can lead a perfectly satisfying life while being celibate.
- Too much sexual activity will worsen HIV or the AIDS condition.

Condoms

- Condoms ruin the enjoyment of sex.
- Condoms are ineffective for long-term family planning.
- There is no point in encouraging married couples to use condoms, because they will not use them.

Adapted from: Ministry of Health. 2005. *Strengthening family planning within the PMTCT program in Uganda*. Uganda.

Unit 2: The Role of FP in HIV Prevention, Care, and Treatment

Unit 2: The Role of FP in HIV Prevention, Care, and Treatment

Session 2.1: Why Include FP in HIV Care and Treatment Services?

Essential Ideas to Convey

- HIV-positive individuals take many emotional, medical, economic, and social factors into account when they are deciding if and when to have another child.
- As ARV drugs become more widely available, more HIV-positive women and men will consider resuming sexual activity. The timing and spacing of future births will thus become an even more important consideration for them when they are planning for their future.
- As ARV drugs become more widely available, many PLHIV will now face lifelong, regular visits to a health care provider (e.g., for 20 or more years). To help sustain healthy behaviors and manage treatment-related problems, the long-term client-provider relationship requires both parties to see each other as equals who share an equal interest in and responsibility for ensuring optimal client-centered care. (***Clients as partners*** *will be discussed in the counseling section.*)
- HIV-positive women *want* to talk about pregnancy and FP with health personnel, but both they *and the health personnel* may be reluctant to raise the subject.
- To make free, informed choices, HIV-positive women and men require comprehensive, accurate, and unbiased information about the considerations and risks of pregnancy and the *range* of FP methods.

Session Purpose and Objectives

The purpose of this session is to introduce the concept of FP and its role in HIV prevention, care, and treatment, as well as those factors interfering with FP use. By the end of this session, the participants will be able to:

- Explain the joint statement by the United Nations Population Fund (UNFPA) and the World Health Organization (WHO) on the sexual and reproductive health rights of PLHIV
- Explain why FP should be a routine component of HIV treatment services and the importance of integrating FP into HIV services
- Discuss factors affecting the decision of PLHIV to use and select FP methods

- Discuss practical issues that arise when providing FP counseling and services to HIV-positive men and women.

Time
1 hour

Materials
- LCD projector
- Laptop computer
- Screen (or other surface on which to project slides)
- PowerPoint presentation: Session 2: Family Planning Prevention, Care, and Treatment (*Note:* At a minimum, include slides [give slide nos.] "Why Include Family Planning in HIV Care and Treatment Services?" "Why Integrate HIV and Family Planning Services?" "Role of Family Planning in HIV Prevention?" "Fertility Choices for Clients with HIV?" "Benefits of Providing Family Planning Services," "Benefits of Involving Men," and "Factors Affecting Family Planning Decision Making")
- Participant Handouts 2.1 and 2.2
- Paper
- Flipchart paper and markers

Advance Preparation
1. Make sufficient copies of Participant Handouts 2.1 and 2.2 to distribute to the group.
2. For additional handouts, selectively download the following documents, if requested or if deemed key to the learning experience.
   - Contraception and ARV Use: www.maqweb.org/techbriefs/tb5arv.shtml
   - Family Planning–ART Integration Priorities: www.maqweb.org/techbriefs/tb11integration.shtml
   - Five Ways to Effective Oral Contraceptive Use: www.maqweb.org/techbriefs/tb30oc.pdf
   - Reducing Medical Barriers: www.maqweb.org/techbriefs/tb29checklist.pdf
   - Useful background information: www.maqweb.org/techbriefs/tb23hormonal.pdf
3. Also, be prepared to hand out copies of the following document: Delvaux, T. and Nöstlinger, C. 2007. Reproductive choice for women and men living with HIV: Contraception, abortion, and fertility, *Reproductive Health Matters*, 15(29 Supplement):46–66. Accessed at: www.hst.org.za/uploads/files/reprohealthmatters.pdf/.
4. Prepare a flipchart listing the group discussion questions in Trainer's Resource 2.1.

Training Steps

1. Tell the participants that you will review briefly why it is important to include FP counseling and the provision of FP methods as an essential component of comprehensive clinical HIV services.
2. Lead a brainstorm using the following questions:
   - ✳ Why should FP be included as a routine component of clinical HIV services?
   - ✳ Why might condoms *alone* be insufficient to address the FP needs of *all* HIV-positive women and men?
   - ✳ Why should other FP methods *in addition* to condoms be discussed and offered to HIV-positive women and men?
3. Record the participants' comments on a blank piece of flipchart paper. Distribute copies of Participant Handout 2.1 and explain that this represents the joint position of the WHO and UNFPA.
4. Begin the PowerPoint presentation. Discuss issues and questions as they arise.
5. After completing the PowerPoint presentation, explain that this represented a brief summary of the importance of including FP in routine clinical HIV care and that this issue is unfortunately often overlooked by health care decision makers and by health personnel.
6. Explain that the participants will now explore some of the reasons why FP is often not covered in counseling and clinical services for HIV-positive women and men.
7. Reveal the prepared flipchart and divide the participants into three groups to discuss the listed questions. (*15 minutes*)
8. Reconvene the participants and ask a representative from each small group to present their findings.
9. Use Trainer's Resource 2.2 as an answer key to ensure that key points are covered.
10. Highlight the points that:
    - FP is effective in preventing HIV.
    - The integration of FP into HIV services helps individuals and couples safely realize their reproductive health rights and desires.
    - Preventing unintended pregnancies can reduce the effects of HIV on pregnancy outcomes for the woman and her baby.
11. Distribute copies of Participant Handout 2.2 and explain that these represented the views of many HIV-positive women and men in South Africa in the mid-2000s, and that these perspectives on reproductive intentions and choices likely still reflect the views of many PLHIV.

Participant Handout 2.1

The Sexual and Reproductive Health Rights of Women and Men Living with HIV

All women have the same rights concerning their reproduction and sexuality, but women living with HIV/AIDS require additional care and counseling during their reproductive life. Often the rights of women are neglected, particularly women living with HIV. Even where the rights of women with HIV are recognized, women are not always able to exercise their rights. The responsible exercise of human rights requires that all persons respect the rights of others.

Family planning services must be comprehensive and address HIV prevention, including, where appropriate, the benefits of abstinence, the risk associated with unprotected sex with multiple partners, as well as the promotion and provision of dual protection.

In addition to medical eligibility criteria, the social, cultural, and behavioral context must be considered and specific recommendations of contraceptive methods individualized for each woman based on her stage of disease and treatment as well as her lifestyle and personal desires. Women living with HIV/AIDS can safely and effectively use most contraceptive methods.

Excerpted from: World Health Organization and United Nations Population Fund (UNFPA). 2006. *Sexual and reproductive health of women living with HIV/AIDS: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.* Geneva and New York. p. 1.

Participant Handout 2.2

Reproductive Intentions and Choices of HIV-Positive Women and Men[2]

Although many HIV-positive women and men do not wish to have more children, some do. The desire and intent to have children among HIV-positive women and men may increase because of the improved quality of life following the commencement of antiretroviral (ARV) treatment.

To better understand HIV-positive people's reproductive intentions and choices, and their need for reproductive health services, the University of Cape Town and the Population Council conducted a qualitative survey in the Cape Town metropolitan area from May 2004 to June 2005. This handout summarizes the survey's findings.

Reproductive Intentions of HIV-Positive Women and Men

Many HIV-positive women and men were firm in their desire *not* to have children. Both women and men feared infecting a partner or their baby and were anxious about possibly dying and leaving their children as orphans. Women and men were concerned about their ability to financially support their children. Women who had given birth to an infected child expressed mixed feelings about becoming pregnant again.

> *I would be committing a great sin if I would have another child knowing . . . this one is sick. I would be putting responsibility on other people and killing myself.*
>
> —Woman on ARV therapy (ART)

At the same time, many HIV-positive women and men felt that children gave meaning to their lives and gave them a reason to live. Many expressed a desire to leave something of themselves behind after they died. Children represented a realization of hope or a sign of normality.

> *People who are unable to have children find it difficult to lead happy lives.*
>
> —Man on ART

Some women expressed a desperate need to have a child, especially if they had no living children:

> *Let's say I have no child at all; I would say to the doctor that, please, I need this child.*
>
> —Woman not on ART

---

[2] Summarized from: Cooper, D., et al. 2005. *Reproductive intentions and choices among HIV-infected individuals in Cape Town, South Africa: Lessons for reproductive policy and service provision from a qualitative study.* Cape Town: University of Cape Town; and New York: Population Council.

One man reported that his decision to reproduce was shaped by a desire to have a larger family, similar to that of his father. Another man expressed his desire for a son:

I have never had a child in my life so I would love to have a child of my own.

—Man on ART

Social Influences

Married women, in particular, reported strong family pressure to reproduce, especially if they had not disclosed their HIV status.

When I am married, I will have to have a baby because . . . only I and my boyfriend . . . are aware that I am HIV-positive and . . . people will ask why am I not becoming pregnant in marriage.

—Woman not on ART

One woman stated that if she did not bring children into a marriage, her child from a previous relationship would be stigmatized. In other cases, where women had disclosed their status to family, they were discouraged from bearing children. Sometimes this was due to concern for the woman's own health.

Women seemed to be more influenced by family attitudes than men. Some men felt that their masculinity was tied to their ability to reproduce and to maintain a family.

There are guys who criticize that you don't have a child yet.

—Man on ART

Most HIV-positive women felt that community attitudes toward them having children would be negative.

[The community] questions a woman falling pregnant while she knew her [HIV] status.

—Woman on ART

Both women and men, however, appeared to be less influenced by the opinions of the community or their friends than they are by those of family. Women and men were strongly influenced by their partners' attitudes towards childbearing. Disclosure was critical in terms of discussing desires. Women and men on ART were far more likely to have disclosed their status to their partner and to have discussed having children. Some women felt pressured by their partner to have a child against their will; others felt strongly that the decision was theirs and that they would rather leave their partner than be coerced into having children. Some men reported feeling that pregnancy and childbirth is a woman's prerogative and that if their partner wished to have children and they did not, they would submit to their partner's wishes.

How PMTCT and ART Programs Shape HIV-Positive Women's and Men's Reproductive Intentions

Some women believed that the availability of services for the prevention of mother-to-child transmission of HIV (PMTCT) would influence them in favor of having children, because they sometimes wished to replace a deceased child or to "do it right" and ensure that a child would not be infected. A number of women, however, believed that the availability of PMTCT services would not influence them if their own health remained poor.

> *It is pleasing to know . . . there is a treatment [PMTCT] that . . . can assist us, [but] it is not only about the child, it is also about us—more so about me. If I decide to fall pregnant, I expect the treatment to help with my condition.*
>
> —Woman not on ART

Women and men on ART overwhelmingly experienced positive effects on their health, and some believed that being on ART would alter their attitudes toward childbearing.

> *I often hear . . . people talking about this within the support groups.... People who resisted having children because of their failing health are now considering having children . . . now that their health has improved through the use of ARVs.* —Woman on ART

Some women on ART, however, feared that their medication could deform their unborn babies. Some men believed the drugs they were on could affect the health of the child they fathered.

> *We were told that if you get pregnant, you will give birth to a child with two heads and all that, your baby will have something wrong.*
>
> —Woman on ART

Perceptions of Health Workers' Respect for HIV-Positive Women's and Men's Reproductive Choices

Most HIV-positive women and men had not discussed their desires and intentions to have children with a health worker because they expected negative reactions. Women tended to view doctors and nurses as handling matters related to care and treatment, while they believed the psychological and social aspects would be handled by counselors.

Some women who had discussed reproduction with a health worker found health workers to be supportive of their choice. Others encountered health workers who expressed negative attitudes about HIV-positive women's becoming pregnant. In some cases, this was even to the point of health workers in antenatal clinics pressing women to terminate their pregnancy.

> *[The nurse] told me that I cannot have a baby in this state.... I need to . . . talk to my husband and tell him that we cannot have children.*
>
> —Woman not on ART

Women on ART, when disagreeing with health workers' opinions, tended to stand their ground.

> *They tell you [in the hospital] . . . there is no need to have a child when you know that you are HIV positive.... They told me . . . I should abort.... I do know it is my right and I do know what chances there are for the child to be or not be positive . . . [and] what the effects of the drugs are.*
>
> —Woman on ART

Men, more than women, tended to feel that health workers would be impartial or sympathetic. Men tended to be more likely to discuss their desires with a doctor than a nurse. Nurses reported that they believed that HIV-positive men were more concerned with sexual performance than with having another child.

> *They [at the clinic] did not have any views [on having children].*
>
> —Man on ART

Trainer's Resource 2.1

Why Include Family Planning in Routine HIV Care and Treatment?

Group Discussion Questions

- *Group 1*: What are some factors (including attitudes and biases) that inhibit health workers from providing counseling about sexual activity, pregnancy, family planning (FP), and FP methods to HIV-positive women and men?

- *Group 2*: What are some factors that inhibit HIV-positive women and men from asking health workers about sexual activity, about the possibility of having a child/another child, or about family planning methods?

- *Group 3:* What practical steps can *we* implement in *our* center to ensure that counseling about sexual activity, pregnancy, family planning (FP), and FP methods is offered to *all* adolescent and adult HIV clients attending our clinics?

Trainer's Resource 2.2

Why Include Family Planning in Routine HIV Care and Treatment?

Possible Responses to Group Discussion Questions

Group 1: What are some factors (including attitudes and biases) that inhibit health workers from providing counseling about sexual activity, pregnancy, family planning (FP), and FP methods to HIV-positive women and men?
o Lack of or little knowledge related to sexuality, HIV and pregnancy, and FP use in HIV o Lack of comfort with and/or skills in discussing sexual matters o Lack of or limited information, education, and communication (IEC) materials to support counseling o Lack of or limited space for privacy in counseling and method provision o Belief that people living with HIV (PLHIV) should not have sex or have children o Pressure placed on women to terminate pregnancy o Behavior (verbal/nonverbal) that communicates lack of willingness to discuss sexual and reproductive health (SRH) matters
Group 2: What are some factors that inhibit HIV-positive women and men from asking health workers about sexual activity, about the possibility of having a child/another child, or about FP methods?
<u>Barriers related to discussing childbearing</u> o Negative attitude of family, if the individual is known to be HIV-positive o Poor condition of health o Concern regarding ability to care for children (financially, physically) o Availability of and access to FP o Amenorrhea o Reduced or no sexual activity o Decreasing CD4 cell count o Abnormal semen (with advanced HIV disease) and reduced sperm motility (with use of ART)
<u>Barriers related to discussing sex</u> o Counseled to abstain o Fear of infecting partner o Feelings of guilt and shame aggravated by HIV stigma o Emotional/psychological distress resulting in reduced desire for or interest in sex o Poor health

Why Include Family Planning in Routine HIV Care and Treatment?

Possible Responses to Group Discussion Questions (*cont.*)

Barriers related to discussing FP

- Fear of side effects
- Lack of knowledge about safety of FP use and FP methods
- Lack of method(s) availability
- Limited method mix
- Limited/no access to FP services
- Desire for pregnancy

Group 3: What practical steps can *we* implement in *our* center to ensure that counseling about sexual activity, pregnancy, FP, and FP methods is offered to *all* adolescent and adult HIV clients attending our clinics?

- Update staff on HIV and pregnancy, on HIV and safe use of FP methods, and on World Health Organization (WHO) Medical Eligibility Criteria; or advocate for staff training in these content areas
- Create awareness among PLHIV networks and communities about safe use of FP and availability of FP services
- Create a private space for FP counseling and method provision
- Assess the facility to see what clinic and system changes are needed to provide FP counseling and method provision to users of the HIV center (supervision, logistics, training, record keeping, referral)
- Establish a referral link with FP clinics that users can easily/conveniently get to

Unit 3: Reproductive Information and Its Use in Counseling

Unit 3: Reproductive Information and Its Use in Counseling

Session 3.1: Reproductive Anatomy, the Menstrual Cycle, and Conception

Essential Ideas to Convey

- For effective communication with clients, providers must be able to explain important aspects of SRH and FP issues in ways that clients understand—particularly anatomy and physiology.
- It is important for health care providers to be able to discuss male and female reproductive anatomy with their clients, especially physiological structures or processes that are affected by or that affect contraceptive use.
- A strong knowledge of the reproductive anatomy, menstrual cycle, and conception will help counselors and providers explain to clients how pregnancy occurs and how various FP methods work to prevent pregnancy.

Session Purpose and Objectives

The purpose of this session is to create an understanding of reproductive anatomy and physiology on which counselors and providers can build SRH and FP method counseling. By the end of this session, the participants will be able to:

- Name and describe the female and male reproductive anatomy
- Explain the menstrual cycle
- Describe the process of conception

Time

2 hours

Materials

- Flipchart paper, markers, and tape
- Participant Handouts 3.1–3.5
- Grab bag, grab bag rewards
- Grab bag questions written on slips of paper, folded

Advance Preparation

1. Make enough copies of the participant handouts.
2. Draw the following visual aids on pieces of flipchart paper:

- Trainer's Resource 3.1: Female Reproductive Anatomy
- Trainer's Resource 3.3: Male Reproductive Anatomy
- Trainer's Resource 3.7: Conception [for the minidrama]

3. Prepare Post-Its or any other small adhesive pieces of paper with the names of the organs shown in the flipcharts and attach them to the underside of the relevant flipchart.
4. Assign readings for the participants for the following day on combined oral contraceptives (COCs), hormonal injectables, and emergency contraception (see page 80, Advance Preparation, Step 2).

Training Steps

Conduct a review or learning session covering female and male reproductive anatomy and physiology, as described below:

Anatomy (30 minutes)

For supervisors/service providers:

1. Display the prepared flipchart showing an unlabeled diagram of the female anatomy.
2. Distribute Participant Handout 3.1. Ask the participants to fill in the names of the indicated organs in the spaces provided.
3. When they have finished, remove the labels from the back of the flipchart and post them along the bottom. Ask for a volunteer to paste a label onto the correct organ, read the first question from Trainer's Resource 3.2, and have the volunteer post the first label (ovary) in the correct location.
4. Confirm or correct the answer, as indicated (using the answer key), ask for another volunteer, and proceed to the next question.
5. Once the diagram has been reviewed and the labels have been placed correctly, distribute copies of Participant Handout 3.2. (This material also can be handed out the day before this session, to be read and studied ahead of time.)
6. Repeat the process for male anatomy using Participant Handout 3.3 and following the answers given in Trainer's Resource 3.4. At the conclusion of this exercise, distribute copies of Participant Handout 3.4. (This material also can be handed out the day before this session, to be read and studied ahead of time.)

For counselors/PLHIV educators:

1. Display the flipchart showing an unlabeled diagram of the female anatomy, remove the labels from the back of the flipchart, and post them along the bottom.
2. Read aloud the questions on female reproductive physiology from Trainer's Resource 3.2 and ask the participants to say what organ they think it is and where they think it is located. Then place the label in the correct position.

3. Repeat this procedure for the male anatomy, using the prepared flipchart showing the diagram of the male anatomy and the questions posed in Trainer's Resource 3.4.
4. Help the participants learn the key structures (vagina, cervix, tube, ovary, and uterus; simplify the male physiology to penis, testes, vas deferens, seminal vesicle, and urethra).

Training Option

The anatomy exercises can be done as a grab bag, in which the participants draw a label from a bag, and the group applies them to the diagram. This will be appropriate for a training group that has already covered this content or were given a reading assignment for this material on the day before (depending on how the schedule has been adapted to local circumstances).

Physiology: Menstrual Cycle

For supervisors/service providers (20 minutes):

1. Distribute Participant Handouts 3.5 and 3.6.
2. Walk the participants through the role of hormones and the stages of the menstrual cycle, highlighting (a) the preparatory activities in the first half of the cycle, (b) ovulation, and (c) the breakdown activities in the second half of the cycle when fertilization does not take place.
3. Allow for participants' questions and clarification.

Training Options

The menstrual cycle material also can be presented as a question-and-answer exercise, using Trainer's Resource 3.5.

For counselors/PLHIV peer educators (15 minutes):

1. Present the menstrual cycle as a story; see Trainer's Resource 3.6 for an example of how this can be done.

Physiology: Conception

For supervisors/service providers (10 minutes):

1. Display the prepared flipchart showing the diagram of conception, remove the labels from the back of the flipchart, and post them along the bottom. Describe the process of conception, highlighting where fertilization takes place, the lifespan of the ovum and the sperm, and when in the menstrual cycle fertilization can occur, and place the labels in the appropriate places on the diagram. Allow for participants to ask questions.
2. Distribute copies of Participant Handouts 3.7 and 3.8 to the participants.

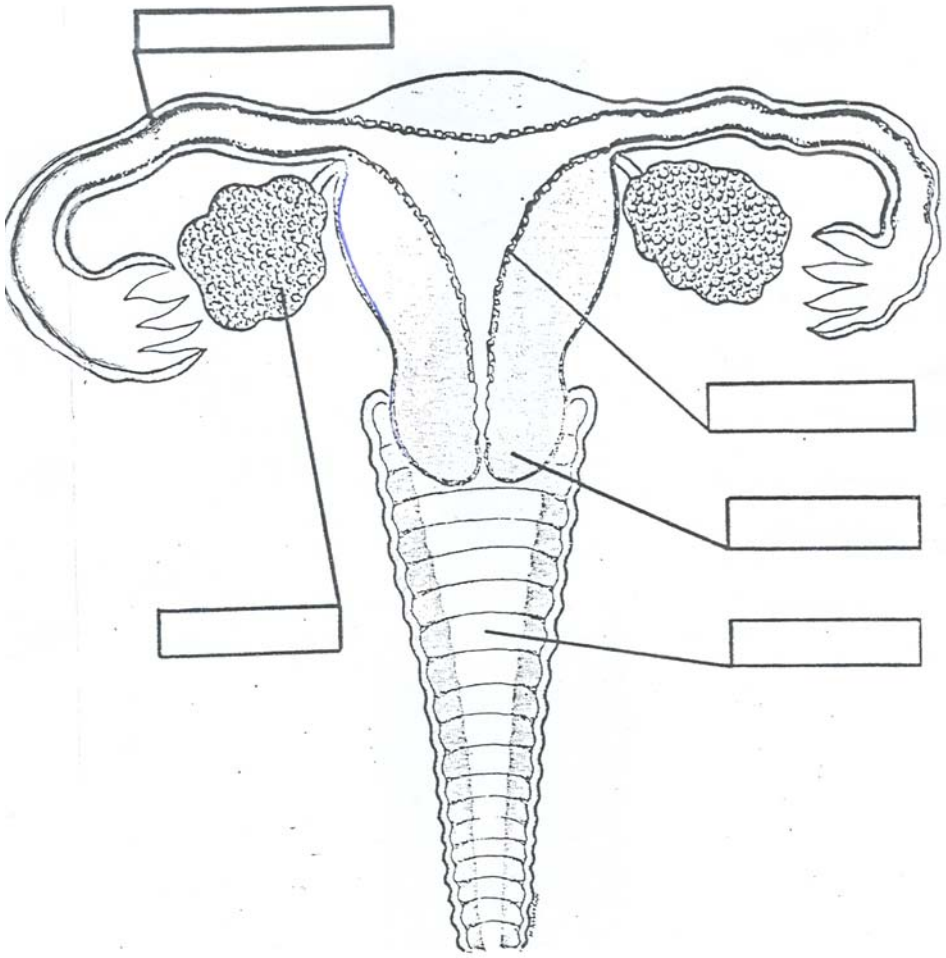
For counselors/PLHIV peer educators (20 minutes):

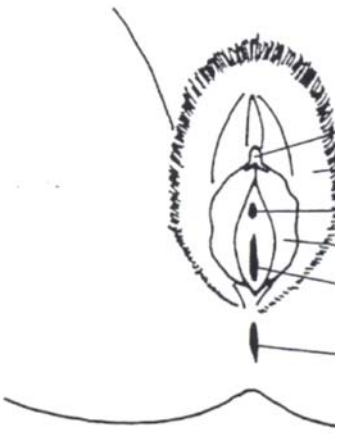
1. Display the prepared flipchart showing the diagram of conception, and present conception as a minidrama. Follow the instructions in Trainer's Resource 3.9.
2. Distribute copies of Participant Handouts 3.7 and 3.8 to the participants to cover the content on conception.

Close the session by explaining that a strong knowledge of the reproductive anatomy, menstrual cycle, and conception will help counselors and providers explain to clients how pregnancy occurs and how various FP methods work to prevent pregnancy. Inform the participants that the following sessions will build on this content and will help reinforce this information. Direct the participants to resources that they can read to support the learning content of this session.

Participant Handout 3.1

Internal and External Female Reproductive Anatomy





External

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Participant Handout 3.2

Female Reproductive Anatomy

External Female Reproductive Organs

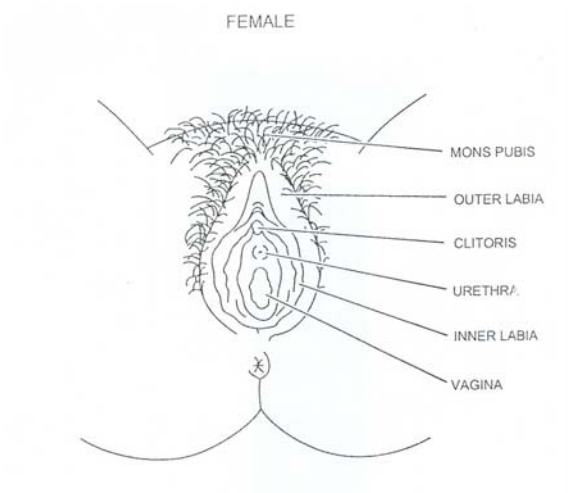
The external female reproductive organs (the genitals) are the mons pubis, the clitoris, the labia majora, and the labia minora. Together, along with the opening of the vagina, they are known as the **vulva**.

The **mons pubis** is a cushion of fat that covers the pubic bone and protects the internal sexual and reproductive organs. Pubic hair grows on this area.

The **clitoris** is an erectile organ that is located above the urethral opening where the folds of the labia majora meet. It contains a high concentration of nerve endings and is very sensitive to stimulation. The clitoris is the only organ whose only function is to provide sexual pleasure.

The **labia majora** are two thick folds of skin—one on either side of the vaginal opening—that cover and protect the genital area.

The **labia minora** are the two small folds of skin between the labia majora.



Participant Handout 3.2

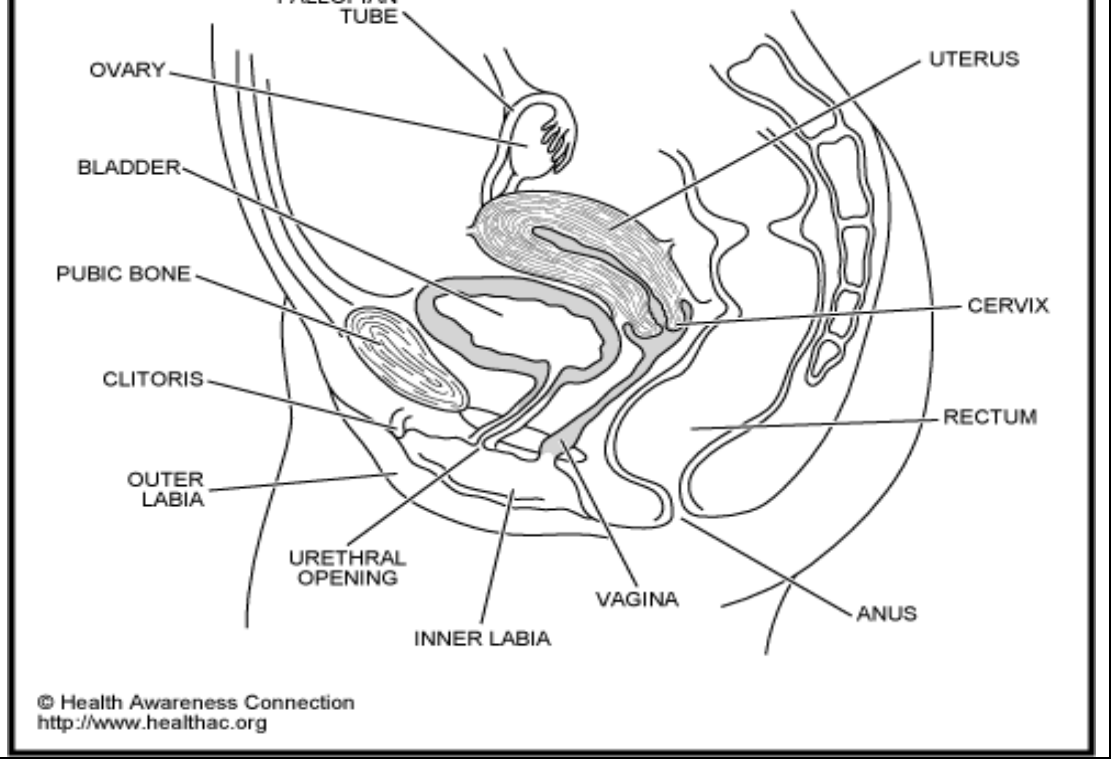
Female Reproductive Anatomy (*cont.*)

Internal Female Reproductive Organs

The internal female reproductive organs are the vagina, the cervix, the uterus, the fallopian tubes, and the ovaries.

The **vagina** is a muscular, highly expandable, tube-like cavity. The vagina is the structure that is penetrated during vaginal intercourse, and it is where menses exit a woman's body once a month if she is not pregnant.

The **Grafenberg spot**, or **G-spot**, is a small area (about 1–2 cm) on the front wall of the vagina (closest to the bladder and urethra), about halfway between the pelvic bone and the cervix, that is especially sensitive to sexual stimulation in some women. The G-spot has no known function for women except as a source of sexual stimulation.



Picture from Health Awareness Connection, http://www.healthac.org

Participant Handout 3.2

Female Reproductive Anatomy (*cont.*)

The **cervix** is the structure that connects the uterus with the vagina. The cervix has a hole that allows the passage of menstrual flow from the uterus and the passage of sperm into the uterus.

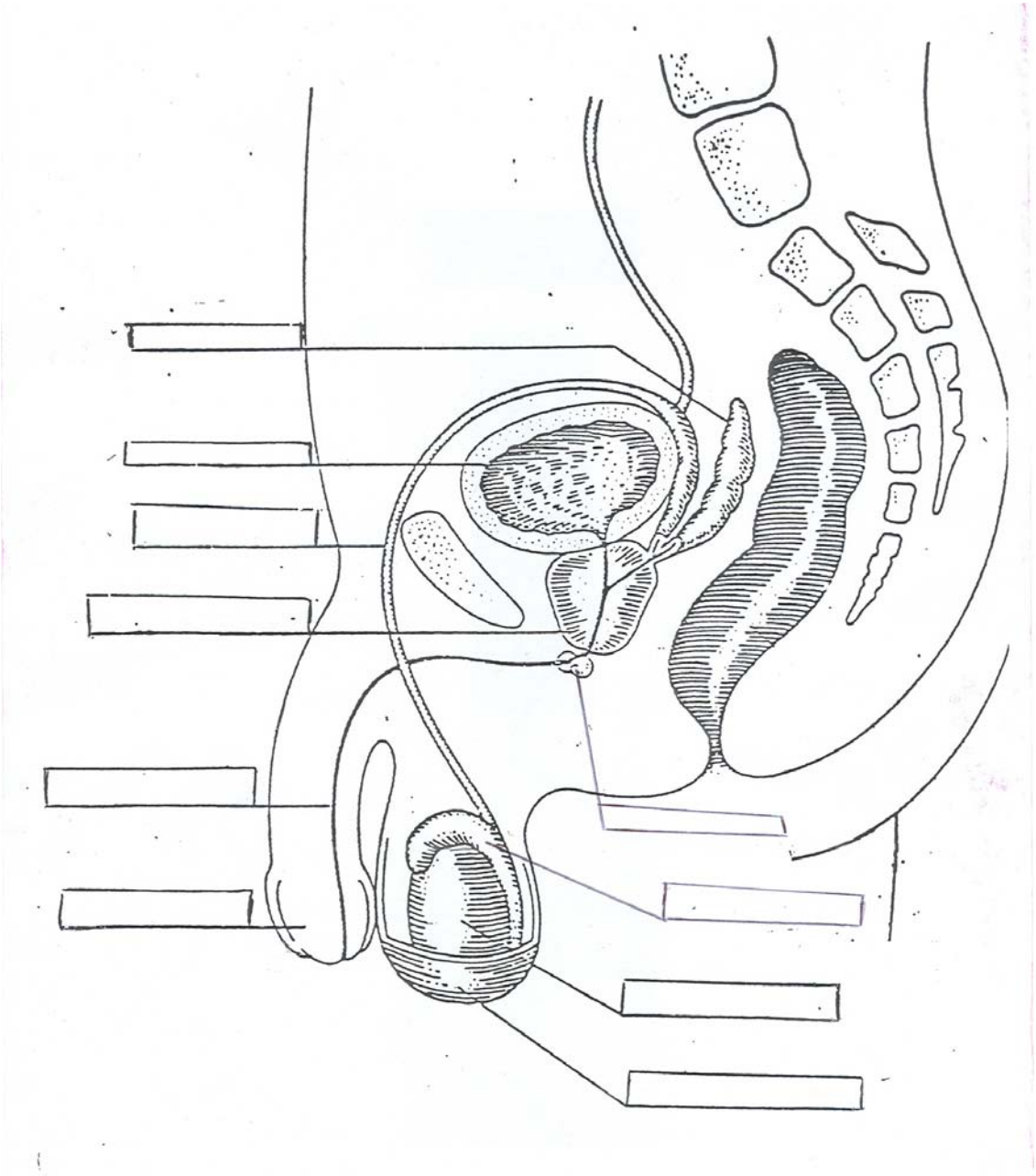
The **uterus**, which is also known as the womb, is a hollow, muscular organ that is about the size of a fist. It is located between the bladder and rectum. The lining of the uterus thickens each month as it prepares for a potential pregnancy. If an egg is fertilized, it will grow and develop in the uterus. If there is no pregnancy, the lining of the uterus is shed every month during menstruation. The uterus is very elastic and can expand to many times its original size during pregnancy.

The **fallopian tubes** are a pair of tubes that connect the ovaries to the uterus. The egg passes through the fallopian tubes on its way from the ovary towards the uterus, and eggs are usually fertilized in the fallopian tubes.

The **ovaries** are two round organs that are located at the end of each fallopian tube. They produce eggs (releasing one per month from puberty to menopause) and also give off hormones.

Participant Handout 3.3

Internal Male Reproductive Anatomy



Participant Handout 3.4

Male Reproductive Anatomy

External Male Genitals

The external male genitals consist of the penis and the scrotum.

The **penis** is a tube-like structure that sticks out from the body. It is used for urination and sexual stimulation and intercourse. When a man is sexually excited, the spaces in the penis fill with blood, causing the penis to become hard (an erection). The head of the penis is covered by a skin called the foreskin. If the foreskin is left intact, then the man is not circumcised. When the foreskin is removed, the penis is circumcised.

The **scrotum** is a pouch of skin hanging directly under the penis that contains the testes. The scrotum protects the testes and maintains the temperature necessary for the production of sperm by the testes.

Internal Male Genitals

The internal male genitals are the testes, the epididymides, the vas deferens, the seminal vesicles, the prostate gland, and the Cowper's glands.

The **testes** are a pair of oval-shaped organs that produce sperm and male sex hormones and are located in the scrotum.

The **epididymides** are the two very coiled tubes located against the back side of the testes where sperm mature and are stored until they are released during ejaculation.

The **vasa deferentia** (vas deferens, sing.) are the tubes that carry mature sperm from the epididymides to the urethra.

The **seminal vesicles** are a pair of sacs that add about 60% of the fluid that makes up the semen in which sperm are transported. This fluid provides nourishment for sperm.

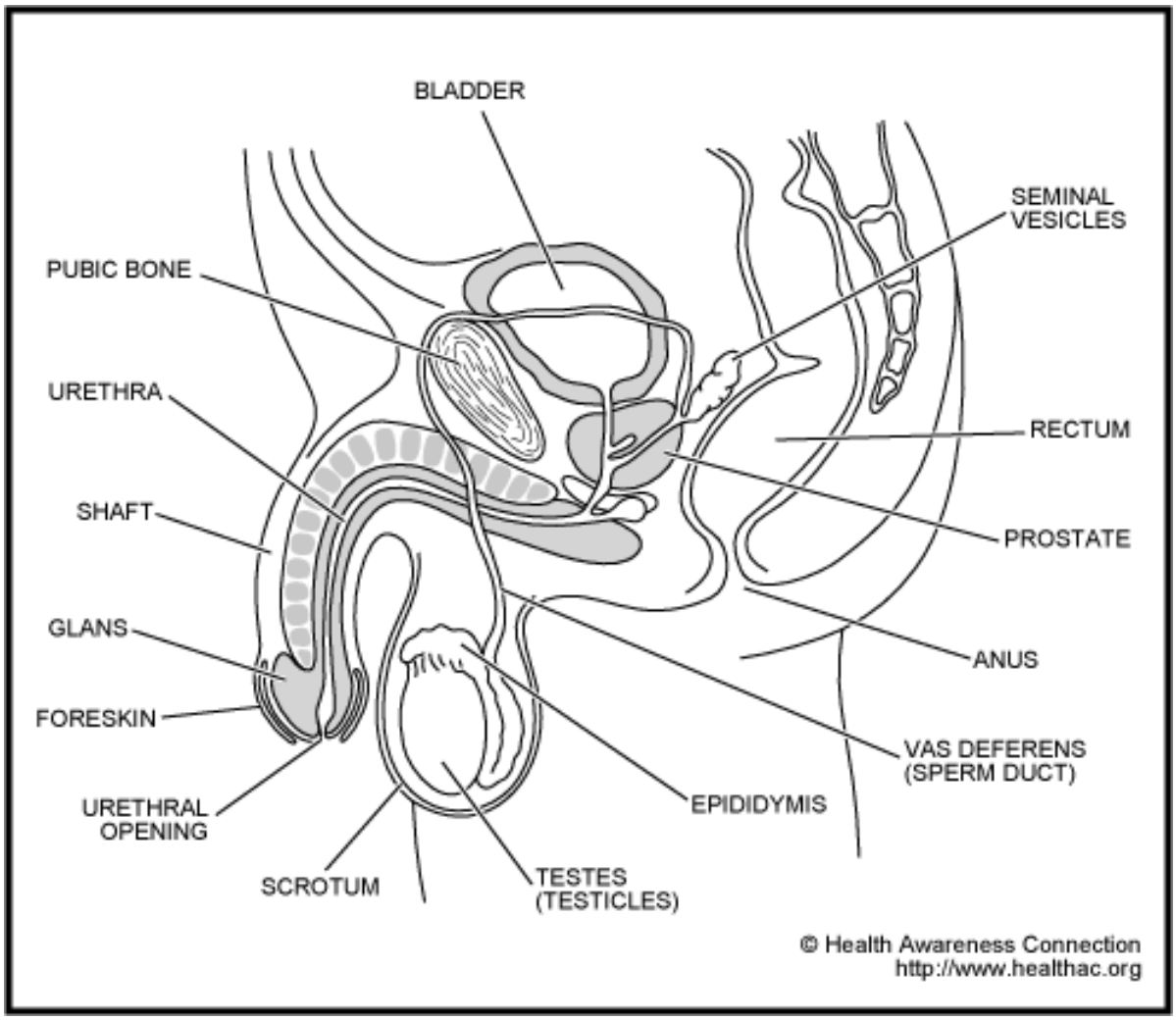
The **prostate gland** is about the size of a small passion fruit. It is a structure that secretes about 30% of the fluid that makes up semen.

Cowper's glands are two pea-sized glands at the base of the penis under the prostate that let off a clear fluid into the urethra during sexual arousal and before ejaculation. These glands produce a fluid in the urethra that acts as a lubricant for the sperm and coats the urethra as semen flows out of the penis.

Participant Handout 3.4

Male Reproductive Anatomy (*cont.*)

Diagram of Male Reproductive Anatomy



Picture from Health Awareness Connection, http://www.healthac.org

Participant Handout 3.5

Hormones

Hormones are chemicals in the body that tell other types of cells what they need to do. Although the body has many types of hormones, this section will focus on the sexual hormones of men and women.

The main male sex hormone, which is called an androgen, is testosterone. Testosterone is produced in the male's testes. The amount of testosterone increases sharply at puberty and is responsible for the development of the so-called secondary sexual characteristics (e.g. body hair, especially on chest and face, and deepening of the voice). Testosterone is also essential for the production of sperm.

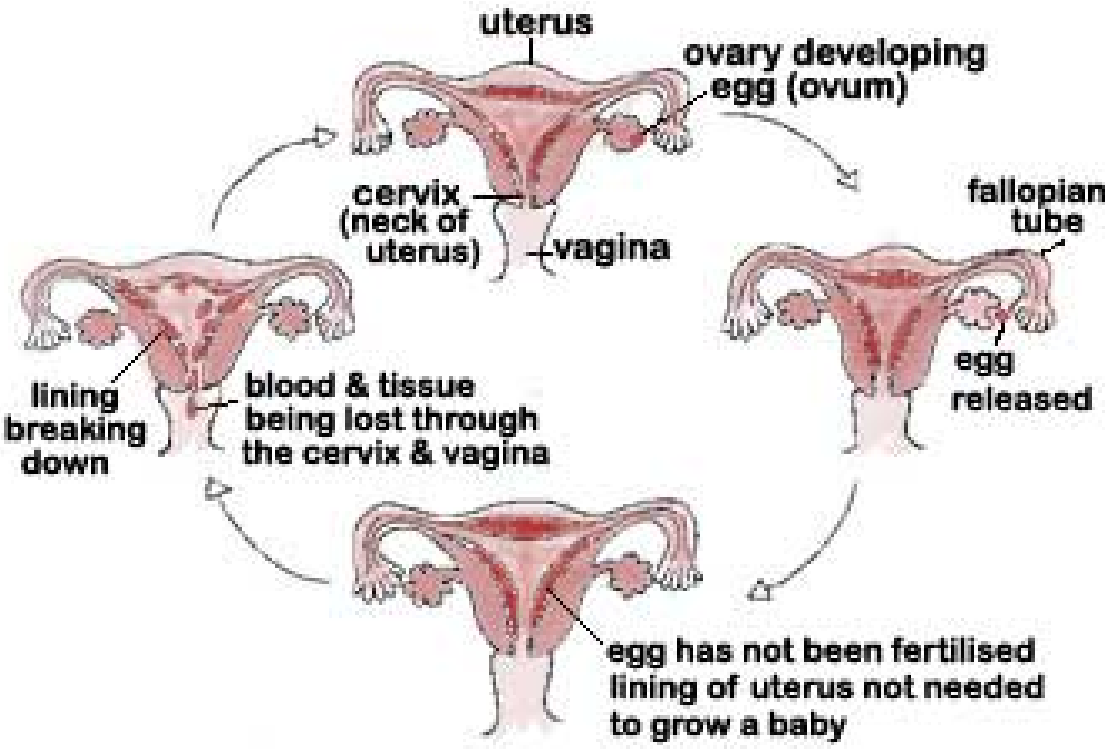
The main female sex hormones are estrogen and progesterone. These hormones are primarily responsible for turning girls into sexually mature women. Increasing levels of estrogen and progesterone in girls at puberty lead to the development of breasts, the further development of the uterus and vagina, a broadening of the pelvis, growth of body hair, and an increase in fat tissue. As the female body is matured by these hormones, the hormones will also cause the onset of menstruation—the monthly process by which the female body prepares for the possibility of a pregnancy.

Participant Handout 3.6

The Menstrual Cycle

The menstrual cycle lasts approximately 28 days. Day 1 of the menstrual cycle begins with menstruation, the loss of some blood and other products from the shedding of the inner lining of the uterus. During this time, an egg begins to develop in one of the ovaries. After menstruation ceases, the egg continues to develop. At the same time, levels of estrogen are rising and this causes the lining of the uterus to become thicker and more richly supplied with blood vessels.

At the middle of the cycle, at about day 14, there is a surge of hormones and this causes the egg that has been developing to pop out of the ovary and into the fallopian tube. This is called ovulation. The egg then begins the trip down the fallopian tube into the uterus. During this time, female hormones continue to prepare the lining of the uterus for a possible pregnancy. If fertilization of the egg occurs, then the egg will implant in the uterus and a pregnancy will begin. If fertilization does **not** occur, hormone levels drop and this causes the lining of the uterus to break down, causing some blood to be lost in the process. This is the menstrual period.

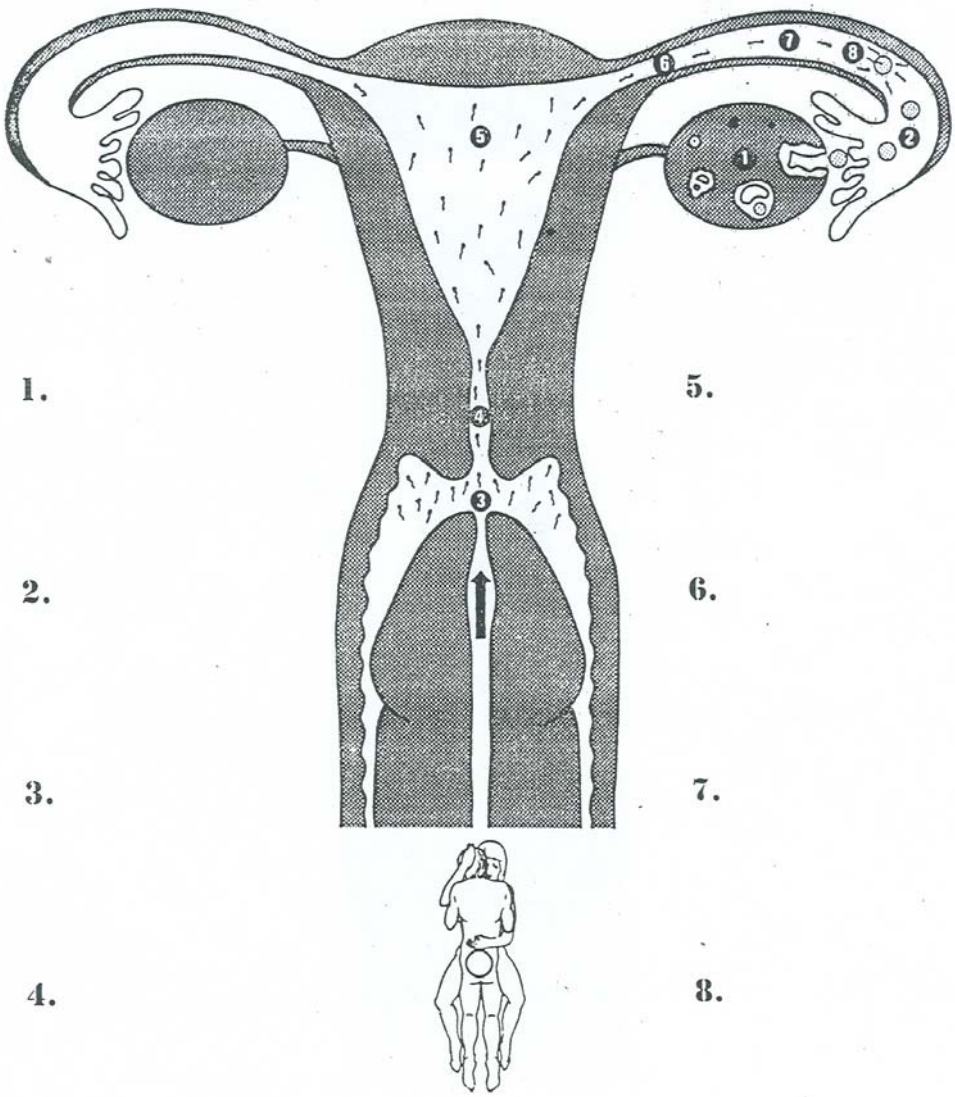


Participant Handout 3.7

Conception Diagram

CONCEPTION

The diagram below shows the route of the sperm from ejaculation to conception.



1.

2.

3.

4.

5.

6.

7.

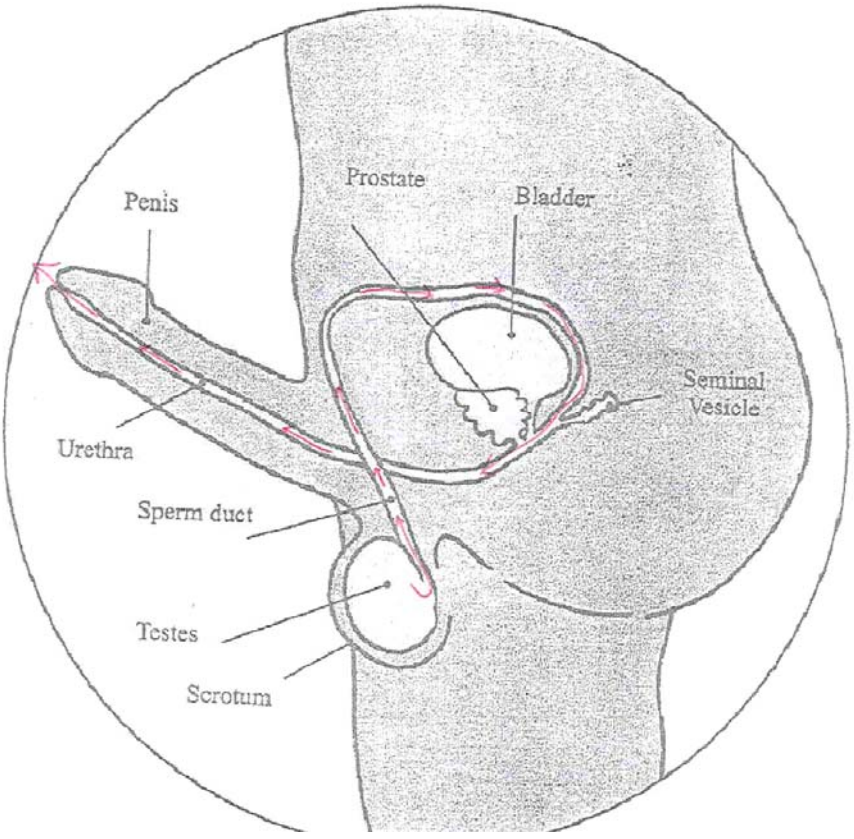
8.

Participant Handout 3.8

The Sperm Pathway

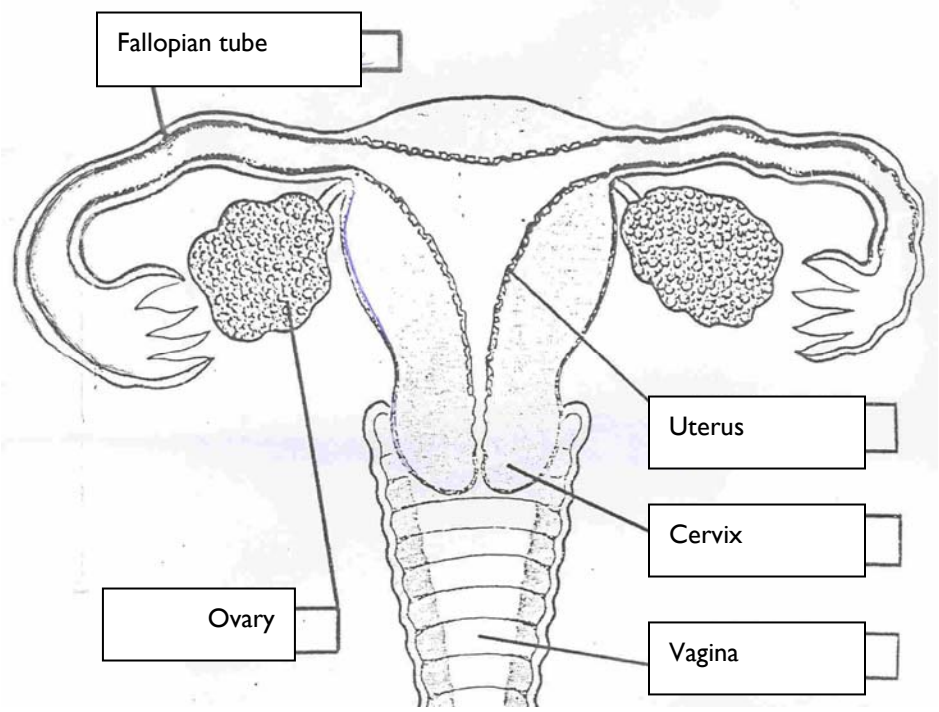
There is no monthly cycle for sperm. Men produce sperm in the testes from the time they begin puberty. It takes about six weeks for sperm to fully develop. Once sperm are made in the testes, they mature and are stored in the epididymis. If a man is sexually excited and he comes to the point of ejaculation, sperm that have been stored in the epididymis will begin their journey. They will move through the vas deferens and then pick up fluids as they pass both the seminal vesicle and the prostate. These liquids together, called semen, help the sperm to move and provide it with food for the journey. Now the semen is ready to come out, but before that happens, a small gland, called the Cowper's gland, sends out a few drops of fluid that clean the urethra, since it is also used for urination. When a man has an erection, a muscle closes off the bladder from the urethra so that he cannot urinate. Once the Cowper's gland has cleaned the tube, the semen continues down through the urethra and out of the penis.

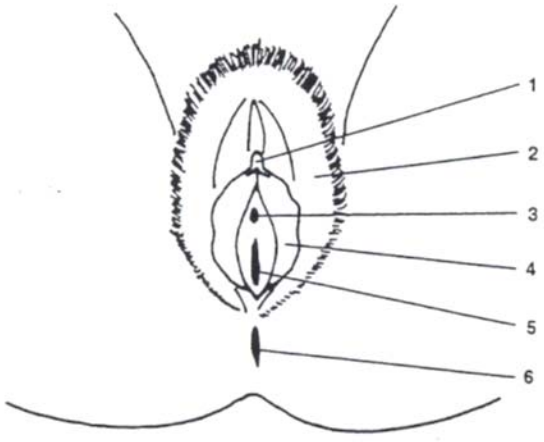
The diagram below shows the path that sperm take, starting in the testes where sperm are made, then on to the epididymis where they are stored and mature. Next they move up the sperm duct, or vas deferens, and over the bladder. From there they pick up fluids from the seminal vesicle and the prostate before going through the urethra on their way out of the erect penis.



Trainer's Resource 3.1

Internal and External Female Reproductive Anatomy—Answer Key





External

1. Clitoris
2. Labia majora (outer lips)
3. Urethra
4. Labia minora (inner lips)
5. Vagina
6. Anus (opening)

Trainer's Resource 3.2

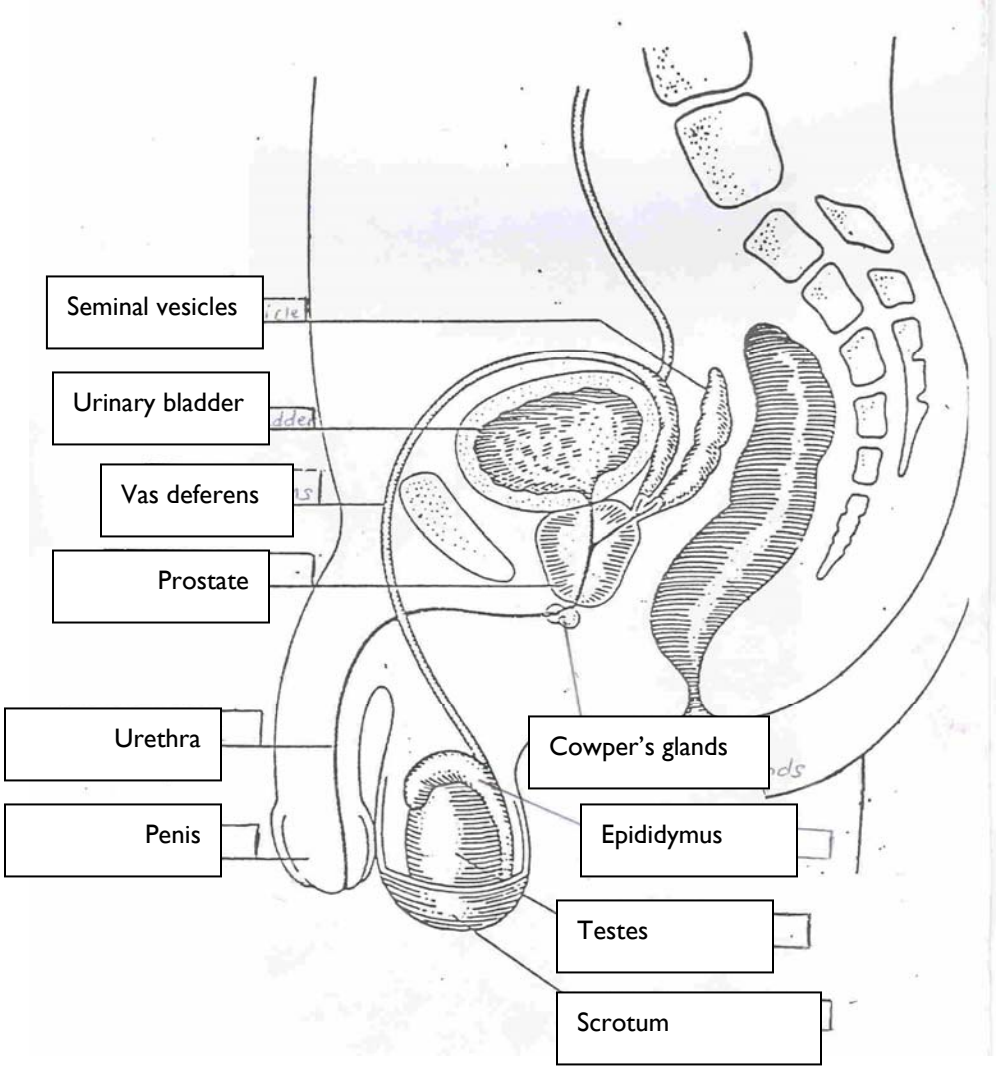
Female Reproductive Physiology Questions—Answer Key

Organs: Vagina, Uterus, Fallopian tubes, Cervix, Ovary, Ovum in ovary

1. If I were the primary sex gland of a woman, producing ova, what would I be called? **Ovary.** Where would I be found? **See diagram.**
2. If I were the pathway through which the released ova travel from the ovary to the uterus, what would I be called? **Fallopian tubes.** Where would I be found? **See diagram.**
3. If I were a pear-shaped organ at the upper end of the vagina with a capacity to stretch to accommodate more than 10 pounds, what would I be called? **Uterus.** Where would I be found? **See diagram.**
4. If I were an elastic-like passage and an opening leading from the inside of the body to the outside with many substances passing into and out from me, what would I be called? **Fallopian tubes.** Where would I be found? **See diagram.**
5. If I were the opening of the uterus into the vagina, what would I be called? **Cervix.** Where would I be found? **See diagram.**
6. If I were the female sex cell, leaving the place where I am produced, what would I be called? **Ova.** Where would I be found? **See diagram.**

Trainer's Resource 3.3

Internal Male Reproductive Anatomy—Answer Key



Trainer's Resource 3.4

Male Reproductive Physiology Questions—Answer Key

Organs: Testicles, urethra, scrotum, penis, seminal vesicle, prostate gland, vas deferens, epididymis, sperm, Cowper's gland

1. If I were the gland responsible for providing lubricating fluid that keeps the urethra moist, what would I be called? **Cowper's gland.** Where would I be found? **See diagram.**
2. If I were the main male sex glands (2) that produced sex cells and the hormone testosterone, what would I be called? **Testicles.** Where would I be found? **See diagram.**
3. If I were a skin sac in which the main sex glands resides, what would I be called? **Scrotum.** Where would I be found? **See diagram.**
4. If I were a tubular, coiled organ that was responsible for maturing sperm, what would I be called? **Epididymis.** Where would I be found? **See diagram.**
5. If I were an organ that produced a sticky fluid in which the sperm moved and fed, what would I be called? **Seminal vesicle.** Where would I be found? **See diagram.**
6. If I were a gland that secreted a clear fluid into the urethra under sexual stimulation, mixing with sperm and contributing to the volume of semen, what would I be called? **Prostate gland.** Where would I be found? **See diagram.**
7. If I were the tubes that led from the epididymis to the seminal vesicles and prostate gland, contracting rhythmically during ejaculation to push out the sperm, what would I be called? **Vas deferens.** Where would I be found? **See diagram.**
8. If I were the male organ for sexual relations and elimination, becoming erect at arousal, what would I be called? **Penis.** Where would I be found? **See diagram.**
9. If I were the male sex cell with a big oval head and a long tail, what would I be called? **Sperm.** Where would I be found? **See diagram.**
10. If I were the pathway running the length of the male organ of sexual relations and elimination, what would I be called? **Urethra.** Where would I be found? **See diagram.**

Trainer's Resource 3.5

Menstrual Cycle Function Questions and Answer Key

1. What event takes place on day 1 of the menstrual cycle?
   Menses or menstrual flow.

2. What does estrogen do to the uterus?
   Estrogen stimulates the lining of the uterus to build-up.

3. What main event does the peak in hormones cause?
   Ovulation.

4. When does ovulation occur in the menstrual cycle?
   14 days (+/- 2 days) before the next menstrual period.

5. What happens to the levels of estrogen and progesterone if fertilization does not take place?
   The levels of estrogen and progesterone decline.

6. What happens to the uterine lining if fertilization does not take place?
   The uterine lining slides off as menstrual flow.

Trainer's Resource 3.6

The Menstrual Cycle Story

Menstrual Cycle 28-Day Story

Once upon a time in a land very nearby, there was an Elder Mother named Hypothalamus; she had a very powerful wand called GN-releasing factor. Elder Mother Hypothalamus could stretch forth her wand and make her younger sister, Auntie Pituitary (Anterior Pituitary), work miracles like causing things to grow, to be stored, and to be released through the efforts of her own two daughters. These two daughters were named FSH (follicle stimulating hormone) and LH (luteinizing hormone). FSH would get things started and LH would finish things off.

One day (Day 1), Elder Mother Hypothalamus received a message from two distant relations called estrogen and progesterone. They cried, "Elder Mother, we are weak, we have worked hard and our energy is very low; we cannot do any more work. We need your help [negative feedback], and there is blood everywhere!"

Hearing this message, Elder Mother Hypothalamus quickly called her sister Auntie Pituitary and told her, "Our relations estrogen and progesterone are very weak; they have little energy to do their work. We must help them!" But Auntie Pituitary took her time; no need to rush, so within five days she got a message to her daughters.

When Auntie Pituitary called her daughters FSH and LH, she said, "You, FSH, since you like to start things, I want you to go down to this owner's factory called Ovary and get them started in producing eggs."

"Yes," said FSH, "I will go right away!" And off FSH went happily. When she arrived at the Ovary, she started stimulating the factory workers called follicles to grow and develop. By doing this, FSH also helped the follicles to produce the much-needed energy called estrogen. Auntie Pituitary was watching from above, and about seven days later, she nudged LH and said,

"Hurry, go relieve your sister. She is getting tired; go down and get one of those follicles to push out an egg. Maybe this month the owner will conceive, and then we can do some different work." Once LH arrived, FSH sent a message back to Auntie Pituitary letting her know that the estrogen levels were high enough and that her work was done (positive feedback), so FSH's level of energy began to diminish.

Meanwhile, LH was a *very* fast runner, so almost instantly she reached the Ovary's production center and sprinkled her own magic juice on all the follicles. LH was sure that at least one follicle would not be able to resist blossoming for her. Within one day of LH's arrival, one follicle blossomed and pushed out an egg (ovum); this was

Trainer's Resource 3.6

The Menstrual Cycle Story (*cont.*)

called ovulation (day 14), and the factory owner would be very pleased if she wanted to make a baby. Once the egg was released, LH could relax, because the remaining shell from where the egg was released (corpus luteum) would produce the needed progesterone (from days 15–27).

However, while all this was going on in the Ovary, the uterus was being affected. When the estrogen levels began to rise from the efforts of FSH and the developing follicles, her walls started to thicken and get very rich with a network of blood vessels. She was looking very pretty with these fattened areas. Even the mouth of the uterus was beginning to open a little and was producing clear, slippery mucus, since she was expecting special visitors (sperm) and wanted them to meet the oncoming egg. While the progesterone levels were high, they also affected the Uterus by making sure the lining of the wall did not overgrow. It caused the fat, juicy walls to develop further by increasing the maturity of the blood vessels and causing the uterine wall to get ready, to welcome a fertilized egg (if the egg and sperm were to meet). Since progesterone was high, she informed the Elder Mother and Auntie Pituitary that there was enough fuel and both her and estrogen's work was completed [positive feedback].

Then they all waited and waited, and by Day 24, everything was ready in the uterus, but the egg traveled along the fallopian tube without meeting any sperm. By Day 25, the shell where the egg came out (corpus luteum) began drying up and producing less and less progesterone. On Day 26, estrogen and progesterone were diminishing more and more. On Day 27, very little estrogen and progesterone were available to support the fattened, juicy uterine lining that was getting ready to receive a fertilized egg. Finally, on Day 28, with estrogen and progesterone almost gone and very weak, the uterus let go of the lining and menstrual blood began to flow. Estrogen and progesterone, almost at death's door, sent out another distress call to Elder Mother Hypothalamus to come to their assistance. Elder Mother never seems to mind when they need help.

But, every now and then, all of their work might result in a fertilized egg, giving estrogen and progesterone a chance to do something different for nine months. When sperm meet the egg within 24 hours of her coming out of the Ovary, fertilization takes place. Then where the fertilized egg attaches itself to the uterine lining, the placenta develops, and it produces another worker, called Human Chorionic Gonadotropin (HCG). The corpus luteum continues to function and produces plenty of progesterone and estrogen until the placenta is able to take over producing these hormones to keep the pregnancy developing. It is HCG that is detected when a pregnancy test is done, letting the woman know that she is pregnant.

Trainer's Resource 3.7

Conception

Conception Diagram

Label activities to place on the conception diagram: (These key points correspond with the conception drawing on the following page).

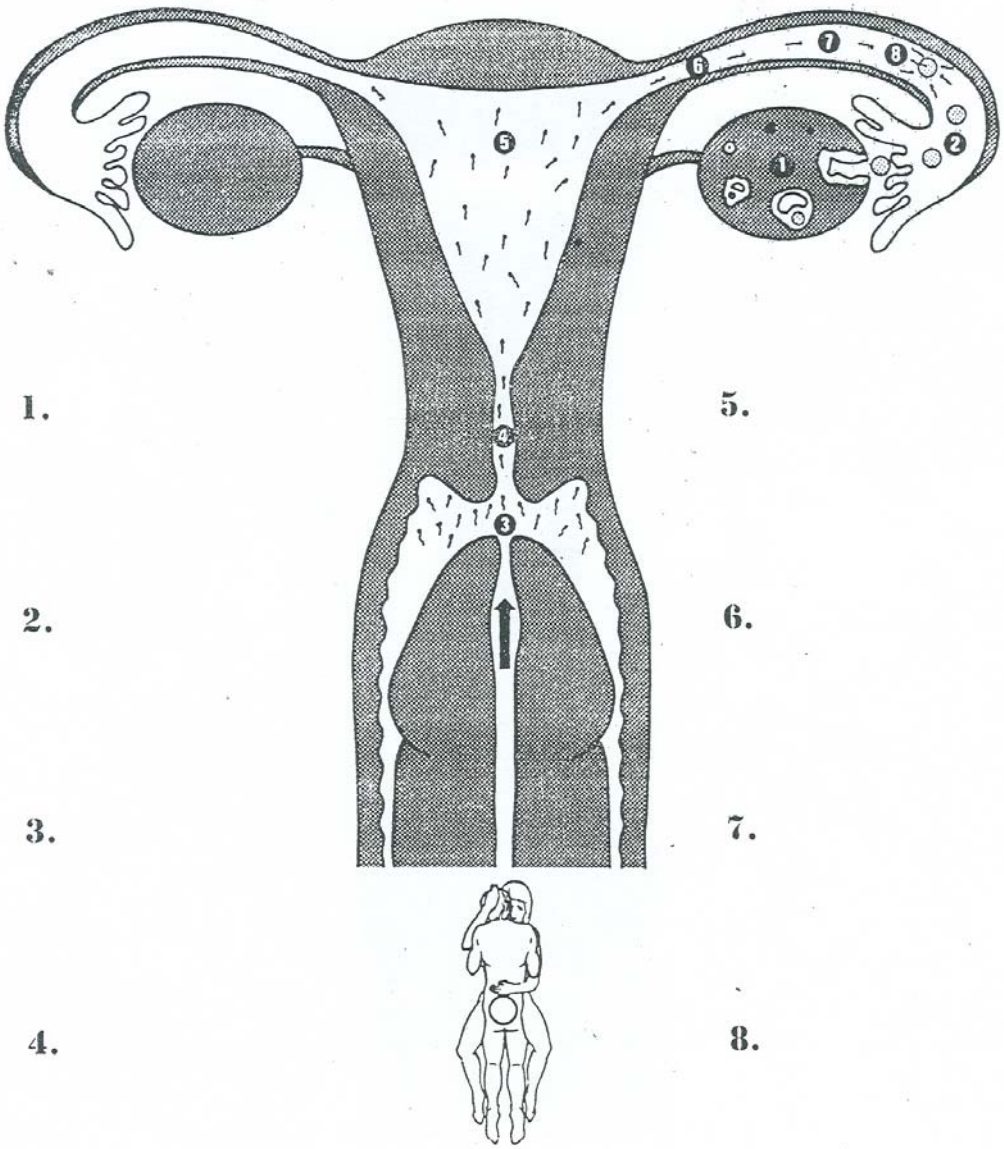
1. **Mature egg coming out of the ovary during ovulation**. If it meets sperm within 24 hours of ovulation, it can be fertilized.
2. **The egg moves through the fallopian tube to the uterus**.
3. **Sexual intercourse with ejaculation takes place sending 400 million sperm into the vagina**.
4. **Sperm enter the cervix**. About half the sperm die in the vagina and never make it into the uterus.
5. **Sperm travel quickly up into the uterus**. There are now only about 6,000 of the original sperm left (approximately 1 hour since ejaculation).
6. **Sperm travel quickly along the fallopian tubes**. About half of the remaining 6,000 sperm have gone the wrong way into the tube without an egg.
7. **A couple hundred sperm complete the journey into the outer third of the fallopian tube where they meet the egg and fertilization takes place**. Sperm can live for up to five days in the woman's reproductive system. As a result, sperm can wait for a newly developed egg to arrive.
8. **Fertilization occurs!**

Trainer's Resource 3.7

Conception (*cont.*)

CONCEPTION

The diagram below shows the route of the sperm from ejaculation to conception.

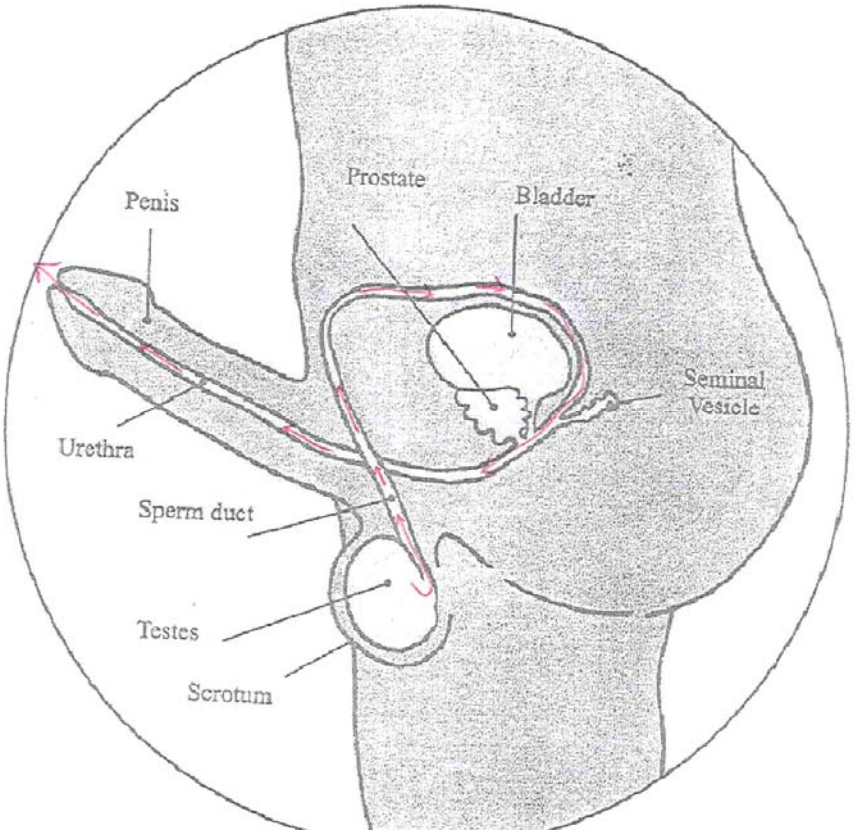


Trainer's Resource 3.8

The Sperm Pathway

There is no monthly cycle for sperm. Men produce sperm in the testes from the time they begin puberty. It takes about six weeks for sperm to fully develop. Once sperm are made in the testes, they mature and are stored in the epididymis. If a man is sexually excited and he comes to the point of ejaculation, sperm that have been stored in the epididymis will begin their journey. They will move through the vas deferens and then pick up fluids as they pass both the seminal vesicle and the prostate. These liquids together, called semen, help the sperm to move and provide it with food for the journey. Now the semen is ready to come out, but before that happens, a small gland, called the Cowper's gland, sends out a few drops of fluid that clean the urethra, since it is also used for urination. When a man has an erection, a muscle closes off the bladder from the urethra so that he cannot urinate. Once the Cowper's gland has cleaned the tube, the semen continues down through the urethra and out of the penis.

The diagram below shows the path that sperm take, starting in the testes where sperm are made, then on to the epididymis where they are stored and mature. Next they move up the sperm duct, or vas deferens, and over the bladder. From there they pick up fluids from the seminal vesicle and the prostate before going through the urethra on their way out of the erect penis.



Trainer's Resource 3.9

Conception Minidrama

Characters:	Ovary Eggs (2, with 1 egg maturing) Sperm (6) • 1 dies at the cervix (desk) • 2 go into the left tube • 3 go into the right tube and surround the egg with 1 getting accepted.	Props:	3 chairs 2 tables Name pins Nameplates

Voices: Narrator

Setting: Events take place on a floor diagram of the female and male reproductive tracts connected.

Scenario:
A group of sperm (6) line up at the base of the penis for the 8 cm dash. Ejaculation calls out, "Ready? Set? Go!"—all 6 start off (fast walk), 1 drops out at the cervix. Five continue to the top of the uterus with 2 going into the left tube and just looking around as if lost. Three go into the right tube and surround the egg that is there. Sperm mark off 2 days on a calendar. The egg accepts the hand of one of the sperm. They continue hand-in-hand along the fallopian tube and rest in the top of the uterus. The other sperm look disappointed as they walk off.

Narrator declares "A pregnancy has begun!"

Unit 4: Family Planning Update and Methods Used by PLHIV

Unit 4: Family Planning Update and Methods Used by PLHIV

Session 4.1: Benefits of FP for PLHIV

Essential Ideas to Convey

- FP improves the health and well-being of families and communities by helping women and couples with HIV space or limit future births.
- Become some ARV drugs have significant potential toxicity and can harm the fetus, FP use while by HIV-positive women who are under treatment not only prevents unintended pregnancy, but also minimizes the potential of fetal exposure to damaging effects of ARV drugs.
- Maternal mortality and morbidity rates are higher for HIV-positive women, so use of FP methods permits such women to space their pregnancies in a way that reduces the risks associated with too many pregnancies or pregnancies spaced too closely.
- By preventing unintended pregnancies, FP use reduces both the number of infants born with HIV and the number of children who are likely to be orphaned in the future.

Session Purpose and Objectives

The purpose of this session is to introduce the concept that the use of FP methods carries a number of potential benefits for PLHIV. By the end of the session, the participants will be able to:

- List the benefits of FP for PLHIV and for those using ARV drugs

Time

30 minutes

Materials

- Flipchart paper and markers
- Rewards for the learning exercise (e.g., candies)

Advance Preparation

1. Gather sweets or some other reward for the group that does the best work on the learning exercise.

Training Steps

1. Divide the participants into two groups.
2. Instruct the members of the two groups to choose writer(s) to compose flipcharts reflecting their discussions.

3. Ask each group to huddle and quickly brainstorm a list of benefits of FP to PLHIV and to individuals using ARV drugs.
4. Allow 10 minutes for the groups to complete their discussion.
5. Ask the first group finished to present their flipchart.
6. When the first group is finished, invite the second group to present their flipchart. Make note of differences between the two flipcharts. Make additions from Trainer's Resource 4.1, if necessary.
7. Give a reward to the group that has presented the most complete list.

Unit 4: Family Planning Update and Methods Used by PLHIV

Session 4.2: Dual Protection

Essential Ideas to Convey

- *Dual protection* addresses clients' needs for protection against both unintended pregnancy and infection/reinfection with HIV and other STIs. Both pregnancy and HIV/STI infections result from unprotected sexual intercourse.
- *Dual protection* counseling upholds the concept of informed choice by making sure that clients are knowledgeable and aware of their dual risks for unintended pregnancy and HIV/STI prevention while making FP decisions.
- When used consistently and correctly, condoms are the *only* modern contraceptive method that protects against *both* undesired pregnancy and HIV/STI infection. To protect themselves effectively, clients need hands-on training in how to use condoms correctly.
- For those for whom pregnancy prevention is the highest priority, *dual method use* (i.e., use of condoms plus another FP method) may be appropriate, but be careful not to stigmatize condoms as a less effective FP method or as a method that only prevents STI and HIV infection/reinfection.

Session Purpose and Objectives

The purpose of this session is to introduce the concept of dual protection, why counseling about dual method use upholds the concept of informed choice, and why it is important not to stigmatize condoms as being less effective or being primarily for the prevention of infection (or reinfection) with HIV or other STIs. By the end of the session, the participants will be able to:

- Explain *dual protection* and *dual method use*
- Understand the role of cooperation among partners in dual protection, and what health care workers can do to help men in using condoms
- Comprehend both the advantages of encouraging couples to use dual protection and the reasons why some couples find dual method use unappealing
- Talk about dual method use with clients in such a way that do not undermine clients' confidence in condoms

Time

1 hour

Materials

- Flipchart paper and markers
- Participant Handout 4.1: Dual Protection (umbrella graphic)
- LCD projector
- Laptop computer
- Screen (or other surface on which to project slides)
- PowerPoint presentation, Session 4: Family Planning Updates and Use by PLHIV (minimum slides are "Dual Protection," "Dual Method Use," "Why ARV clients benefit from contraception")

Advance Preparation

1. Prepare a flipchart showing the four group-work questions:

> Group 1: How does focusing on dual protection, rather than only on infection prevention, better meet HIV-positive women's and men's needs?
>
> Group 2: How does promoting condoms as an effective FP method (either alone or in combination with another FP method) help to destigmatize condom use?
>
> Group 3: How does promoting condoms for dual protection (either alone or in combination with another method) help women and men to negotiate use with their partners?
>
> Group 4: Why do we need to promote dual protection among adolescents?

2. Make enough copies (color) for all participants of Participant Handout 4.1.

Training Steps

1. Begin this activity by asking the participants to explain what *dual protection* is.
2. Distribute Participant Handout 4.1 and discuss how it conveys the concept of dual protection.
3. Present a PowerPoint presentation on dual protection. Describe briefly the elements of dual protection.

Highlight the following:

Dual protection prevents both HIV/STI transmission and unintended pregnancy.

Dual protection involves:

- Using condoms alone to prevent both infection transmission and undesired pregnancy,
- Using condoms (to prevent infection transmission) and another FP method to prevent pregnancy (dual method use), or
- Avoiding sexual activities that can transmit infection or result in unintended pregnancies.

4. Divide the participants into four groups and invite each group to discuss briefly one of the questions written on the prepared flipchart. *(10 minutes)*
5. Have a representative from each group present their conclusions.
6. Discuss the work of each group with all of the participants (about five minutes for each group).
7. Refer to Trainer's Resource 4.2 as an answer key and add anything the group has omitted. Continue a guided discussion using the Key Discussion Points.

Unit 4: Family Planning Update and Methods Used by PLHIV

Session 4.3: FP Method Options

Essential Ideas to Convey

- People who are infected with HIV can use most FP methods safely and effectively.
  - Male and female condoms are the only FP methods that prevent the transmission of HIV, and they can prevent "superinfection" with multiple strains of HIV.
  - Most hormonal methods—oral contraceptives, progestin-only pills, injectables, and implants—can be used by any women infected with HIV and by most women receiving ARV treatment.
  - A woman with HIV can have an IUD inserted, and an HIV-positive woman who develops AIDS while using an IUD can safely continue using it. A woman with AIDS should not have an IUD inserted unless she is clinically well on ARV therapy.
  - There are no medical reasons why HIV-positive clients cannot rely on either male or female sterilization. It may be optimal to delay performing a sterilization procedure in the case of a client with an acute HIV-related infection.
  - HIV-positive clients and clients with AIDS should not use spermicides (including in conjunction with the diaphragm), as use may increase the risk of HIV transmission.

- It is possible that the use of ARV drugs may reduce the effectiveness of or increase the side effects of hormonal FP methods, and hormonal methods may at times decrease the effectiveness of ARV treatment.

- Emergency contraceptive pills (ECPs) are safe for use by all women with HIV and AIDS and by women taking ARV drugs.

Session Purpose and Objectives

The purpose of this session is to introduce detailed information about the FP methods that are available locally, about the theoretical concerns about ARV interaction with hormonal FP methods and how these may affect instructions to user, and about when and how to provide emergency contraceptive pills (ECPs). By the end of the session, the participants will be able to:

- List the FP methods that are appropriate for PLHIV to use
- For each of the FP methods available in the area (e.g., male condoms, COCs, injectable hormones, implants, the IUD, vasectomy, tubal ligation, the lactational

- Explain the theoretical concerns of drug interactions between ARV drugs and hormonal contraceptives and how they affect user instructions
- Describe the use of ECPs

Time

3 hours, 30 minutes

Materials

- LCD projector
- Laptop computer
- Screen (or other surface on which to project slides)
- PowerPoint presentation, Session 4: Family Planning Updates and Use by PLHIV (minimum slides are "Contraceptive Options for Women and Couples with HIV," and "Family Planning Methods")
- National FP service delivery guidelines, or country-specific FP service delivery guidelines, if current
- FHI Quick Reference Chart for WHO Medical Eligibility Criteria for Contraceptive Use (see Appendix C)
- World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), INFO Project. 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva: CCP and WHO, 2007.
- Family Planning Methods Study Guides 1, 2, and 3 (Participant Handouts 4.2, 4.3, and 4.4) *(to be assigned to support reading before and after this session)*
- Family Health International and The ACQUIRE Project. 2005. *Contraception for women and couples with HIV.* Research Triangle Park, NC. CD-ROM.
- Optional exercise: Medical Eligibility Criteria (see Trainer's Resource 4.6)

Advance Preparation

1. Make enough copies (color) for all participants of:
   - FHI Quick Reference Chart for WHO Medical Eligibility Criteria for Contraceptive Use (Appendix C)
2. Prepare copies of the following excerpts from *Family planning: A global handbook for providers*:
   - Chapter 1
   - Chapter 3
   - Chapter 4
   - Appendix A (optional)

- Appendix D (optional)

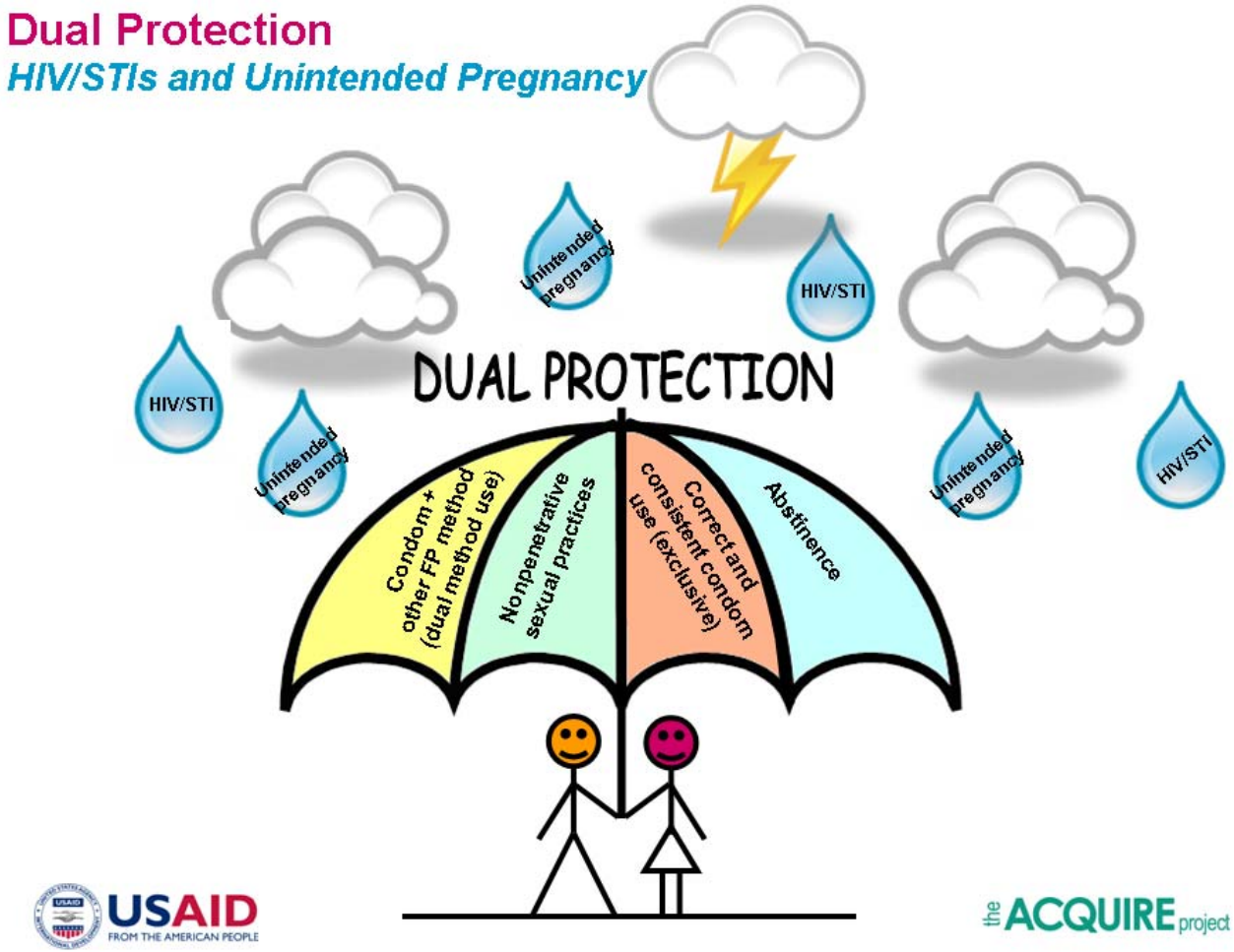
Note: The content of the Global Handbook was updated in 2008 to reflect revisions by the WHO. The most up-to-date version of the content can be accessed at: www.infoforhealth.org/globalhandbook/.

Training Steps

1. Present the CD-ROM slide set for FP method options of condoms, oral contraceptives, injectable hormones, implants, the IUD, vasectomy, tubal ligation, ECPs, LAM, and SDM. This presentation should build on the previous day's assigned reading for this session.
2. After covering each method, pause and allow time for questions.
3. Distribute blank copies of the three self-learning study guides (Participant Handouts 4.2, 4.3, and 4.4) and assign the participants to find answers from the content in the handout(s) after the day's work. Set aside 30 minutes at the beginning of Day 3 to answer any remaining questions from the guides that participants were not able to answer using their handout(s). The study guides can be completed over two evenings, allowing time each of the following mornings to address any unanswered questions. Alternatively, a review of study guides can be done at the end of each day.
4. Use the answer keys (Trainer's Resources 4.3, 4.4, and 4.5) as a guide when reviewing the participants' work.
5. Direct the participants to the appropriate excerpts from *Family planning: A global handbook for providers* and present the content on drug interactions between ARV drugs and hormonal contraceptives and the theoretical risk.
6. Present the content on ECPs; highlight how they are believed to prevent pregnancy (and therefore are not an abortifacient), the need for ongoing contraceptive use *immediately* following ECP treatment, and the opportunity for bridging the use of ECP to ongoing use of FP method(s).
7. Wrap up by sharing with the participants that they will be using this new information in the counseling exercises and clinical practice experiences during the remainder of the training.

Training Option

The trainers should decide in advance whether they want to incorporate the alternate training exercise (Trainer's Resource 4.6) on medical eligibility criteria into this activity.


Dual Protection
HIV/STIs and Unintended Pregnancy
DUAL PROTECTION
Unintended pregnancy
HIV/STI
HIV/STI
Unintended pregnancy
Unintended pregnancy
HIV/STI
Condom + other FP method (dual method use)
Nonpenetrative sexual practices
Correct and consistent condom use (exclusive)
Abstinence
USAID
FROM THE AMERICAN PEOPLE
the ACQUIRE project

Participant Handout 4.2

Family Planning Study Guide 1: Combined Oral Contraceptives

Instructions:

- Read the assigned materials on family planning.
- When you have completed the reading, answer the questions as best you can, without referring to the reading materials; leave blank anything that you do not remember.
- When you are finished with the study guide, go back to the reading materials and confirm your answers; make any corrections that are needed.
- Then, refer to the reading to fill in the information you did not remember.

Part A
Definition:
Family planning is defined as:

_____
_____
_____
_____

Benefits of Family Planning
List at least four benefits of family planning:

- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____
- _____
  _____

Dual Protection/Dual Method Use

Explain the purpose of these approaches and how they work: "dual protection" and "dual method use"

Dual protection:

_____
_____
_____
_____

Dual method use:

_____
_____
_____
_____

Combined Oral Contraceptives (COCs)

1. COCs are considered highly effective when taken correctly. If 1,000 women used COCs for one year with ***perfect*** use, how many would be expected to become pregnant? _____

   How many might become pregnant with *typical* use? _____

2. COCs work the following three ways to prevent pregnancy:
   a. _____
   _____
   b. _____
   _____
   c. _____
   _____

3. *Circle the correct word or words*: COCs offer/do not offer protection against HIV.

4. List at least five characteristics of COCs:
   - _____
   _____
   - _____
   _____
   - _____
   _____
   - _____
   _____
   - _____
   _____

- _____
  _____
- _____
  _____
- _____
  _____

5. Using the FHI Quick Reference for Medical Eligibility Criteria (WHO) (and local Family Planning Service Delivery Guidelines, if available), state whether the following clients can use COCs:

   a. HIV-positive woman on ARV drugs:
      _____
      _____

   b. HIV-positive couple with three children, unsure about ending their fertility:
      _____
      _____

   c. HIV-positive woman with varicose veins:
      _____
      _____

Circle the word "true" if the sentence is <u>correct</u>; circle the word "false" if the sentence is <u>incorrect</u>.

6. A woman can start taking her first packet of COC on any day that she is certain she is not pregnant.
   True/False
7. After a woman takes the last pill from a 28-day packet, she will take the first pill from the new packet the following day.
   True/False
8. A woman or couple should be instructed to use condoms to prevent STI and HIV reinfection while using the COC.
   True/False
9. After using COC for two years, a woman should take a "rest" and stop taking them.
   True/False
10. For women taking ARV drugs, using COC requires that they take the COC consistently, meaning taking the pill the same time every day without forgetting.
    True/False

11. List the warning signs for women using COC:
    - _____
      _____
    - _____
      _____
    - _____
      _____

- _____
  _____
- _____
  _____

A woman should return to the family planning clinic or facility if she experiences the following:

- _____
  _____
- _____
  _____
- _____
  _____

Part B

TRUE/FALSE: Circle true if the statement is correct; circle false if the statement is incorrect.

1. Emergency contraceptive pills (ECPs) prevent pregnancy by interfering with ovulation and/or making the sperm unable to fertilize the egg.
   True/False
2. ECPs are appropriate for use as an ongoing method of FP.
   True/False
3. ECPs can be effectively used up to 120 hours (five days) following unprotected intercourse.
   True/False
4. ECPs can dislodge an established pregnancy.
   True/False
5. A second dose of ECPs is given 12 hours after the first dose.
   True/False
6. Immediately following completion of ECP treatment, a woman/couple must use another FP method until the next menstrual period and continue using the method(s) for as long as she does not want to become pregnant.
   True/False
7. After ECP treatment, the woman should expect to have a menstrual period within three weeks.
   True/False

Participant Handout 4.3

Family Planning Study Guide 2: Injectables

Instructions:

- Read the assigned materials.
- When you have completed the reading, answer the questions as best you can, without referring to the reading materials; leave blank anything that you do not remember.
- When you are finished with the study guide, go back to the reading materials and confirm your answers; make any corrections that are needed.
- Then, refer to the reading to fill in the information you did not remember.

1. **Depo Provera** (DMPA) works the following three ways to prevent pregnancy:
   a. HIV-positive woman on ARV drugs:
      _____
      _____
   b. HIV-positive couple with three children, unsure about ending their fertility:
      _____
      _____
   c. HIV-positive woman with varicose veins:
      _____
      _____

2. DMPA is also considered a highly effective method. If 1,000 women used DMPA for one year with *perfect* use, how may would be expected to become pregnant? _____.

   How many might become pregnant with *typical* use? _____

3. Circle the correct word or words: DMPA provides/does not provide protection against STI and HIV.

4. List at least five characteristics of DMPA:

- _____
- _____
- _____
- _____
- _____
- _____
- _____
- _____

TRUE/FALSE: Circle "true" if the statement is correct; circle "false" if the statement is incorrect.

a. If there is any reduction in the effectiveness of DMPA, it will likely occur at the end of the three-month (12-week) period; therefore, women should be advised to return for the next injection on time (e.g., during the 11th or 12th week).
True/False

b. It is very important for women and couples to know that DMPA may cause unpredictable bleeding patterns and that a woman may stop having menstrual bleeding after one year of DMPA use.
True/False

c. If the first DMPA injection is given during the first five days of a woman's menstrual period, no back-up method is necessary.
True/False

5. List the warning signs for women using DMPA:

- _____
- _____
- _____
- _____

- _____
  _____

6. Using the FHI Quick Reference for Medical Eligibility Criteria (WHO) (and local Family Planning Service Delivery Guidelines, if available), state whether the following clients can use DMPA:

   a. HIV-positive woman on ARV drugs:
      _____
      _____

   b. HIV-positive adolescent:
      _____
      _____

Participant Handout 4.4

Family Planning Study Guide 3: IUD, Implants, LAM, Standard Days Method, and Permanent Methods

TRUE/FALSE: Circle true if the statement is correct; circle false if the statement is incorrect.

1. The IUD can be provided to women who are HIV-positive, to women using ARV drugs, and to women who are "clinically well." **True**/False
2. A woman living with HIV who is already using the IUD must have the IUD removed if she develops clinical HIV disease. True/**False**
3. Voluntary sterilization, the lactational amenorrhea method (LAM), the standard days method (SDM), and hormonal implants can be used by women/couples who are HIV-positive or who are using ARV drugs. **True**/False
4. The Copper-T 380A IUD works to prevent pregnancy by preventing sperm from fertilizing the woman's egg. **True**/False
5. The Copper-T 380A IUD can remain in place for up to 12 years, providing nearly 100% effectiveness in preventing pregnancy (less than a 1% failure rate). **True**/False
6. Studies have shown that women who have never had a child can use the Copper-T 380A without its negatively impacting their future fertility. **True**/False
7. The IUD offers protection against STIs and HIV. True/**False**
8. LAM is a temporary FP method that can be used for up to six months postpartum by women who are exclusively (fully or nearly fully) breastfeeding and who continue to have no menstrual periods. **True**/False
9. Exclusive breastfeeding during the first six months postpartum may reduce the risk of a baby's getting HIV when compared with the results of mixed feedings; therefore, LAM would be a safe FP method for mother and infant. **True**/False
10. Only 1–2% of women who meet the criteria will become pregnant using LAM. **True**/False
11. Women who are HIV-positive can use hormonal implants without restrictions. **True**/False
12. There are no restrictions for an HIV-positive woman or man to use sterilization if they are certain they do not want more children. **True**/False
13. Following a vasectomy, the man is immediately sterile. True/**False**
14. Following a tubal ligation, the woman is immediately sterile. **True**/False
15. If a woman or man has an acute AIDS-related illness, a surgical sterilization procedure should be delayed until the client's condition has improved. **True**/False

Trainer's Resource 4.1

Benefits of Family Planning for PLHIV—Answer Key

- For women and couples with HIV, FP improves the health and well-being of families and communities through the spacing or limiting of births.
- Some ARV drugs themselves have significant potential toxicity and can harm the fetus. Notably, efavirenz (EFZ) is considered a potent teratogen; therefore, using FP methods while under treatment with EFZ prevents unintended pregnancy and possible exposure of the fetus to the damaging drug's effects.*
- When FP services are accessible, clients with HIV can manage the size of their families, thereby regulating the number of children they desire and are able to care for.
- Women can space their pregnancies in a way that reduces the risks associated with too many pregnancies or pregnancies spaced too closely. Maternal mortality and morbidity are higher for HIV-positive women.*
- FP prevents unintended pregnancies, thereby reducing the number of infants born with HIV and reducing the number of future orphans.
- FP prevents unintended pregnancies, thereby preventing prematurity and other poor birth outcomes that HIV-positive women are more likely to experience.*

*_Source:_ Richey, C. 2007. Contraception for women taking antiretroviral medications (ARVs): An update. _Global Health Technical Briefs._ Baltimore, MD: INFO Project/Johns Hopkins University Center for Communications Programs.

Trainer's Resource 4.2

Dual Protection Discussion Questions

Group 1

How does focusing on dual protection, rather than only on infection prevention, better meet HIV-positive women's and men's needs?

- Most HIV-positive women and men are sexually active, especially when they are married or young and they are feeling well. They are therefore at risk of unintended pregnancy, reinfection with more virulent strains of HIV, and infection with other sexually transmitted infections (STIs). They may also inadvertently pass HIV on to their partners, if they are not already infected (i.e., if the couple is serodiscordant).
- Many HIV-positive women and men are afraid or unable to disclose their HIV status to their sexual partners. They fear that by using condoms, their partners will guess that they are HIV-positive. Using condoms as a family planning (FP) method will allow them to talk about pregnancy prevention while protecting their partner from HIV infection.
- When condoms are not positively promoted as an effective FP method, HIV-positive men and women (and others) may come to the dangerous and incorrect conclusion that "Condoms are no good for FP, therefore they can't be any good in preventing infections either."

Group 2

How does promoting condoms as an effective FP method (either alone or in combination with another FP method) help to destigmatize condom use?

- Condoms often are stigmatized as only being useful for disease prevention. People believe that only unfaithful partners and high-risk groups such as sex workers and truck drivers use them. When HIV and FP clinic staff also promote condoms as an effective FP method, clients may perceive them less negatively and may be more prepared to use them *consistently with all sexual partners*, not just with "casual" partners.
- When clients introduce condoms into their relationships for FP purposes, their partners might find this less threatening than if the stated reason for using them is HIV/STI prevention.

Trainer's Resource 4.2

Dual Protection Discussion Questions (*cont.*)

Group 3

How does promoting condoms for dual protection (either alone or in combination with another method) help women and men to negotiate use with their partners?

- Emphasizing condoms for FP rather than for preventing HIV/STIs makes their use less threatening to sexual partners, because then women and men are not implying that they or their partners are being unfaithful.
- Many women and their partners are actively seeking a reliable FP method. They are comfortable discussing FP, but may not be comfortable discussing infection prevention.
- When condoms are recognized and promoted as an effective FP method, either alone or in combination with another FP method, the couple can focus on the FP benefits of consistent condom use, while at the same time gaining protection from HIV/STI infection or reinfection.

Group 4

Why do we need to promote dual protection among adolescents?

- Regardless of whether adults or health workers approve, many adolescents are sexually active. For many young people, the need to avoid an unintended pregnancy is more immediate and "real" than is the need to avoid HIV/STI infection or reinfection. They may be more ready to use condoms for pregnancy prevention than for disease prevention.
- Sexually active single adolescents generally have sex occasionally. Condoms (combined with emergency contraceptive pills [ECPs], should the condoms fail) are often a cheaper and more practical contraceptive method than other methods.
- Whether married or single, HIV-positive adolescents are even less able to disclose their HIV status or to negotiate consistent condom use for disease prevention than are older adults.
- Adolescents are more open to trying condoms than are older adults who have become set in their ways. Once adolescents have become accustomed to the idea that condoms are a natural and normal part of lovemaking, they will continue to use them throughout their lives. This will have a major, long-term impact on reversing the pandemic.

Trainer's Resource 4.2

Dual Protection Discussion Questions (*cont.*)

Key Discussion Points

A. One difficulty faced by women who want to use dual protection is that their partners must cooperate in using condoms. What can health workers do to assist men in using condoms, either alone or in combination with another FP method?

Possible responses include the following:

- Involve men in dual protection education and outreach, so they are aware of the risks (of both unintended pregnancy and infection) and know how to protect themselves and their partners.
- Encourage women to bring their partners for couples counseling.
- Help women to develop strong communication and negotiation skills through role-playing and other one-on-one counseling activities.
- Conduct health education sessions for women on dual protection: Hearing how other women discuss dual protection and negotiate condom use with their partners can be motivating and supportive.
- Promote dual protection and/or dual method use by conducting outreach to men (such as through community health workers, male peer educators, field officers, or drama groups).
- If available, promote the use of female condoms, which do not depend on men's using them (but may require men's acceptance of their presence during sexual activity).

B. What is the advantage of encouraging couples to consider dual method use (condoms plus another FP method)?

Answers may include the following:

- ECPs provide an important back-up to prevent pregnancy should a condom slip, break, or spill.
- Another FP method provides valuable back-up should couples sometimes forget to use condoms.
- For couples whose primary concern is to prevent pregnancy, other FP methods are more effective in preventing pregnancy in typical use.

Trainer's Resource 4.2

Dual Protection Discussion Questions (*cont.*)

C. Why do some clients find it unappealing to use dual methods (i.e., condoms plus another FP method)?

Answers may include the following:

- Using two methods costs twice as much.
- Using two methods may be more disruptive to spontaneous sex.
- It is more difficult to remember or to use two methods consistently than it is to use one method.
- There is less motivation to use both methods because one can seem sufficient.
- It can be hard enough convincing a partner to use one method, let alone two.

D. How might promoting dual method use (i.e., condoms plus another FP method) affect how clients view condoms?

Answers may include the following:

- If you are promoting another method because it is a more effective FP method, clients may decide that condoms are ineffective FP methods and may therefore not want to use them.
- Clients may not want to "bother with" condoms if they perceive them to be ineffective.
- Clients may associate condoms only with the prevention of HIV/STIs and not with pregnancy prevention.

E. How might one talk about dual method use (i.e., condoms plus another FP method) without undermining clients' confidence in condoms as both an effective FP method and the only method that protects against HIV/STI infection or reinfection?

Answers may include the following:

- Emphasize that, for male and female condoms to achieve their maximum potential in preventing unintended pregnancy, they must be used correctly every time a person has sexual intercourse.
- Although very uncommon, even experienced condom users may sometimes experience condom slippage, breakage, or leakage. In these circumstances, ECPs provide valuable back-up to prevent unintended pregnancy.
- Among those for whom pregnancy prevention is the highest priority, adding another contraceptive method to condom use provides additional protection, especially when couples forget to use condoms.

Trainer's Resource 4.3

Family Planning Study Guide 1: Combined Oral Contraceptives—Answer Key

Part A
Definition:
Family planning is defined as:

A voluntary and informed decision by an individual or a couple to decide on the number of children to have, when to have them, the interval between births, and when to stop by use of natural and/or modern contraceptives.

Benefits of Family Planning

List at least four benefits of family planning:
Any four of the following:

- *Improves the health and well-being of women/couples with HIV by helping them manage their fertility (e.g., space or limit births)*
- *Prevents pregnancy while a woman is using ARV drugs that can cause damage to the fetus*
- *Reduces the mortality and morbidity risks of pregnancy to HIV-positive women*
- *Reduces mother-to-child transmission of HIV*
- *Eeduces the likelihood of children being left as orphans*
- *Reduces poor pregnancy outcomes to women who are HIV-positive, by preventing unintended pregnancy*

Dual Protection/Dual Method Use

Explain the purpose of these approaches and how they work: "dual protection" and "dual method use"

Dual protection:

Prevents both unintended pregnancy and HIV/STI transmission through the following:

- Using condoms alone to prevent both infection transmission and undesired pregnancy
- Using condoms (to prevent infection transmission) and another contraceptive method to prevent pregnancy (dual method use)
- Avoiding sexual activities that can transmit infection or result in unintended pregnancies

Dual method use:

Involves using *condoms* to prevent *HIV/STIs* and using *another contraceptive method* to prevent *unintended pregnancy*.

Family Planning Study Guide 1: Combined Oral Contraceptives—Answer Key (*cont.*)

Combined Oral Contraceptives (COCs)

1. COCs are considered highly effective when taken correctly. If 1,000 women used COCs for one year with *perfect* use, how many would be expected to become pregnant? ___3___

   How many might become pregnant with *typical* use? ___80___

2. COCs work the following three ways to prevent pregnancy:
   a. *Thicken* the cervical mucus to prevent the sperm from going into the woman's uterus
   b. *Inhibit or stop* ovulation
   c. make the sperm *incapable* of *fertilizing the egg (ovum)*

3. *Circle the correct word or words*: COCs offer/**do not** offer protection against HIV.

4. List at least five characteristics of COCs:
   Any five of the following:
   - May rapidly reverse effects after stopping use (can become pregnant easily after stopping use)
   - Decreases menstrual cramps and pain
   - Decreases menstrual blood loss
   - Reduces the risk of endometrial and ovarian cancer
   - Decreases risk of benign breast conditions (e.g., fibrocystic breast changes)
   - Reduces the risk of iron deficiency anemia by reducing menstrual blood loss
   - May increase sexual pleasure either by increasing libido or increasing lubrication
   - Requires pills be taken daily
   - Offers no protection against STIs/HIV
   - May increase risk of heart attack, stroke, venous thromboembolism (blood clots in the veins), hypertension, and cholestatic (gall bladder) jaundice

Family Planning Study Guide 1: Combined Oral Contraceptives—Answer Key (*cont.*)

5. Using the FHI Quick Reference for Medical Eligibility Criteria (WHO) (and local Family Planning Service Delivery Guidelines, if available), state whether the following clients can use COCs:

   a. HIV-positive woman on ARV drugs:
   Can use, but will need to be very strict in pill-taking; may be burdened by additional pill-taking
   b. HIV-positive couple with three children, unsure about ending their fertility:
   Can use, but may be interested in knowing more about long-acting method options
   c. HIV-positive couple with three children, unsure about ending their fertility:
   Can use COCs

Circle the word "true" if the sentence is correct; circle the word "false" if the sentence is incorrect.

6. A woman can start taking her first packet of COCs on any day that she is certain she is not pregnant.
   True/**False**
7. After a woman takes the last pill from a 28-day packet, she will take the first pill from the new packet the following day.
   True/False
8. A woman or couple should be instructed to use condoms to prevent STI and HIV reinfection while using COCs.
   True/False
9. After using COCs for two years, a woman should take a "rest" and stop taking them.
   True/**False**
10. For women taking ARV drugs, using COCs requires that they take COCs consistently, meaning taking the pill at the same time every day, without forgetting.
    True/False

11. List the warning signs for women using COC:
    - *Severe abdominal pain*
    - *Severe chest pain*
    - *Severe headaches, migraine with weakness, difficulty speaking*
    - *Eye problems, visual disturbances, blurred vision*
    - *Severe leg pain (blood clot in the vein in the leg)*

Family Planning Study Guide 1: Combined Oral Contraceptives—Answer Key (*cont.*)

A woman should return to the family planning clinic or facility if she experiences the following:

- *Severe mood swings or depression*
- *Jaundice*
- *Two missed periods or signs of pregnancy*

Part B

TRUE/FALSE: Circle true if the statement is correct; circle false if the statement is incorrect.

1. Emergency contraceptive pills (ECPs) prevent pregnancy by interfering with ovulation and/or making the sperm unable to fertilize the egg.
   True/False
2. ECPs are appropriate for use as an ongoing method of FP.
   True/**False**
3. ECPs can be effectively used up to 120 hours (five days) following unprotected intercourse.
   True/False
4. ECPs can dislodge an established pregnancy.
   True/**False**
5. A second dose of ECPs is given 12 hours after the first dose.
   True/False
6. Immediately following completion of ECP treatment, a woman/couple must use another FP method until the next menstrual period and continue using the method(s) for as long as she does not want to become pregnant.
   True/False
7. After ECP treatment, the woman should expect to have a menstrual period within three weeks.
   True/False

Trainer's Resource 4.4

Family Planning Study Guide 2: Injectables—Answer Key

1. **Depo Provera** (DMPA) works the following three ways to prevent pregnancy:
   - *Inhibits or stops ovulation*
   - *Changes (thins) the lining of the uterus*
   - *Thickens the cervical mucus (preventing the sperm from getting through the cervix to the uterus).*

2. DMPA is also considered a highly effective method. If 1,000 women used DMPA for one year with *perfect* use, how may would be expected to become pregnant? ____3___.

   How many might become pregnant with *typical* use? ___30___

3. Circle the correct word or words: DMPA provides/**does not provide** protection against STIs and HIV.

4. List at least five characteristics of DMPA:
   - *Contains no estrogen (therefore, does not cause the rare but serious complications of thrombophlebitis [blood clots in the veins], pulmonary embolism)*
   - *Reduces menstrual blood loss*
   - *Reduces menstrual cramps, pain, mood changes, headaches, breast tenderness, and/or nausea*
   - *Decreases the risk of endometrial cancer, ovarian cancer, and pelvic inflammatory disease*
   - *Known as effective, long-term contraception, but is costly*
   - *Causes absence of menstrual bleeding after 9 to 12 months of use*
   - *Causes minimal drug interaction*
   - *Reduces the frequency of sickle cell crisis and reduces the frequency of seizures*
   - *Offers no protection against STIs and HIV*
   - *Causes menstrual irregularity, which is the most common reason for discontinuation*
   - *Causes weight gain (approximately five pounds in the first year, eight pounds after two years of use)*
   - *Causes depression*
   - *Cannot be discontinued immediately*

Family Planning Study Guide 2: Injectables—Answer Key (*cont.*)

TRUE/FALSE: Circle "true" if the statement is correct; circle "false" if the statement is incorrect.

a. If there is any reduction in the effectiveness of DMPA, it will likely occur at the end of the three-month (12-week) period; therefore, women should be advised to return for the next injection on time (e.g., during the 11th or 12th week).
True/False

b. It is very important for women and couples to know that DMPA may cause unpredictable bleeding patterns and that a woman may stop having menstrual bleeding after one year of DMPA use.
True/False

c. If the first DMPA injection is given during the first five days of a woman's menstrual period, no back-up method is necessary.
True/False

6. List the warning signs for women using DMPA:

- *Repeated, very painful headaches*
- *Heavy bleeding*
- *Depression*
- *Severe, lower abdominal pain (may be sign of pregnancy)*
- *Pus, prolonged pain, or bleeding at the injection site*

7. Using the FHI Quick Reference for Medical Eligibility Criteria (WHO) (and local Family Planning Service Delivery Guidelines, if available), state whether the following clients can use DMPA:

a. HIV-positive woman on ARV drugs:

Can use, but will need to return on time for repeat injections (e.g., at 11 or 12 weeks).

b. HIV-positive adolescent:

Can use.

Trainer's Resource 4.5

Family Planning Study Guide 3: IUD, Implants, LAM, Standard Days Method, and Permanent Methods—Answer Key

TRUE/FALSE: Circle true if the statement is correct; circle false if the statement is incorrect.

1. The IUD can be provided to women who are HIV-positive, to women using ARV drugs, and to women who are "clinically well." **True**/False
2. A woman living with HIV who is already using the IUD must have the IUD removed if she develops clinical HIV disease. True/**False**
3. Voluntary sterilization, the lactational amenorrhea method (LAM), the standard days method (SDM), and hormonal implants can be used by women/couples who are HIV-positive or who are using ARV drugs. **True**/False
4. The Copper-T 380A IUD works to prevent pregnancy by preventing sperm from fertilizing the woman's egg. **True**/False
5. The Copper-T 380A IUD can remain in place for up to 12 years, providing nearly 100% effectiveness in preventing pregnancy (less than a 1% failure rate). **True**/False
6. Studies have shown that women who have never had a child can use the Copper-T 380A without its negatively impacting their future fertility. **True**/False
7. The IUD offers protection against STIs and HIV. True/**False**
8. LAM is a temporary FP method that can be used for up to six months postpartum by women who are exclusively (fully or nearly fully) breastfeeding and who continue to have no menstrual periods. **True**/False
9. Exclusive breastfeeding during the first six months postpartum may reduce the risk of a baby's getting HIV when compared with the results of mixed feedings; therefore, LAM would be a safe FP method for mother and infant. **True**/False
10. Only 1–2% of women who meet the criteria will become pregnant using LAM. **True**/False
11. Women who are HIV-positive can use hormonal implants without restrictions. **True**/False
12. There are no restrictions for an HIV-positive woman or man to use sterilization if they are certain they do not want more children. **True**/False
13. Following a vasectomy, the man is immediately sterile. True/**False**
14. Following a tubal ligation, the woman is immediately sterile. **True**/False
15. If a woman or man has an acute AIDS-related illness, a surgical sterilization procedure should be delayed until the client's condition has improved. **True**/False

Trainer's Resource 4.6

Alternate Exercise: Medical Eligibility Criteria

Instructions

1. In advance, write the following headings on pieces of flipchart paper to post on the wall:
   - COCs: Who can use?
   - COCs: Who should not use?
   - DMPA: Who can use?
   - DMPA: Who should not use?
2. Cut several pieces of masking tape and attach them to the wall next to the posted headings.
3. Copy each response of "who can use" and "who should not use" onto a single index card for COCs and for DMPA. There should be one pack of a combined "who can use" and "who should not use" lists for each method. (Use the table on the next page as the basis of these cards.)
4. Divide the group into two teams.
5. Assign COCs to one team and DMPA to the second team.
6. Instruct the teams to huddle for three minutes to sort through the pack and separate out the "who can use" cards from the "who should not use" cards.
7. Have each group paste the cards to the wall under the correct heading.
8. Note the team that finishes first and give the remaining team three minutes to complete the exercise after the first team has finished.
9. Review the work of the first team with the large group for correctness, and correct as indicated.
10. Reward the team that finishes first having all the correct answers for their method (with sweets or any small item that the participants would appreciate).
11. If neither team completes the exercise with all of the correct answers, still reward their efforts.

Trainer's Resource 4.6

Alternate Exercise: Medical Eligibility Criteria (*cont.*)

Who Can and Who Should Not Use COCs and DMPA

Can Use (without restriction)	Should Not Use
Combined oral contraceptives (COCs)	
Anemia	Pregnancy
Varicose veins	Breastfeeding less than six months
History of ectopic pregnancy	Less then three weeks postpartum (whether breastfeeding or not)
STIs, including HIV	History of breast cancer
Undergoing treatment with ARV drugs	Hypertension (>140/100)
Unexplained vaginal bleeding	Undergoing treatment with drugs that affect the liver enzymes (e.g., rifampicin)
Sexually active adolescents	
Irregular menstrual cycles	
Depo Provera (DMPA)	
Women having no children	Pregnancy
Breastfeeding (more than six weeks) postpartum)	Breastfeeding less than six weeks postpartum
Postabortion	Hypertension (>160/100)
Sickle cell anemia	Diabetes, age more than 20 years
Hypertension (140–159/90–99)	Current breast cancer
Undergoing treatment with ARV drugs	Active liver disease (e.g., hepatitis, cirrhosis, tumors)
Undergoing treatment with rifampicin	Multiple cardiovascular risk factors (older age, smoking, diabetes, and hypertension)
Diabetes without vascular complications	

Source: Uganda National Guidelines and Service Standards for Reproductive Health Services, Addendum to Section 3.9, Eligibility for Family Planning Methods.

Unit 5: Use of Updated FP Information in Health Talks and Counseling

Unit 5: Use of Updated FP Information in Health Talks and Counseling

Session 5.1: Providing FP Information in Health Talks

Essential Ideas to Convey

- Family planning helps HIV-positive clients to: space their pregnancies, providing time for them to recuperate and build up their reserves and to provide time for the baby to grow and survive; have the number of children they want and can afford; protect against unintended pregnancy, which in turn reduces the number of babies born infected with HIV, reduces HIV-related infant deaths, and saves women's lives from the increased risks of pregnancy complications; engage their partner in preventing reinfection with HIV, infection with other STIs, and unintended pregnancies; reduce the number of orphans and the associated costs to the community; and prevent damage to a developing fetus when the client is using certain ARV drugs.

- Women and their partners may want to space births or limit the number of children they have, but they are often confused by misinformation about FP methods. If left uncorrected, these misconceptions create barriers to the FP use, and these put women at risk of unintended pregnancy, with sometimes negative social and health consequences.

- Health talks offered at the ART center or in the local community can be used to provide basic information about available FP methods, so that clients can have time to consider what they have heard and be better prepared to discuss FP methods with the counselor.

Session Purpose and Objectives

The purpose of this session is to refresh the participants' skills in information sharing and help them build FP content into their existing information-sharing skills. By the end of the session, the participants will be able to

- Dispel common rumors, myths, and misconceptions about FP methods in relation to the needs of people living with HIV and those using ARV drugs
- List key discussion points for use in health education talks about FP
- Explain the risks associated with pregnancy among women with HIV and the positive developments that have occurred in this area

Time
1 hour

Materials
- Flipchart paper, markers, and tape
- Pieces of paper (for Optional Exercise on myths and rumors)
- Participant Handout 5.1: Health Talk Content
- LCD projector
- Laptop computer
- Screen (or other surface on which to project slides)
- PowerPoint presentations "Client-Focused RH Counseling"; "Pregnancy in Women with HIV," "Reasons to Consider Pregnancy," and "Reasons to Avoid Childbearing"; selected slides for hormonal contraceptives, hormonals and ARV drugs, IUD, LAM, and ECP

Advance Preparation
1. Make enough copies of Participant Handout 5.1 to distribute to all participants.
2. If using the Optional Exercise described in the Trainer's Tip on page 109, write questions from Trainer's Resource 5.1 on single pieces of paper.

Training Steps
1. Introduce this unit by informing the participants that women living with HIV and their partners—including people who are HIV-negative—need to make a variety of reproductive health decisions about pregnancy, childbearing, and FP use. Women who are HIV-positive, however, may be more vulnerable to societal, religious, or family pressures than are women who are HIV-negative. Health personnel must take special care to ensure that women and their partners do not feel pressured into making certain reproductive choices.
2. Begin the PowerPoint presentation by reviewing the content on "Pregnancy in Women with HIV," "Reasons to Consider Pregnancy," and "Reasons to Avoid Childbearing."
3. Move on to FP myths and rumors by commenting that although women and their partners may want to space births or limit the number of children they have, they are often confused by misinformation about FP methods. If left uncorrected, these misconceptions create barriers to the FP use, and these put women at risk of unintended pregnancy, with sometimes negative social and health consequences.
4. Allow time to answer the participants' questions and continue discussing FP myths and rumors.
5. Ask the participants to brainstorm a list of FP-related rumors from the communities they serve, including those rumors and misconceptions related to the use of FP by PLHIV or by people using ARV drugs.
6. Record their answers on a piece of flipchart paper.

Training Option

The following Optional Exercise, called "Did You Hear….?" can be conducted with participants who are service providers or counselors with a medical or nursing background. The trainers should write as many of the "Did you hear…?" questions in Trainer's Resource 5.1 as possible on sheets of paper.

Training Steps

1. Divide the participants into pairs.
2. Direct the pairs to select a piece of paper and take turns reading aloud and explaining why the question is correct.
3. If the partner cannot answer the question, ask a volunteer from the larger group to answer. Then have the pairs switch, so that the person who answered the question previously will now select a question and read aloud for her/his partner to answer.
4. Repeat the process until all of the questions have been answered. When the participants have difficulty answering questions, provide the answer, along with recommendations about where they can find the information.

7. Share with the participants what you may know about the concerns of local community members and users of ART services about side effects of FP methods, particularly those related to irregular bleeding and weight gain (based on the findings of whatever assessments have been carried out recently in the country or locality where the training is being conducted). (***Note:*** *If local information is not available, incorporate assessment findings about myths and concerns from any country setting in which FP-HIV integration has taken place.)*
8. Lead a discussion in which you ask participants to use the updated FP information provided earlier in the training to explain or dispel the identified rumors or misconceptions.
9. Correct and/or elaborate on the participants' responses, as indicated.
10. Ask the participants to list the FP information that they think would be appropriate to include in health talks at their ART center or in their community. Emphasize that the information presented during health talks should give clients basic information about available FP methods so they can think about what they have heard and ask questions that will help the provider tailor counseling to their situation. The challenge is to provide enough information without overloading the client.
11. Record the results of this discussion on a piece of flipchart paper.
12. Pass out copies of Participant Handout 5.1 and compare what is there with their brainstormed list. Remind the participants that the health talk should not overload clients with information, but should give clients enough information to ask their care providers informed questions and help streamline counseling to the client's needs.

Session 5.2: Addressing Attitudes toward Providing FP Counseling

Essential Ideas to Convey

- Although HIV counselors and HIV care and treatment providers have successfully offered services for many years, they may be reluctant to discuss explicit sexual practices with clients. As ART becomes increasingly available, PLHIV are reevaluating their sexual and reproductive health options; consequently, there is a need for counselors and service providers to be able to address sexuality more frankly and directly.
- It is important not only to be aware that discussing sexual practices is difficult for both the client and the provider, but also to understand how biases on the part of the provider might affect a client's feelings about discussing such intimate issues.
- The term "sex" is often thought to refer to penile-vaginal intercourse only, but sexual behaviors can be defined much more broadly. If providers assume that sex only means penile-vaginal intercourse, they may be missing important information.
- We all make value judgments when it comes to sexual behavior and the circumstances under which people engage in particular sexual practices, but to be effective in their work, providers and counselors cannot impose their own values on clients as clients' individual needs and situations are being explored and discussed.
- If a counselor or provider does not address the issue of sexual practices, clients may receive inadequate or inappropriate information, and consequently may be unable to protect themselves from infection or from unintended pregnancy. Assumptions and misunderstandings about clients' sexual practices can leave them without the information, skills, or methods that they need to protect themselves, their partner, and any future offspring.

Session Purpose and Objectives

The purpose of this session is to help participants appreciate the importance of biases and value judgments about sexual behavior (both on their part and among clients) and become more comfortable in addressing this topic. By the end of the session, the participants will be able to

- Acknowledge their own biases and value judgments about particular sexual behaviors
- Acknowledge differences in individual and cultural perspectives about sexual behavior, including differences in what is considered "normal" or "acceptable"
- Demonstrate increased comfort about discussing a range of sexual behaviors during FP counseling simulation exercises

Time

45 minutes

Materials

- Markers, cards, and tape
- Flipchart paper (Option 1 of the exercise)
- Letter-sized sheets of colored paper (use heavy paper or card stock, if available)

Advance Preparation

1. Decide whether to use Option 1 or Option 2 for the exercise (see Trainer's Tips, page 113).
2. Write one sexual behavior on each piece of colored paper (see Trainer's Resource 5.2: Different Types of Sexual Behavior for a list of sample behaviors). Use a thick marker and print in large letters, or use a computer and print in a large, bold font so that the words can be read from a distance. Write the phrases "OK for me," "OK for others, but not OK for me," and "Not OK" in small letters at the bottom of each card, so the participants can circle their response (see sample below).

3. Create three additional sheets of paper: one with the phrase "OK for me" written in large print, one with the phrase "OK for others, but not OK for me," and one with the phrase "Not OK." Use a different color of paper for these three sheets, if possible. Post these three sheets high on a wall in the training room, and ensure that there is sufficient space under them so that 3–5 vertical rows of cards can be stuck to the wall beneath each.
4. Prepare enough small pieces of tape so that the prepared sheets can be affixed to the wall.

Training Steps

1. Introduce the exercise by explaining to the participants that they will be exploring the range of sexual behaviors that people engage in and the attitudes and values that everyone has about those behaviors. This interactive exercise will allow them to

Trainers' Tips

This exercise is meant to be completely confidential, so the participants should not share the behavior presented on their card or their response with anyone. To ensure confidentiality, before distributing the cards, ask the participants to rearrange their seats or spread around the room so that no one can see their cards and their responses. (See *Considerations for Trainers/Training Options,* page 114.)

Also, note that this exercise has two options:

- **Option 1**—Begin the exercise by asking the participants to brainstorm a list of all of the sexual behaviors that they can name (*Note*: This will take an extra 10–15 minutes.)
  - Ask the participants to think broadly and include those behaviors that are not common or that are taboo in their communities. The list should include both sexual acts (e.g., vaginal sex, oral sex) and sexual dynamics or situations (e.g., sex with commercial sex workers, sex with someone older, sex with a person of the same sex).
  - Write all responses on a piece of flipchart paper. If two trainers are present, one can lead the brainstorming, while the second can write each of the sexual behaviors onto a piece of paper or card as they are mentioned. (*Note*: Be sure to write the phrases "OK for me," "OK for others, but not OK for me," and "Not OK" in small letters at the bottom of each card so the participants can circle or check their response). The trainer may ask for one or two volunteers to write down the comments, but be sure to invite the volunteer to record his or her comments as well. After brainstorming, if the list of behaviors does not represent a wide range of sexual behaviors, add some of the prepared cards from the list of sexual behaviors (Trainer's Resource 5.2) to the participants' cards before they are distributed.
- **Option 2**—Use only the prewritten sexual behavior cards. Be sure to review Trainer's Resource 5.2 before beginning this exercise and add new behaviors or omit others, based on the local situation. (*Note*: It is important to include behaviors that are outside the mainstream or that are taboo, even if these behaviors are not generally acknowledged to occur in the local setting.)

2. Tell the participants that each person will be given one or more cards on which a sexual behavior is written. Instruct them to read each card, determine how they personally feel about the particular behavior written on it, and indicate this by circling one of the "OK/Not OK" phrases.
3. Explain that "OK for me" means that it is a behavior that the participant personally would engage in, that "OK for others, but not OK for me" means it is a behavior that the participant personally would *not* engage in but that he or she has no problem with

other people doing it, and that "Not OK" means it is a behavior that no one should engage in because it is morally, ethically, or legally wrong.

4. Be sure to remind the participants that this exercise is confidential.
5. Distribute the sexual behavior cards to the participants, attempting to give each person the same number of cards, until all cards have been distributed. Repeat the meanings of the three "OK" cards (which are positioned on the wall) and ask if everyone understands.
6. Tell the participants to mark their responses by circling one of the "OK" phrases. Instruct them *not* to write their names on the cards and to place the cards with their circled responses face down in a pile in the center of the room.
7. Mix up or shuffle the cards, and ask all participants to take as many cards as they put down.
8. Invite the participants to take turns, one by one, reading aloud each card and then taping the card on the wall under the appropriate "OK" category, according to what is indicated on the card. ***Remind*** *the participants to put each card in the category that is circled, even if they personally do not agree with it.* Encourage the participants to stay standing, line up (queue) to read their card, and do so quickly, one after the other.
9. Once all of the cards have been posted, instruct the participants to gather around the wall and give them a few minutes to observe the placement of the cards.
10. Facilitate a group discussion based on the Key Discussion Points on the following page. *Do not remove a card if there is disagreement about where it should be posted; simply acknowledge the difference of opinion and leave the card as it is.*

Considerations for the Trainer/Training Options

- Some cards may address behaviors that some participants do not understand. If necessary, stop the exercise to define the behaviors for participants, or ask other participants to do so.
- It is helpful to continually remind the participants that this exercise is not about HIV risk, but about values and judgments around sexual behaviors. Sometimes participants have difficulty separating their ideas about disease risk from their value judgments about behaviors.
- If some participants indicate that a particular sexual practice does not exist in their culture (e.g., anal sex), ask other participants to verify whether this is true. Some participants may be more aware of the variations in sexual behavior and can help their colleagues understand.
- Do not ask the participants to identify who placed any behavior in a particular category. If some participants would like to volunteer such information to explain their answer, they may do so, but to ask this might make the participants uncomfortable and take away the anonymity from the exercise.

Key Discussion Points

- Are you surprised by the placement of some of the cards? Which one surprised you and why?
- How would you feel if someone placed a practice that you engage in yourself in the "Not OK" category?
- How would you feel if someone placed something you believed was wrong or immoral in one of the "OK" categories?
- Does the placement of the cards imply that some behaviors are "right" and others "wrong"? How do you feel about that?
- Are there behaviors that are "Not OK" under any circumstances?
  Possible responses may include:
  - Rape
  - Pedophilia
  - Incest
  - Behaviors that violate human rights
- How did you feel about placing someone else's response card on the wall? Would you have felt comfortable placing your own responses in front of the group?
- What does this exercise tell us about how clients might feel when providers ask them about their sexual practices?
  Possible responses may include:
  - Clients may fear being judged negatively.
  - Clients may be embarrassed or ashamed to admit that they engage in particular behaviors.
  - Clients may fear that their behaviors are not "normal."
- How do you think providers' and educators' values and attitudes about different sexual practices affect their work?
- How can providers and educators feel more comfortable in addressing sexuality issues with clients?
  Possible responses may include:
  - On-site refresher practice sessions can help build confidence and comfort among all staff involved in direct client counseling or supervision of client interactions.
  - Over time and with practice, you will feel more comfortable.
  - Talk about your fears and concerns with colleagues and/or trusted supervisor.
  - Explore/recognize what makes you uncomfortable and why, to desensitize yourself.
- How can providers and educators help clients feel more comfortable discussing sex?
  Possible responses may include:
  - Create a welcoming and nonjudgmental environment.
  - Assure clients of confidentiality.
  - Explain that you discuss these issues with all clients so as to provide them with high-quality sexual and reproductive health services.
  - Reassure them that many clients are initially uncomfortable discussing sexuality.

Session 5.3:
FP Information
Provided in Counseling

Essential Ideas to Convey

Part I

- HIV-positive women have other FP options in addition to using condoms. A wider range of options will result in more women and men being willing to use modern FP methods.
- Each FP method has its own characteristics, level of effectiveness, ease of use, and side effects. Each person ranks the importance of these issues differently. Factors that are critical to one person may be unimportant to another. Health personnel must respect their clients' decisions, even when they do not agree with their priorities.
- Because male and female condoms are the *only* FP method that also protects against HIV and STI infection or reinfection, health personnel should discuss dual protection with all FP clients—using condoms alone for both purposes or with another method (dual method use). Explore with women (and their partners, where feasible) the benefits and challenges and generate practical solutions to support new behaviors.

Part II

- HIV-positive men and women are often reluctant to raise issues concerning sexual activity, pregnancy, and contraception with health personnel, even though they *want* to discuss them. It is therefore important to explain that you understand their concerns and to explain why you are asking sensitive questions on these topics
- Interactions between a health worker and a client are influenced by personal factors such as age, gender, ethnicity, and socioeconomic status. Health workers must make the effort to help all clients feel comfortable and to bridge these gaps. Where and when possible, health workers and clients should be more evenly matched in terms of age, sex, or other crucial factors, to successfully address sensitive issues.
- When counseling clients, **how** a counselor or provider asks questions is just as important as **what** she or he asks. If a counselor appears nervous or uncomfortable, the client will feel the same way. Counselors need to be aware that their body language, facial expressions, and tone of voice can convey messages as easily as language does.

Part III

- Integrated reproductive health counseling moves away from the traditional FP counseling model, which relies on giving detailed information about every method. Instead, by exploring a client's individual circumstances and fertility intentions, the provider can better tailor the information to the client's needs. This not only saves time by building on the information provided during FP health talks, it better meets clients' needs.

- Understanding and exploring the social context of decisions is critical in helping clients to determine their own risks and to make realistic decisions. These social contexts include a client's power to make decisions about reproduction and sexuality and the people and factors influencing a woman's decisions (e.g., partners, family members, or friends). This process also includes anticipating the ramifications of decisions, such as whether a decision could result in marital upheaval, abandonment, or violence.
- **Pregnancy in women with HIV** does not speed up progression of the disease. Pregnancy, however, often carries serious consequences for the infant. Without treatment, about one-third of mothers with HIV will pass the virus to their newborns during pregnancy, delivery, or breastfeeding. Some evidence suggests that pregnancy in women with HIV increases the risk of stillbirth and of low birth weight.

Session Purpose and Objectives

The purpose of this session is to refresh the participants' counseling skills and build FP and sexuality content into their existing counseling skills. By the end of the session, the participants will be able to:

- Describe the components of integrated reproductive health counseling
- Generate strategies for asking HIV-positive clients sensitive questions about their sexual activity, pregnancy desires, and contraceptive practices
- Discuss key FP information to cover during posttest counseling, including FP information for women using ARV drugs
- Practice integrated reproductive health counseling skills during a classroom simulation exercise

Time

3 hours

Materials

- Participant Handout 5.2: Integrated Reproductive Health Counseling Framework (Long Version)
- Trainer's Resource 5.3: Integrated Reproductive Health Counseling Framework (Short Version)
- Participant Handout 5.3: Sexual Activity, Pregnancy, and Contraception: Raising the Subject with HIV-Positive Clients
- Trainer's Resource 5.4: Family Planning Content for Counseling HIV-Negative and HIV-Positive Individuals
- Flipchart paper
- LCD projector
- Laptop computer
- Screen (or other surface on which to project slides)

- PowerPoint presentation, "Client-Focused RH Counseling": "Family Planning Counseling for Clients with HIV"

Advance Preparation

1. Make enough copies of Participant Handout 5.2.
2. Write out a flipchart showing the "short version" of the Integrated Reproductive Health Counseling Framework (Trainer's Resource 5.3).
3. Write out the points in Trainer's Resource 5.5 ("Rules for Giving and Receiving Feedback") on a sheet of flipchart paper.
4. Make copies of Trainer's Resource 5.6 for use in the classroom counseling skills practice.
5. Write out the counseling skills checklist on a sheet of flipchart paper.
6. Write out the following exercise instructions on a sheet of flipchart paper:

Instructions for Small-Group Discussions

- All group members should take turns practicing counseling as a health provider and as an HIV-positive client.
- All clients are HIV-positive and are using ARV drugs.
- Members of the group other than the "provider" and the "client" should observe the counseling and provide constructive feedback after each practice, using the counseling checklist.
- Groups should continue in this manner until everyone has played both roles.
- Each counseling practice should take no more than 10 minutes.

Training Steps

Introduce *counseling* by using the PowerPoint slide presentation to give participants an overview of counseling issues for HIV-positive clients.

Part I

1. Introduce the integrated reproductive health counseling framework (Participant Handout 5.2), explaining that it is a *practical, four-step guide* to assist health personnel to *counsel clients efficiently and effectively*. Explain that integrated reproductive health counseling helps health personnel explore a client's circumstances, helps them to provide relevant information to fit the client's needs, and ensures that HIV-positive women and their partners make free, informed decisions about pregnancy, FP, and the prevention of STI and HIV reinfection. Such a counseling approach also helps clients develop skills for carrying through with their decisions.

2. Pass out Participant Handout 5.2 and orient the participants to the counseling framework by reviewing it carefully and allowing for questions along the way.
3. Summarize the content by posting the prepared flipchart showing the short version of the framework and by asking a volunteer (or volunteers) to read it aloud.
4. Explain that the participants should use the posted version as a guide while incorporating updated FP information during classroom simulation practice and during the practicum.
5. Divide the participants into two groups. Ask one group to generate a list of key FP points that should be included in counseling the posttest/HIV-negative client, and ask the second group to generate a list of key FP points that should be included in counseling the posttest/HIV-positive client.
6. Allow the two groups 15 minutes to complete the assignment.
7. Ask each group to present their list. Compare their ideas with those listed in Trainer's Resource 5.4: Family Planning Content for Counseling HIV-Negative and HIV-Positive Individuals.
8. Add (or have the participants add) any omitted points to their flipcharts, or distribute Trainer's Resource 5.4 as a handout and review the content together.

Part 2

1. Begin by acknowledging that many health workers find it challenging to initiate a discussion about sexual activity, pregnancy, and contraception with HIV-positive clients.
2. Conduct a large-group brainstorming session by asking the following questions:
   - ✳ How can health workers put HIV-positive clients at ease when asking sensitive questions about their sexual activities, pregnancy desires, and FP practices?
   - ✳ How can health workers raise the subjects of sexual activity, pregnancy, and contraception with HIV-positive clients?
   - ✳ What questions can health workers ask to explore HIV-positive clients' concerns about these issues?
3. On a piece of flipchart paper, record the participants' ideas for each question.
4. Discuss the responses, making sure that the following points are included:
   - ✓ Make sure that you talk with HIV-positive clients about sensitive issues only in a private space where the conversation cannot be overheard.
   - ✓ Explain to the client from the beginning that there are some standard questions that you ask all HIV-positive clients. Let him/her know that you do this to be able to help him/her think through managing concerns and needs.
   - ✓ Explain to the client that being HIV-positive does not stop someone from having thoughts and desires about sex, nor does it stop him/her from thinking about having children. Explain that you understand that many HIV-positive people continue to have sexual relations.
   - ✓ Talk to the client about the importance of being honest and reassure him/her that you are not there to judge. Explain that he/she should not worry about what you

- ✓ Reassure the client that everything he/she talks about will be kept confidential and private between the two of you and that if you needed to discuss the situation with another provider, you will get the client's permission first.

5. Distribute Participant Handout 5.3 and review it with the participants, asking if they have any questions. Ask if there is anything they would like to add to the points raised in the handout.

Part 3

1. Post the prepared flipchart showing the rules for giving and receiving feedback and review these with the participants.
2. Divide the participants into several smaller groups, with a co-trainer assigned to each.
3. Display the prepared flipchart showing the instructions for the small-group exercise and review them with the participants.
4. Assign three FP methods to each group, so that the participants have an opportunity to apply as much FP method information as possible. (For example, one group could be assigned LAM, DMPA, and ECPs; another, implants, condoms, and COCs; and the third, the IUD, vasectomy, and tubal ligation.)
5. Reconvene once all of the participants have practiced and have given feedback.
6. Process the exercise by asking the following questions:
   - ✳ How did the participants feel about giving and receiving feedback on their counseling practice?
   - ✳ How did they feel about giving this new information?
   - ✳ What insights did they gain that they might use when counseling clients at their center?
7. Form six groups for the next day's simulation counseling practice.
8. Assign each group a scenario from Trainer's Resource 5.6. Explain that after the completion of every counseling scenario, two participants from each group will shift to the group to their right. All of the participants should get a chance to practice being the provider. Each group should be monitored by a co-facilitator during the counseling practice, to ensure that the FP information and guidance being given is correct for the needs of the client in the scenario.

Session 5.4:
Negotiating Condom Use

Essential Ideas to Convey

- Some reasons that people give for not talking about or using male condoms can sound like excuses. It is important to remember that the reasons are real to the person who expresses them. Many women have limited options for talking and negotiating with their sexual partners.
- Health workers may feel frustrated and powerless when they hear these statements. They should remain patient and supportive, however, and encourage their clients to keep thinking about the issue and how they may be able to resolve the problems they have raised. Behavior change, as will be discussed in a later session, takes time. It is often a slow process, which includes a lot of backtracking.

Session Purpose and Objectives

The purpose of this session is to help providers develop condom negotiation skills to use with clients seeking FP services. By the end of the session, the participants will be able to:

- List common reasons that men, women, and health workers give for why they are unable to talk about or use male condoms
- Develop strategies to help clients confront reasons for not talking about or using male condoms
- Help clients develop condom negotiation skills through a classroom exercise

Time

1 hour, 30 minutes

Materials

- Flipchart paper, markers, tape
- Participant Handout 5.4: Helping Clients Communicate with Their Partners

Advance Preparation

1. Prepare a flipchart showing the three group discussion questions from Trainer's Resource 5.7.
2. Prepare a flipchart showing the partner statements assigned to each of the four groups for discussion:
   - **Group 1**—"It will not feel as good…"
   - **Group 2**— "I do not have any disease!"
   - **Group 3**— "You are already using a family planning method!"
   - **Group 4**— "Just this once without a condom…"

Additional statements might include**:**

- "Don't you trust me?"
- "I'm too big for a condom."
- "I got tested last year and I was negative."
- "Honey, do I look like I have AIDS?"

Training Steps

1. Explain that much time has been spent discussing how the male condom (and the female condom, where available) is the *only* FP method that protects against *both* pregnancy and HIV/STI infection or reinfection. Even though this has been known since the beginning of the HIV pandemic, many sexually active people still do not use condoms. Ask the participants if they *routinely* discuss the male condom (and the female condom, where available) with *all* of their clients and if they believe that their clients *always* use condoms when they have sexual intercourse.
2. Divide the participants into three groups. Reveal the prepared flipchart showing the three discussion questions. Ask each group to brainstorm for 10 minutes and write on a piece of flipchart paper as many possible endings as they can to these sentences.
3. After 10 minutes, ask each group to turn their lists over to the next group (i.e., Group 1 gives its list to Group 2, Group 2 gives its list to Group 3, and Group 3 gives its list to Group 1). Ask these groups to now discuss and list the suggestions they would make or strategies they would use if a health worker or client mentioned any of the reasons written on the sheet that the previous group prepared. Allow 15 minutes for this activity.
4. Reconvene the participants and have a representative from each group present the various *I can't ask . . .* statements plus their suggestions and strategies for responding to the objections raised.
5. Lead a group discussion based on the discussion points in Trainer's Resource 5.8: Key Discussion Points and Possible Responses.
6. Pass out Participant Handout 5.4, ask the participants to quickly read through the handout, and lead them in a brief discussion of the points they captured from the reading that they might use during counseling and negotiation skills building.
7. Explain that providers often need to work with clients to think through possible responses to their partners' reluctance to use condoms. As an example, choose a statement from Trainer's Resource 5.9 (such as "Condoms are for prostitutes; why do you want to use one?"), read it to the participants, and ask them to suggest replies. (These might include: "Condoms are for couples who want to protect each other," "Condoms communicate caring between partners," or "Condoms are for everyone.")
8. Divide the participants into four smaller groups, and ask them to choose a recorder and reporter for each group.
9. Reveal the prepared flipchart with partner statements and assign one partner statement to each group. Instruct each group to list on a blank piece of flipchart paper

10. Allow 15 minutes for the groups to brainstorm and to write down the responses they develop.
11. Reconvene the group and facilitate a discussion with the participants about how they felt about the exercise: Was it hard, or easy? How did it make them feel?
12. Have each group present the results of their brainstorm. Use Trainer's Resource 5.9 as an answer guide. Add appropriate participants' responses to the resource to enhance the reply options.
13. Explain to the participants that the content covered in this unit will be used during the counseling simulation practice before going into the clinical practice area.

Participant Handout 5.1

Health Talk Content

Key Family Planning (FP) Information to Provide in Health Education Talks
Explain the meaning of FP • FP allows individuals/couples to achieve their desired number of children through the spacing and timing of their births.

Communicate the benefits of FP to the HIV-positive woman or couple, to a child, and to the community
Key Messages: Family planning helps you…
• Space pregnancies for 3–5 years, to provide time for a woman to recuperate and build up her reserves and to provide time for the baby to grow and survive.
• Have the number of children you want and can afford to feed, clothe, house, educate, and cover their medical care.
• Protect against unintended pregnancy, which in turn
  o Reduces the number of babies infected with HIV
  o Reduces HIV-related infant deaths
  o Saves women's lives from the increased risks of pregnancy complications, such as anemia, hemorrhage, sepsis, and increased susceptibility to life-threatening opportunistic infections (OIs) (e.g., pneumocystis carinii pneumonia, tuberculosis, and malaria)
• Engage your male/female partner in preventing reinfection with HIV, infection with other sexually transmitted infections (STIs), and unintended pregnancies
• Reduce the number of orphans and the associated costs to community
• Prevent unintended pregnancy when the female partner is using a particular antiretroviral (ARV) drug that should not be given to a pregnant woman because it may damage a developing fetus

Describe FP methods, including the lactational amenorrhea method (LAM) and emergency contraceptive pills (ECPs).
Explain how to use FP methods (briefly).
Encourage the use of dual protection, such as dual method use, including demonstrating the use of condoms.
Emphasize the importance of condoms during pregnancy and breastfeeding, if the client is pregnant or breastfeeding.
Mention the common side effects of FP methods.
Dispel myths and rumors.
Explain when to start an FP method.
Describe where FP methods can be obtained, including the costs, if any
Explain when to return to the clinic for FP follow-up

Adapted from: Ministry of Health. 2005. *Strengthening family planning within the PMTCT program in Uganda*. Kampala.

Participant Handout 5.2

Integrated Reproductive Health Counseling Framework

STEP 1: Introductions

1. **Welcome the client.**
   - Greet the client warmly.
2. **Make introductions.**
   - Identify the reason for the client's visit.
   - Ask general questions, such as name, age, or number of children.
3. **Assure confidentiality.**
   - Make the client feel comfortable by assuring confidentiality.
4. **Help the client to relax and feel comfortable.**

STEP 2: Exploration

1. **Explore the client's needs, risks, sex life, social context, and circumstances.**
   Explore the following:
   - Client's current family situation (number of children, living situation, extended family, social networks)
   - Client's current work situation
   - Client's overall health
   - Client's sources of support in his or her family and/or community
   - The circumstances of client's sexual relationships:
     a. What sexual relationship(s) is she or he in, what is the nature of the relationship(s) (including any violence or abuse), and how does she or he feel about it?
     b. How does she or he perceive his or her sexual pleasure and sexual problems?
     c. Is she or he able to communicate with partner(s) about sexual activity, FP, HIV, and STIs?
     d. What does she or he know about partners' sexual behavior outside of their relationship?
   - Client's STI history and present symptoms and knowledge of partner's STI history, and knowledge of partner's HIV status
   - Other factors about the client's circumstances that may limit her or his power to make decisions, such as financial dependence on the partner, tensions within an extended family, and fear of violence

Participant Handout 5.2

Integrated Counseling Framework (*cont.*)

2. **Provide relevant information about prevention of HIV/STI infection or reinfection, unwanted pregnancy, and dual protection.**
   - Explore the client's knowledge of HIV, STIs, FP, and dual protection, and fill in gaps.
   - Discuss relevant FP options, including their effectiveness for preventing both HIV/STI infection or reinfection and pregnancy.
   - Explain HIV/STI infection or reinfection and pregnancy risks relevant to the client's personal circumstances.
   - Discuss the importance of condoms as the only method that protects against both pregnancy and HIV/STI infection or reinfection.
3. **Assist the client to determine her or his own risk for unintended pregnancy and HIV/STI infection or reinfection.**

STEP 3: Decision Making

1. **Discuss dual protection, pregnancy prevention options, and prevention of HIV/STI infection or reinfection.**
   - Make sure that the discussion centers on options that are appropriate to the client's individual needs.
   - For those FP methods that the client seems interested in, provide more detailed information on how to use the method, potential side effects, potential impact on sexual relations, and how it does or does not prevent the transmission of HIV and other STIs.
   - Help the client to choose the contraceptive method that best meets her or his needs
2. **Assist the client to make realistic decisions.**
   - Help the client to assess whether her or his decisions are feasible, given her or his relationship(s), family life, economic situation, etc.
   - Brainstorm with the client how to overcome potential barriers to carrying out her or his decisions.
3. **Help the client to anticipate the potential outcomes (positive or negative) of her or his decisions.**
   - Assist the client to identify the possible outcomes of the actions that she or he chooses to take.
   - Explore with the client how her or his partner(s) may react to actions that she or he is choosing to take (e.g., suggesting condom use, discussing sexuality)

Participant Handout 5.2

Integrated Counseling Framework (*cont.*)

4. **Discuss options.**
   - Help the client to determine the incremental steps that she or he can take over time to reduce her or his risks.
   - Help the client to consider other options when she or he is unable to talk with her or his partner(s), such as indirect communication or avoiding risky situations
   - Discuss the local community resources that are available to support her or him (e.g., PLHIV groups)

STEP 4: Skills Building for Action

1. **Develop partner communication and negotiation skills.**
   - Discuss the client's concerns about talking with partner(s) about dual protection, condoms, and FP, and offer ideas for improving communication and negotiation.
   - If she or he finds it difficult to talk about condoms, discuss whether it might be easier to talk about condoms as an FP method.
   - Role-play with the client possible situations that may crop up when talking about FP and condoms
2. **Develop condom use skills.**
   - Demonstrate correct male and female condom use on penis and vagina models; ask the client to repeat the demonstration to be sure that she or he understands.
   - Discuss ways of making condoms more appealing and fun to use.
   - Provide condoms to the client and make sure she or he knows where and how to obtain more.
3. **Develop other FP method use skills.**
   - Make sure that the client understands how to use any other FP method that she or he has selected, by repeating basic information and by encouraging her or him to ask for clarification.
4. **Develop a plan for carrying out decisions.**
   - Develop a *plan of action* that addresses specific steps, such as obtaining condoms and/or another FP method, talking with partner(s), etc.
   - Invite the client back for a follow-up visit to provide ongoing support and encouragement.
5. **Refer the client to other health services or community support groups, as required**

Participant Handout 5.3

Sexual Activity, Pregnancy, and Contraception: Raising the Subject with HIV-Positive Clients*

HIV-positive women and men have the same sexual thoughts, desires, and feelings as HIV-negative persons of the same age. Many have an overwhelming desire to have children; however, many are also confused, ashamed, and afraid of these feelings. They have heard about the risks of transmitting HIV to others, but they still have strong sexual desires and the need to have sexual relations. They have heard about the importance of disclosing their HIV status to their partners, but they may feel unable to do so. Moreover, they assume that health workers expect that all HIV-positive people should avoid sexual relations completely, regardless of their circumstances, and that they certainly should never get pregnant.

As a result, HIV-positive men and women are often reluctant to raise issues concerning sexual activity, pregnancy, and contraception with health workers, even though they *want* to discuss these issues. It is therefore important that health workers raise these topics with their HIV-positive clients of all ages, regardless of their sex, religion, or marital status. Despite the need, however, health workers find discussing these subjects challenging. It is important in such discussions that health workers have the following abilities:

- Be knowledgeable of the medical and social issues involved
- Acknowledge that they may not understand how their clients are thinking and feeling but that they are willing to try
- Provide factual, unbiased, and comprehensive information that allows the client to make free, informed choices
- Remain nonjudgmental, while not condoning or reenforcing behaviors that may put others unknowingly at risk of HIV infection

Not surprisingly, health workers often find it difficult to ask personal, sensitive questions. The following guidelines may help.

Getting Started

It is best to start with general, open-ended questions to get the conversation rolling. Asking open-ended questions concerning a client's reasons for coming to the clinic, her general health, and so forth, will help pave the way to asking more sensitive questions. Eventually, more pointed questions can be used to obtain specific information. The provider should introduce the discussion in his or her own way, depending on the client.

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*Adapted from: EngenderHealth. 2001. *Sexuality and sexual health: On-line mini-course*. New York. Accessed at: www.engenderhealth.org/res/onc/sexuality/index.html.

Participant Handout 5.3

Sexual Activity, Pregnancy, and Contraception: Raising the Subject with HIV-Positive Clients (*cont.*)

Examples

Assure the client that the questions are routine and that everyone is asked the same questions. For example:

> *"I am going to ask you some personal questions now. I ask these questions of all my HIV-positive clients, because I know that these issues are of concern to many of them, and they often do not know who they can talk with about them."*

Reassure the client that the questions will have direct bearing on the client's health care and the decisions made during the visit:

> *"It is important for me to ask you these questions so that I can help you to make decisions that are right for you. It is important that you answer the questions honestly so that we can discuss the issues fully. Don't worry about what I might think; I'm not here to judge you. Anything we discuss today will be completely confidential and private between you and me."*

Be sure that the client feels comfortable:

> *"If there are any particular questions you do not feel comfortable answering, feel free to let me know."*

Introduce the questions by acknowledging that you understand that HIV-positive people have sexual desires and feelings:

> *"Being HIV-positive doesn't stop you from having exactly the same sexual feelings, desires, and thoughts as other men and women your age."*

General Questions

You may start with some very general questions to get the conversation going, such as the following:

- Are you currently in, or are you thinking about starting, a sexual relationship?
- How do you feel about having a sexual relationship?
- Do you think that you might change your mind about having a sexual relationship in the future? What might make you change your mind?
- How do you feel about your current sexual relationship?
- Do you have any questions or concerns that you would like to discuss about your sexual relationship with your partner/s?

Participant Handout 5.3

Sexual Activity, Pregnancy, and Contraception: Raising the Subject with HIV-Positive Clients (*cont.*)

Getting Specific

This list of issues *should not* be used as a checklist; it is merely a guide to help you remember the information to elicit. Questions should be worked into a two-way conversation about the client's individual situation.

Sexual activity

- What kinds of sexual practices do you and your partner(s) engage in? What ways do you have sex? (**Note: A client will often respond "***We have sex."* It is important to be specific about what ***sex*** *means* to the client. If she says *intercourse,* find out if that is vaginal or anal, as well as whether she has performed or received oral sex.)
- Have you heard about *safer sex?* What does *safer sex* mean to you?
- Do you have any other sexual partners? Do you think that your partner may have other partners?
- Do you feel any itching, burning, or other discomfort? Do you or have you ever had an unusual discharge from your penis/vagina?
- If you avoid having sex, how do you feel about that? How does avoiding sex affect your relationship(s) with others?

Condoms

- How do you and your partner(s) feel about using condoms?
- Have you talked with your partner(s) about using condoms? How did they respond?
- Have you and your partner(s) used condoms when you have sex?
- How often do you and your partner(s) use condoms?
- Have you had any problems with using condoms? What problems? What did you do about them?
- Would you like to discuss any questions or concerns about using condoms?

Disclosure of HIV status

- Have you told anyone else yet that you are HIV-positive? Who have you told?
- What happened when you told them? How did they react?
- Have you told your sexual partner that you are HIV-positive?
- What happened when you told them? How did he/she react?
- How do you feel about not telling your partner you're HIV-positive? How is not disclosing that you're HIV-positive affecting your relationship?
- Would you like to discuss any questions or concerns you have about telling people that you are HIV-positive?

Participant Handout 5.3

Sexual Activity, Pregnancy, and Contraception: Raising the Subject with HIV-Positive Clients (*cont.*)

Pregnancy

- How do you feel about (another) pregnancy at this time? How does your partner feel?
- Do you think that you might change your mind about being pregnant in the future?
- What factors might make you change your mind about being pregnant?
- Do you have any questions or concerns about pregnancy?

Contraception

- Have you ever used any kind of contraception (family planning methods) in your sexual relationships? If so, which methods? How frequently have you used these methods? How did you feel about using them? How did your partner feel about using them?
- Are you currently using any family planning method or methods? What method(s)? How do you feel about using this method(s)? How does your partner feel about using this method(s)?
- Would you like to discuss any questions or concerns about family planning?

Participant Handout 5.4

Helping Clients Communicate with Their Partners*

To help clients better communicate with their partners, assess clients' willingness and ability to talk with their partners about sexual issues, giving particular attention to their values or feelings about sex, the nature of their relationship with their partners, issues of economic survival or personal safety, and cultural norms related to what is appropriate for women and men to do or say. Use the following guidelines for assistance:

- Explore what clients mean when they say that they ***trust*** their partners.
- Listen for assumptions (e.g., "My partner would ***never*** agree to do that." "She would leave me if I said that.")
- Ask what it might be like to discuss a sensitive subject with their partner.
- Validate concerns they may have about discussing sexual issues.
- Listen for issues of personal safety or survival, and acknowledge that they are real concerns.
- Offer options, but do not tell the client what to do.
- Help the client to develop communication skills by weighing the potential costs and benefits, by role playing with the client, and so forth (e.g., offer to role play as the client's partner so that the client can practice strategies for bringing up sensitive subjects).
- Ask clients what they think their partners will say or do when they bring up a certain topic.
- Ask clients exactly how they intend to bring up the topic, including the time, place, and words they will use.
- Ask clients, "How are you feeling right now, talking with me about talking with your partner?" Doing so will provide a sense of the clients' willingness, resourcefulness, comfort, and likelihood of having the discussion.

If appropriate, confront contradictions: "You say that you love your partner, and vice versa. Can you tell me what it's like to be in a relationship where you don't talk about subjects that are important to you such as [*INSERT TOPICS OF CONCERN TO THE CLIENT*]

- …preventing unintended pregnancy?"
- …how many children you want to have?"
- …other sexual partners?"

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* *Adapted from:* AIDS Health Project. 1999. *Building quality HIV prevention counseling skills: The basic training.* San Francisco: University of California, San Francisco.

Helping Clients Communicate with Their Partners (*cont.*)

Point out past successes: "You say that you've been in this relationship for a long time. What difficult subjects have you successfully been able to bring up and talk about in the past?" (Look for examples such as religious practices, relations with in-laws, raising children, and finances)

Remember that behavior change happens in small, incremental steps: Counseling will have been equally successful whether clients leave questioning previously held assumptions or whether they leave with the determination and skills to have a serious conversation with their partner.

- How would you work with HIV-positive men and women who, regardless of the number or variety of suggestions you give or the number of role plays that you do, maintain that discussing these issues with their partners is still impossible?

  Possible responses:

  - Tell the client that it doesn't seem as if she/he is ready to talk to her/his partner just yet. Tell the client that you will be there to support her/him when she/he is ready.
  - Ask clients to think about other difficult things they have done in the past and to think about how they went about it. Can they apply any of those steps to bringing up difficult topics with their partner?
  - Encourage clients to take small steps by bringing up a related topic, but not the one they are afraid to address, to see how their partners respond. As they develop confidence, they can take on the "scary" topic.

Trainer's Resource 5.1

Questions for "Did You Know…?" Exercise, and Sample Explanations

Question	Sample Explanation
"Did you know/hear that…?"	"Yes, …
Hormonal methods	
1. Women with unexplained vaginal bleeding can start and use combined oral contraceptives (COC)?	… they can, but they should then have an examination done as soon as possible to determine the underlying cause."
2. Women starting COCs or the progestin-only pill within the first five days after starting their menstrual bleeding will not need additional contraception?	… because the pills will begin to have their effect to prevent ovulation early in the menstrual cycle, before the natural hormones have a chance to build up."
3. Women taking drugs, such as rifampicin, that affect their liver enzymes should not use hormonal contraceptives?	…because the hormonal contraceptives are processed in the liver, and drugs affecting the liver enzymes may make the hormonal contraceptives less effective."
4. Women at risk of or already infected with HIV, as well as those with AIDS, can use hormonal contraceptives?	…they can, but certain ARV drugs will reduce the blood concentration of oral contraceptives and thereby reduce effectiveness. These drugs include ritonavir, nelfinavir, and nevirapine. As a result, client must be advised of the importance of taking the pills daily without forgetting and/or using condoms as a back-up method or dual method to prevent unplanned pregnancy."
IUDs	
5. Women with pelvic inflammatory disease (PID), including PID diagnosed within the last three months, may start or continue to use an IUD so long as they do not have PID at the time of insertion?	…because studies have shown that the IUD does not cause infection, and if infection is diagnosed while the woman is using the IUD, she can be treated without the IUD being removed."
6. Women who present with pus-like (purulent) cervical discharge (chlamydia or gonorrhea) should not start use of the IUD?	… because they should first be treated and have the IUD inserted after they have been cured, if the IUD remains their method of choice. If an IUD user presents with PID or an STI, she should be adequately treated with antibiotics with the IUD in place, and she may continue to use the method, if she wishes."

Questions for "Did You Know…?" Exercise, and Sample Explanations (*cont.*)

Question	Sample Explanation
"Did you know/hear that…?"	"Yes, …
IUDs (*cont.*)	
7. An IUD can be started or continue to be used by women considered at high risk of HIV or those already HIV-positive?	… because studies have shown (i) that women who are HIV-positive and healthy can start and continue to use the IUD; (ii) that women using ARV drugs who are clinically well can start or continue to use the IUD; (iii) that women who develop AIDS should not start with an IUD, but should use another method until they are clinically well; and (iv) that women who develop AIDS while using the IUD may continue using the method while undergoing treatment.
Emergency Contraceptive Pills (ECPs)	
8. ECPs can be started within 120 hours (five days) of unprotected sex?	…but the sooner they are started following unprotected sex, the better.
9. Any woman forgetting to take her contraceptive pills for more than two days can use ECPs?	… because they will more effectively prevent unplanned pregnancy.
Other Methods	
Spermicides 10. Women who are at risk of HIV, who are HIV-positive, or who have AIDS should not use spermicides unless no other method is available or acceptable?	… because chemicals in the spermicide (e.g., nonoxynol-9), when used frequently, can irritate the vaginal tissue, thereby allowing entry of HIV into the body through the blood.
Female Sterilization 11. Women who have had PID or a pus-like discharge from the cervix within the past three months, but do not currently have this condition, can undergo tubal ligation?	… because there is no increased risk of infection when there is no pelvic infection at the time of surgery.
Lactational Amenorrhea Method (LAM) 12. Women with HIV can use LAM?	…exclusive breastfeeding, among other options, should be presented to the woman so she can make an informed choice that she can sustain; then she should be supported in whichever choice she makes.

Source: Ministry of Health. 2005. *Addendum to Section 3.9, Eligibility for Family Planning Methods, Uganda National Policy Guidelines and Service Standards for Reproductive Health Services, Issued December 2005*. Kampala.

Trainer's Resource 5.2

Different Types of Sexual Behavior

Note: These behaviors represent a wide range of sexual activity. Add new behaviors not included on the list, based on the local situation.

Hugging
Kissing
Giving oral sex
Receiving oral sex
Participating in group sex
Engaging in anal sex
Having sex with someone of the same sex
Using objects or toys during sex
Getting paid for sex
Engaging in sex in public places
Being faithful to one partner
Having sex with a person who is much younger
Masturbating
Manually stimulating your partner (using your hand)
Having sex with a person who is much older
Engaging in vaginal sex
Watching pornographic movies
Having sex with many partners
Having sex with people who you do not know
Having sex with your spouse
Initiating sexual encounters
Participating in sadism and masochism
Engaging in sex with your student
Participating in oral-anal sex
Engaging in "dry sex" (omit if not practiced in your culture)
"Cleansing" rituals (sex with a relative of a deceased husband) [omit if not practiced in your culture]
Engaging in sex with a child, who is related
Having sex with someone other than your spouse (adultery)
Raping another person
Paying someone for sex
Engaging in premarital sex

Trainer's Resource 5.2

Different Types of Sexual Behavior (*cont.*)

Having sex with animals (bestiality)
Having sex with a relative considered too close (incest)
Swallowing semen
Having sex with children (pedophilia)
Telling someone a lie just to have sex
Having sex with someone of another race or ethnicity
Having sex whenever your partner wants it
Having sex with someone who is married
Having sex with a disabled person
Having sex under the influence of drugs or alcohol
Watching other people have sex
Sharing sexual fantasies with others
Being celibate
Having sex in exchange for money to support your children
Having sex without pleasure
Having sex with your spouse because it is your duty
Agreeing to have sex with someone who won't take "no" for an answer
Using a vibrator for sexual pleasure
Placing objects in the rectum
Placing objects in the vagina
Placing devices on the penis to maintain an erection
Tying up your partner
Being tied up by your partner

Trainer's Resource 5.3

Integrated Reproductive Health Counseling Framework (Short Version)

Step 1: Introductions

1. Welcome the client.
2. Make introductions.
3. Assure confidentiality.
4. Help the client to relax and feel comfortable.

Step 2: Exploration

1. Explore the client's needs, risks, sex life, social context, and circumstances.
2. Provide relevant information about prevention of HIV/STI infection or reinfection, unwanted pregnancy, and dual protection.
3. Assist the client to determine her or his own risk for unintended pregnancy and HIV/STI infection or reinfection

Step 3: Decision Making

1. Discuss dual protection, pregnancy prevention options, and prevention of HIV/STI infection or reinfection.
2. Assist the client to make realistic decisions.
3. Help the client to anticipate the potential outcomes (positive or negative) of her or his decisions.
4. Discuss options.

Step 4: Skills Building for Action

1. Develop partner communication and negotiation skills.
2. Develop condom use skills.
3. Develop other FP method use skills.
4. Develop a plan for carrying out decisions.
5. Refer the client to other health services or community support groups, as required.

Trainer's Resource 5.4

Family Planning Content for Counseling HIV-Negative and HIV-Positive Individuals

HIV-Negative Posttest Counseling—Key Points	HIV-Positive Posttest Counseling—Key Points
Engage men as a partner in supporting successful FP practices, with the woman's agreement.	
Explore the client's/couple's fertility desires and STI/HIV risks to tailor information regarding FP and protection against HIV and STIs.	Explore client's/couple's fertility desires and help client/couple match desires with FP method(s) that fit her/their needs.
Help the client/couple explore the characteristics of FP methods in relation to their fertility desires (e.g., birth spacing, duration of spacing, limiting number of pregnancies).	Explain the increased risks associated with pregnancy in women who are HIV-positive: ☞ Pregnancy complications such as anemia, hemorrhage, sepsis ☞ Increased susceptibility to life-threatening OIs (e.g., pneumocystis carinii pneumonia, tuberculosis, and malaria).
Discuss common side effects of FP methods and explore client's/couple's concerns.	
Support the client in choosing her preferred FP method.	
Encourage range of dual protection, including dual method use.	
Explain how to use FP methods.	
Explain when to start the FP method.	
Discuss where FP methods can be obtained, and include costs, if any.	
Explain when to return to clinic for FP follow-up, if initiating or continuing with an FP method at this visit.	
	For women on nevirapine wanting to use COCs, explain to the client that she will need to take her pills consistently every day, and use condoms consistently along with the pills.
	For women on nevirapine wanting to use Depo-Provera, encourage the client to return on time for the repeat injections. It is possible that the effectiveness of nevirapine might be reduced toward the end of the three-month period.
For Pregnant or Breastfeeding Clients	
Discuss when to initiate FP method(s) postpartum.	
Emphasize the benefits of using condoms and other safer sex practices during pregnancy and the benefit of breastfeeding exclusively to reduce risks of HIV infection or reinfection.	
Tell the client when to return to clinic for postnatal care and FP services for herself and health monitoring care for her infant.	

Adapted from: Ministry of Health. 2005. *Strengthening family planning within the PMTCT program in Uganda*. Kampala.

Trainer's Resource 5.5

Rules for Giving and Receiving Feedback

Giving feedback includes providing people with information about what they do well, in addition to identifying aspects of their performance that needs improvement, as well as offering and soliciting their participation in realistic strategies for improving their performance.

Giving Feedback

- ☑ Offer praise or present the positive observations before sharing constructive critique.
- ☑ Offer feedback using the first person—"I think…", "I saw…", "I feel…", or "I noticed…"
- ☑ Be brief in your comments.
- ☑ Direct comments towards behaviors over which the person has control and can change.
- ☑ Present the observation(s) do not criticize the performer; describe what you saw and heard but avoid making judgments.
- ☑ Offer constructive ideas for improvement and invite the person to contribute suggestion as well.

Receiving Feedback

- ☑ Ask for specific and descriptive feedback.
- ☑ Ask clarifying questions to understand the feedback.
- ☑ Accept feedback without becoming defensive or justifying behavior.
- ☑ Reflect on the feedback and use relevant feedback as information to improve performance.
- ☑ Contribute to strategies for improving performance when invited to do so.

Source: Wegs, C., Turner, K., and Randall-David, B. 2003. *Effective training in reproductive health: Course design and delivery. Reference Manual.* Chapel Hill, NC: Ipas.)

Trainer's Resource 5.6

Counseling Scenarios

FP Information Sharing and Counseling

Note: Counseling scenarios should be copied and given to participants. These can be used as a guide for observing the thoroughness and accuracy of content presented in the counseling skills simulation practice.

Counseling scenarios

Client 1: Sarah is a 22-year-old woman who is four months pregnant with her second child. At her first antenatal clinic visit six weeks ago, Sarah had an HIV test, which came back positive. Since then she has been very worried and confused. She is also concerned about what this will mean for her life and that of her children.

Sarah's husband, who is five years older, is a policeman. He sometimes gets drunk, and he has hit her a few times when he has been under the influence. Sarah has been too scared to tell him the results of her HIV test. She is also scared about becoming pregnant in the future if she does not do something, but she does not know what to do now that she is HIV positive.

Since the test result, Sarah has been avoiding having sex, telling her husband that she does not want to "damage the unborn baby." She knows he is suspicious, because she did not stop having sex the last time she was pregnant.

Sarah has been reluctant to discuss this with you, her health care provider, because she believes the staff is very busy and she feels ashamed that she is HIV positive. During today's visit, however, your warmth assures her that she can confide in you and so she begins to share her concerns.

How will you (the provider) counsel Sarah?

Counseling Scenarios (*cont.*)

Client 2: Jesse is a 25-year-old single man. When he applied for a job after leaving the university two years ago, he was required to have a preemployment HIV test, which revealed he was HIV positive. Since then, he has been feeling well.

Jesse believes that since he is HIV-positive, he should not have sex, but sometimes the urge is too great. Afterwards, he feels guilty, but the guilt is not strong enough to stop him from having sex again. He knows about condoms, but has heard that they don't really work. He is also concerned that if he were to use them, his partner would believe that he is promiscuous.

In the last few months, Jesse met a girl whom he loves very much. He wants to marry her, but he is afraid to tell her that he is HIV-positive for fear she will leave him. He does not know what to do and has been reluctant to discuss this with health workers, because he is worried that they will judge him negatively. Recently, however, a friend introduced him to a men's peer counselor, and Jesse is feeling comfortable about sharing his concerns for the future: Can he marry, can he have children, how can he protect the woman he loves?

How will you (men's peer counselor) counsel Jesse?

Trainer's Resource 5.6

Counseling Scenarios (*cont.*)

Client 3*:* Mercy is a 30-year-old married woman. She was diagnosed as HIV-positive three years ago at the antenatal clinic during her first pregnancy. Her husband subsequently had an HIV test, and he too tested positive. Their son died a year ago from malaria.

Mercy and her husband desperately want to have another child—someone who will carry on the family line after they are gone. Their relatives, who do not know that Mercy and her husband are HIV-positive, are also pressuring the couple to have another child. Mercy and her husband are afraid that if Mercy gets pregnant again, the baby may be born with HIV. In addition, at the last clinic visit, the doctor mentioned that Mercy might need to start taking antiretroviral (ARV) drugs. Mercy does not know if taking ARV drugs will stop her from becoming pregnant, or, if she becomes pregnant, whether she will have to stop taking ARV drugs. She is unsure of what to do.

Mercy does not want to hear a counselor tell her, "HIV-positive women have no right to get pregnant." Mercy recently saw a family planning sign on the HIV clinic's door that makes her believe there may be hope.

How will you (the counselor) counsel Mercy?

Trainer's Resource 5.6

Counseling Scenarios (*cont.*)

Client 4*:* Esther is a 32-year-old married woman. Esther's husband was admitted to the hospital last year and was diagnosed with tuberculosis. During the admission, he was also found to be HIV-positive. Since he has been on treatment, he has felt much better. Esther has not had an HIV test, because she feels, "What's the point? Life will take its course."

Since Esther's husband's health has improved, the couple has resumed having sexual intercourse. The couple does not use condoms because they are not comfortable using them. Esther and her husband have both decided that they do not want to have any more children because they do not want to leave any orphans behind.

Esther is shy about discussing all of this with a health worker, because she fears that she will scold her for not having had an HIV test and for not using condoms. Her husband's field officer has come to check up on him and assess how the couple is coping with the HIV diagnosis and to possibly encourage Esther to get tested.

How will you (field officer) counsel Esther and her husband?

Trainer's Resource 5.6

Counseling Scenarios (*cont.*)

Client 5: Tara is a 36-year-old HIV-positive woman. Since she started taking antiretroviral drugs four months ago, she has been feeling much better and has resumed having sexual relations with her husband. Condom use has been difficult for Tara and her husband because he has difficulty keeping an erection when he puts it on. However, Tara wants to avoid having another pregnancy at this time. She does not know if she might change her mind about this in the future, and her husband supports whatever decision she makes.

Tara feels convinced that the nurse at the antiretroviral therapy (ART) center will react badly if she admits that they have not been using condoms.

How will you (nurse) counsel Tara?

Trainer's Resource 5.6

Counseling Scenarios (*cont.*)

Client 6: Stella is a 37-year-old married woman with four healthy children.

Both Stella and her husband, James, were diagnosed with HIV three years ago. James is also being treated for tuberculosis. Stella's tuberculosis tests have been negative, but as a precaution, she is taking prophylactic isoniazid. Since Stella began taking antiretroviral drugs eight months ago, she has been feeling much better and has resumed having regular sexual relations with James.

Because they both are HIV-positive, the couple decided against using condoms, but neither of them wants to get pregnant again. In the past, Stella used oral contraceptive pills and liked them. She would like to start using them again.

The staff in the antiretroviral therapy (ART) center are always nice to Stella, but Stella does not think that the center's staff knows much about family planning; after all, they have never raised the subject with her before. Stella is considering going to the family planning clinic, but she is not sure how the staff there will respond if she tells them that she is HIV-positive. A couple of years ago, when Stella had the flu, she told a nurse in the general clinic that she was HIV-positive, and the nurse treated her very badly. Since then, Stella has been wary of disclosing her HIV status to any health worker (apart from those who are working in the ART center). Stella decides to take a chance and ask the ART staff about family planning; maybe they might know where to send her.

How will you (ART staff person) counsel Stella?

Trainer's Resource 5.7

Negotiating Condom Use

Group Discussion Questions

Group 1:

Women: *I can't/won't ask my husband to use condoms because . . .*

Group 2:

Men: I can't/won't talk about or use condoms because . . .

Group 3:

Health workers: I can't/won't talk about or give male/female condoms to <u>all</u> my clients (young people, single people, married men, married women, and older people) because . . .

Trainer's Resource 5.8

Key Discussion Points and Possible Responses

Key Discussion Points

What are the main themes you see expressed as to why health workers find it difficult to discuss male/female condom use with their clients?

Possible responses:

- Embarrassed to talk about sexual issues
- Concern that talking about and giving out condoms will "increase promiscuity"
- Belief that using condoms is immoral
- Fear that clients will be upset if the health worker discusses condoms
- Fear of being accused of "promoting promiscuity" by local community leaders, religious leaders, or politicians
- Lack of confidence in talking about and demonstrating how to use condoms
- Lack of confidence in talking about practical problems that can arise when using male/female condoms (e.g., how to deal with loss of erection)

What are the main themes you see expressed as to why women find it difficult to discuss condom use with their partners?

Possible responses:

- Fear (of violence; of partner thinking she is cheating; of abandonment)
- Desire to become pregnant
- Belief (her own or partner's) that using condoms is immoral
- Against partner's wishes (e.g., he does not like them; finds them unpleasant or a bother; diminishes sexual experience or sensation)
- Lack of confidence in using condoms
- Stigma (the belief that only unfaithful people, sex workers, or truck drivers use condoms)

What are the main themes you see expressed as to why men find it difficult to talk about or use condoms?

Possible responses:

- Stigma (the belief that only unfaithful people, sex workers, homosexuals, and drug users use condoms)
- Embarrassed to buy condoms
- Don't know where to get condoms/can't afford them
- Belief (his own or partner's) that using condoms is immoral
- Fear that partner will think he is unfaithful

Key Discussion Points and Possible Responses (*cont.*)

- Fear that partner will think he has HIV/STIs and will refuse to have sex
- Doesn't know how to use them
- Negative previous experiences with condoms (e.g., unable to get or maintain an erection; condom broke or slipped off)

How did you feel when discussing the reasons why health workers or clients cannot talk about or use condoms? Did some reasons feel more like excuses to you? Why is it important to recognize how particular reasons and responses might affect you as a provider?

***Possible responses**:*

- If you believe that certain **reasons** people give are really only **excuses**, you might feel frustrated and you might convey your impatience during your conversation.
- Some barriers such as moral objections to using condoms, lack of transport to the clinic, or lack of money to purchase condoms may also leave you feeling powerless to help and frustrated.

Trainer's Resource 5.9

Condom Negotiation Skills Exercise: Suggested Responses

If female clients are concerned about how their partners will respond to their suggestion to use a condom, offer them the following as possible responses to their partners:

If he says:	Try saying:
Condoms are for prostitutes; why do you want to use one?	Condoms are for couples who want to protect each other. Condoms communicate caring between partners. Condoms are for everyone.
It will not feel as good…	It may feel different, but it will still feel good. Here, let me show you. You can last even longer and then we will both feel good!
I don't have any disease!	I don't think I have any either, but one of us could and not know it.
You are already using a family planning method!	I would like to use this anyway as additional back-up. One of us might have an infection from before that we did not know about.
Just this once without a condom…	It only takes one time without protection to get an HIV infection, and I am not ready to be pregnant.

Unit 6: Management of Side Effects from Selected FP Methods

Unit 6: Management of Side Effects from Selected FP Methods

Session 6.1: Side Effects of FP Methods

Session Purpose and Objectives

The purpose of this session is to build the participants' skills at managing FP methods' side effects, so as to increase clients' satisfaction with their chosen method and to reduce client drop-out from dissatisfaction over side effects. By the end of this session, the participants will be able to:

- List the common side effects and complications for COCs and DMPA
- Explain the Subjective/Objective Assessment Plan (SOAP) process
- Describe the management of side effects and complications of FP methods, particularly COCs and DMPA, using the SOAP process
- Demonstrate an ability to manage the side effects and complications of DMPA using the SOAP process

Time

2 hours

Materials

- Flipchart paper, markers, tape
- An FP flipchart or other IEC materials
- Samples of FP methods
- Participant Handout 6.1: Management of Side Effects for Selected FP Methods
- Participant Handout 6.2: Examples of Applying the SOAP Process
- Participant Handout 6.3: Answer Key to Case Studies on Managing Side Effects of FP Methods

Advance Preparation

1. Assign Participant Handout 6.1 to be read on the evening before the training session.
2. Assign FP side effects management case studies.
3. Prepare enough copies of Participant Handout 6.2 and Participant Handout 6.3 to distribute to all participants.
4. Prepare a flipchart showing the information in Trainer's Resource 6.1: Application of the Subjective/Objective Assessment Plan (SOAP) Process.

5. Prepare the following flipchart showing the assignments for the six groups in the SOAP management exercise:

> Group Assignments
>
> - Group 1: COCs—spotting
> - Group 2: COCs—absence of menstruation (amenorrhea)
> - Group 3: COCs—headache
> - Group 4: DMPA—spotting, amenorrhea
> - Group 5: DMPA—heavy bleeding
> - Group 6: DMPA—weight gain

Training Steps

1. Introduce this session by stating that there is a great need to effectively counsel clients about and manage the side effects of contraceptive methods. The fear of side effects is believed to be one of the most important reasons for contraceptive nonuse among married women who are not using an FP method. To address this issue, this training session will cover the management of side effects for COCs and DMPA, two of the most commonly used FP methods. (*Note:* In this introduction, use supporting evidence from the country in which FP-HIV integration will be implemented and incorporate management of side effects for any other specific methods being offered at the HIV care and treatment site.)
2. Display the prepared flipchart and present the content on the SOAP approach to client management.
3. Distribute Participant Handout 6.2 and review it with the participants to introduce the SOAP approach; allow time for questions. Reinforce this new management approach by choosing a second example from Trainer's Resource 6.1 and applying the SOAP approach to it.
4. Divide the participants into six groups to apply the SOAP management approach to various side effects, as indicated in the prepared flipchart.
5. Distribute one of the case studies from Trainer's Resource 6.2: Case Studies on Managing Side Effects of FP Methods to each group for management using the SOAP approach.
6. Allow 20 minutes for group discussion and then 10 minutes for the members of each group to write management procedures on a piece of flipchart paper.
7. Reconvene the participants and allow 10 minutes for each group to present and discuss their management recommendations.
8. Distribute Participant Handout 6.3 (the answer key) and encourage the participants to read and reflect on the information included there.

9. Close the session by clarifying how to manage other side effects about which the participants have concerns.

Management of Side Effects for Selected FP Methods

Side effects	Management	Symptoms of problems that require medical attention: Warning Signs
COCs: Women on antiretroviral drugs will need to be strict about taking their pills daily.		
Most common in first three months		
Nausea	• Advise the client that this symptom usually resolves within the first three months. • Suggest that the client take COCs with food or at night. • *Note:* If the client misses a pill, advise her to take pills 12 hours apart rather than take two pills at once (which may increase the likelihood of nausea).	**Inform** the client to return to the provider if she experiences: ☞ **Abdominal pain**, severe ☞ **Chest pain**, severe ☞ **Leg pain**, severe ☞ **Headache**, severe ☞ **Eye** problems: flashing lights, blurred vision, or loss of vision; associated with severe headache. ***Inform the client to return to the provider if she develops severe mood swings, depression, or yellow-color skin (jaundice), or if she misses two periods or has signs of pregnancy.***
Spotting or bleeding between menstrual periods	• Women's bodies must adjust to the additional estrogen, so spotting during the first three months is understandable and should improve by the third pack. • Check with the client to rule out other causes of spotting, such as pregnancy, infection, medication (e.g., rifampicin), vomiting or diarrhea (interference with absorption of hormones), or missed pills. • <u>If the spotting or bleeding was due to missed pills:</u> o **If the client missed one or two pills** or is starting a new pack one or two days late, advise her to take a missed hormonal pill as soon as possible. o **If the client missed three or more pills** in the *first or second week*, or is starting a new pack three or more days late, advise her to take a hormonal pill as soon as possible, use a back-up method for seven days, and use emergency contraceptive pills (ECPs) if she has had unprotected sex in the past five days. o **If the client missed three or more pills** in the *third week*, advise her to take a hormonal pill as soon as possible, finish all of the pills in the pack and discard the nonhormonal pills, start a new pack next day, and use ECPs if the client has had unprotected sex in the past five days.	

Management of Side Effects for Selected FP Methods (*cont.*)

Side effects	Management	Symptoms of problems that require medical attention: Warning Signs
COCs: Women on antiretroviral drugs will need to be strict about taking their pills daily.		
Most common in first three months		
Spotting or bleeding between menstrual periods (*cont.*)	• If the symptom persists after three months and is not related to other non-COC causes, counsel the client concerning her pill-taking habits; determine the client's level of distress with spotting; change the type of pill, if feasible; or counsel the client about use of another method and initiate use of it.	
Light menstrual periods	Note: Inform the client that menstrual periods may be significantly lighter with the use of COCs. • In the absence of missed pills and drug interactions, which could result in a pregnancy, there is no management for lighter menstrual periods with COC use.	
Missed period	*Note:* Inform the client that the presence or absence of menstrual periods vary with different pills and duration of use. • Explore with the client how she is taking the pills (see management for missed pills, above). • In the absence of missed pills and drug interactions, which could result in a pregnancy, there is no management for the absence of menstrual periods during COC use; if the client is comfortable with it, continue COC use. • If the client is not comfortable with missing menstrual periods, counsel her and help her switch to another brand of COC, if feasible, or another FP method.	
Mild headaches	• If the client begins having headaches or if her headaches worsen after starting COCs, ask her how long the headaches have been severe; ask if she is experiencing throbbing or constant headaches, with vision changes, loss of vision, changes in speech, weakness, or numbness. In the presence of these symptoms, advise her to stop the pills and provide an alternate FP method. (progestin-only injectable, barrier, or LAPM).	

Management of Side Effects for Selected FP Methods (*cont.*)

Side effects	Management	Symptoms of problems that require medical attention: Warning Signs
COCs: Women on antiretroviral drugs will need to be strict about taking their pills daily.		
Most common in first three months		
Mild headaches (*cont.*)	• Suggest use of the following: Aspirin 325-650 mg, or ibuprofen 200-400 mg with food, or paracetamol 325-1,000 mg, or other pain reliever.	
Breast tenderness	• Advise the client that the hormones in COCs affect the breast, but are not dangerous. • Advise the client to wear a supportive bra. • Suggest that she apply hot or cold compresses to the breast. • Suggest aspirin 325–650 mg or ibuprofen 200–400 mg with food, or paracetamol 325–1,000 mg, or some other pain reliever. • If not satisfied with management, counsel the client about switching to another type of COC, if feasible, or to another FP method (such as a barrier method or a long-acting or permanent method).	
Moodiness, depression	Note: Low-dose pills have not been found to increase depression. • Explore with client other possible factors to mood change and manage accordingly. • Ask about changes in client's life that could affect her mood, including changes in her relationship with partner. • If serious mood changes, such as depression, refer client for care. • If found to be associated with the start of COC use or around expected time of menstrual period, counsel client to change to another pill, if feasible, or another method.	

Management of Side Effects for Selected FP Methods (*cont.*)

Side effects	Management	Symptoms of problems that require medical attention: Warning Signs
Depo Provera (DMPA): Women on ARV drugs will need to be strict about returning for the repeat injection on or before 12 weeks. (DMPA can be given as much as two weeks early.)		
Changes in menstrual bleeding: • Spotting, most common in the first few months	*Note:* **It is important to inform clients in advance that changes will occur in their menstrual cycles.** (A major reason for discontinuation is when the client is not informed about side effects or when the client's symptoms are not managed satisfactorily.) Also, inform the client that **absence of menstruation will increase over time,** but that this is not harmful; also, irregular bleeding for the first several months, followed by no monthly bleeding, is common and not harmful. • In the absence of any other underlying causes (infection, cervical lesions), spotting can be managed by offering the client COCs for five days or one cycle, or ibuprofen, 800 mg, three times per day. Inform the client that irregular bleeding may return. • If spotting is annoying the client, counsel her about another FP method. Inform her that it may be a number of months before her periods return to normal after the last DMPA injection.	**Inform** clients to return to provider if she experiences - ☞ Repeated, very painful **headaches** ☞ Heavy **bleeding** ☞ **Depression** ☞ Sever, lower **abdominal pain** (may be a sign of pregnancy) ☞ Pus, prolonged pain, or bleeding at injection site
Amenorrhea (normal after first 9–12 months of use)	• Ask about symptoms of pregnancy; if these are present, perform a pregnancy test; if there are no symptoms, reassure the client that this is a common side effect with use of DMPA over time (after 9–12 months) and is not harmful. • If the client desires menstruation, counsel her to switch to another FP method (COCs, or an LAPM). Inform the client that a number of months may pass before her periods return to normal after the last DMPA injection.	
Heavy bleeding (rare)	• Explore other underlying causes (pregnancy, cervical infection). • Treat bleeding with a nonsteroidal inflammatory (e.g., ibuprofen, 800 mg, three times a day, or 50 micrograms of ethinyl estradiol for 21 days, or COCs for 21 days). • If the client develops anemia and the bleeding does not resolve, discontinue the method, provide an alternative, client-preferred method, and treat her for anemia.	

Management of Side Effects for Selected FP Methods (*cont.*)

Side effects	Management	Symptoms of problems that require medical attention: Warning Signs
Depo Provera (DMPA): Women on ARV drugs will need to be strict about returning for the repeat injection on or before 12 weeks. (DMPA can be given as much as two weeks early.)		
Weight gain	Note: The client may gain weight due to increased appetite. • Take her diet and exercise history. • Counsel the client about eating smaller, frequent meals with more protein, vegetables, and fruit; increasing daily exercise daily; and increasing intake of water (10 glasses per day). • If weight gain is not improving or is unsatisfactory to the client, counsel her about changing her FP method and initiate the client's chosen method.	
Delayed return of fertility	Note: Inform the client that DMPA may prevent her from becoming pregnant for more than three months after the last injection (average delay in return to fertility is 10 months). However, DMPA does not decrease fertility overall. Note: Because return of ovulation may take approximately one year or more, women who want to become pregnant sooner should consider another FP method.	

Management of Side Effects for Selected FP Methods (*cont.*)

Side effects	Management	Symptoms of problems that require medical attention: Warning Signs
Depo Provera (DMPA): Women on ARV drugs will need to be strict about returning for the repeat injection on or before 12 weeks. (DMPA can be given as much as two weeks early.)		
Other: • Mild headaches **(rare)**	Suggest ibuprofen 20–400 mg, or paracetamol 325–1,000 mg, or other pain relievers. Aspirin 325–650 mg may also be used, if the client is not experiencing irregular bleeding.	
• Breast tenderness	See COCs management.	
• Moodiness	Depression may worsen with DMPA; refer the client for medical or psychiatric management if she is severely depressed; discontinue DMPA if the client is concerned about mood changes.	
• Nausea	No management found for this in current resources.	
• Loss of libido	No management found for this in current resources. See management of side effects of COCs.	
• Acne, hair loss	No management found for this in current resources.	

Adapted from: Uganda MOH. 2005. *Strengthening family planning within the PMTCT program in Uganda*. Kampala. Sources: Hatcher, R.A., et al. 2004. Contraceptive technology, 18th Edition. Ardent Media; and Hatcher, R.A., et al. 2007. *Managing contraception, 2007–2009 edition*.

Participant Handout 6.2

Examples of Applying the SOAP Approach

Example of SOAP Process Application

A client complains of having "no menstruation" for two months. She is at the end of the third packet of COCs.

Subjective	• Determine from the client if she has experienced any bleeding or spotting while taking COCs. • Ask how the client takes COCs—whether it's a 21-day or 28-day pack. (***Note****: Always ask the client to bring the pill pack to confirm her pill-taking habits and clarify the client's complaints.*) • Ask the client if she is taking any other drug (e.g., rifampicin for tuberculosis) • Ask the client about the type of COC (50 mcg or sub-50 mcg dose) or name of pill she is taking. • Ask the client about any interruptions in pill-taking (missed pills, drug interactions, and severe or persistent diarrhea and/or vomiting). • Ask the client to describe her last menstrual period and whether she is experiencing any signs of pregnancy.
Objective	Based on the subjective findings (history): • Determine whether the client is pregnant by doing physical assessment: looking for breast changes, uterine enlargement, and softening and change of color of cervix *(to be done by a provider trained in pelvic assessment).* • Test urine for pregnancy, if possible.
Assessment	Based on the subjective (history) and objective (physical exam, labs) information gathered above: *If the client is not pregnant:* • Conclude that missed periods are caused by inadequate build-up of endometrium due to hormones in the COCs. *If the client is pregnant:* • Conclude whether this may be due to missed pills, drug interactions, or a problem with absorption in the presence of severe or persistent diarrhea and/or vomiting

Participant Handout 6.2

Examples of Applying the SOAP Approach (*cont.*)

Plan	Inform the client about the findings and reassure her of her ability to manage side effects. *If the client is not pregnant:* • Offer the client the option to continue taking COCs and explain the reason; tell her to return if she experiences any *warning signs* or wishes to change her FP method; tell her to return if amenorrhea persists for another cycle. o If the client is on low-dose COCs, let her continue taking the pill, give her a higher estrogen dose (not > 50 mcg) of COCs (if available), or change her FP method. o If the client is not taking the "placebos" but is going directly to the next pack (21-day pack), tell her that this practice will prevent menstruation; review pill-taking instructions. • Evaluate the client's understanding of instructions and schedule a follow-up appointment date. *If the client is pregnant:* • Discontinue COCs. • Refer the client for antenatal care, and stress the importance to optimal pregnancy outcomes of seeking antenatal care and services to prevent mother-to-child transmission of HIV. • Consult immediately with an HIV care provider about any possible changes in the antiretroviral drug being used.

Participant Handout 6.3

Case Studies on Managing Side Effects of FP Methods—Answer Key

Note: Use the "Large-Group Case" to conduct the management exercise with all participants together. This can be used as an additional case to reinforce the SOAP process of client management. Then, break the group into individual working groups for each case.

Large-Group Case

Gloria is 27 years old, has two children, and is using ARV drugs. She tested HIV-positive during her last pregnancy four years ago and does not know whether it will be safe for her to have another child without passing on the infection. Gloria has decided to use COCs along with the condoms that she and her partner had been relying on, because she wants to finish school before having another child. After starting her first packet, Gloria immediately started feeling nauseous. She is visiting you today because she is concerned about the nausea, does not want to be pregnant at this time, and is wondering if the COCs are "fighting with the HIV drugs" and making her sick.

How will you manage Gloria's complaint?

SOAP	Details
S	Check history for pill-taking habits (e.g., when she is taking pill; whether she has missed any pills; how many she has missed; when in her cycle she has missed; when was her last natural menstrual period)
O	Perform a pelvic examination; look for signs of pregnancy, if she has missed pills or has been taking pills inconsistently; administer a pregnancy test, if feasible.
A	Nausea due to COC hormones
P	Counsel client to take pills at night, after a meal; monitor her for 3–4 months, with a follow-up visit scheduled if her condition is not improved.

Participant Handout 6.3

Case Studies on Managing Side Effects of FP Methods—Answer Key (*cont.*)

Case 1

Elsie is a 26-year-old woman with two children (ages 7 and 5) who had been using condoms and, since her husband has been away studying abroad for the past five years, has been practicing abstinence. Neither she nor her husband is interested in having more children at any time soon. In anticipation of her husband's permanent return, Elsie started using COCs six weeks ago. Today, Elsie is seeing you about complaints of spotting that has persisted since she started taking the fourth row of the first pack of pills.

How will you manage Elsie's complaint?

SOAP	Details
S	Check history for pill-taking habits (e.g., when she is taking pill; whether she has missed any pills; how many she has missed; when in her cycle she has missed; when was her last natural menstrual period)
O	Perform a pelvic examination; look for signs of pregnancy, if she has missed pills or has been taking pills inconsistently; administer a pregnancy test, if feasible.
A	Irregular bleeding, possibly due to COC hormones or drug interaction
P	If she has missed pills, manage the client depending on where in her cycle the pills were missed; reinforce the importance of taking pills in a systematic way. Inform the client about the body's need to adjust to the hormones during the first three months. If the spotting is unacceptable to the client and persists beyond three months, consider changing the pills; encourage dual protection. Consider exploring with woman long-acting or permanent method options, since neither she nor her husband wants any more children.

Participant Handout 6.3

Case Studies on Managing Side Effects of FP Methods—Answer Key (*cont.*)

Case 2

Zina is a 35-year-old widow with three adolescent children. Her husband died of AIDS four years ago, but she has never tested positive. She has been using DMPA for four months, since she recently became sexually active in a new relationship. Zina received her second injection on time and was having no problems following the first injection. Zina is seeing you today with complaints of irregular bleeding and concerns that, since her second injection, her menses are not coming at the time they usually do.

How will you manage Zina's complaint?

SOAP	Details
S	Check the client's history for her pattern/amount of bleeding; rule out other possible causes; find out when was her last natural menstrual period.
O	Perform a pelvic examination to assess the cervix, uterus, and adnexa.
A	Irregular bleeding
P	If no noninjection-related cause is found, offer the client ibuprofen 800 mg, three times daily for approximately 3–5 days. Inform her that bleeding may return after this management. If, after treatment, spotting persists, counsel the client about other methods and initiate the chosen method.

Participant Handout 6.3

Case Studies on Managing Side Effects of FP Methods—Answer Key (*cont.*)

Case 3

Velma is a healthy HIV-positive woman who started using DMPA three months ago and is experiencing heavier-than-normal bleeding, which is soaking through her pads—something that never occurred before using DMPA. Velma is finding the bleeding to be potentially embarrassing and difficult to deal with; she is considering changing to another FP method, and she wants to know more about the IUD. Velma has one adolescent child and does not plan to have another child soon. Her partner says that he has never been tested and is reluctant to do so.

As Velma shares her frustration with you, how will you manage her complaint?

SOAP	Details
S	Check for other causes for heavy bleeding (e.g., pregnancy, infection, cervical/uterine abnormality); find out when was her last natural menstrual period.
O	Perform a pelvic examination, looking for signs of pregnancy if she has missed pills or has been inconsistent in her pill-taking; administer a pregnancy test, if feasible.
A	Heavy bleeding, possibly in association with DMPA use
P	Offer ibuprofen 800 mg three times daily. If heavy bleeding does not improve at follow-up, counsel for use of another method (e.g., IUD, hormonal implant, permanent method).

Participant Handout 6.3

Case Studies on Managing Side Effects of FP Methods—Answer Key (*cont.*)

Case 4

Diane is a 31-year-old woman who has used ARV drugs for one year and DMPA for nine months. Diane has been doing well and her partner—also on ARV drugs—is clinically well. Diane has four children, all boys. Diane wants a daughter, so she is not ready to end her childbearing, although she is concerned about HIV and about the risk of infecting the baby. Over the last few months, Diane has noticed that her clothing is fitting more tightly, and she is concerned about "getting fat" since she has always been thin. Today, at her reinjection visit, you notice that Diane has gained 10 pounds since her first injection.

How will you manage Diane's situation?

SOAP	Details
S	Increased weight gain, 10 pounds gained in one year; find out when was her last natural menstrual period. Take a history of client's diet and physical activity; explore what may have changed in her lifestyle.
O	Check the client's blood pressure.
A	Weight gain in association with DMPA use and lifestyle
P	If due to increased appetite and limited activity, counsel the client about eating small, frequent meals, increasing her consumption of water (e.g., 10 glasses), and increasing her physical activity. If not satisfied with management at follow-up visit, counsel the client about other FP methods and initiate chosen method. Inform the client that she will still have to manage her food intake and activity level to lose the 10 pounds and to avoid gaining more.

Participant Handout 6.3

Case Studies on Managing Side Effects of FP Methods—Answer Key (*cont.*)

Case 5

Frances has been using COCs for three months now and has noticed that she is getting headaches more frequently. At times, Frances takes pain relievers for the headaches, because they really bother her. Frances is interested in changing her FP method and wants to know more about hormonal implants. When you question Frances, she denies having any changes in her vision, loss of vision, change in her speech, weakness, or numbness.

How will you manage Frances' complaint?

Progressively worsening headaches, if associated with migraine symptoms, are a *warning sign* about continued use of COCs. Since the client's headaches are getting worse and are not managed by pain relievers, her headaches should be evaluated; counsel the client about changing her FP method, since she is already considering switching.

Case 6

Holly is a 33-year-old woman with three children; she is in a happy marriage and has a satisfying job. Although Holly is HIV-positive and uses ARV drugs, she is healthy. She and her husband do not want to have any more children. Holly has been using DMPA for 15 months, since switching from COCs (she got tired of taking pills every day), and she has never missed or been late for her injection. Holly comes to you today complaining that she has not experienced menses for two months. She states that she does not feel pregnant, but she does not understand why she is not bleeding as part of her normal cycle. She does not want to be pregnant.

How will you manage Holly's complaint?

Reassure the client that, over time, many women using DMPA will stop having monthly bleeding and that this is not harmful. Blood does not build up in the abdomen when there is no bleeding. Reassure the client that she can continue to use DMPA with no risk to her health and can benefit from the reduced cost of not having to buy menstrual protection. If the client is dissatisfied, assure her that she can change to an IUD, a hormonal implant, or a permanent method.

Trainer's Resource 6.1

The Subjective/Objective Assessment Plan (SOAP) Process Application

SOAP stands for:

Subjective: Collect information on the situation from the client (through history taking or counseling)

Objective: Collect information on the situation from physical examination, investigations such as laboratory studies, if indicated, and/or other observation

Assessment: Review subjective and objective information and make a conclusion/diagnosis

Plan: Determine strategy to resolve the situation (e.g., treatment, change of method, counseling, repeat instruction, or referral); share your plan with the client for her/his input. Remember to evaluate client's understanding before she/he leaves the facility; arrange for follow-up visit.

Trainer's Resource 6.2

Case Studies on Managing Side Effects of FP Methods

Note: Use the "Large-Group Case" to conduct the management exercise with all participants together. This can be used as an additional case to reinforce the SOAP process of client management. Then, break the group into individual working groups for each case.

Large-Group Case

Gloria is 27 years old, has two children, and is using ARV drugs. She tested HIV-positive during her last pregnancy four years ago and does not know whether it will be safe for her to have another child without passing on the infection. Gloria has decided to use COCs along with the condoms that she and her partner had been relying on, because she wants to finish school before having another child. After starting her first packet, Gloria immediately started feeling nauseous. She is visiting you today because she is concerned about the nausea, does not want to be pregnant at this time, and is wondering if the COCs are "fighting with the HIV drugs" and making her sick.

How will you manage Gloria's complaint?

Case 1

Elsie is a 26-year-old woman with two children (ages 7 and 5) who had been using condoms and, since her husband has been away studying abroad for the past five years, has been practicing abstinence. Neither she nor her husband is interested in having more children at any time soon. In anticipation of her husband's permanent return, Elsie started using COCs six weeks ago. Today, Elsie is seeing you about complaints of spotting that has persisted since she started taking the fourth row of the first pack of pills.

How will you manage Elsie's complaint?

Trainer's Resource 6.2

Case Studies on Managing Side Effects of FP Methods (*cont.*)

Case 2

Zina is a 35-year-old widow with three adolescent children. Her husband died of AIDS four years ago, but she has never tested positive. She has been using DMPA for four months, since she recently became sexually active in a new relationship. Zina received her second injection on time and was having no problems following the first injection. Zina is seeing you today with complaints of irregular bleeding and concerns that, since her second injection, her menses are not coming at the time they usually do.

How will you manage Zina's complaint?

Case 3

Velma is a healthy HIV-positive woman who started using DMPA three months ago and is experiencing heavier-than-normal bleeding, which is soaking through her pads—something that never occurred before using DMPA. Velma is finding the bleeding to be potentially embarrassing and difficult to deal with; she is considering changing to another FP method, and she wants to know more about the IUD. Velma has one adolescent child and does not plan to have another child soon. Her partner says that he has never been tested and is reluctant to do so.

As Velma shares her frustration with you, how will you manage her complaint?

Trainer's Resource 6.2

Case Studies on Managing Side Effects of FP Methods (*cont.*)

Case 4

Diane is a 31-year-old woman who has used ARV drugs for one year and DMPA for nine months. Diane has been doing well and her partner—also on ARV drugs—is clinically well. Diane has four children, all boys. Diane wants a daughter, so she is not ready to end her childbearing, although she is concerned about HIV and about the risk of infecting the baby. Over the last few months, Diane has noticed that her clothing is fitting more tightly, and she is concerned about "getting fat" since she has always been thin. Today, at her reinjection visit, you notice that Diane has gained 10 pounds since her first injection.

How will you manage Diane's situation?

Case 5

Frances has been using COCs for three months now and has noticed that she is getting headaches more frequently. At times, Frances takes pain relievers for the headaches, because they really bother her. Frances is interested in changing her FP method and wants to know more about hormonal implants. When you question Frances, she denies having any changes in her vision, loss of vision, change in her speech, weakness, or numbness.

How will you manage Frances' complaint?

Trainer's Resource 6.2

Case Studies on Managing Side Effects of FP Methods (*cont.*)

Case 6

Holly is a 33-year-old woman with three children; she is in a happy marriage and has a satisfying job. Although Holly is HIV-positive and uses ARV drugs, she is healthy. She and her husband do not want to have any more children. Holly has been using DMPA for 15 months, since switching from COCs (she got tired of taking pills every day), and she has never missed or been late for her injection. Holly comes to you today complaining that she has not experienced menses for two months. She states that she does not feel pregnant, but she does not understand why she is not bleeding as part of her normal cycle. She does not want to be pregnant.

How will you manage Holly's complaint?

Unit 7: Logistics and Record Keeping in FP-ART Integrated Services

Unit 7: Logistics and Record Keeping in FP-ART Integrated Services

Note: The following two sessions (Session 7.1 and Session 7.2) should be conducted by trainers using their country-specific FP stock inventory forms and FP record-keeping forms.

Session 7.1: Logistics Systems

Session Purpose and Objectives

The purpose of this session is to help the participants learn to effectively use their logistics systems for establishing and maintaining FP commodity stock levels, to ensure uninterrupted method provision. By the end of the session, the participants will be able to:

1. Explain how to use a stock card and maintain proper stock levels for commodities
2. Explain how to calculate the stock on hand
3. Explain how to determine the quantity of commodities needed to order
4. Complete the facility order form for contraceptives
5. State when and how to place an emergency order
6. Explain how the order form proceeds from the health facility to the supply stores
7. Demonstrate the ability to store essential drugs and commodities according to established guidelines

Time

3 hours

Materials

- Flipchart, markers, tape
- Copies of stock cards from the participants' facilities
- Participant Handout 7.1 (Whatever instructional resource is available for helping staff remember to correctly complete the required forms)
- Samples of contraceptives in their order unit forms

Advance Preparation

1. Consult with the management of the facility or facilities where the participants work to ensure that all materials used for this session are representative of the materials used to order supplies in that locality.
2. Make sufficient copies of any stock cards and job aids that are relevant to the session, for distribution to all of the participants.

3. Modify or adapt the case study in Trainer's Resource 7.1 to be relevant to the situation at the facility where the training is taking place. Write the main points of the case study on a piece of flipchart paper.

Trainers' Tip

Note: This unit requires adaptation for use with the logistics system currently in place in the respective country. Ideally, the trainers need to investigate the details of the logistics system that is used in the area where the training takes place, choose the relevant materials, and develop training steps to help the participants learn how to use this system to order contraceptives and other supplies needs for FP provision.

Training Steps

1. Distribute and refer the participants to the relevant job aid or guidelines for ordering contraceptive supplies, or distribute a handout defining the some of the primary terms used in logistics management in that country (such as "stock on hand," "rate of consumption," etc.).
2. Ask a volunteer to read from the job aid or to read the definitions of the relevant terms.
3. If the facility uses a stock card, refer the participants to it, lead the group in a review of the information on the stock card, and agree on how it should be filled in correctly.
4. Guide the participants to practice filling in the stock card.
5. Lead the participants in a review of how to determine the stock on hand (e.g., the opening stock balance, plus the stock received during the last two months, minus the stock dispensed to FP clients over last two months equals the stock on hand.).
6. Explain to the participants that to determine the quantity of supplies needed, one must first determine the average monthly consumption (or whatever period the facility uses) and then calculate the needed quantity. Lead them in an exercise on how to determine average monthly consumption, using local forms and examples.
7. Ask the participants to describe what the "order units" are for each contraceptive (e.g., "condom—one pack of three pieces"; "Microgynon—3 cycles"). Record their responses on a blank piece of flipchart paper.
8. Ask the participants to identify who is responsible for ordering contraceptives at their facility.
9. Ask the participants when and how often they must order contraceptives.
10. Discuss with the participants any storage guidelines that their facility has for contraceptive supplies.
11. Post the prepared flipchart, and lead the participants in a discussion of the case study. Ask them to work through the questions posed on the flipchart.
12. Allow for remaining questions and close the session.

Session 7.2:
Logistics Management

Session Purpose and Objectives

The purpose of this session is to help participants accurately complete and maintain the FP service statistics and record-keeping forms required for upward reporting and for use on-site for service delivery decision making. By the end of the session, the participants will be able to:

- List the various client cards and registers that will be used at the ART center to capture FP service activities
- List the purposes of these client cards and registers
- Explain the reasons for accurately filling each column on the registers
- Complete each of the registers in a classroom exercise

Time

1 hour

Materials:

- Client cards
- Service registers
- Flipchart, markers, tape
- Case studies

Advance Preparation

1. Prepare a flipchart showing the purposes of service registers:

Purposes of Service Registers

Registers:

- Monitor and evaluate the activities at the health facility in relation to set goals
- Contain data on clients/patients attending a particular health unit, such as
  - Number of children coming for immunizations
  - Number of postnatal women receiving FP services
  - Number of new FP users
  - Number of clients switching methods, reasons for switching, and methods switched to and from
- Monitor any increases/decreases in number of clients served
- Provide information that can be used as a basis for continuous improvement of service quality
- Provide solutions to critical management issues to ensuring quality health care
- Report outputs of health facility to the district level, and in turn to the national level
- Provide information to use for planning at both the local and the national levels, including advocacy for budgetary allocations

Purposes of Client Cards

Client cards:

- Can be used to monitor and evaluate client treatment and progress
- Enable the health personnel to assess and provide continuous comprehensive care to clients
- Enable clients to take more active responsibility in their health care, by keeping the cards and presenting them at every visit to the health unit

Training Steps

1. Ask the participants what they believe would be the purpose for and importance of keeping records on FP services at their ART center. Answers might include the following:
   - Monitor the community's use of FP services
   - Monitor the center's performance in responding to an articulated need or demand for FP services
   - Plan more effectively for service needs (e.g., commodities, supplies, space, staffing)
   - Determine needs for expansion of method options or scale-up of services
   - Ensure continuity of care and safety in client management
   - Monitor clients' progress and experience with FP methods
2. Describe service registers and client cards (if any of the participants are unfamiliar with them) and ask the participants to brainstorm a list of the types of registers and client cards or forms used in reproductive health service delivery that contain FP information.
3. Record their responses on a blank piece of flipchart paper. Their responses may include the following:

Client cards	Registers
Postnatal card	Postnatal care register
FP client card	PMTCT follow-up register
FP appointment card	FP register
	Activities register

4. Conduct a brainstorm by asking the participants the purposes of service registers. Encourage them to generate as many realistic purposes as possible. Acknowledge their responses, and then display the first prepared flipchart. Ask one participant to read the purposes and explain each purpose as you go along.

5. Distribute one sample page of a service register. Describe the details of the register and explain how to fill in the various columns—the information that should be placed in each column.
6. Explain how to add a "PNC column" to an FP register in order to find out how many postnatal women come for FP services; discuss the value of postnatal FP to maternal and child health.
7. Explain how to add an "FP column" to the postnatal care register (if available); this will provide an opportunity to capture FP as an integral component of postnatal services.
8. Explain how to add a "partner attended" column to the antenatal care, postnatal care, FP, and/or maternity registers, and the value of monitoring this information.
9. Conduct another brainstorm by asking the participants the purposes of client cards. Acknowledge their responses, and then display the second prepared flipchart. Ask a participant to read the purposes, and explain each as you go along.
10. Distribute a sample client card, describe the details of the client card, and discuss how information related to receipt of various services (including FP) can be added to the card.

Session 7.3: Implementing FP-Integrated ART Services On-Site

Session Objectives

By the end of the session, the participants will be able to:

- Discuss the purpose of developing a plan for facilitating FP integration on-site
- Develop an FP integration implementation plan that will guide application of learning from this training and provide the basis for posttraining follow-up

Time

1 hour, 30 minutes

Materials

Flipchart, markers, tape

Advance Preparation

None

Training Steps

1. Ask the participants to *brainstorm* a list of purposes for developing a plan to facilitate FP integration onsite. Answers may include the following:
   - Involve all staff members in examining how services may need to change to accommodate FP integration
   - Foster a team approach in planning changes to accommodate FP integration, using each other as a resource
   - Create a quick reference of the activities that will be necessary to facilitate FP integration in a given time period
   - Create an orderly sequence of implementation activities through staff assignments
   - Clarify roles and responsibilities of each individual or staff members on the team
   - Provide feedback to senior staff and external supervisors about the resources that may be needed to integrate FP
   - Provide a frame of reference for trainers to support when conducting posttraining follow-up
2. Divide the participants into teams of (1) facility-based services and (2) community-based/outreach services.
3. Ask each group to discuss, develop a plan, and write on a flipchart for presentation the following areas to address for operationalizing FP-integrated HIV care and treatment services:

For the facility

- Location of counseling and initiation of methods
- Organization of client flow
- Organization of clinic activities
- Staffing pattern modifications
- Logistics/commodities management
- Record-keeping
- Staff meeting with community-based staff

For the community

- Management of time during home-based services
- Logistics/commodities management
- Organization of home-based activities
- Staffing pattern modification
- Record keeping
- Staff meeting with facility-based staff

4. Allow 45 minutes for the group work.
5. Reconvene the participants and invite each team to present and discuss its results. Provide feedback to further assist the participants' thinking through service-delivery challenges and possible solutions.
6. Make copies of the plan as a trainer's resource and use it during posttraining follow-up and future facilitative supervision and COPE® interventions for implementation of FP-integration within country-specific programming.

Trainer's Resource 7.1

Case Study for Session on Logistics

Nurse Teopista Aheebwa works at a health center providing antiretroviral (ARV) therapy and is in charge of all drugs, including contraceptives. She must maintain a minimum stock level of 300 cycles of combined oral contraceptives (COCs).

On January 1, Teopista requisitioned 300 cycles and received them, allowing her to reach the maximum stock level of 600 cycles.

On January 2, Teopista issued 150 cycles to Maurine, the in-charge at the family planning (FP) clinic.

On January 5, Teopista received 150 cycles that the district nursing officer had collected from Kyambura Health Center II.

On January 8, Teopista issued another 100 cycles to Maurine in the FP clinic.

On January 15, Teopista issued 50 cycles to the FP clinic.

On January 18, Teopista issued another 100 cycles to Maurine in the FP clinic.

On January 20, Teopista issued another 50 cycles to Maurine.

Instructions

Enter the above information on the stock card and answer the following questions.

1. What was the stock level on hand on January 15?
2. When should Nurse Teopista requisition new stock?
3. What should Nurse Teopista do when she receives the new stock?

Answers

1. 450 cycles
2. January 20
3. Enter the new stock and update the stock card with the date and the amount of stocks received.

Family Planning-ART Integration Pilot: Application of Learning

Clinical Practicum

The clinical practicum is held in the second week of this training to allow the participants to apply new FP content in conducting health talks, counseling, and providing FP methods and follow-up, including the management of selected FP methods' side effects. The practicum should be arranged to help the participant achieve the clinical objectives and complete the training by demonstrating beginning-level competence and confidence in the new practices.

Performance checklists (see Appendix D) should be shared with the participants, so they can become familiar with the expected performance standards.

Each clinical practicum session should begin with a **preclinical meeting** between the trainer and the participant, to focus on the skills to be practiced during that session. Each clinical practicum session should end with a **postclinical meeting** between the trainer and the participant to (a) encourage the participant to analyze his or her performance, (b) provide constructive feedback, and (c) develop a plan for the next clinical practicum session, as well as strategies for resolving performance problems.

Clinical Objectives

By the end of the clinical practicum, participants should have:

1. Conducted at least two health talks (facility- or community-based) covering the FP-ART integrated content outlined in Unit 4.
2. Conducted at least three FP-ART integrated counseling sessions, including sharing information on the use and availability of ECPs and on dual protection.
3. Initiated at least two clients in the use of COCs and two clients in the use of DMPA.
4. Counseled clients interested in FP methods not available on-site, and made the appropriate referrals.
5. Completed at least three client record and service statistic entries.
6. Demonstrated an open, nonjudgmental, and helping attitude toward client while providing FP-integrated ART services.

Posttraining Follow-up

Upon satisfactory completion of training, participants will be visited within two months to support new practices, assist with solving problems encountered, and identify areas to strengthen during subsequent trainings. Performance checklists used during training will be used to assess the degree to which the former participant is practicing to standard. Where internal supervisors have been oriented or trained in FP-integrated HIV care and treatment service-delivery content, trainers will coordinate posttraining follow-up and ongoing performance improvement support.

Unit 8: Conclusion of Training

Session 8.1:
Conclusion of Training

Essential Ideas to Convey

Reassure the participants that:

- Integration of FP services with HIV care and treatment services will take time; it requires a planned process that will not happen overnight.
- Resistance from colleagues and/or others to changes in practice and the organization of work may take time to overcome.
- Participants should use the trainer as an ally in facilitating integration at their site.
- Participants can begin the change process with their own practices and become the model for integrated service delivery.

Session Purpose and Objectives

The purpose of this session is to carry out activities to end the training and to provide a final opportunity for assessing participants' preparedness to provide FP services within the HIV care and treatment setting. By the end of the session, the participants will:

- Develop a posttraining action plan that they will used upon their return to their home site
- Complete the posttraining knowledge assessment test, if necessary
- Complete the training course evaluation
- Share in the closing activities for the training

Time

Up to 4 hours (Posttraining Action Plans) (*Note:* If additional practicum experience is needed or if a final performance assessment needs to be conducted, the entire last day may be used.)
30 minutes (Posttraining knowledge assessment, if necessary)
20 minutes (Final evaluations)

Materials

- Posttraining Action Plan form (blank)
- Posttraining knowledge assessment tool
- Final training evaluation tool
- Copies of posttraining follow-up agreement/plans
- Box or large envelope for collecting completed final evaluation forms

Training Steps

1. Direct the participants to the objectives of the day. For participants who need to have their final performance assessment completed, this is the last opportunity within the

3. Distribute the Posttraining Action Plan form and review it with the participants.
4. Ask each participant to develop a posttraining action plan that will identify how they will be integrating FP into their individual HIV care and treatment settings and what specific support they will need from their immediate supervisor or in-charge. If more than one participant attends the training from the same site, ask them also to identify activities that they may jointly accomplish to facilitate integration at their site. Ask the participants to include community-based or outreach services that would create awareness of, demand for, and use of FP-integrated HIV services. Guide the participants to consider how they would address particular issues in their plans with their supervisors:
   - **For the facility**:
     - Location of counseling and initiation of methods
     - Organization of client flow
     - Organization of clinic activities
     - Modifications in staffing patterns
     - Logistics/commodities management
     - Record keeping
     - Staff meeting with community-based staff
   - **For the community**:
     - Management of time during home-based services
     - Organization of client flow
     - Organization of home-based activities
     - Modifications in staffing patterns
     - Record keeping
     - Staff meeting with facility-based staff
5. Copy and use these action plans during phone follow-up calls conducted shortly after training, in communications with the participants' supervisors or in-charges, and when conducting the posttraining follow-up visit. This will help trainers and supervisors or in-charges monitor the participants' individual progress and the progress of the supervisor's and participants' posttraining plans to establish or improve the quality of FP-integrated HIV care and treatment services.
6. Circulate among the participants and assist them, as necessary; collect, copy, and return the action plans to participants. (*Optional:* If time permits and you deem the sharing of plans to be of value to other participants, ask each participant pair or group to present their plan to the larger group.)
7. Make copies of the plans as a Trainer's Resource and use them during posttraining follow-up and future facilitative supervision and COPE® interventions.

8. Close the session and move to the activities for ending training.
9. If there are participants who need to take a posttraining knowledge assessment (i.e., retake it because they did not achieve the required 85% at the midpoint assessment), have a co-trainer administer the tool to those participants in a designated area. Allow 30 minutes for completion. Mark, document, and return the assessments to the participants for them to review. If any participant still has not performed to the standard, set up a meeting to problem-solve the learning needs for the required content and withhold certification until the participant is performing to standard in those areas of knowledge, attitudes, and skills.
10. Distribute the training's final evaluation form and ask the participants to complete it anonymously. Direct the participants to place their filled forms into a box or envelope.
11. Thank the participants for their active involvement in the training and either begin closing ceremonies with distribution of certificates or distribute certificates and then thank the participants.

Appendixes

Appendix A

Daily Reflection Forms

REFLECTIONS

1. The one thing that I learned today that I do not want to forget is:

2. The information or activity that I found most useful today was:

3. The one suggestion I have for improving today's session is:

4. Additional comments:

REFLECTIONS

1. One new thing I learned today that I do not want to forget is:

2. One thing I relearned today that I do not want to forget is:

3. One thing that surprised me today was:

4. One thing that disappointed me today was:

5. One thing from today that I can use in *my* everyday work is:

Appendix B

Family Planning-ART Integration Training Evaluation Tool

Family Planning-ART Integration Training: End-of-Course Evaluation

We are interested in learning your views so we can improve future courses. Please complete all sections of this evaluation form. Please use the reverse side for comments, if needed. Thank you for your time.

1. Please *circle* the choice that best reflects your overall evaluation of this training:

5	**4**	**3**	**2**	**1**
Very Good	Good	Fair	Poor	Very Poor

2. How well did the course content meet your expectations?

5	**4**	**3**	**2**	**1**
Very well	Mostly well	Somewhat	Not very well	Not at all

3. How well did the course meet your emerging work needs?

5	**4**	**3**	**2**	**1**
Very well	Mostly well	Somewhat	Not very well	Not at all

4. Which three session were the ***most*** useful, and why?
   a._____
   _____
   _____

   b._____
   _____
   _____

   c._____
   _____
   _____

5. Which three session were the ***least*** useful, and why?

a._____
_____
_____

b._____
_____
_____

c._____
_____
_____

6. How useful were the participant materials in helping you learn the new information?

5	**4**	**3**	**2**	**1**
Very useful	Mostly useful	Somewhat useful	Not very useful	Not useful at all

7. How well did the training methods contribute to achieving the workshop objectives?

5	**4**	**3**	**2**	**1**
Very well	Mostly well	Somewhat	Not very well	Not at all

Specify any training methods (e.g., role play, case studies) that were particularly meaningful to your learning:

_____
_____
_____

8. How well did the clinical, counseling, and/or community outreach practicum prepare you to perform your new tasks in sharing family planning information, counseling in family planning, and providing family planning method(s)?

5	**4**	**3**	**2**	**1**
Very well	Mostly well	Somewhat	Not very well	Not at all

Comments:

_____
_____
_____

9. Please <u>check</u> (✓) any of the following that you feel could have improved the workshop:

☐ Use of more realistic examples and case studies

- More time to become familiar with ideas
- More time to practice counseling skills
- More time to practice applying new information and skills in clinical, counseling, and community outreach activities
- More effective group interaction
- More effective training activities
- Other

Comments (elaborate on any of these items, if explanation is necessary):

_____
_____
_____

10. What three things could the coordinators of this training have done to make the training more effective for you?

a._____
_____
_____

b._____
_____
_____

c._____
_____
_____

Additional comments/suggestions:

Thank you

APPENDIX C

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use –

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD)

CONDITION		COC	DMPA	Implants	Cu-IUD
Age	Menarche to 39 years	1			
	40 years or more	2			
	Menarche to 17 years		2	1	
	18 years to 45 years		1	1	
	More than 45 years		2	1	
	Menarche to 19 years				2
	20 years or more				1
Nulliparous		1	1	1	2
Breastfeeding	Less than 6 weeks postpartum	4	3	3	*
	6 weeks to 6 months postpartum	3	1	1	
	6 months postpartum or more	2	1	1	
Smoking	Age < 35 years	2	1	1	1
	Age ≥ 35 years, < 15 cigarettes/day	3	1	1	1
	Age ≥ 35 years, ≥ 15 cigarettes/day	4	1	1	1
Hypertension	History of hypertension where blood pressure:				
	CANNOT be evaluated	3	2	2	1
	Is controlled and CAN be evaluated	3	2	1	1
	Systolic 140 - 159 or diastolic 90 - 99	3	2	1	1
	Systolic ≥ 160 or diastolic ≥ 100	4	3	2	1
Headaches	Non-migrainous (mild or severe)	I C	1	1	1
	Migraine without aura (age < 35 years)	I C	2	2	1
	Migraine without aura (age ≥ 35 years)	I C	3	3	1
	Migraines with aura	4	I C	I C	1
History of deep venous thrombosis		4	2	2	1
Superficial thrombophlebitis		2	1	1	1
Complicated valvular heart disease		4	1	1	2
Ischemic heart disease/stroke		4	3	I C	1
Diabetes	Non-vascular disease	2	2	2	1
	Vascular disease or diabetes of > 20 years	4	3	2	1
Malaria		1	1	1	1
Non-pelvic tuberculosis		1	1	1	1
Thyroid disease		1	1	1	1
Iron deficiency anemia		1	1	1	2
Sickle cell anemia		2	1	1	2

CONDITION		COC	DMPA	Implants	Cu-IUD
Known hyperlipidemias		3	2	2	1
Cancers	Cervical (awaiting treatment)	2	2	2	I C
	Endometrial	1	1	1	I C
	Ovarian	1	1	1	I C
Cervical ectropion		1	1	1	1
Breast disease	Undiagnosed mass	**	**	**	1
	Current cancer	4	4	4	1
Uterine fibroids without cavity distortion		1	1	1	1
Endometriosis		1	1	1	2
Vaginal bleeding patterns	Irregular without heavy bleeding	1	2	2	1
	Heavy or prolonged, regular and irregular	1	2	2	2
	Unexplained bleeding	2	3	3	I C
Cirrhosis	Mild	1	1	1	1
	Severe	4	3	3	1
Current symptomatic gall bladder disease		3	2	2	1
Cholestasis	Related to pregnancy	2	1	1	1
	Related to oral contraceptives	3	2	2	1
Hepatitis	Acute or flare	I C	1	1	1
	Chronic or client is a carrier	1	1	1	1
Liver tumors (hepatocellular adenoma and malignant hepatoma)		4	3	3	1
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea	1	1	1	I C
	Vaginitis	1	1	1	2
	Current pelvic inflammatory disease (PID)	1	1	1	I C
	Other STIs (excluding HIV/hepatitis)	1	1	1	2
	Increased risk of STIs	1	1	1	2
	Very high individual risk of exposure to STIs	1	1	1	I C
HIV	High risk of HIV or HIV-infected	1	1	1	2
AIDS	No antiretroviral therapy (ARV)	1	1	1	I C
	Clinically well on ARV therapy	see drug interactions			I C
	Not clinically well on ARV therapy	see drug interactions			I C
Drug interactions including use of:	Nucleoside reverse transcriptase inhibitors	1	1	1	2
	Non-nucleoside reverse transcriptase inhibitors	2	1	2	2
	Ritonavir, ritonavir-boosted protease inhibitors	3	1	2	2
	Rifampicin or rifabutin	3	1	2	1
	Other antibiotics	1	1	1	1

Source: Adapted from *Medical Eligibility Criteria for Contraceptive Use*. Geneva: World Health Organization, updated 2008. Available: http://www.who.int/reproductive-health/family_planning/guidelines.htm

Category 1 There are no restrictions for use.

Category 2 Generally use; some follow-up may be needed.

Category 3 Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

Category 4 The method should not be used.

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I/C (Initiation/Continuation): A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the category indicated — whether or not she is initiating or continuing use of the method.

* Breastfeeding does not affect initiation and use of the copper-IUD. Regardless of breastfeeding status, postpartum insertion of the copper-IUD is Category 1 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

** Evaluation should be pursued as soon as possible.

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Appendix D

Provision of COCs at Initial Visit: Counseling Skills Performance Assessment Tool

Legend:

- S=Done to standard
- SP=Done to standard with prompting
- ND=Not done to standard or not done

Skills	1	2	3	4	Comments
Job Task 1: Screens client for suitability to pills					
1.1. Provides auditory and visual privacy					
1.2. Assembles materials for history-taking, behavior change communication, and IEC					
1.3. Greets client; explains to client the need for history taking and reassures client of confidentiality					
1.4. Obtains client's history and records accurately on the client record card.					
1.5. Reviews findings on history to identify need for physical examination (e.g., history of STI, pregnancy, liver disease, name of ARV drugs or TB drugs the client is taking *[may not be a candidate for COCs if on long-term TB treatment]*)					
1.6. Performs breast exam and other relevant examinations, if indicated by history					
1.7. Shares findings with client and ascertains whether client is suitable for the method according to ***Uganda MOH Family Planning/Reproductive Health Service Delivery Guidelines (2005)***					

Appendix D

Provision of COCs at Initial Visit: Counseling Skills Performance Assessment Tool

(cont.)

Skills	1	2	3	4	Comments
Job Task 2: Reviews client's understanding of the pills chosen					
2.1. Uses BCC and IEC materials to support counseling					
2.2. Asks client what she remembers about her chosen method: • How the method works • How the method is used • Side effects • When to return to clinic (even with emergency, if experiencing *warning signs*)					
2.3. Commends client for what she remembers and adds any missing information					
3.4. Corrects any misinformation					
Job Task 3: Gives client pills					
3.1. Explains to client that she will receive three cycles of the chosen pills					
3.2. Checks expiration dates of the pills and gives three cycles of pills					
Job Task 4: Gives client instructions on how to take the pills					
4.1. Explains to the client when and how to take the pills					
4.2. Holds one pack of pills and shows client which pill is taken first and which direction to follow.					
4.3. Explains that one pill should be taken every day at the same time *even if the partner is away*					

Appendix D

Provision of COCs at Initial Visit: Counseling Skills Performance Assessment Tool

(cont.)

Skills	1	2	3	4	Comments
4.4. Emphasizes the importance of taking pills on time and not forgetting if taking ARV drugs.					
4.5. Explains that if pills are started after Day 5 of the menstrual cycle, condoms should be used correctly and consistently for the next seven days to avoid unintended pregnancy					
Job Task 5: Explains when to expect and what to expect of periods					
5.1. Tells client that she will have periods when taking brown COC pills					
5.2. Explains that if she does not get a period while taking the brown pills, client should continue with another cycle of pills but come to clinic for pregnancy check					
5.3. Informs the client that she may experience amenorrhea (no periods) while taking COC, however, if she misses her period for two months, client should come to the clinic to be examined for pregnancy					
Job Task 6: Explains managing missed pills and when to use backup method					
6.1. Tells the client that pills must be taken every day at the same time to work effectively					
6.2. Explains that if client forgets one to two active pills of COC during the first three rows of pills, she should take a hormonal pill as soon as possible, finish the packet, and ***use backup method (e.g., condoms) for the next seven days***					

Appendix D

Provision of COCs at Initial Visit: Counseling Skills Performance Assessment Tool

(cont.)

Skills	1	2	3	4	Comments
6.3. Explains that if client forgets three or more pills during the first or second week (row of pills), she should take a hormonal pill as soon as possible, and ***use a backup method (e.g., condoms) for the next seven days***. ***Note***: Instructs the client to use ECP if she has had unprotected sex in the last five days					
6.4. Explains that if client forgets three or more pills during the third week (row of pills), she should take a hormonal pill as soon as possible, finish all pills in the pack, and discard the nonhormonal pills; start a new pack the next day. ***Note:*** Instructs the client to use ECP if she has had unprotected sex in the last five days					
6.5. Explains to the client how to ***use back-up method for seven days*** if she has diarrhea and /or vomiting within one hour of taking the pill or if diarrhea and/or vomiting persists for more than 24 hours					
6.6. Pauses to allow client to ask questions and answers factually					
6.7. Checks client's understanding of instructions given					
Job Task 7: Explains when to return to the clinic					
7.1. Informs client that if she is taking drugs, the possible (theoretical) interaction between the pills and HIV/TB drugs and some antifungal drugs and the need to take the pills regularly					

Appendix D

Provision of COCs at Initial Visit: Counseling Skills Performance Assessment Tool

(cont.)

Skills	1	2	3	4	Comments
7.2. Instructs client to return to the clinic if she experiences *warning signs*: severe headache, blurring of vision, severe abdominal pain, severe chest pain, or pain in the calf muscles					
7.4. Tells client routine return date (second visit) for resupply of pills					
Job Task 8: Reviews side effects of the pill with client					
8.1. Asks client what she remembers as minor side effects of the chosen pills					
8.2. Explains to client what to do when she gets side effects (both minor and severe)					
Job Task 9: Reviews risk of STI, including HIV, while taking the pills					
9.1. Explains that the pills do not protect against STI, including HIV, or HIV reinfection					
9.1. Encourages client and her partner to use condom as well as COC (dual method use) and provides condoms to client					
Job Task 10: Explains storage of pills					
10.1 Explains to the client the proper storage of the pills: cool, dry place away from children and rodents					
Job Task 11: Concludes session					
11.1. Asks client to demonstrate how she will take the pills					
11.2. Asks the client to repeat the instructions					

Appendix D

Provision of COCs at Initial Visit: Counseling Skills Performance Assessment Tool

(cont.)

Skills	1	2	3	4	Comments
Job Task 12: Conducts recordkeeping/bids farewell					
12.1. Records type of method and return date on the client's appointment card					
12.2. Records type of pills, quantity supplied, and return date on client's clinic card					
12.3. Records information in the family planning register					
12.4. Bids client farewell					

Appendix D

Provision of COCs at Follow-Up Visit: Counseling Skills Performance Assessment Tool

Legend:
S=Done to standard
SP=Done to standard with prompting
ND=Not done to standard or not done

Skills	1	2	3	4	Comments
COC Follow-up Task					
1.1. Provides auditory and visual privacy					
1.2. Has client's record available and reviews it					
1.3. Greets client and explains the purpose of the follow-up visit					
1.4. Uses BCC/IEC materials to support counseling					
1.5. Asks client to show (using her own pack or demonstration pack) how she has been taking the pills					
1.6. Commends or corrects pill-taking practice					
1.7. Asks client if she has had any difficulty remembering to take the pills daily					
1.8. Asks client if she has had any side effects (e.g., nausea, vomiting, mild headache, changes in her period)					
1.9. If client has had side effects, asks how has she managed them and what has been the outcome					

Appendix D

Provision of COCs at Follow-Up Visit: Counseling Skills Performance Assessment Tool

(cont.)

Skills	1	2	3	4	Comments
1.10. Asks client if she has had any of the *warning signs* (severe headache with blurred vision, headache, chest pain, calf pain)					
1.11. If yes, counsels client on the need to discontinue the COC and the need to use another method to avoid unintended pregnancy					
1.11a. Counsels client for another method, if indicated					
1.11b. Asks the client to repeat the instructions					
1.12. If client has no problem, asks client if she is satisfied with the COC and wishes to continue using them					
1.13. Dispenses six cycles of pills if the client's pill-taking habit is correct* *Provides 6–12 cycles at third visit if client has no problems/complaints and knows when to return to the clinic if *warning signs* occur.					
1.14. Asks client to demonstrate how she will take the pills					
1.15. Records number and name of COC packets given on the client's appointment card					
1.16. Gives the client a return date					
1.17. Records visit in the FP register					
1.18. Bids client farewell					

Appendix D

Provision of Injectable (DMPA) at Initial Visit: Counseling Skills Performance Assessment Tool

Legend:

- S = Done to standard
- SP = Done to standard with prompting
- ND = Not done to standard or not done

Skills	1	2	3	4	Comments
Job Task 1: Screens client for suitability to use injectable hormone (DMPA)					
1.1. Provides auditory privacy					
1.2. Assembles materials for history taking, BCC, and IEC					
1.3. Greets client; explains the need for history taking and reassures client of confidentiality					
1.4. Obtains client's history and records accurately on the client record card					
1.5. Reviews findings on history to identify need for physical examination (e.g., history of STI, pregnancy, liver disease; name of ARV or TB drugs the client is taking).					
1.6. Performs breast exam and other relevant examinations, if indicated by history					
1.7. Shares findings with client and ascertains whether client is suitable for the method according to ***Uganda MOH FP/RH Service Delivery Guidelines (2005).***					

Appendix D

Provision of Injectable (DMPA) at Initial Visit: Counseling Skills Performance Assessment Tool *(cont.)*

Skills	1	2	3	4	Comments
Job Task 2: Reviews client's understanding of the injectable hormone (DMPA)					
2.1. Asks client what she remembers about her chosen method: • How the method works • How the method is used • Side effects • When to return to clinic (even with emergency)					
2.2. Commends client for what she remembers and adds any missing information					
2.3. Corrects any misinformation					
Job Task 3: Gives the client DMPA injection					
3.1. Asks the client whether she prefers to receive the injection in her arm or in her hip					
3.2. Administers the DMPA according to injection safety protocols:					
3.2.1. Cleans the skin with antiseptic solution					
3.2.2. Gives DMPA by deep intramuscular method					
3.2.3. Applies pressure to the injection site with a clean swab ***without massaging the site***					
3.2.4. Disposes of the needles/syringe in a puncture-resistant container without recapping.					

Appendix D

Provision of Injectable (DMPA) at Initial Visit: Counseling Skills Performance Assessment Tool *(cont.)*

Skills	1	2	3	4	Comments
Job Task 4: Gives client postinjection instructions					
4.1. Informs client of date for next injection					
4.2. Emphasizes the importance of returning at 11 or 12 weeks from today's injection, if on ARV drugs, since the drugs *might* reduce the injection's effectiveness towards the end of the three-month period					
4.3. If injection was given after the first five days of the menstrual cycle, instructs client to use backup method (e.g., condoms) for the next seven days					
4.4. Instructs client to return to the clinic if experiencing *warning signs*: repeated, painful headaches; heavy bleeding; depression; severe, low abdominal pain; pus; prolonged pain; or bleeding at the injection site (infection)					
Job Task 5: Explains when to expect and what to expect of periods					
5.1. Reminds client that she might experience irregular periods with spotting in between periods (common occurence) in the beginning of method use					
5.2. Informs client that she may experience amenorrhea (no periods) after taking the injection for 9 to 12 months (common occurence, and not harmful); however, if she experiences any symptoms of pregnancy, she should come to the clinic immediately					

Appendix D

Provision of Injectable (DMPA) at Initial Visit: Counseling Skills Performance Assessment Tool *(cont.)*

Skills	1	2	3	4	Comments
Job Task 6: Explains dual method use					
6.1. Informs client that DMPA does not protect against STI and HIV or HIV reinfection, therefore, condoms should be used					
6.2. Demonstrates to client how to use condoms, and then asks client to demonstrate					
6.3. Confirms or corrects condom return demonstration as indicated					

Appendix D

Provision of Injectable (DMPA) at Follow-Up Visit: Counseling Skills Performance Assessment Tool

Legend:

- S = Done to standard
- SP = Done to standard with prompting
- ND = Not done to standard or not done

Skills	1	2	3	4	Comments
DMPA Follow-Up Visit					
1.1. Provides auditory and visual privacy					
1.2. Has client's record available and reviews it					
1.3. Greets client and explains the purpose of the follow-up					
1.4. Uses BCC/IEC materials to support counseling					
1.5. Asks client if she has had any *side effects* and whether they are disturbing to her (e.g., mild headache, weight gain, depression, and changes in her period)					
1.6. If client has had side effects, asks how has she managed them and what has been the outcome; manages side effect(s) if disturbing client					
1.7. Asks client if she has had any of the *warning signs* (severe headache, heavy bleeding, weight gain, or depression)					

Appendix D

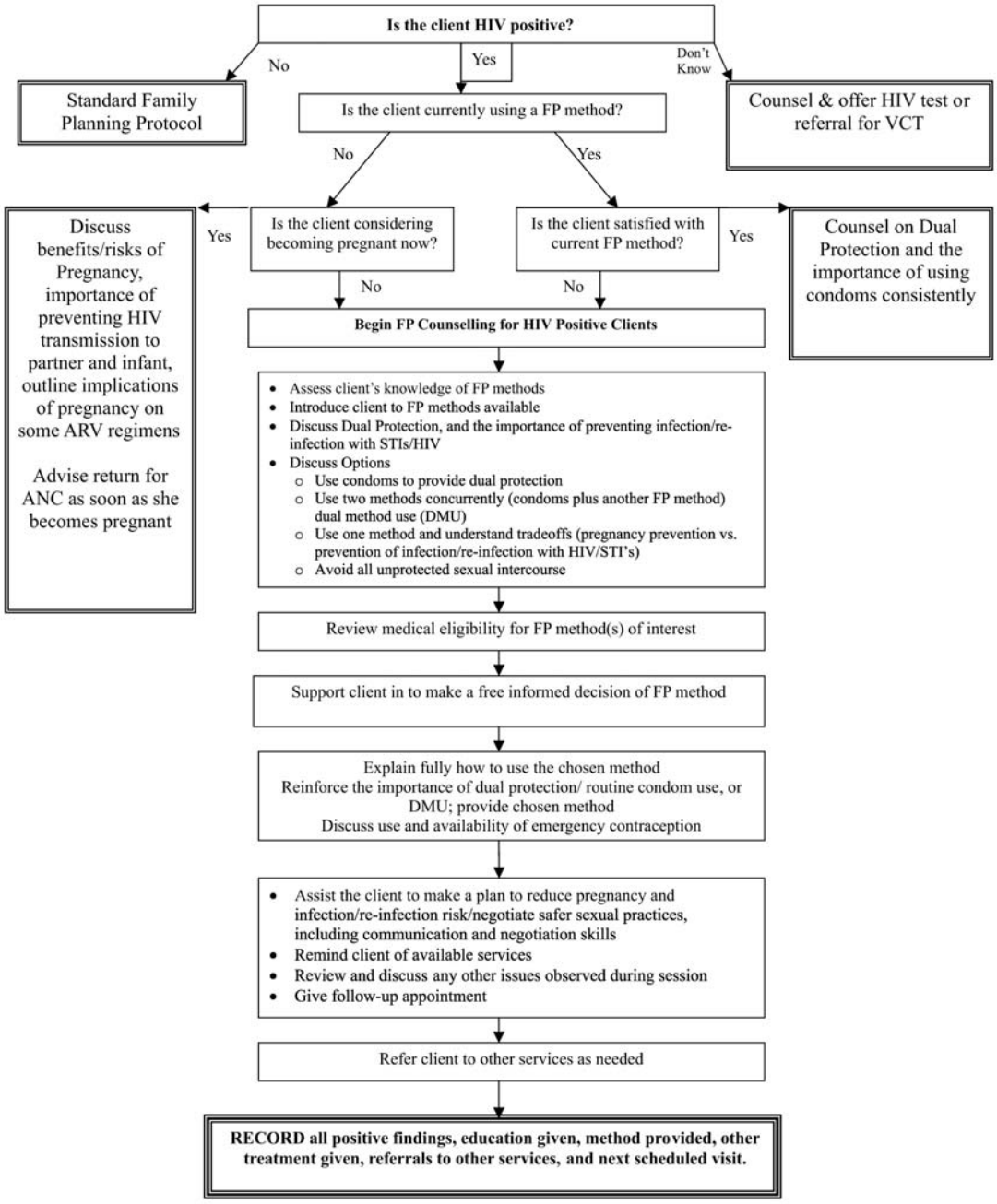
Provision of Injectable (DMPA) at Follow-Up Visit: Counseling Skills Performance Assessment Tool *(cont.)*

Skills	1	2	3	4	Comments
1.8. If yes, counsels client on the need to discontinue the DMPA and use another method to avoid unintended pregnancy					
1.8a. Counsels for another method, if indicated					
1.8b. Asks the client to repeat the instructions					
1.9. If client has no problem, asks client if she is satisfied with the DMPA and wishes to continue using this method					
1.10. Gives the repeat injection according to injection safety protocols					
1.11. Reinforces the importance of returning during week 11 or 12 for the next injection					
1.12. Reinforces dual method use, if at risk of STI or HIV reinfection and provides condoms					
1.13. Gives the client a return date					
1.14. Records visit in the FP register					
1.15. Bids client farewell					

Appendix E

Assorted Job Aids

Client-centered RH Counselling



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FAMILY PLANNING (FP) & ANTIRETROVIRAL THERAPY (ART)

GHANA HEALTH SERVICE
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Your need for family planning may change as you go through the different stages of your reproductive life. As a young adult, you may want to postpone your first pregnancy until you are ready to start having children. Later on, you may want to use contraceptives to space your pregnancies. Finally, there may come a time when you decide you do not want any more children.

Make sure to talk with your health care provider about the family planning method you can use if you are HIV-positive or using AIDS medicines (ARVs).

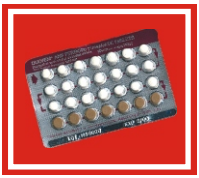
To decide which family planning method to use now, you need to know if:

* It will protect you against HIV reinfection?

* It will increase your risk of exposure to an STI or HIV reinfection?

* Any of your medicines have an effect on the effectiveness of the method?

We hope the information in this brochure can help you to decide what method you would like to use. When you choose a method, your health care provider (counsellor) will ask you questions and in some cases, do a physical examination to make sure that the method will be safe for you to use.



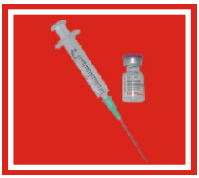
The Pill

The Pill is a small tablet that a woman takes every day to prevent pregnancy. It is most effective when taken at about the same time everyday. When a woman stops taking the Pill, she can become pregnant.

Characteristics

- Can be used by women of childbearing age, whether or not they have had children; for as long as they want to prevent pregnancy.
- Monthly periods are regular and bleeding is lighter.
- May cause nausea, mild headaches, slight pain in the breast within the first 3-4 weeks of taking the Pill, and slight weight gain.
- Does not protect against sexually transmitted infections (STIs) including HIV.

***Note**: Rifampicin may reduce effectiveness of hormonal contraceptives; therefore long-term use of rifampicin requires use of a back up method such as condoms or selection of another contraceptive method during and for two weeks after treatment ends.*



The Injectable

The Injectable is a family planning injection given to a woman at regular intervals by a trained health provider. The three commonly used Injectables are: Depo-Provera given every three months, Noristerat given every two months and Norigynon given every month. **A woman can become pregnant after she stops taking any of these injections.**

Characteristics

- It is private. No one else can tell that you are using it.
- One injection prevents pregnancy for extended periods of time.
- May cause light bleeding between monthly periods, and in some cases the periods to stop for sometime.
- May cause slight weight gain.
- Does not protect against sexually transmitted infections (STIs) including HIV.

If you are HIV-positive or using ARVs:

- ✍ You will need to use condoms in addition to the injectable to protect yourself against HIV reinfection and STIs.
- ✍ You will need to return on time for each injection since the ARVs may reduce the strength of the injectable to prevent pregnancy towards the end of the 3-months.
- ✍ May cause light bleeding between monthly periods, and in some cases the periods to stop for sometimes.

Norplant Implants

This is a set of six small capsules put under the skin of a woman's upper arm by a doctor or a nurse. These capsules can prevent pregnancy for 7 years. The capsules must be removed or replaced after 7 years, when they will no longer protect against pregnancy. The capsules can be removed earlier if the woman desires to become pregnant.

Characteristics

- Effective within 24 hours of insertion.
- Fertility returns almost immediately after capsules are removed.
- Light spotting or bleeding between monthly periods improving over time; or temporary absence of menstrual periods may occur.
- Does not protect against sexually transmitted infections (STIs) including HIV.

If you are HIV-positive or using ARVs:

✍ you will need to use condoms in addition to the Implants to protect yourself against HIV reinfection and STIs

Note: Rifampicin may reduce effectiveness of hormonal contraceptives; therefore long-term use of rifampicin requires use of a back up method such as condoms or selection of another contraceptive method during and for two weeks after treatment ends.

Intrauterine Device (IUD)

An IUD is a small flexible device that is placed in the woman's womb through her vagina to prevent pregnancy. It prevents pregnancy for 12 years but can be taken out sooner if the woman desires to become pregnant.

Characteristics

- When women have their IUD removed, they can become pregnant as quickly as women who have not used IUDs.
- Can be inserted immediately after childbirth or after an abortion (if there is no evidence of infection)
- In the first three months, some women bleed more during their periods or may have painful periods.
- Does not protect against sexually transmitted infections (STIs) including HIV.

If you are HIV-positive or using ARVs:

- You may start or continue using the IUD.
- If you are being successfully treated for AIDS.
- If you have untreated AIDS, you may be advised to use another method until your health is improved with treatment, then you may use the IUD.
- You will need to use condoms in addition to the IUD to protect yourself against HIV reinfection and STIs.

The Male Condom

The Condom is a close fitting rubber sheath a man wears on his erect penis during sexual intercourse.

Characteristics

- Prevents STIs including HIV, as well as pregnancy, when used correctly with every act of sexual intercourse. Can be used with other methods, except female condoms.
- Enables a man to take responsibility for preventing pregnancy and disease.
- Condoms can weaken and may break during use if stored too long in too much heat, or sunlight.
- Using anything made with oil like vaseline, baby oil or cooking oil to make condoms wet can make it burst.
- May take some practice to feel confident to put on, take off, or throw away.

If you are HIV-positive or using ARVs:

Male condoms are an effective option for preventing re-infection and pregnancy when used with every act of sex.

The Female Condom

The Female Condom is a thin, transparent and soft plastic (polyurethane) that the woman puts inside her vagina before sex.

Characteristics

- A condom used by the woman.
- Prevents pregnancy and protects against STIs including HIV.
- More expensive than the male condom.
- Usually needs partner support.

If you are HIV-positive or using ARVs:

Female condoms are an effective option for preventing re-infection and pregnancy when used with every act of sex.

Female Sterilisation

This is a small operation that closes the tubes that carry eggs from the egg bag to the womb, to prevent the sperm and egg from meeting. After the procedure is performed, women still have periods regularly but cannot become pregnant anymore.

Characteristics

- Permanent. A single procedure leads to lifelong, safe and very effective prevention of pregnancy.
- No need to continue visiting the family planning clinic or buying contraceptive.
- Reversal surgery is not available. Women who may want to become pregnant in the future should choose a different method.
- Does not protect against sexually transmitted infections (STIs) including HIV.

If you are HIV-positive or using ARVs:

You will need to use condoms even after the sterilization procedure to protect yourself against HIV reinfection and STIs.

Vasectomy

Vasectomy is a permanent method for men who want to stop having children. It involves a short and simple operation to cut or block the tubes that carry the sperm from a man's testicles (balls) to the penis. After a vasectomy, a man can have sex just as before, but cannot make a woman pregnant

Characteristics

- Does not affect a man's ability to have sex.
- Permanent. A single, quick procedure leads to lifelong, safe, and very effective family planning.
- **Not immediately effective**; **the couple must use another family planning method during the first 3 months following the procedure.**
- Does not protect against sexually transmitted infections (STIs) including HIV.

If you are HIV-positive or using ARVs:

✍ **You will need to use condoms even after the sterilization procedure to protect yourself against HIV reinfection and STIs.**

Lactational Amenorrhea Method (LAM)

LAM prevents pregnancy (stops the ovaries from releasing an egg) when all three conditions are present:

- Baby is six months old or younger.
- Your menses has not returned since delivery.
- The baby feeds frequently day and night (e.g., avoids long intervals between breastfeeds-more than four hours during the day and six hours at night).

Characteristics

- Causes no medical or hormonal side effects
- Does not require buying contraceptives
- Limited period of effectiveness, for six months after delivery
- May be difficult to exclusively breastfeed depending on baby's pattern or woman's activities.
- Does not protect against sexually transmitted infections (STIs) and HIV.

If you are HIV-positive or using ARVs:

- ✍ You will need to use female or male condoms in addition to LAM to protect yourself against HIV reinfection and STIs
- ✍ HIV will more easily be passed to the infant if s/he received "mixed" feeding that is breastmilk AND other food, drink, or formula.

Note: **HIV can be passed to the baby in breastmilk. Where a safe replacement infant formula is available and affordable, you should consider infant feeding options and use another family planning method. If no safe replacement infant formula is available or affordable, you should breastfeed exclusively. After 6 months, or if a safe replacement food becomes available, you should stop breastfeeding and use another family planning method of your choice, while using condoms.**

Emergency Contraception

- Emergency Contraception (EC)...
  ...is designed to prevent pregnancy ***after*** unprotected vaginal intercourse. Note: EC does not interrupt an established pregnancy.
  ...is provided in two ways:

- **Emergency contraceptive pills** can reduce the risk of pregnancy if started within 120 hours after unprotected vaginal intercourse. The sooner they are taken, the better. They work best when they are taken within 72 hours. During this time they can reduce the risk of pregnancy from 75 to 89%. Nausea, vomiting, and cramping are common side effects when combined hormone pills estrogen and progestin are used. You can continue using the pill (combined oral contraceptive) for on-going pregnancy prevention just after you finish taking the Emergency contraception tablets.

- **Emergency IUD insertion within five days of unprotected intercourse is 99.9% effective. You can continue using the IUD as your family.**

- Emergency contraceptive pills do not protect against sexually transmitted infections (STIs) and HIV. Planning method if this is available as EC.
- Consult a health care provider about what kind of emergency contraception pills may be best for you:

You May Want Emergency Contraception if...

- His condom broke.
- You forgot to take your pill.
- He did not pull out in time.
- You were not using any family planning method.
- He forced you to have unprotected sex.

NOTES

Contraceptive Methods: Quick Reference Chart

	Most effective	Method	How to make the method most effective	Protects against STIs / HIV	Special considerations when HIV- positive	Anything to do before sex?	Can have Children later?	Good when Breast feeding	Few side effects	Offers Dual Protection	Easy to use	Easy to stop	Use only when needed
Generally 2 or fewer pregnancies per 100 women having regular intercourse during the course of one year		 **Vasectomy** **Female Sterilization**	One-time procedures. Nothing to do or remember at the time of intercourse. **Vasectomy- must use contraceptive during first 3 months after procedure.**	No	Use Condoms to prevent HIV re-infection	No	No	Yes	Yes; pain at cut site, infection, bleeding at site.	No	Requires skilled health worker to perform surgery	Permanent	No
		 **IUD**	One-time procedure. Nothing to do or remember at the time of intercourse	No	May use IUD if HIV positive or successfully treated for AIDS (but do not use with untreated AIDS)	No	Yes. Immediate return of fertility after removing IUD	Yes	Yes; heavier menses, cramping.	No	Requires trained health worker to insert	Requires trained health worker to remove	No
		 **Implants**	One-time procedure. Nothing to do or remember at time of intercourse.	No	Do not use or use back up method if taking Rifampicin	No	Yes. Immediate return of fertility	Yes, after six weeks	Yes; menstrual changes.	No	Requires trained health worker to insert	Requires trained health worker to remove	No
		 **Injectable**	Need repeat injections every 1 to 3 months (depending on injection type)	No	Should not use or use back up method with monthly injectables if on Rifampicin	No	Yes. Delayed return of fertility	Yes, after six weeks	Yes; menstrual changes.	No	Requires health worker to inject	Yes	No
About 15 pregnancies per 100 women having regular intercourse during the course of one year		 **Oral contraceptive Pills**	Must take one pill each day	No	Do not use or use back up method if taking Rifampicin	No	Yes. Immediate return of fertility	Yes, after six weeks	Yes; menstrual changes.	No	Yes	Yes	No
		 **L A M**	Must follow LAM instructions. ***Ineffective unless all criteria are met*** (see "Breastfeeding" column)	No	Possibility that HIV may be passed in breast milk	No	Yes. Immediate return of fertility	LAM is **only** effective when **all** the following criteria are met: • Woman is exclusively breast Feeding • Less than six months post partum • Menses have not Returned	No	No	No; exclusive breast feeding may be inconvenient for some working mothers	Yes	Yes
		 **Condoms (male and Female)**	For maximum effectiveness, must use every time you have sex; requires partner's cooperation.	**Yes**	Highly effective against HIV reinfection. Also provide varying protection against other STIs, including herpes and HPV virus	Yes	Yes. Immediate return of fertility	Yes	Yes; Condom or lubricant may cause itching or rash on the genitals for some people.	**Yes**	Yes. To ensure that condoms are used effectively every time, health workers must demonstrate condom use and ask clients to return the demonstration to ensure correct technique.	Yes	Yes
About 30 pregnancies per 100 women having regular intercourse during the course of one year		**Emergency Contraception**	Take within 120 hours of unprotected sex.	No	None	No	Yes Immediate return of fertility	Yes with Progestin-only ECPs.	Yes; nausea, vomiting.	No	Yes	Yes	Yes
	Least effective	 **Periodic abstinence** (e.g. Standard Days method, Billings method, Basal Body Temperature)	Must abstain or use condoms on fertile days; requires partner's cooperation.	No	May be difficult if have AIDS or taking ARVs because of changes in menstrual cycle and higher body temperatures	No	Yes. Immediate return of fertility.	Yes When regular Menses return	No	No	Standard Days Method - Yes Billings Method - No Basal Body Temperature - No	Yes	Yes

Adapted from: WHO and Johns Hopkins Bloomberg School of Public Health, CCP (JHU/CCP), Information and Knowledge for Optimal Health (INFO).
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