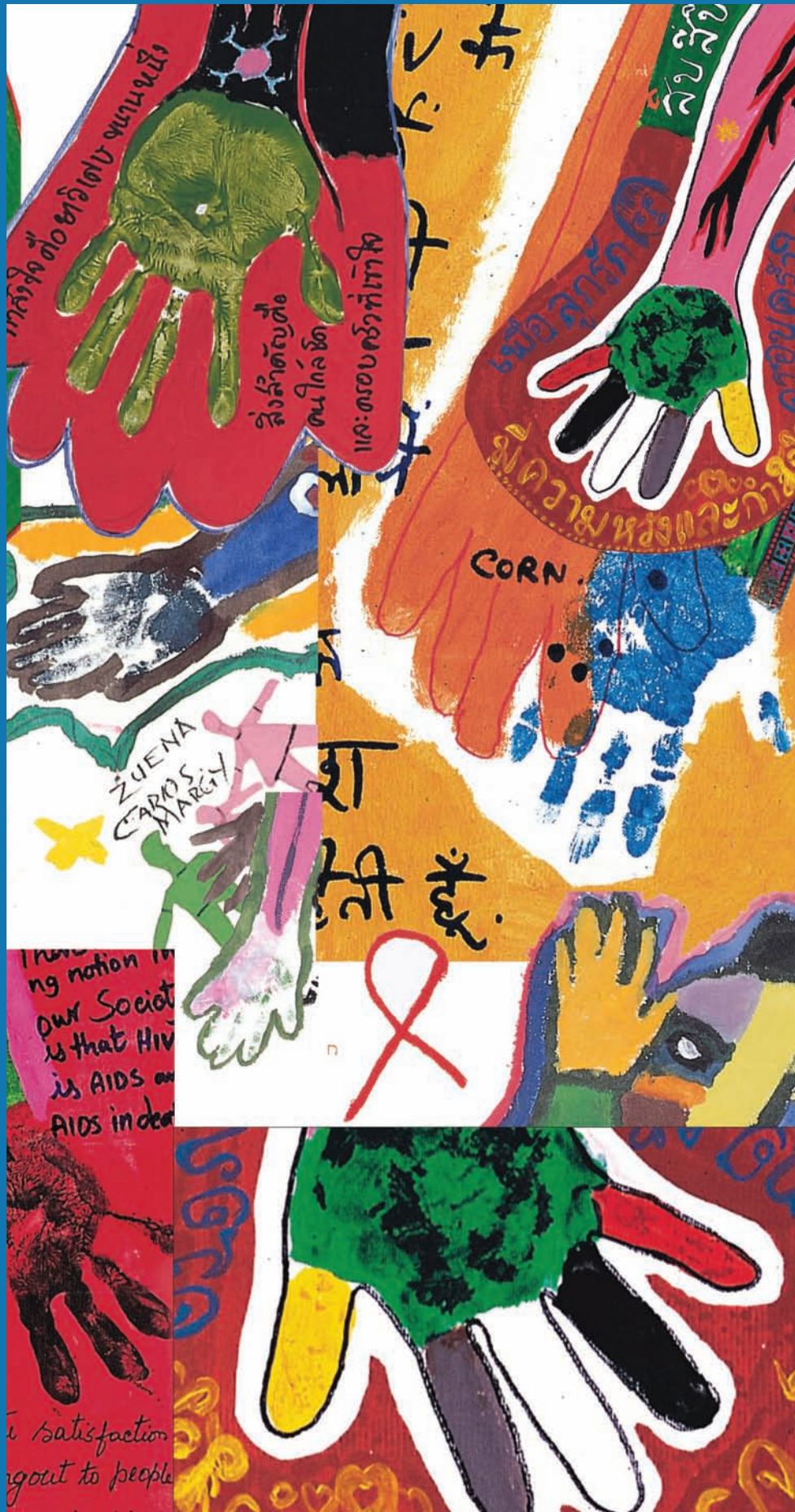




ENGENDERHEALTH



International Community of Women Living with HIV and AIDS



Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls

Manual for Trainers and Programme Managers

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Sexual and
Reproductive Health
for HIV-Positive
Women and
Adolescent Girls:

Manual for Trainers and
Programme Managers



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The cover is a collage of the hands of HIV-positive women in Asia and Africa who painted body maps as part of an ongoing TICAH project called “Our Positive Bodies: Mapping our Treatment, Sharing our Strategies.” TICAH, which is based in Nairobi, Kenya, shares body maps, treatment stories, death stories, and nutritional and herbal treatment strategies as part of their “Listening To Those Who Live It” project. TICAH aims to influence AIDS policies and programs so that they respond better to women’s desires, needs, power, and realities. TICAH partners with Point of View (India) and with positive women’s and children’s support groups in India, Thailand, and Kenya in this work. TICAH welcomes anyone interested in more information to visit their website (www.ticahealth.org) or to write to listening@ticahealth.org.



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Our thanks also go to the Trust for Indigenous Culture and Health (TICAH), for allowing us to use the cover image. This collage shows the hands of HIV-positive women in Asia and Africa who painted body maps as part of an ongoing TICAH project called “Our Positive Bodies: Mapping Our Treatment, Sharing Our Strategies.”

Diana Quick-Groh edited the manuscript, Cassandra Cook designed and composed the manual, and Michael Klitsch managed the overall editorial/production process.

Abbreviations and Acronyms

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ARV	antiretroviral
AZT	Azidothymidine (zidovudine)
CPI	client-provider interaction
ECP	emergency contraceptive pill
FHI	Family Health International
FP	family planning
HAART	highly active antiretroviral therapy
HIV	human immunodeficiency virus
HPV	human papillomavirus
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IDU	injecting drug user
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
IVF	in vitro fertilization
LAM	lactational amenorrhea method
MSM	men who have sex with men
MTCT	mother-to-child transmission (of HIV)
NGO	nongovernmental organization
OI	opportunistic infection
PCR	polymerase chain reaction
PEP	postexposure prophylaxis
PID	pelvic inflammatory disease
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
REDI	Rapport-building, Exploration, Decision making, and Implementing the decision
RH	reproductive health
RTI	reproductive tract infection
SDG	service-delivery guideline
SRH	sexual and reproductive health
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	voluntary counselling and testing
WHO	World Health Organization

Preface

Sexual and reproductive rights apply to all individuals regardless of HIV status. Yet more often than not, the rights of HIV-positive women and adolescent girls are not recognized or given priority. Gender inequality and some social and cultural practices often tightly restrict and sometimes control the decisions that women and girls can make regarding their sexual and reproductive choices. Due to poverty, HIV-related stigma, and discrimination, the access of HIV-positive women and adolescent girls to critically needed information and services is severely curtailed, with dire consequences.

Sexual and reproductive health (SRH) services for HIV-positive women and adolescent girls are limited in scope, access, and quality—where they exist at all. This is due, in part, to the low priority of such services, itself a manifestation of gender inequality and stigma and discrimination against people living with HIV, as well as to deficiencies in health services delivery and legal or policy barriers constraining access to care.

Some examples of the connections between HIV, SRH, rights, and gender inequality are listed below and illustrate why sexual and reproductive rights are particularly important for HIV-positive women and adolescent girls, their partners, and families:

- HIV transmission mainly occurs in sexual relationships.
- HIV testing often happens in SRH services (for example, in antenatal care, abortion, and sexually transmitted infection [STI] clinics).
- Violations of women's and men's sexual and reproductive rights increase their vulnerability to HIV infection, and their HIV status increases their vulnerability to sexual and reproductive rights violations.
- Violations of HIV-positive women's sexual and reproductive rights increase the impact of HIV on women.
- Violations directly impact women's and men's access to and experiences of HIV-related services and their ability to use information and services provided to improve their well-being.
- The quality and form of testing, treatment, and care services can make violations of the sexual and reproductive rights of HIV-positive women and men worse (for example, pressuring a woman to test with her partner when that might exacerbate domestic violence).
- Societal and health care delivery service inequalities interact with the stigma and discrimination surrounding HIV and AIDS.
- Gender and other inequalities make it harder for HIV-positive women and men to realize their rights to sexual and reproductive health.
- Gender violence increases the vulnerability of women and adolescent girls to HIV transmission.
- Adolescent girls seldom have access to youth-friendly, quality SRH services; those who are HIV-positive are even more likely to be subject to stigma and discrimination.

The international community has clearly stated and widely endorsed the rights of individuals to access SRH services, to make their own decisions about their SRH care, and to have

the information necessary to make those decisions, through the Programme of Action adopted at the 1994 International Conference on Population and Development (ICPD) and through subsequent reviews of the ICPD Programme of Action.¹ However, many countries still lack policies and programmes that protect the rights of people living with HIV or take into consideration the specific needs of people living with AIDS.

Attaining and preserving the rights of HIV-positive women and adolescent girls will help ensure that SRH services are of the appropriate range and quality and that they are accessible to all who need them. SRH services need to be comprehensive and linked, and include a range of services: family planning; maternal care; prevention of mother-to-child transmission of HIV (PMTCT); voluntary counselling and testing for HIV (VCT); quality counselling; gender-based violence services; sexual health information and counselling; gynaecological care, including STI screening and treatment; cervical cancer screening and treatment; fertility options; abortion, where legal; postabortion care; and psychosocial services. Health workers need both training and support to eliminate facility-based stigma and discrimination and to provide quality safe and compassionate care to HIV-positive women. In general, there needs to be a greater awareness of the larger social context of issues such as those affecting sexuality, sexual health, access to care, and confidentiality.

The close relationship between SRH and improved prevention, treatment, and care for HIV/AIDS, and their role in contributing to meeting the Millennium Development Goals, are now widely recognized.² Challenges to SRH and HIV/AIDS share the same root causes, including poverty, gender inequality, marginalization, and stigmatization.³ Therefore, ensuring access to SRH services for HIV-positive women and adolescent girls contributes both to an effective global response to HIV and to the reduction of poverty and gender inequality.

Recently, the international community has been galvanized to intensify these linkages at the policy and programming level. Specifically, strong indications of the readiness of both the SRH and HIV/AIDS community to embrace this synergistic approach include the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health⁴; the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children⁵; and the Call to Action: Towards an HIV-Free and AIDS-Free Generation,⁶ which was issued following the December 2005 meetings held in Abuja, Nigeria.

¹ ICPD. 1994. *Programme of Action*. Retrieved 7 September 2006 at: www.unfpa.org/icpd/icpd_poa.htm; subsequent reviews of ICPD include ICPD+5, retrieved 7 September 2006 at www.unfpa.org/publications/detail.cfm?ID=276, and ICPD+10, retrieved 7 September 2006 at: www.unfpa.org/publications/detail.cfm?ID=226.

² United Nations Population Fund (UNFPA). No date. *Millennium Development Goals and reproductive health*. New York. Retrieved 23 June 2006 at: www.unfpa.org/icpd/mdgs-rh.htm.

³ UNFPA. No date. *Linking HIV/AIDS with sexual and reproductive health*. Retrieved 23 June 2006 at: www.unfpa.org/hiv/linking.htm.

⁴ UNFPA. 2004. *New York Call to Commitment: Linking HIV/AIDS and sexual and reproductive health*. 7 June 2004. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=195&filterListType=1.

⁵ UNFPA. 2004. *Glion Call to Action on Family Planning and HIV/AIDS in Women and Children*, Glion, May 3-5, 2004. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=199&filterListType=1.

⁶ UNFPA. 2005. *Call to action: Towards an HIV-free and AIDS-free generation*. Report of the Prevention of Mother to Child Transmission (PMTCT) High Level Global Partners Forum, Abuja, Nigeria, December 3, 2005. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=259&filterListType=1.

While the New York Call to Commitment addresses all potential areas of convergence between SRH and of HIV, the Glion Call to Action focuses on the nexus between family planning and SRH, and primarily on PMTCT within HIV/AIDS. The Glion consultation was a watershed initiative for identifying a priority area for linking SRH and HIV/AIDS, by advocating that the most effective way to reduce the proportion of infants who become HIV-positive is by preventing primary HIV infection in women and by preventing unintended pregnancy among HIV-positive women.

The commitment of the international community and national governments to integrating PMTCT interventions into maternal and child health services and strengthening linkages to other health programmes, including other SRH programmes and HIV care, support, and treatment programmes, was more recently echoed in the Call to Action: Towards an HIV-Free and AIDS-Free Generation. The December 2005 Abuja Call to Action notes that “comprehensive PMTCT programs should include strategies to: prevent HIV transmission to women; provide reproductive health care to women living with HIV; prevent HIV transmission during pregnancy, labour and delivery; and minimise HIV transmission through safer infant practices”.⁷

While assisting HIV-positive women to prevent unintended pregnancy has been recognized as a key strategy in PMTCT,⁸ the focus has been primarily on the child. When included as a component of comprehensive SRH care of HIV-positive women and fully respecting the right to make uncoerced fertility decisions, preventing unintended pregnancies is as much about the health concerns of the woman as it is about her unborn infant. This holistic definition of reproductive health and its comprehensive view of SRH care are central to the discussion around SRH services for HIV-positive women and adolescent girls in this training and programming manual. In lieu of policy and programmatic guidance on the SRH of people living with HIV, the clinical recommendations in this manual are based on UNFPA’s and WHO’s *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*⁹ and on WHO’s *Medical Eligibility Criteria for Contraceptive Use*¹⁰.

This manual is designed to provide information and structure for a four-day training and a two-day planning workshop that will enable programme managers and health workers in resource-constrained settings to offer comprehensive, nonjudgemental, and quality care and support to HIV-positive women and adolescent girls in the local context. The manual also

⁷ Ibid.

⁸ The authors, along with the rest of the international community, recognize that an effective PMTCT response requires a much more comprehensive, four-pronged approach, including preventing HIV infection among girls and women; preventing unintended pregnancies among women living with HIV; reducing mother-to-child transmission through antiretroviral drugs, safer deliveries, and infant feeding counseling; and providing care, treatment, and support to women living with HIV and their families.

⁹ UNFPA and World Health Organization (WHO). 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. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=297&filterListType=1.

¹⁰ WHO. 2004. *Medical eligibility criteria for contraceptive use, third edition*. Geneva. Retrieved 7 September 2006 at: www.who.int/reproductive-health/publications/mec/.

urges male involvement and promotes a holistic approach to integrated SRH counselling and programme planning that links SRH and HIV/AIDS services.

It is based on the perceptions and understanding of SRH issues for HIV-positive women and adolescent girls, shared by HIV-positive women and adolescent girls themselves, their male partners, health workers, policy makers, and community leaders, gained through a qualitative research study conducted by EngenderHealth and UNFPA in Brazil, Ethiopia, and the Ukraine. The manual was field-tested with SRH and HIV/AIDS programme managers and health workers in Brazil, Ethiopia, and the Ukraine and the feedback from the field-tests was incorporated into this final version.

Introduction to the Training Curriculum

Overview

Need for This Course

The international community has broadened its focus in recent years to take a holistic view of sexual and reproductive health (SRH), in which SRH service delivery is linked with HIV/AIDS services. As a result of this change, a need has emerged for training that will prepare health workers to:

- see the client as a whole person with a range of interrelated SRH needs, including information, decision-making assistance, and emotional support;
- address sensitive issues of sexuality with greater comfort;
- support and protect the client’s sexual and reproductive rights;
- more easily access resources covering a variety of SRH services.

This curriculum attempts to meet that training need in several unique ways:

- by introducing the concept of “integrated SRH counselling”;
- by adapting counselling frameworks from the SRH and HIV/AIDS fields to help health workers effectively assess and address the comprehensive SRH needs of HIV-positive women and adolescent girls.

Goal and Objectives

The goal of this training is to enable health workers to address the SRH needs of HIV-positive women and adolescent girls by offering comprehensive SRH services within their own particular service-delivery setting.

The United Nations Population Fund (UNFPA) has identified the following core areas of a comprehensive SRH package:¹¹

- family planning (FP)/birth spacing services;
- antenatal care, skilled attendance at delivery, and postnatal care;
- management of obstetrical and neonatal complications and emergencies;
- management of abortion complications and provision of postabortion care;
- prevention and treatment of reproductive tract infections (RTIs) and sexually transmitted infections (STIs), including HIV/AIDS;
- early diagnosis and treatment for breast cancer and reproductive tract cancers (men and women);
- promotion, education, and support for exclusive breastfeeding;¹²

¹¹ UNFPA. No date. *Reproductive health services: offering essential services*. Retrieved 23 June 2006 at: www.unfpa.org/rh/services.htm.

¹² Because HIV can be transmitted through breast milk, the guidelines around infant feeding for women who are HIV-positive differ from those for women who are HIV-negative. See the following resource for the ways in which they differ: UNFPA. 2003. *HIV and infant feeding: Framework for priority action*. New York. Retrieved 23 June 2006 at: www.unfpa.org/publications/detail.cfm?ID=156&filterListType=1.

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- prevention and appropriate treatment of subfertility and infertility;
- active discouragement of harmful practices, such as female genital cutting/mutilation;
- adolescent SRH;
- prevention and management of gender-based violence.

The general objectives of this curriculum are to ensure that, by the end of the training, the participants will have the knowledge, attitudes, and skills necessary to carry out the following key tasks in relation to the above core areas:

- help clients assess their own needs for a range of SRH services, information, and emotional support;
- provide information and services that are both age appropriate and appropriate to clients' identified problems and needs;
- assist clients in making their own voluntary and informed decisions;
- help clients develop the skills they will need to carry out those decisions.

Rationale: Why Comprehensive SRH Services?

Clients typically seek SRH services for one particular need or problem—e.g., FP, an STI, abortion (where legal) and postabortion care, or some aspect of maternal health care—and health workers typically respond to that one particular need or problem. However, people living with HIV may have other needs or concerns that contribute to their primary problem but that are never identified or addressed by a service provider. By not addressing those needs, health workers may miss key opportunities to improve clients' overall health status. This problem of missed opportunities is particularly serious in SRH services, given the potentially life-threatening consequences of pregnancies, STIs, and AIDS, and both the social stigma associated with HIV and AIDS and the discomfort that many clients and health workers feel about discussing these issues.

By taking a broader perspective and *linking* the immediate needs or problems of the HIV-positive woman or adolescent girl to her overall health status, this training can help health workers assist clients to prevent potential SRH problems. By focusing on the client as a whole person by considering factors both inside and outside the clinic setting, health workers will be better able to assess and meet a client's needs. This will help HIV-positive women and adolescent girls make and carry out decisions more effectively.

Approach to Training

This curriculum presents counselling as a general service-delivery skill that relates to *all* areas of SRH. It emphasizes the client's comprehensive needs, the client's rights, and how the decision-making process is influenced by a combination of sociocultural, economic, personal, and service-delivery factors.

This core curriculum is intended to be supplemented by one-day modules that focus on the specific concerns and counselling needs of clients seeking particular services. These can be conducted immediately following the core curriculum or at some later time. Further in-depth training—whether on its own or in conjunction with this basic skills course—can be offered in substantive areas through the use of other curricula developed by EngenderHealth, the

International Community of Women Living with HIV/AIDS (ICW), UNFPA, and others. (See Appendix E, p. 165, for a list of these resources.)

Course Participants and Trainers

This curriculum can be used to train any SRH and HIV/AIDS health worker. The term *health workers* is used here to refer to the staff who provide clinical care, counselling, or other support services on-site or through outreach. A team of at least two trainers is necessary for this intensive workshop. As one trainer facilitates a session, the other(s) can record information on flipcharts, monitor time, help keep the discussion on track with the session objectives, monitor small-group work, and act in demonstration role-plays.

It is imperative for the trainers to have extensive experience either in counselling or in counselling training. Since this training is about “linking” different service areas, the trainers’ backgrounds should complement each other and (as much as possible) represent the range of services being covered in the training.

This manual is designed for use by skilled, experienced trainers. While the manual contains information to guide the trainers during a workshop and to assist them in making decisions that will enhance the learning experience, it is assumed that the trainers understand adult learning concepts and know how to employ a variety of participatory training methods and techniques and how to adapt materials to meet the participants’ needs.

Note: It is very likely that among the training participants will be some who are HIV-positive, suspect that they might be positive, or have (or had) friends or relatives who are positive. It is important to keep this in mind as the training is being conducted and be sensitive to these issues.

How to Use This Curriculum

Format

This curriculum consists of:

- an introduction for the trainers;
- detailed session guides;
- appendices containing additional training materials and programming tools.

The session guides in the curriculum have the following basic components:

1. **Objectives**—The objectives are the concrete, measurable behaviours that the participants should have adopted by the end of each session. These provide the basis for immediate outcome assessment and/or subsequent follow-up evaluations of the training.
2. **Time**—A guideline for the anticipated length of the session.
3. **Materials**—A list of materials needed to carry out the session.
4. **Advance Preparation**—Preparatory steps that the trainers should complete prior to conducting the session.
5. **Key Ideas to Convey**—A summary of relevant points that the participants should retain

from the session. (These should be conveyed during the session; the trainers can use these points to summarize at the end of each session.)

6. **Training Steps**—Detailed directions that guide the trainer on how to conduct the activities.
7. **Notes for the Trainer/Training Options**—These are additional suggestions on how to conduct activities.
8. **Participant Handouts**—These are prepared for use by the participants and are in Appendix C of this manual.
9. **Trainer’s Resources**—Some sessions have an additional handout, table, or figure for use by the trainer.

The appendices contain explanatory materials and tools that will help the trainers conduct the training activities as effectively as possible, as well as provide follow-up activities on how to design programme interventions that link SRH and HIV/AIDS. The appendices include:

- **Appendix A: Sample Four-Day Training Agenda.** The trainers can adapt this agenda according to the needs of their participants.
- **Appendix B: Pretest/Posttest Questionnaire for Trainees.** This self-assessment is designed to be administered at both the beginning and the end of the workshop. When it is given at the beginning of the workshop, the trainers can use the results to customize the training to best suit the participants’ level of knowledge and experience. When it is given at both the beginning and the end of the workshop, the trainers can use the survey to gauge how participants’ knowledge and attitudes changed over the course of the workshop.
- **Appendix C: Participant Handouts.** These handouts have the dual purpose of providing participants with information they will need to complete some of the training activities, as well as providing them with reference material on key topics. Copies of all of the resources can be distributed as a handbook, at the beginning of the training, or a particular handout can be distributed at the end of the relevant session.
- **Appendix D: Participant Evaluation Form.** The trainers should make, distribute, and collect copies of this form at the end of the training.
- **Appendix E: Additional Resources.** This appendix consists of a listing of Web sites and curricula available from EngenderHealth, ICW, UNFPA, and other organizations.
- **Appendix F: SRH Fact Sheets for HIV-Positive Women and Adolescent Girls.** This appendix is a collection of handouts adapted from ICW, the World Health Organization (WHO), and UNFPA.
- **Appendix G: Planning Programme Interventions That Link SRH and HIV/AIDS.** Contained in this appendix are activities for programme managers and health workers to help them plan and design SRH interventions for HIV-positive women and adolescent girls, including related worksheets and tools for exploring more fully the needs in their setting and how these can be met in the planning process.

Preparation for the Trainers

It is recommended that the trainers review the entire training resource (including the handouts and other accompanying materials) to get an idea of what types of sessions are offered and to understand the purpose, content, and approach of the training guide. Trainers can

then select the specific content areas and activities that are most appropriate to the needs of their training participants.

They should then meet with programme administrators at the institution requesting or sponsoring the training. Administrators at the service sites that requested this training should be aware of its goals, objectives, and intended audience. Together, the trainers and administrators should clarify the purpose of the training and confirm the time committed for the training.

During this visit, the trainers should:

- identify the specific areas of SRH and the community groups or client populations to be emphasized in the training;
- identify and schedule follow-on modules or more in-depth content trainings that would best meet the training and service-delivery needs of the participants;
- agree on steps for follow-up to training, with timing and responsibility assigned (i.e., to the trainers or to programme supervisors);
- identify which *health workers* will be included, so that a representative sampling of skills and services will be covered;
- identify which *programme managers* will attend the trainings, or plan for a separate workshop to specifically address their needs (Not all sessions need to be attended by supervisors or administrators.);
- identify which *programme managers* and staff will attend the two-day programme planning workshop (described in Appendix G, p. 185).

Try to visit the service site before the workshop is to take place. Before the training, trainers should have a thorough understanding of the participants' backgrounds (including previous counselling training, if any), work assignments, and training needs. It is recommended that trainers observe the participants at work and note the current status of SRH and HIV/AIDS service provision in their facilities. In addition, trainers should talk with the participants to find out their experience with SRH and/or HIV/AIDS service provision, asking specific questions related to their level of knowledge and attitudes.

Cross-Cultural Adaptability

This training manual is intended for a wide variety of cultural settings. Therefore, trainers are encouraged to adapt the sessions, including case studies and role-play suggestions, to reflect the needs of the participants and the norms of the local setting. These adaptations could be as simple as changing case-study characters' names, or they may be as complex as developing a new series of role-play suggestions or even brand-new exercises.

Gender and HIV/AIDS

This training manual recognizes that inequalities between women and men, as well as different norms for women's and men's sexual behaviour, affect the SRH of HIV-positive women and adolescent girls. In addition, the curriculum explores ways in which violations of HIV-positive women's sexual and reproductive rights impact on their ability to access

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care, treatment, and support. Integrated throughout the manual is an overall philosophy of empowering women and promoting male involvement, to reduce the social, gender, cultural, economic, and legal barriers to effective SRH care of HIV-positive women and adolescent girls.

Objectives

- Officially welcome all participants and introduce the participants, any guests, and trainers.
- Describe the purpose and agenda.
- Create a set of “ground rules” or “group norms” by which the group and trainer(s) agree to work throughout the training.
- Explore the participants’ expectations.
- Administer the pretest questionnaire.

Time

90 minutes

Materials

- copies of the daily agenda;
- a flipchart showing the daily agenda (optional);
- copies of the four-day agenda (Appendix A, with any changes for current training based on adapting it to meet participants’ needs);
- copies of the pretest questionnaire (Appendix B).

Advance Preparation

1. Any guest speakers should be thoroughly briefed in advance, to explain the purpose of the training and to be clear about the length and subject desired for their opening remarks.
2. Prepare and photocopy the four-day training agenda for all guests and participants. It is also helpful to have the daily agenda written up on a flipchart and posted on the wall throughout the day. It might be preferable to leave out the precise times for the activities, so the trainers can have flexibility, as needed.
3. Prepare and photocopy the pretest questionnaire for the number of participants in the group.

Key Ideas to Convey

- Everyone in this training comes with experience that is valuable to the process. While we intend to provide and review some information and skills, these four days will be an interactive process during which we will learn from each other, not just from the trainers.

- HIV and AIDS affect all of us in the community. It is highly likely that among the trainers, participants, and their friends and families, there are people who are HIV-positive. It is important to keep this in mind throughout the training. Anyone who chooses to identify as positive is free to do so. Reassure the group that this is a safe and confidential environment, and disclosure should never go beyond the group.
- The overall purpose of this training is to prepare participants to provide SRH services for HIV-positive women and adolescent girls in an effective, comfortable, client-centred fashion. We will do this through a combination of information-sharing, role-playing, and small- and large-group processes to create an interactive learning environment. The days will build on each other, so it is vital that everyone commits to staying through all four days.
- By focusing on the client as an individual with rights, and by considering factors both inside and outside the clinic setting, including gender dynamics, health workers will be better able to assess and meet a client's needs.

Training Steps

1. A representative of the local “host” organization formally opens the training by welcoming the participants, explaining the purpose of the training, and introducing the trainers.
2. After this, the trainers should go around the room and have each participant *briefly* state his or her name, clinic, and job title, the number of years each has been working in this field, and *one thing* (emphasize and stick to the request for one thing only) he or she hopes to gain from participating in this training. Record these ideas on a flipchart and post it. (You may refer back to the list during the last day's closing session.)
3. One trainer will provide an overview of the training by reviewing the goals and overall objectives for the workshop. (For reference, see the Introduction, pages xiii–xviii, for the training goals and background on why this curriculum was developed. The trainer's comments can be drawn from this, depending on the background and interests of the participants.) The trainers can then distribute the agenda for Day 1 and go through it with the participants. Respond to any questions about the day or about the four-day programme.
4. Create a set of ground rules or group norms with the participants. A trainer can ask whether anyone in the group has been to a workshop before, and if so, whether they developed ground rules or group norms at the beginning. If so, have the participant explain the purpose of ground rules. If not, explain why ground rules are set up:
 - to create a safe learning environment for everyone involved;
 - to have written expectations of how the group will work together during the training;
 - to help facilitate meeting the training's objectives.
5. Ask the group to brainstorm ground rules and write these on a flipchart. Suggested ground rules include:
 - Show respect, especially for differences of opinion.

- Speak one at a time, so that we can all hear what everyone else is saying.
 - Avoid side conversations, because they distract people around you from hearing what someone else is saying.
 - Start and end on time.
 - Use “I” statements when expressing your opinion. For example, try saying “I believe...” instead of “We all believe...”.
 - If possible, participate fully and equally. Mention the participants’ right to “pass” (i.e., if people feel uncomfortable with something, they can choose to “pass” from participating in the discussion).
 - Promise confidentiality. (Even though this will have been discussed during the introductory session, it is a good idea to have it on the ground rules list.)
 - Have fun. (This is important: Let the participants know that while they will be discussing very serious topics, they will be doing so in a dynamic way, so the hope is that everyone will have fun while working together.)
 - Have the right to make mistakes and recognize them.
6. Distribute the pretest (which appears in Appendix B, p. 95), briefly point out the different sections, and ask if the participants have any questions. Give the participants 30 minutes to complete the test, with time checks at 10 minutes and 20 minutes. (In field tests of this curriculum, some participants were not able to complete the pretest in 30 minutes, but all were able to finish the posttest in that time.)
7. After collecting the pretests, explain that group scores will be announced the next day. You will not be reviewing the test questions, but all of the necessary information to answer these questions should be covered during this training workshop. The pretests themselves will be returned at the end of the training, after the participants have taken the posttest, so they can compare their own scores before and after the workshop.

Basic HIV and AIDS Information

2

Objectives

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

- explain trends in HIV/STI transmission in the local context and the implications of these trends for women, their children, and their partners;
- describe the basic information pertaining to HIV transmission and HIV disease progression.

Time

30 minutes

Materials

- Participant Handout 2.1: Basic HIV and AIDS Information, p. 104
- flipchart paper
- markers
- masking tape
- a collection of background information about the HIV and AIDS situation in your local context

Advance Preparation

1. **Important:** Trainers will need to assess the training group's level of knowledge regarding HIV, AIDS, and STIs prior to structuring this exercise. Trainers will also need to supply the participants with factual information about HIV, AIDS, and STI trends and patterns in the local context (particularly those pertaining to women and adolescent girls) from local sources of information on HIV/STI prevalence and HIV/STI risk behaviours/attitudes, such as ministries of health, nongovernmental organizations that focus on AIDS, or other local groups. Information can also be obtained from Web sites such as those of UNAIDS (www.unaids.org), WHO (www.who.org), or UNFPA (www.unfpa.org).
2. If possible, the participants should receive the background information at least one week before the workshop so they can familiarize themselves with the content. If this is not feasible, give the background information to the participants at the beginning of the workshop and instruct them to read it in their spare time.
3. Make a copy of the factual information about HIV and STIs for each participant from the resources that you identified.

Key Ideas to Convey

- Information about HIV and AIDS is subject to change as scientists discover new details about the infection and treatment process. As health workers, it is important to keep up with information, to respond to clients' questions as accurately as possible.
- It is essential that health workers understand the key concepts about HIV, AIDS, general transmission of HIV, specific transmission of HIV in women, mother-to-child transmission (MTCT), the important link between HIV and other STIs, and HIV disease progression.
- It is important for health workers to understand local HIV and STI transmission patterns and how they may directly affect women, their children, and their partners.
- Practising how to convey factual information about HIV/STI transmission and prevention can help health workers feel more comfortable when they work with such clients on these issues, as well as reinforce health-seeking behaviours.
- Grasping the basics of HIV transmission and disease progression will help health workers understand the rationale for integrated SRH and HIV/AIDS services

Training Steps

Activity A: Presentation (30 minutes)

1. Tell the participants that you will provide them with some basic information about HIV transmission and HIV disease progression.
2. Give the participants a short presentation on the basics of HIV and AIDS. Cover the points in the Participant Handout 2.1: Basic HIV and AIDS Information, p. 104).
3. Distribute copies of the factual information about the local situation for HIV and STIs to each participant.
4. Provide the participants with a summary of the key points to convey.

Notes for the Trainer/Training Option

If feasible and appropriate, invite an outside expert on HIV, AIDS, and STIs to provide a short presentation on the basics.

If the basic HIV and AIDS knowledge of the group is high, consider conducting the session as an ice-breaker or game to reinforce what the participants already know. For example, review the Participant Handout and develop 7–10 key questions for the participants to answer. Provide a small prize to the participant who gives the best answer for each question.

Exploring Beliefs, Values, and Attitudes about HIV and AIDS

3

Objectives

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

- describe their beliefs and values about a range of potentially sensitive issues related to HIV and AIDS;
- share the diversity of opinions within the group;
- demonstrate awareness of how their own beliefs/values influence their attitudes regarding HIV and AIDS and how these might impact their work;
- explain ways to remain neutral while working with clients, even if they have beliefs and values that differ from those of the clients.

Time

90 minutes

Materials

- flipchart paper
- markers
- masking tape

Advance Preparation

1. Prepare two pieces of flipchart paper by writing “Agree” on one of them and “Disagree” on the other.
2. Post the “Agree” and “Disagree” signs on opposite sides of the room, or on one large wall, a few body lengths apart.
3. Select 4–6 statements from the list of belief statements that will stimulate discussion in the local setting (see samples in Trainer’s Resource 3.1, p. 10, at the end of this session) and/or create new statements, depending on the needs and particular interests of your training group.
4. Arrange the training room so that there is adequate open space for participants to assemble near the “Agree” and “Disagree” signs.

Key Ideas to Convey

- Anyone can get HIV; therefore, we should not make assumptions about who may or may not be HIV-positive.
- People living with HIV are entitled to make their own reproductive decisions, free of coercion.

- People living with HIV have the right to a safe and satisfying sex life and to a full range of SRH services.
- Universal or standard precautions¹³ are the best way to ensure prevention of HIV transmission in a clinical setting and can help decrease health workers' and clients' fears about HIV transmission.
- It is unethical to test a person for HIV without his or her consent, to withhold the results, or to not provide adequate pretest and posttest counselling. (Session 11 addresses HIV disclosure issues.)
- Health workers have a professional obligation to remain objective and nonjudgemental with clients and to avoid letting their personal beliefs, values, and attitudes become barriers to providing compassionate and quality care to HIV-positive clients or those perceived to be HIV-positive or at risk.
- There is no justification for asking job applicants or workers to disclose their HIV status or require an HIV test. The International Labour Organization states in its Code of Practices that: "In the spirit of decent work and respect for the human rights and dignity of persons infected or affected by HIV/AIDS there should be no discrimination against workers on the basis of real or perceived HIV status".¹⁴

Training Steps

Activity A: Large-Group Activity (45 minutes)

1. Explain that this exercise will help us understand viewpoints that are different from our own, and to consider how these beliefs and attitudes about HIV and AIDS might affect the way we treat clients. State that for the purpose of this exercise, there are no "right" or "wrong" answers, and we are all entitled to our own opinions. However, as this training workshop will emphasize, health workers have a responsibility to ensure that these beliefs and attitudes do not infringe on clients' rights or compromise provision of quality care. This exercise will help reveal the range of different views.
2. Ask participants to gather in the centre of the open area. Direct their attention to the "Agree" and "Disagree" signs.
3. Explain that you will be reading a series of value statements. After you read a statement aloud, the participants will decide whether they agree or disagree with the statement. Those who agree will move and stand by the "Agree" sign. Those who disagree will move and stand by the "Disagree" sign. Let participants know that if they hear something that causes them to change their opinion during the course of the activity, they may move from one area of the room to another.

¹³ Universal or standard precautions are simple infection control measures that reduce the risk of transmission of blood-borne pathogens through exposure to blood or body fluids among patients and health care workers. Under the "universal precaution" principle, blood and body fluids from all persons should be considered as infected with HIV, regardless of the known or supposed status of the person (WHO. 2006. Universal precautions, including injection safety. Geneva. Retrieved 14 September 2006 at: www.who.int/hiv/topics/precautions/universal/en/).

¹⁴ International Labour Organization. 2001. An ILO code of practice on HIV/AIDS and the world of work. Geneva. Retrieved 26 June 2006 at: www.ilo.org/public/english/protection/trav/aids/publ/codelanguage.htm

4. Read a statement out loud. Ask 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” or “Disagree”) to explain why they have chosen to stand where they are.
5. The trainer remains neutral, by not offering interpretations for the statement that would influence participant responses. However, he or she can share factual information to clarify matters, as needed. After hearing a representative from each position, give participants the option of switching positions if they wish. When participants move, ask them what prompted their decision to change position.
6. Repeat this process until you have posed all of the statements that you wish the group to consider.

Activity B: Discussion (15 minutes)

1. Ask the participants to return to their seats for a group discussion. Facilitate a discussion to explore differences of opinions and values more deeply, based on the following questions:

(*Note:* If time is limited, prioritize the questions you will use.)

- How did you feel during this exercise? What was it like for you?
- Were there any opinions or values expressed that surprised you?
- Which statements were the most controversial? Why?
- How can you explain the differences among individuals in this group?
- How did you feel when other people expressed values and beliefs that were the same as yours? Different from yours?
- Would an HIV-positive client at your facility have a different opinion about these issues?
- Would an HIV-positive employee at your facility have a different opinion about these issues?
- Why is exploring these issues important?
- How might attitudes and beliefs affect the way you behave toward or treat clients?
- How do fears about HIV and biases against people living with HIV or those perceived to be HIV-positive, or at risk, influence our beliefs, attitudes, and actions?
- How can we keep our own beliefs and attitudes from influencing our work in a negative way?
- How might you address some of these difficult issues at your health care facility?

2. Provide the participants with a summary of the essential ideas to convey.

Select four to six belief statements (from the following list of options) that will stimulate discussion.

- It is permissible to isolate patients living with HIV in a separate ward.
- Patients who are HIV-positive should be treated the same as other patients.
- Since there is little we can do for a patient with AIDS, it is better to spend time and limited resources on patients with treatable illnesses.
- It is permissible to reveal the HIV status of a patient to his or her spouse or close relatives.
- A health worker should be much more careful of needle-stick injuries or other potential exposure with a client who is a sex worker than with a monogamous married woman.
- Health staff should routinely be tested for HIV as a means to prevent staff from transmitting HIV to clients.
- Health staff should have the right to refuse to provide services if materials they need to apply universal precautions are not available.
- HIV-positive staff should make their HIV status known to their colleagues.
- Doctors and nurses living with HIV should not be allowed to care for patients.
- An HIV-positive woman should not have a baby.
- People who get HIV through sex deserve it because of their behaviour.
- People who get HIV through injecting illegal drugs deserve it because of their behaviour.
- If a health worker is afraid of getting HIV from a patient, he or she should have the option not to see that patient.
- If HIV testing is available, health workers have a right to test their clients for HIV so they know the HIV status of the clients they treat.
- If a woman comes in who says that she uses drugs, you should expect that she is HIV-positive.
- It is okay to refer to a person's HIV status out loud, within earshot of other clients and health workers in the health setting.
- If an HIV-positive woman has already had four children, she should be sterilized.

Basic Counselling Skills and Approaches

4

Objectives

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

- describe basic communication skills of an effective counsellor;
- describe REDI, a framework for integrated SRH counselling;
- identify which elements of this counselling framework the participants are already doing, which would require more training, and which would encounter barriers at their work sites;
- explain the importance of applying counselling frameworks to each client's unique situation;
- explain the importance of addressing the context for decision making in integrated SRH counselling;
- describe how integrated SRH counselling supports informed and voluntary decision making by clients.

Time

90 minutes

Materials

- flipchart paper
- markers
- masking tape
- Participant Handout 4.1: Communication Skills of an Effective Counsellor, p. 106
- Participant Handout 4.2: Overview of REDI Counselling Model, p. 109

Advance Preparation

1. Prepare a flipchart with the following definition of integrated SRH counselling:

Integrated SRH counselling is a two-way interaction between a client and a health worker, to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service they are working within or what service the client has requested.

2. Prepare a flipchart with the three questions for the REDI tables (see Activity B, Step 1).
3. Prepare four flipcharts, one for each phase of REDI, showing the steps for each phase and including columns for checking off the current status of that step (Activity B, Step 2). See Trainer's Resource 4.1: REDI Stages, p. 14.

Key Ideas to Convey

- The REDI framework (REDI stands for Rapport-Building, Exploration, Decision Making, and Implementing the Decision) is useful for integrated SRH counselling: It emphasizes the client’s responsibility for making a decision and for carrying it out; it provides guidelines for considering the client’s sexual relationships and context; and it addresses the challenges that a client may face in carrying out this decision by offering skills development to help clients meet these challenges.
- REDI provides a useful framework, but this does not mean that it must be followed exactly or in sequential order during a counselling session. Frameworks can be helpful to health care workers in giving you a structure for talking with the client, so that you do not miss important steps.
- Whatever framework is used for counselling, it is important to personalize counselling sessions. By personalizing the discussion and applying it to the client’s specific situation, you can help clients to perceive their own risk and vulnerability, rather than think of unintended pregnancy or HIV and AIDS as “things that happen to other people”.
- During client-centred counselling, avoid overloading clients with unnecessary information. To do this, you should first examine the client’s situation and then tailor the session to meet her and her partner’s needs.
- Understanding and exploring the context of decisions is critical to helping clients determine their risk and vulnerability and make realistic decisions about their SRH needs. This also includes anticipating the outcomes of decisions, such as whether a decision (e.g., suggesting condom use with a partner) could lead to violence.

Training Steps

Activity A: Brainstorm/Discussion (20 minutes)

1. Ask the participants to name as many communication skills of a good counsellor as they can. Write their suggestions down on flipchart paper. After 10 minutes, briefly review the communication skills of a good counsellor—Participant Handout 4.1, p. 106—noting which skills the group had identified on the flipchart and highlighting which skills the group had not mentioned.
2. Divide the participants into **four** groups. (If this requires the participants to move, ask them to take their handbooks, notepads, and pencils or pens with them.)
3. Introduce the exercise by telling the participants that they will now examine a counselling framework for integrating FP, sexuality, HIV and STI prevention, treatment, and care, maternal health care, postabortion care, counselling, etc.
4. Emphasize that in all counselling, the client is more important than the framework. During the following exercises and discussions, they should keep in mind that frameworks can be helpful to health workers in giving them a structure for talking with the client, so they do not miss important steps. However, the framework is only good if it allows them to attend to the individual client’s unique needs and concerns.

5. Refer the participants to Participant Handout 4.2, p. 109, and ask them to find the description of REDI. Briefly review the phases and steps. Note that the REDI framework is designed for integrated SRH counselling because:
 - It emphasizes the client’s rights and responsibility for making a decision and for carrying it out.
 - It provides guidelines for considering the client’s sexual relationships and context.
 - It addresses the challenges that a client may face in carrying out this decision and offers skills development to help clients meet these challenges.
6. Post the flipchart with the definition of integrated SRH counselling and ask the participants if they agree with the definition or if they have any suggestions/additions to make the definition clearer.

Activity B: Small-Group Activity (20 minutes)

1. Post the flipchart with the following questions for small-group work. Explain that each group will consider one phase of REDI and answer the questions for each step:
 - Which steps are you already doing in your counselling?
 - Which steps would require further training, whether for knowledge, for skills, or for making health workers more comfortable? (Further training might also be considered useful for steps that they are already doing.)
 - Which steps would be challenging to implement, and why?
2. Assign one phase of REDI to each of the four groups, and distribute the separate prepared flipchart sheets accordingly (see below).
3. Ask the participants to refer to the more detailed version of REDI on their handout for a better understanding of each step.
4. Explain to the participants that for each step, they should review the description in Participant Handout 4.2, consider these questions, and check any boxes in the table that apply to their work setting. It is possible that they may check more than one box—or all three boxes—for some steps. If there are different opinions within the group, put a question mark in the box.
5. Ask each group to choose one member to fill in the table for their group and one member who report back on behalf of the group.
6. Give the groups 15 minutes to complete their tables. Check each group quickly to ensure that they understand the instructions. If some groups finish earlier, they can go on to other phases of REDI and discuss their answers to those questions among themselves.

4.1 Trainer's Resource

REDI Stages

REDI Stages	Already doing	Need training	Challenges anticipated
Rapport-building			
1. Welcome the client			
2. Make introductions			
3. Introduce the subject of sexuality			
4. Assure confidentiality			
Exploration			
1. Explore the client's SRH needs, including sexual health, risks, context, and circumstances			
2. Assess the client's knowledge and give information, as needed			
3. Assist the client to perceive or determine her fertility intentions, and her STI risk or risk for HIV reinfection.			
Decision making			
1. Identify what decisions the client needs to make			
2. Identify the client's options for each decision			
3. Weigh the benefits, disadvantages, constraints and consequences for each			
4. Encourage the client to make his or her own decision, recognizing limitations beyond the control of the client			
Implementing the decision			
1. Make a concrete and specific plan for carrying out the decision			
2. Identify skills that will be needed by the client			
3. Practise skills, as needed, with the provider's help			
4. Make a plan for follow-up			

Activity C: Plenary/Discussion (50 minutes)

1. Starting with “Rapport-building”, ask each group reporter to post the group’s flipchart, corresponding to the phase of REDI it was assigned, and explain the group’s findings. If there is any missing information, ask for a brief explanation. Also ask for a brief (five-minute) explanation of “challenges”. (20 minutes for all four groups)
2. Ask the participants what they learned from this exercise. (5 minutes)
3. Facilitate a discussion by asking the following questions. (15 minutes)
 - How does this framework ensure that the counselling is client-centred?
 - How much time do health workers in your facility generally spend counselling each client? Do you think this framework helps health workers to work within this time-frame? Do you think health workers can save time with this framework? If yes, how? If no, why not?
 - How does the framework address the “context” of clients’ decisions?
 - How does this framework ensure a client’s informed and voluntary decision making?
4. Ask if the participants have any further comments or questions.
5. Emphasize that they will spend the rest of the workshop developing and practising counselling skills, addressing the attitudinal challenges for health workers in integrated SRH counselling, and identifying key information needed in each area of service delivery.
6. Provide the group with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

Participants should note that they are already doing many of the steps of integrated SRH counselling. The steps for which they feel they need more training may be beyond the scope of this training. However, the trainers can share these anticipated challenges with participants’ supervisors or programme managers (who may be participating in this workshop or a separate orientation), and this can become part of training follow up.

Sexual and Reproductive Health Vulnerability of HIV-Positive Women and Adolescent Girls

5

Objectives

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

- define the terms sex, gender, sexuality, sexual health, and reproductive health (RH);
- explain the difference between sex and gender;
- list and explain at least three causes and consequences of SRH problems of HIV-positive women and adolescent girls at various life stages;
- describe the biological, social, cultural, economic, gender, and political factors that increase the SRH vulnerability of HIV-positive women and adolescent girls at various life stages.

Time

90 minutes

Materials

- flipchart paper
- markers
- masking tape
- pieces of paper or cards, 8¹/₂ x 11 inches (or A4) in size
- two pads of 3 x 4 inch self-adhesive notes (commonly referred to as “Post-Its”), if available—one pad of pink and one pad of light blue
- Participant Handout 5.1: Key SRH Concepts and Definitions, p. 113

Advance Preparation

1. On separate pieces of flipchart paper, write each of the following:
 - Sex
 - Gender
 - Reproductive Health
 - Sexual Health
 - Sexual and Reproductive Rights.
2. On pieces of 8¹/₂ x 11 inch or A4 paper (or cards), write each of the following age-groups:
 - infants and young girls (0–9)
 - adolescent girls (10–14)
 - young women (15–24)
 - adult women (25–40)
 - older women (over 40)

Tape each piece of paper in a row on one of the walls. Ensure that there is enough space between each one to allow for participants to tape their responses under each category.

3. Write the following questions on separate pieces of flipchart paper:
 - What kinds of SRH problems do HIV-positive women and adolescent girls experience at this stage of their life?
 - What are the underlying biological, social, cultural, gender, and political factors that contribute to the SRH problems of HIV-positive women and adolescent girls?
 - What are the consequences of these problems for women and adolescent girls living with HIV?

Key Ideas to Convey

- Definitions of sexual health and RH overlap. The International Conference on Population and Development (ICPD) Programme of Action¹⁵ is the major international consensus document that elaborates RH and reproductive rights. ICPD Paragraph 7.2 states “reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so”.
- The ICPD Programme includes sexual health under the definition of RH. Thus, by implication, rights related to sexual health are covered by the definition of reproductive rights. In reality, sexual rights have been subsumed under reproductive rights, making it more of a challenge to promote and protect these rights, particularly for women, youth, and marginalized populations (e.g., people living with HIV/AIDS, sex workers, injecting drug users [IDUs], men who have sex with men, and migrants).
- The term “vulnerability” is considered more appropriate than “risk” because it includes root causes that are largely beyond the scope of the individual to change simply through individual behaviours (e.g., economic, social, cultural, political, gender, and other structural factors that contribute to HIV/STI transmission, progression of HIV illness, unintended pregnancies, and SRH problems).
- In many cultures, inequitable gender relations result in a lack of power among women and girls at all stages of life, which prevents them from protecting themselves from SRH problems, even if they are aware that their partner’s behaviour may be putting them at risk.
- Some women and girls are also sexually abused, sexually exploited, raped, and subject to incest. Since these acts are about control and power, health workers also need to be sensitive to the needs of women and girls who are in situations over which they have no control.
- HIV-positive women and their children, some of whom may themselves have been infected through perinatal transmission during pregnancy, labour, delivery, or breastfeeding, also suffer from the consequences of stigma and discrimination, including poverty,

¹⁵ International Conference on Population and Development (ICPD). 1994. *Programme of Action*. Cairo. Retrieved 31 August 2006, at: www.unfpa.org/icpd/icpd_poa.htm.

isolation, ill health, and violence. Their access to care and support is sometimes delayed or limited, and some get no care or support, since family resources in the case where both partners are living with HIV are mainly devoted to caring for the man and for the children. In addition, if a woman is rejected by her family and community, her children may be left without caretakers if she dies.

- All of these factors increase the vulnerability of HIV-positive women and adolescent girls to SRH concerns, ranging from STIs/RTIs to unintended pregnancies and to unsafe abortions.
- It is important to encourage men's involvement in SRH so men adopt safer sex practices and prevent unintended pregnancies, thereby removing some of the burden from women.
- Health care workers alone cannot address the root causes of SRH problems; however, general awareness of these root causes will help health workers better understand the context of their clients' lives.
- Health care workers can help create a safe and supportive environment for HIV-positive women and adolescent girls to explore ways to have safe and healthy pregnancies and reduce their risk for unintended pregnancies and STIs/RTIs.

Training Steps

Activity A: Brainstorm/Discussion (30 minutes)

1. Ask the participants to define the term “sex”. (*Note:* Clarify that you are not referring to specific sexual practices such as sexual intercourse, oral sex, etc.) Write down their ideas on the piece of flipchart paper marked “sex”. After a few minutes, ask them to define the word “gender”, writing down their ideas on another piece of flipchart paper with “gender” at the top. Repeat the same process for the terms “sexual health” and “reproductive health”. Tape all of the pieces of flipchart paper on the wall so all can see them.
2. Referring participants to Participant Handout 5.1: Key Concepts and Definitions, p. 113, explain that the handout has a more complete list of terms, and review the definitions for the following terms (*Note:* Tell the participants that a later session will explore sexual and reproductive rights):

Sex concerns the biological differences between men and women. Human beings are born male or female with different reproductive capacities; these are called sex differences.¹⁶

Gender involves how an individual or society defines “female” or “male”. Gender roles are socially and culturally defined attitudes, behaviours, expectations, and responsibilities for males and females. Gender identity is the personal, private conviction each of us has about being male or female; it defines the degree to which each person identifies himself or herself as male, female, or some combination of the two.¹⁷

¹⁶ EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum. Participant Handbook*. New York, p. 6.

¹⁷ *Ibid.*; see also: UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS. 2006. *Resource pack on gender and HIV/AIDS*. Retrieved 26 June 2006 from www.unfpa.org/publications/detail.cfm?ID=279&filterListType=1.

Sexuality is the way in which an individual experiences being male or female. This includes physical and biological aspects of one's life (e.g., menstruating, being pregnant, or having sexual intercourse), as well as emotional aspects (such as having feelings for another person) and social aspects (such as behaving in ways that are expected by one's community, based on whether one is male or female; this includes gender roles).¹⁸

Sexual orientation describes the general groups to which a person may be sexually attracted. Heterosexuality is an erotic or romantic attraction to people of the opposite sex. Homosexuality is an erotic or romantic attraction to people of the same sex. Bisexuality is an erotic or romantic attraction to people of both sexes.¹⁹

Reproductive health is a state of complete physical, mental, and social well-being, and is not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people have the capability to reproduce and the freedom to decide if, when, and how often to do so (ICPD, Paragraph 7.2).²⁰ It is based on the recognition of the basic right of all couples and individuals to decide freely and responsibly on the number, spacing, and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents (ICPD, Paragraph 7.3).²¹

Sexual health includes aspects of sexuality not necessarily related to reproduction. It recognizes the fact that people may have sex for the purpose of pleasure, not just reproduction, and that people have health needs related to such sexual activity. Attaining sexual health means having a responsible, satisfying, and safe sex life. Achieving sexual health requires a positive approach to human sexuality and mutual respect between partners. By recognizing sexual health—and sexual rights—health and education systems can help prevent and treat the consequences of sexual violence, coercion, and discrimination, and can ensure that healthy human sexuality is enjoyed by all people and is accepted as part of their overall well-being.²² The UN agencies adhere to the ICPD Programme of Action, which subsumes sexual health under reproductive health. The Programme of Action states that reproductive health implies that people are able to have a satisfying and safe sex life (ICPD, Paragraph 7.2).

¹⁸ EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum. Participant Handbook*. New York, p. 6.

¹⁹ Ibid.

²⁰ ICPD. 1994. *Programme of Action*. Retrieved 26 June 2006 from: www.unfpa.org/icpd/icpd_poa.htm#ch7.

²¹ Ibid.

²² EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum. Participant's Handbook*. New York, p. 7.

Sexual and reproductive health. Definitions of sexual health and RH overlap. To avoid confusion and to ensure that all areas are covered, many health workers, planners, and policymakers now use the term “sexual and reproductive health”, which refers to everything included in both sexual health and RH. This term can refer to a state of health and well-being, types of services, or an “approach” to service delivery. The UN agencies adhere to the ICPD Programme of Action, which subsumes sexual health under RH.²³

3. Facilitate a short group discussion with the following questions:
 - Do any of these definitions surprise anybody? If so, ask why.
 - What are the differences between the definitions people came up with compared with the ones provided?

Activity B: Small-Group Activity (40 minutes)

1. Divide the participants into four groups and assign one of the four life stages to each group. Provide each group with pieces of paper and different coloured markers.
2. Refer the participants to the questions on the flipchart paper and instruct them to discuss these in their small groups as they apply to the life stage they were given. Ask them to write down on pieces of paper as many SRH problems, causes, and consequences of the SRH vulnerability of HIV-positive women and adolescent girls.
3. **Problems:** Ask them to first brainstorm what SRH problems HIV-positive women and adolescent girls have at their assigned stage of life. Examples include:
 - lacking information;
 - having trouble negotiating condom use;
 - having low self-esteem;
 - lacking autonomy in sexual and reproductive decision making;
 - being stereotyped as “sexually immoral” or “promiscuous”;
 - being assumed to be sex workers;
 - facing challenges around HIV disclosure (to partner, to family, to parents, to children, to co-workers, etc.);
 - contracting STIs/RTIs;
 - having unintended pregnancies;
 - lacking access to HIV/AIDS care, treatment, and support services;
 - not knowing they are HIV-positive;
 - being coerced into having abortions;
 - getting cancer;
 - not knowing that they can have safe and healthy pregnancies;

²³ Ibid.

4. **Causes:** Ask the participants to brainstorm the causes of SRH problems for HIV-positive women and adolescent girls. Explain that a cause could range from the personal to the community and societal levels, as well as to the biological level (e.g. “lack of control over sexual life and inability to negotiate condom use”, “biological vulnerability”, “not knowing they are at risk”, “cultural taboos about sex”, “exchanging sex for money or financial support due to poverty”, etc.). Tell the small groups that for each factor, they should “dig deeper” to explore additional subfactors or causes. For example, the factor of “cultural taboos about sex” might be “cultural traditions about abstinence or decreased sexual activity during their partner’s period of pregnancy or postpartum”, “acceptability of male partners’ having multiple partners during pregnancy and postpartum”, “gender inequities”, or “men’s objectification of pregnant women”. Going deeper, the causes of “abstinence” might be “cultural policies”, “lack of gender policies”, “legal restrictions on women’s rights”, or “religious traditions”.
5. **Consequences:** After the problems and causes have been identified, ask the participants to brainstorm the consequences of these problems. Encourage the participants to think of consequences or results at different levels (the family, the health care system, the individual, the societal, the national, the economy, etc.). For example, some of the consequences may be “Women are getting sick and seeking treatment”, “Women are dying”, “Babies are getting infected”, “Women are getting forced out of their homes and ostracized”, or “Women are being blamed for infecting male partners, sometimes leading to violence”. As with the “root causes”, the small groups should examine each consequence and determine if other consequences may result from that particular problem. For example, some consequences of “Women are dying” might be “Children are becoming orphaned”, “Communities are losing valuable members”, and “Families are losing sources of support”.
6. After 30 minutes have passed, direct the groups’ attention to the four charts on the wall with the different life stages written on them. Ask the groups to tape their pieces of paper with the problems, causes, and consequences they identified on the wall under the life stage they were given to discuss.

Activity C: Discussion (20 minutes)

1. Ask the participants to walk around and read the other groups’ root causes and consequences taped on the wall.
2. While the participants are still standing in front of the wall, facilitate a discussion based on the following questions:
 - How do you view the SRH problems of HIV-positive women and adolescent girls now that we have done this exercise?
 - How does gender inequality contribute to these problems?
 - Do the causes and consequences differ at various life stages?
 - Which of the causes do you think it is possible for us to address in our work?
 - How, if at all, do you think addressing the “causes” will affect the “consequences”?
 - How can we address the consequences through our work?
 - Does it make sense to address consequences without addressing the causes?
3. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

The following are some alternative activities:

- * As an alternative to Activity A: Put up two flipcharts on the wall—one labeled “female”; one labeled “male”. Have each person in the group mention one activity or aspect that is generally considered “female” or “male”. Write each one on a pink or a blue self-adhesive note (e.g., in the United States, the colour pink conventionally represents “female”, and light blue represents “male”) and stick it to the appropriate flipchart paper. After going around the room twice (or three times, as time allows), stop and read each note. Decide, as a group, whether the attribute is sex-based or gender-based (e.g. “having a baby” might be considered sex-based; “liking to shop” would be gender-based). Discuss the differences and the stereotypes that may be involved in gender-based assumptions.
- * As an alternative to Activity B: Begin each small group with one age-group to identify the problems on a flipchart. Then switch age-groups for each small group to identify causes; rotate again to consider the consequences. Repeat until each small group has discussed more than one age-group at least once.

Addressing HIV and AIDS Stigma and Discrimination in the Health Care Setting

6

Objectives

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

- describe the difference between stigma and discrimination;
- describe the types of stigma that HIV-positive women and adolescent girls experience;
- explain how stigma related to HIV and AIDS impacts the ability of HIV-positive women and adolescent girls to access health services;
- describe at least two ways of addressing stigma and discrimination within the health care setting.

Time

90 minutes

Materials

- flipcharts
- Trainer's Resource 6.1, p. 29
- Trainer's Resource 6.2, p. 30

Advance Preparation

1. Write the definitions of stigma and discrimination found in Trainer's Resource 6.1, p. 29, on flipchart paper.
2. Refer to Trainer's Resource 6.2, p. 30, and preselect 4–5 scenarios for small-group role-plays, based on the number of participants in your group.

Key Ideas to Convey

- Stigma and discrimination in the community and family can prevent HIV-positive women and adolescent girls from accessing health care facilities (e.g. for fear of being seen by the neighbours at a clinic designated for HIV, or accessing health services in general if one is not pregnant if this is not the norm).
- Stigma and discrimination can also keep HIV-positive women and adolescent girls from acting on health advice and treatment given (for fear of neighbours/families/partners guessing their status).
- Stigma and discrimination within the health care setting, which often manifest themselves in biased attitudes or refusal to provide services, is a direct violation of the right of HIV-positive women and adolescent girls to nonjudgemental and quality services.
- Gender stereotypes sometimes subject HIV-positive women and adolescent girls to greater stigma than men. For example, the association of HIV with promiscuity and so-

cial misconceptions about women’s sexuality lead to discrimination when they try to seek contraceptive or antenatal care services.

- In countries where antenatal care clinics are the main location for HIV testing, women tend to find out their status before their male partners and may be blamed for “bringing HIV into the family”. In some societies, men’s reluctance to seek health care increases this tendency for women to test (or be tested) and disclose first.
- Gender inequality can leave women more vulnerable to being forced into early and involuntary disclosure. For example, they may have to seek permission or financial support from male family members or partners to access services.
- Tapping into male responsibility for the prevention of HIV infection can be a powerful asset in prevention programming: “Men are involved in almost every transmission of the virus. They also have the power to stop this mode of transmission, given the overwhelming leverage they exert in sexual relations”.²⁴
- The combination of these experiences can prevent HIV-positive women and adolescent girls from using health services, including prevention of mother-to-child transmission (PMTCT) services, to improve their health and well-being. For example, once women and adolescent girls have access to treatment, adherence might be inhibited by the risk of disclosure; if a woman follows advice to bottle feed her infant, that action might also lead people in the community to assume that she is HIV-positive.²⁵
- Recognizing and addressing stigma and discrimination in both the health care setting and the community and protecting the human rights of the client are imperative to promoting the safety and social acceptance of HIV-positive women, men, and children.

Training Steps

Activity A: Discussion (45 minutes)

1. Ask participants to define stigma and ask for examples.
2. Ask participants to define discrimination and ask for examples. Encourage them to draw from experience.
3. Post the definitions of stigma and discrimination on the wall and ask the participants if they agree with them.
4. Ask participants why stigma is attached to HIV and whether and how HIV-positive women and adolescent girls experience this stigma differently from HIV-positive men and adolescent boys. Ask participants for examples of both and encourage them to draw from experience.

²⁴ UNFPA. *Population Issues; Preventing HIV Infection, Male Involvement in Preventing HIV Infection*. Retrieved 26 June 2006 from www.unfpa.org/hiv/strategic/enabling.htm.

²⁵ UNFPA. 2003. *HIV and infant feeding: A guide for health-care managers and supervisors*. Retrieved 26 June 2006 from www.unfpa.org/publications/detail.cfm?ID=203&filterListType=1; WHO. No date. *Child and adolescent health and development, nutrition: Infant and young child, hiv and infant feeding*. Retrieved 26 June 2006 from www.who.int/child-adolescent-health/NUTRITION/HIV_infant.htm; and UNICEF. No date. *Nutrition: Infant feeding and HIV*. Retrieved 26 June 2006 from www.unicef.org/nutrition/23964_infantfeeding.html.

5. Ask participants to give examples of how HIV-related stigma leads to discrimination. Encourage them to look at all levels (e.g., in the community; within families, health centres, and the media; and within institutions, such as the church and the government, etc.).
6. Discuss how HIV-related stigma and discrimination might inhibit an HIV-positive woman's or adolescent girl's ability to access health care. (Use probing questions about the community.) You may elicit the following responses:
 - fear of telling their family/partner;
 - fear of being seen at the clinic by someone they know;
 - fear that they might know one of the health workers;
 - denial;
 - concerns about pregnancy and MTCT;
 - concern about transmitting HIV to others;
 - concerns about illness and death;
 - fear of violence from, or abandonment by, a partner or family;
 - fear of revealing HIV status to health worker;
 - concerns about confidentiality;
 - fear of losing job if others find out they are living with HIV;
 - fear of loss of home and social support;
 - concerns about maintaining health and questions about expected life span;
 - fear of experiencing stigma and discrimination within the health care setting.
7. Discuss how HIV-related stigma and discrimination within the health care setting have an impact on the quality of care by asking the following questions:
 - Is there stigma related to HIV and AIDS in your community and/or in the health care setting where you work? If there is, how is it expressed?
 - How does discrimination affect quality of care for HIV-positive women and adolescent girls coming to your facility?

Activity B: Role-Play Practice (45 minutes)

1. Assign each group a scenario selected from Trainer's Resource 6.2, p. 30. Tell the groups they will be developing a role-play around the scenario and provide them with the following additional instructions:
 - Choose one person in each group to play the counsellor, client, and observer.
 - Assume the role-play takes place in a health care facility. The client has come to see the counsellor or has been referred. The observer helps develop the role-play, observes a run-through, and offers feedback.
 - The aim of the role-play is to examine the stigma and discrimination experienced by the client and how to address it.
 - Give the groups 15–20 minutes for role-playing in their small groups. If the group is able to complete one run-through of the role-play, ask group members to switch roles so that everybody has a chance to play either the counsellor or the client.

2. After 15–20 minutes have passed, debrief the role-play by facilitating a large-group discussion with the following questions:
 - What was the source of discrimination in your scenario?
 - Was the counsellor able to address the discrimination? Why or why not?
 - Was there anything else he or she could have done?
3. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

If time permits, further discussion could be sparked by the following anecdote, provided by the International Community of Women Living with HIV/AIDS (ICW): *“We face a common problem that our husbands or partners tend to force us to give them our ARV dose while they have not tested for HIV and don’t know their CD4 count. They do not want to go for testing while they show all HIV symptoms. Even if you refuse, they will find where you keep your medicines and steal them”*.

This quote helps illustrate how fear and stigma and discrimination often stop men from HIV testing and accessing ARV treatment themselves and increase the vulnerability of HIV-positive women to disease progression and other potential SRH problems.

Stigma refers to unfavourable attitudes and beliefs directed towards someone or something—usually culturally constructed. Stigmatizing attitudes are directed towards people with HIV and towards behaviours believed to have caused the infection. People who are often already socially marginalized—poor people, indigenous populations, men who have sex with men, IDUs, and commercial sex workers—frequently bear the heaviest burden of HIV/AIDS-related stigmatization. People who are HIV infected are often assumed to be members of these groups, whether they are or not.

Discrimination, which can be expressed as both negative attitudes or particular behaviour or actions, is often described as a distinction that is made about a person that results in their being treated unfairly and unjustly on the basis of their belonging, or being perceived to belong, to a particular group. For example, stigma can lead to prejudice and active discrimination directed towards persons who are actually, or are simply perceived to be, living with HIV, and towards social groups and persons. Discrimination is often defined using the language of human rights and entitlements in various areas, including health care, employment, the legal system, social welfare, and reproductive and family life.

Sources:

EngenderHealth. 2004. *Training for health care workers: Reducing stigma and discrimination related to HIV and AIDS*. New York.

WHO/CDC. 2004. *Prevention of mother-to-child transmission of HIV*, Generic Training Package, pp. 5-2 and 5-3.



Scenarios (based on reported experiences of women living with HIV)

1. "I'd been to a hospital, and was told to have an IUD [intrauterine device] fitted. When I went for the fitting, they did not allow me to use it because I did not live permanently with my sex partner. They asked me why I should bother using it. Then, when they checked my medical file and learned that I've got HIV, they said 'Oh! This one was infected! The HIV-infected should not use it'. They said this as if those who were infected should not be given any services".
2. "It seems that now they know in the hospital that I am positive, they want to keep away from me as much as possible. I am ill and need care, but they leave me alone, they don't like to touch me, and I feel abandoned".
3. "The nurses advised me not to have any children again. I gave birth two years later, but my husband became ill and died of AIDS in the same year. The nurses shouted at me why did I not listen to their advice".
4. "I do not want to have a child at this stage and requested my pregnancy to be terminated. The doctors agreed to the termination only on condition that I consent to being sterilized. I have no option. I have to put up with the judgemental attitude of the health care staff, including their disbelief that a woman with HIV would get pregnant".
5. "I have experienced difficulty in accessing Acyclovir in the local clinic and hospitals. Having lived with herpes for a long time, I know the symptom of when it is about to manifest on the skin surface. The doctors will not give the treatment until it manifests, which in most of the cases it might occur at the weekend by the time you get the chance to see the doctor; it is useless to take the meds because the virus at this stage takes its course, which is painful and embarrassing. Taking the medication as soon as the symptoms appear stops the development of the sores, etc. But the doctors refuse to listen to us".
6. "I know my body and I wish that the doctors could understand that. One doctor put me on prophylaxis and then my regular doctor stopped and asked me if I knew how expensive it is costing the hospital to provide me with the drugs. We are told to seek medical help as soon as possible, but the reality is that the medical team delays the process, resulting in our sexual and reproductive health conditions getting worse".
7. "The doctor told me you are illegal and don't have the correct documents. I can't give you the treatment you need. I am worried that I will get deported". (statement from an HIV-positive woman migrant)
8. "I have not sought treatment because of the negative attitudes of health workers. I feel like they might think I am unworthy of care and I fear losing my children". (statement from an IDU)
9. "I am pregnant and 16 years old. I only know my school and local community. I am not allowed out as a young woman, only men are because it is dangerous. How could I know what to ask for at the clinic? We can't assert our rights because we do not know our rights".

6.2**Trainer's
Resource****Role-Play Scenarios on Stigma and Discrimination**

10. “Women are very embarrassed, especially when the doctor is a man. We feel uncomfortable. If a woman goes and [the examination] is done by a man she may not return. With doctors it is hard to say it is my body, I know what I am feeling and what is right for me”.
11. “Programmes push you to disclose and you are threatened. They tell you, ‘you are killing others and may have to go to court and prison’ ”.

Source: ICW. 2006. Unpublished interviews with ICW members.

Sexual and Reproductive Rights of HIV-Positive Women and Adolescent Girls

7

Objectives

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

- demonstrate a greater understanding of the realities in which HIV-positive women and adolescent girls live their lives;
- explain the concept of rights, specifically sexual and reproductive rights, and the interrelationship between rights and different aspects of HIV-positive women's and adolescent girls SRH choices.

Time

90 minutes

Materials

- flipchart
- markers
- pens
- blue and yellow index cards
- Participant Handout 7.1: Overview of Sexual and Reproductive Rights, p. 117 (which includes list of fundamental human rights)
- Participant Handout 7.2: Testimonies of HIV Positive-Women and Adolescent Girls, p. 122

Advance Preparation

1. Write the examples of sexual and reproductive rights from Participant Handout 7.1, p. 117, on flipchart paper.
2. Preselect four to five testimonials from Participant Handout 7.2, based on the number of participants. The testimonies are taken from “Dreams and Desires” (2004), a publication of the International Planned Parenthood Federation (IPPF) and the ICW²⁶; from ICW staff and member testimonies; and from the ICW newsletter. You may decide to use the testimonies provided, find ones that are more context-specific, or adapt the ones contained. Make multiple copies of the selected testimonies so that each group member can read through the testimony for herself/himself.
3. It works well to contact a local organization or network of people living with HIV/AIDS to invite a woman living with HIV to lead this session. Give her the outline of this session plus the handouts to give her ideas and to help her see what you intend to cover.

²⁶ International Planned Parenthood Federation (IPPF) and International Community of Women Living with HIV/AIDS (ICW). 2004. *Dreams & desires: Sexual and reproductive health experiences of HIV positive women*. London. Retrieved 26 June 2006 at: <http://content.ippf.org/output/ORG/files/5306.pdf>.

4. Find out whether the country where the training is taking place has signed on to the ICPD Programme of Action.

Key Ideas to Convey

- Human rights provide the legal framework within which national laws, policies, and services should be formulated and monitored, as well as an approach to designing policy and programmes.
- While the concept of human rights in theory encompasses the sexual and reproductive rights of PLHIV and other key vulnerable populations, in practice there are many examples of national laws and policies that forcibly restrict these rights. Most countries have adopted some laws and policies related to HIV and AIDS; however, some of them have been known to severely restrict or impede the rights of people living with HIV/AIDS, sex workers, IDUs, men who have sex with men, youth, prisoners, migrants, etc.
- Sexual and reproductive rights are distinct, though linked. Although sexual rights are essential for the upholding of reproductive rights, women's and adolescent girls' sexual rights should not only be considered in the context of reproduction. Too often, programmes for women focus on their reproductive roles—having healthy children or preventing unintended pregnancies. This not only misses women who are not having children (for example, prepubescent girls, postmenopausal and infertile women), but also fails to address sexual health and rights outside the context of reproduction.
- Many HIV-positive women and adolescent girls desire to have sexual relations and may also choose to have children. They have the same rights to sexuality and reproduction as women and adolescent girls not affected by HIV—e.g., the right to have a safe and satisfying sex life and to decide on whether to have children and how many to have.
- Gender inequality already makes it difficult for women and adolescent girls to realize their sexual and reproductive rights, but the stigma and discrimination surrounding HIV-positive status interacts with gender inequality to increase the barriers to the realization of those rights.
- Given a supportive legal and policy environment, HIV-positive women and adolescent girls can enjoy their full sexual and reproductive rights.

Training Steps

Activity A: Small-Group Activity (30 minutes)

1. Explain that the participants will be exploring human rights and sexual and reproductive rights issues as they pertain to HIV-positive women and adolescent girls. Divide participants into four or five groups.
2. Distribute one testimony to each group (with enough copies for each group member to read individually). Give each group a flipchart and markers, and ask each group to choose a note-taker and a reporter. After everyone has had time to read through the testimony they received, ask participants to consider, within their groups:
 - What pressures or issues the HIV-positive women or adolescent girls faced?

- What sources of help were available to them?
 - What made their challenges more difficult, and what would help them more?
3. Ask each group to prepare a short summary of their discussion.
 4. Facilitate (or have the guest speaker facilitate) small-group reports back to the large group. Aspects that participants should identify and list on the flipcharts include:
 - stigma and discrimination within family, society, and health centres, and the consequences of these;
 - human rights violations;
 - not being able to make informed choices;
 - family pressures to behave or not to behave in certain ways, especially regarding sexual and reproductive rights;
 - issues around body image, sexual desires, or wanting to have children;
 - issues around disclosure, particularly linked to sexual and reproductive choices;
 - concerns for other family members, especially in HIV-discordant couples (i.e., couples in which one person is HIV-positive and the other is HIV-negative);
 - support groups;
 - social networks, including family;
 - access to condoms and female condoms;
 - access to treatment;
 - having healthy pregnancies;
 - experiences of having children who are healthy and HIV-negative;
 - good and bad experiences of nonjudgemental and judgemental treatment by health workers;
 - coerced sex or other forms of violence and abuse pertaining to negotiating sexual relationships.

Activity B: Discussion (60 minutes)

1. Facilitate a discussion by asking the participants the following questions:
 - What are human rights?
 - What are sexual and reproductive rights?
 - Who is responsible for respecting, protecting, and fulfilling human rights? Sexual and reproductive rights?
2. Post the flipcharts listing examples of sexual and reproductive rights from Participant Handout 7.1, p. 117, on the wall and review the rights. (*Note:* When a country signs a treaty about reproductive or human rights, it is incumbent upon that country to translate its international-level commitments into national laws and policies that promote and protect the rights of its populations, including people living with HIV.)
3. Ask each participant to write on several yellow cards the rights that he or she exercises or would like to exercise. Ask participants to place each one next to the right on the flipchart that they think protects it. Discard duplicates.
4. Refer the group to the examples of sexual and reproductive rights. Explain that the ICPD

was the first international document to define reproductive rights, and that while as a declaration it is not legally binding like a treaty, most governments have stated their support for the ICPD. If the country where the training is taking place has signed on to the ICPD Programme of Action, discuss its current status in that country.

5. Ask each participant to write on several blue cards the sexual and reproductive rights that were violated/upheld in the testimonials in the previous activity. Ask participants to place each one next to the right on the flipchart that they think protects it.
6. Referring to Participant Handout 7.1, p. 117, discuss obstacles to realizing these rights. Tell the participants that a later session will explore how other national laws and policies can constrain the realization of sexual and reproductive rights.
7. Facilitate a large-group discussion based on the following questions:
 - What are the consequences of the violation of the rights of HIV-positive women and adolescent girls on their sexual and reproductive health?
 - What rights need to be upheld in order for HIV-positive women and adolescent girls to fulfil their sexual and reproductive rights? And vice versa—how does upholding sexual and reproductive rights help them realize other rights? You could mention the 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), an international treaty that protects a range of women’s rights.
 - What do participants feel their role is in helping HIV-positive women and adolescent girls protect and fulfil their sexual and reproductive rights? Let participants know that this will be further explored in later sessions.
8. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

Six testimonies are provided with this training package (Participant Handout 7.2, p. 122). If these are not sufficient or not considered to be locally relevant, others can be found through *ICW News*, the IPPF publication *Dreams and Desires*, or through local sources.

Alternatively, the trainer can skip Activity A and divide participants into small groups for Activity C. This will allow for more small-group discussions, if desired.

Supporting Clients' Informed and Voluntary Decision Making

8

Objectives

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

- explain what is meant by informed and voluntary decision making;
- describe the challenges to making and acting on decisions experienced by HIV-positive women and adolescent girls both within and outside the health care setting;
- explain at least two ways of supporting clients in their decision making;
- explain the importance of referrals and follow-up.

Time

60 minutes

Materials

- flipchart
- pens
- card stock (8½ x 11 inch or A4) in four different colours (green, blue, pink, and yellow, if available)
- Participant Handout 8.1: Informed and Voluntary Decision Making, p. 129

Advance Preparation

1. Cut out eight card figures of women (about six inches high) from the pink paper and write one of the following terms on each cut-out figure (alternatively, use eight pictures of women or adolescent girls from photo archives or magazines, and place labels on them with one of the eight terms, below, on each picture):
 - sexual relationships
 - contraception
 - abortion
 - HIV counselling and testing
 - disclosure
 - infant feeding options
 - children (whether to have them, when, how many)
 - sterilization
2. Cut out 30 card arrows in each of three different colours (yellow, blue, and green), for a total of 90 arrows.

Key Ideas to Convey

- The process of counselling and supporting a client has to be carried out with an understanding of the circumstances in which the HIV-positive woman or adolescent girl will be carrying out her decisions. Decisions made within the health care setting need to take into account obstacles in the family and community.
- Counsellors should not assume that clients are automatically able to make informed and voluntary decisions within the health care setting.
- Health workers are often seen as authority figures. Power imbalances between clients and health workers may keep clients from requesting information regarding a full range of options or may make clients feel that they have to consent to the suggestions put to them by health workers.
- HIV-positive adolescent girls and some adult women clients may experience a greater power imbalance when counselled by a health worker who is an older woman or a man.
- The process of informed and voluntary decision making takes place in two stages: (1) making decisions within the health care setting, and (2) acting on that decision within the family and community setting. The second stage may be ongoing. Both stages of the process are affected by gender and power relations. (For example, using dual protection, such as condoms, requires a partner's consent.)
- Some SRH decisions that HIV-positive women and adolescent girls will make may require ongoing counselling and support. Whether the health worker provides ongoing counselling and support or refers the client elsewhere, follow-up visits or referrals should be scheduled in advance.

Training Steps

Activity A: Brainstorm/Discussion (20 minutes)

1. Ask participants what is meant by the term “informed decision making”. Write participants’ ideas on flipchart paper.
2. Ask participants what is meant by “voluntary decision making”. Write participants’ ideas on flipchart paper.
3. Referring the group to Participant Handout 8.1, p. 129, ensure that the points brainstormed by the group include:
 - Clients are free from coercion or force or violence or the threat of same.
 - Full and accurate information is presented about all options, including potential risks.
 - Information is presented without bias.
 - The counsellor or health worker does not put his or her personal preferences forward.
 - Individual women’s circumstances are explored and taken into account in giving advice.
4. Facilitate a large-group discussion from the following questions:
 - Why is informed decision making important?
 - How do the participants make their own choices around health care issues? Who is involved? What factors influence their decisions?

Activity B: Small-Group Activity (20 minutes)

1. Divide the participants into eight groups and ask them to brainstorm the kinds of SRH choices HIV-positive women and adolescent girls might be making—e.g., whether to have children; what contraceptive to use; whether to have an abortion, if legal; whether to be sterilized; whether to get tested; and whether to disclose and to whom. Refer the group to Participant Handout 8.1, p. 129, for possible suggestions. Ensure the following areas are mentioned:
 - sexual relationships
 - contraception
 - abortion
 - HIV testing
 - disclosure
 - feeding options
 - children (whether to have them, when, how many)
 - sterilization
 - antiretroviral (ARV) care and treatment
 - PMTCT
 - STI/RTI diagnosis and treatment
 - cancer screening.
2. Tape the eight cut-outs (or pictures) of women on the wall.
3. With the participants in their same groups, assign each group one of the cutout figures to discuss, and distribute the different coloured arrows. Provide the following additional instructions:
 - On blue arrows, write the factors that affect an HIV-positive woman’s or adolescent girl’s ability to make a voluntary and informed decision regarding this SRH choice.
 - On green arrows, write the different people who influence an HIV-positive woman’s or adolescent girl’s decisions.
 - On yellow arrows, write what can help HIV-positive women and adolescent girls deal with/resist the pressures on them that influence their decisions. (Encourage participants to think beyond the health care setting.)
4. After 15 minutes have passed, ask the groups to tape the blue and green arrows pointing *towards* the “woman” they were assigned and the yellow arrows pointing *away from* their assigned “woman”.

Activity C: Discussion (20 minutes)

1. Facilitate a large-group discussion based on the following questions:
 - How can counsellors help a client make an informed and voluntary decision? For example, explore ways in which the client could discuss issues with her partner and/or family members (think also about the type of information provided, your manner, the counselling environment, making referrals).
 - In which areas do you feel more able to help and in which do you feel powerless to help?
 - What information can you offer your clients to take home? What information can you

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draw on to help you understand the SRH needs of HIV-positive women and adolescent girls? What are the advantages and disadvantages of this information?

- For what SRH decisions might HIV-positive women and adolescent girls require ongoing support? Why is it important to schedule a follow-up visit?
- To whom can you refer clients to in your local area, so they can get further support? What are the advantages and disadvantages of referrals?

2. Provide the participants with a summary of the essential ideas to convey.

Ethical Issues in Counselling

9

Objectives

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

- explain the legal and ethical issues to consider in providing SRH care for HIV-positive women and adolescent girls;
- describe at least two laws and workplace policies that promote access to HIV-related services;
- explain the current national policy on partner notification of HIV status to sexual contacts, if one exists, and its implications for HIV-positive women and adolescent girls.

Time

75 minutes

Materials

- flipchart paper
- markers
- masking tape
- Participant Handout 9.1: Laws and Policies Constraining HIV-Positive Women's and Adolescent Girls' Access to SRH Care, p. 132

Advance Preparation

1. Review Participant Handout 9.1.
2. Gather and review:
 - National HIV/AIDS policy brief or document on legal and ethical issues (if available);
 - UNAIDS/WHO policy statement on voluntary counselling and testing (VCT), available at www.who.int/hiv/pub/vct/statement/en/.
3. Invite a lawyer or expert in your country's national AIDS policy to discuss legal and ethical issues around HIV/AIDS and counselling. Ask the guest speaker to stay for the large-group discussion that will follow his or her presentation. Provide the guest speaker with the prepared list of questions (see training steps, below, for the list of questions): If you feel that other questions are more relevant for the country context, please add to or adapt the list as needed.

Key Ideas to Convey

- Health workers handle many sensitive issues when working with people living with HIV. Most countries around the world have adopted some laws and policies related to HIV and AIDS. Health workers should be knowledgeable about current laws and policies protect-

ing the rights of people living with HIV and apply them in their day-to-day work in a manner that is respectful of a client's privacy and confidentiality.

- Whether to test for HIV is a personal choice influenced by many factors, including knowledge about HIV, knowledge about the advantages and disadvantages of testing, the level of stigma in the community, the potential for being subjected to ostracism or violence if one tests positive, and personal ideas and feelings about risk, death, and dying, among others.
- The UN system does not support mandatory testing of individuals on public health grounds, since voluntary testing is more likely to result in behaviour change to avoid transmitting HIV to other individuals.
- HIV testing must not be used as a tool for discrimination. People must not be tested without their knowledge or against their will, and positive HIV test results must not be used to deny treatment to anyone or to segregate them from other patients (unless it is clinically warranted).
- VCT can help women to adopt behaviours to prevent STI infection or repeated exposure to HIV and to make realistic plans for themselves and their family members. For those who test positive, VCT can provide linkages to treatment, care, and support programmes.
- Couples counselled and tested together, who receive their results together, are more likely to change their sexual behaviours. Women should not be pressured into couple counselling, and health workers should make an effort to understand the client's relationship with her partner, particularly the potential for violence, before recommending couple counselling.
- When counselling a couple for HIV testing, each individual must consent, separately, to be tested. The counsellor must ensure that each person is there of his or her own free will. If necessary, the couple should be separated during the consent process to ensure each person is making his or her own voluntary informed decision about being tested.
- Health care staff may not ethically refuse to treat a client who is HIV-positive, nor should they withhold indicated procedures for fear of the risk to themselves of acquiring the virus. They can protect themselves from exposure to blood-borne organisms and reduce their risk of occupational HIV infection by consistently using standard precautions.
- Health workers' attitudes and beliefs about HIV and AIDS should not influence the client's ability to make informed decisions about his or her care. Decision making about FP/RH issues should never be coercive or directive.
- Workplace policies should be developed and implemented that protect the privacy and confidentiality of clients as well as employees living with HIV and that ensure their health and welfare and create a safe and supportive environment, free from discrimination and stigma.
- Health workers should never communicate the HIV serostatus of an HIV-positive woman or adolescent girl without her prior consent. If national partner notification guidelines currently exist, health workers are obliged to explain these guidelines to HIV-positive women and adolescent girls. If such guidelines do not exist, health workers should discuss with each HIV-positive woman and adolescent girl the best approach and timing for notifying partners.

Training Steps

Activity A: Presentation by Legal Expert (35 minutes)

1. Introduce the guest speaker. Refer the participants to Participant Handout 9.1, p. 132.
2. Encourage participants to take notes.
3. Distribute to each participant a national AIDS policy handout (if available).

Activity B: Discussion (40 minutes)

1. Facilitate a large-group discussion based on the following questions. (*Note:* Only ask as many questions as you have time for.) Alternatively, you may conduct this exercise as a debate.
 - How have the government and nongovernmental organizations (NGOs) worked to counteract stigma and discrimination against people living with HIV?
 - Should there be mandatory HIV testing?
 - Are legal and ethical guidelines available to personnel working in the HIV/AIDS field? If so, what are they and where can they be obtained?
 - Are partner notification guidelines included in national VCT guidelines? If not, how should health workers handle this issue when counselling clients?
 - Is it the HIV-positive person's responsibility to protect the sexual health of his or her partner, or is it the partner's responsibility to protect his or her own health?
 - In this country, where can HIV-positive women and adolescent girls go for assistance and advice about the legal aspects of HIV and AIDS?
 - What are the legal consequences of breach of confidentiality in caring for HIV-positive women and adolescent girls?
 - What constitutes "consent"?
 - What constitutes consent in the context of pretest counselling (age requirements for consent, who can consent)?
 - Under what circumstances is consent not needed?
 - Under what circumstances would you recommend couple counselling?
 - How is the consent process for VCT different when counselling a couple?
 - Is preemployment testing discriminatory? Legal? Illegal?
 - Should there be mandatory HIV testing before college acceptance?
 - Should there be mandatory HIV testing before marriage?
 - To what resources do clients have access if they feel they have been treated unfairly or illegally because of their HIV status?
 - Do clients know about these resources? Are they accessing them? If not, why not?
 - To what resources do staff have access if they feel they have been treated unfairly or illegally by their employer because of their HIV status?

- Do staff know about these resources? Are they using them? If not, why not?
 - What are the advantages/disadvantages of mandatory testing?
 - What is the incentive to be tested for future married couples?
 - What is the incentive to be tested for pregnant women?
 - What are the advantages/disadvantages for women and adolescent girls to be tested for HIV?
 - What are the advantages/disadvantages for key populations (e.g., sex workers, IDUs, etc.) of being tested?
 - What is provider responsibility versus client responsibility with respect to partner notification? What about notifying current partners versus former partners?
 - What is the provider's responsibility versus the client's responsibility for notifying other health workers about the client's HIV status?
 - Do parents of minors have to be notified about their underage child's HIV status?
 - Is it necessary to write in the client's record each time you discuss disclosure or encourage clients to notify their partners?
2. Provide the participants with a summary of the essential ideas to convey.

Providing Psychosocial Support for a Positive Diagnosis

10

Objectives

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

- explain how to give a positive diagnosis in as safe and comfortable an environment as possible;
- describe ethical guidelines for providing a positive diagnosis, including ensuring confidentiality and maintaining a nonjudgemental attitude;
- explain at least two ways of responding to the possible concerns and reactions of HIV-positive women and adolescent girls.

Time

75 minutes

Materials

- index cards (at least as many as number of participants; 1/3 of cards should be yellow and 2/3 should be blue)
- pens
- flipchart paper
- markers

Advance Preparation

1. Write on the index cards examples of reactions (on yellow cards) and concerns (on blue cards) of a woman and adolescent girls receiving an HIV-positive diagnosis, including:
 - *Reactions (yellow cards)*: fear, self-loathing, anger, loneliness, crying, not saying anything, hysteria, panic, suicidal feelings, denial, symptoms of shock, violence; for some it may also be a sense of relief if they have been sick for a while and now know the reason why, etc.
 - *Concerns (blue cards)*: fear of death, illness, and pain; fear of others knowing or telling others; fear of loss of children, home, livelihood, friends; fear of rejection and abandonment; fear of violence; fear of having to disclose; not being able to have children; not being able to have sex; concerns about telling former, present, and future sexual partners; protecting sexual partners; status of current sexual partner; if pregnant, health of fetus; fear of impact on existing children; financial concerns around care and treatment, etc.
2. Consider inviting a female representative of the local organization or network of people living with HIV to facilitate this session. It would be better if she had counselling experience. If you decide to invite a guest presenter, be sure she is briefed on the session objectives and activities beforehand.

Key Ideas to Convey

- The way in which a diagnosis of HIV infection is given can have a significant impact on how a person comes to terms with her or his diagnosis.
- For many people, HIV can signify death or at the least illness, maltreatment, and a complete halt on sexual and reproductive activity. In contexts where women or adolescent girls feel they already have limited control over their lives, an HIV diagnosis adds another layer of perceived disadvantage and reduction in bargaining power.
- Any reactions and concerns should be treated seriously, because they are grounded in the reality of the client, whether actual or perceived.
- People living with HIV can have safe and satisfying sexual and reproductive lives and have the same right to this as people who are not affected by HIV.

Training Steps

Activity A: Brainstorm (15 minutes)

1. Ask the group to brainstorm the possible reactions and concerns a woman or adolescent girls may experience when she receives an HIV-positive test result. Ask the group the following questions:
 - What are the likely reactions of a woman or adolescent girl on receiving a positive diagnosis?
 - What are the likely concerns of a woman or adolescent girl on receiving a positive diagnosis?

Activity B: Small-Group Activity (10 minutes)

1. Divide the participants into groups of three and give them one yellow card with a reaction on it and two blue cards with concerns. Ask participants to discuss:
 - Why is the person having this reaction/concern?
 - How can they, in their role as health worker, respond?

Activity C: Role-Play Practice (40 minutes)

1. With participants in the same groups ask them to develop a role-play around handling a positive diagnosis and provide them with these additional instructions:
 - Choose one person in each group to play the counsellor, the client, and the observer.
 - Assume that the interaction takes place in a health facility. The client is there to see the health worker or counsellor for his or her HIV test result and will demonstrate one of the reactions or concerns they discussed in the previous activity. The observer helps to develop the role-play, observes a run-through, and offers feedback. The counsellor will help address and support the client's reactions and concerns.
 - The aim of the role-play is to examine how to create a safe and comfortable counseling environment and respond to the client's reactions and concerns about an HIV-positive diagnosis appropriately and sensitively.

- Give the small groups 30 minutes for role-playing. If the group is able to complete one run-through of the role-play, ask group members to switch roles so that everybody has a chance to play either the counsellor or the client.
2. After 30 minutes have passed, debrief the role-players by asking the groups the following questions:
 - What were the reactions and concerns of the client they explored in their role-play?
 - What methods did they find most useful to creating a safe and comfortable environment and reassuring clients?
 - What conditions are fundamental to being able to handle an HIV-positive diagnosis?
 3. Write these conditions on a flipchart as groups share their response.
 4. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

If time permits, ask one group to volunteer to present its role-play to the whole group.

Objectives

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

- explain the reasons women and adolescent girls would or would not disclose a positive HIV status;
- describe the different factors affecting the decision to disclose within different environments;
- describe the different levels of control that an individual has over his or her disclosure;
- describe at least two ways of supporting an HIV-positive woman or adolescent girl's decision to disclose her HIV status.

Time

90 minutes

Materials

- paper (8¹/₂ x 11 inch or A4)
- markers
- masking tape
- Participant Handout 11.1: Disclosure Guidelines, p. 134
- self-adhesive notes (e.g., “Post-Its”), in multiple colours

Advance Preparation

1. Select role-play scenarios from Trainer's Resource 6.2, p. 30.
2. Review the “story” in the Trainer's Note at the end of this session. If you decide to use it in the training, make enough copies for each participant and distribute.

Key Ideas to Convey

- Disclosure is not a one-time decision or action. Disclosure to health workers, partners, families, friends, communities/neighbours, and the public all involve different degrees of anxiety and problems that do not necessarily diminish with time.
- Although there are advantages of disclosure, there are also disadvantages that may be more severe for some women and adolescent girls, such as violence, abandonment, and loss of livelihood. Therefore, clients should not be pressured to disclose before they feel ready.
- People who have been diagnosed as HIV-positive have the right to privacy; it is an abuse of that privacy if there is “disclosure of test results without consent”.²⁷

²⁷ ICW. 2006. *Human rights and HIV*. Fact Sheet #9. London. Retrieved 27 June 2006 at: www.icw.org/tiki-list_file_gallery.php?galleryId=1.

- When discussing disclosure with clients, an individual's lack of control over disclosure needs to be taken into consideration and strategies identified to help the client regain as much control as possible.

Training Steps

Activity A: Role-Play Practice/Discussion (40 minutes)

1. Brainstorm the different people or groups of people to whom an HIV-positive woman or adolescent girl could disclose her HIV status. Write each suggestion on 8¹/₂ x 11 inch or A4 paper and place it on the wall. Ensure that the group identifies each of the following:
 - partner(s)
 - family (mother, mother-in-law, sister, sister-in-law, etc.)
 - friends
 - health workers
 - community
2. Divide the participants into groups of three. Distribute one role-play scenario (from the handout, Trainer's Resource 6.2, p. 30) to each group and provide the following instructions.
 - Choose one person in the group to play the role of HIV-positive woman or adolescent girl, a second person to play the role of someone who does not know that the woman is HIV-positive (a partner, mother-in-law, work colleague, new dentist, etc.), and the third person to be an observer who will help develop the role-play and provide feedback.
 - The participant playing the HIV-positive woman or adolescent girl practises disclosing (or not disclosing) her status. If she chooses not to disclose, she must give another explanation for her actions (e.g., not breastfeeding her baby, or insisting on condoms when having sex).
 - After the participant playing the HIV-positive woman or adolescent girl has had a chance to practise, change roles. Continue to practise and change roles as often as possible, so that each member of the group has a turn at being the HIV-positive woman. (*Note:* Some of the people taking part in this training will be living with HIV, and may or may not be aware of their status. There may also be people who are HIV-positive and will take this opportunity to share their own disclosure experiences. Remind the participants of the ground rule related to confidentiality and emphasize that what is said in this training in confidence must be respected.)
3. After 20 minutes have passed, debrief the role-players by facilitating a large-group discussion using the following questions:
 - What did it feel like to disclose your status while playing the role of an HIV-positive woman or adolescent girl?
 - Why did you decide to disclose (if you did)?
 - What did it feel like not to disclose?
 - Why did you decide not to disclose (if that was your decision)?

- Did you feel comfortable disclosing to some people and not others?
- Did you feel comfortable disclosing in some situations and not others?
- What are some of the factors that put you in a situation in which you might feel you had to disclose (a situation that was outside your control)?
- How are the issues pertaining to disclosure different for women than they are for men?
- What particular disclosure issues do adolescent girls face?
- In what other situations can a person be presumed to have HIV and potentially pressured to disclose? Examples include:
 - choosing not to breastfeed in a context where breastfeeding is culturally accepted;
 - not having children in a context where the number of children one has is a sign of good health;
 - showing signs of ill health;
 - showing signs of weight loss or redistribution;
 - taking medication that needs to be kept refrigerated or taken at certain times of day;
 - protecting partner access to certain services or benefits;
 - being the object of gossip or of negative attitudes and behaviour of health care workers, auxiliary staff, receptionists, porters, etc.
- In what situations can disclosure be outside a person's control? Examples include:
 - accessing services that require repeated HIV disclosure;
 - experiencing breach of confidentiality by a health worker, friend, or family member, etc.;
 - encountering separate services or spaces for the use of HIV-positive women or adolescent girls;
 - living in a place that criminalizes nondisclosure of HIV status;
 - meeting the requirements of jobs, research trials, visa applications, insurance, etc.;
 - encountering health workers who are obliged by law to tell parents or a legal guardian the test results of adolescent clients.

Activity B: Small-Group Activity (25 minutes)

1. Referring to Participant Handout 11.1, p. 134, divide the participants into 4–5 groups. Ask them to develop a set of guidelines for health workers at their health facility on counselling an HIV-positive woman or adolescent girl on HIV disclosure. Participants could use examples from their own work or examples from the scenarios they used in the role-play.
2. Encourage participants to think about the following issues as they develop their guidelines:
 - local realities in your community that might affect the decision to disclose;
 - to whom, how, and when to disclose;
 - potential consequences of disclosure;
 - strategies for increasing the woman's or adolescent girl's level of control over her disclosure;
 - potential sources of support.

3. After 15 minutes, ask each small group to share the guidelines they developed.
4. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

To help debrief the role-players, you can consider using the following story to illustrate the complexity of HIV disclosure and the importance of framing it in broader sexual and reproductive rights issues, including the rights of people living with HIV.

Sylvia, an HIV-positive young woman (who had been infected at birth), asked her doctor for advice about having sex with men (before she started doing so) and what was or was not safe. The doctor told her that oral sex without a condom was fine and that penetrative sex with a condom was fine and that in neither case was there sufficient risk of transmission for her to feel obliged to tell her partner that she is HIV-positive. So, having taken her doctor's advice, she did just those things when she started having sex, without telling her sexual partners. Unfortunately, she had sex recently with a guy and the condom broke—whereupon she immediately told the guy that she is HIV-positive and they went together to a health centre (and he went on prophylactic treatment for a month and was eventually tested three months later and tested negative). Luckily, the guy was really supportive, but their friends and even some of the health staff (they were at university and away from her usual health centre), who were not HIV specialists, thought the risks were much greater than they are in her specialist's experience, and so they treated her really badly for not having disclosed her status first. She had not disclosed because she felt nervous about rejection if her boyfriend knew, and she felt that she was acting responsibly by having checked things out first with her specialist. She felt upset that her own doctor had not warned her what the public reaction might be, on the basis of popular ignorance, and had only told her the facts. She said that her specialist also recognized in hindsight that he had let her down—in that he had not thought through the consequences of just telling her the scientific facts, rather than discussing with her the implications of ill-informed public opinion.

Note: According to WHO, oral sex is a low-risk but not a zero-risk activity. For more information pertaining to the level of risk associated with different sexual activities, please refer to the WHO guide, retrieved 27 June 2006 at: www.wpro.who.int/NR/rdonlyres/986C9723-13B5-425F-B1EDCD159344E088/0/Advocacy_and_Activity_Guide.pdf; see also CDC. No date. *Preventing the sexual transmission of HIV, the virus that causes AIDS: What you should know about oral sex*, retrieved 27 June 2006 at: www.cdc.gov/hiv/pubs/faq/faq19.htm

Addressing Sexuality with HIV-Positive Women and Adolescent Girls

12

Objectives

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

- explain the issues HIV-positive women and adolescent girls face with regard to their sexuality and how their HIV status relates to their sexual and reproductive health and well-being;
- describe ways of discussing this sensitive topic with HIV-positive women and adolescent girls;
- explain at least two ways health workers can introduce the topic of sexuality with HIV-positive women and adolescent girls.

Time

90 minutes

Materials

- index cards
- pens
- flipchart
- markers
- Participant Handout 4.1: Communication Skills of an Effective Counsellor, p. 106
- Participant Handout 4.2: Overview of REDI Counselling Model, p. 109

Advance Preparation

1. Preselect 15 examples of sexual practices/customs from Trainer's Resource 12.1, p. 57, and write them separately on index cards.
2. Write the following questions on flipchart paper:
 - How does each sexual practice or custom represent the degree to which a woman or adolescent girl has the ability to look after her sexual and reproductive health and well-being?
 - What are the key points pertaining to each sexual practice or custom that they would want to discuss in a session with a client? (*Trainer note:* In this exercise, participants need to consider the purpose of discussing the key points with clients.)
 - How can you, as a health worker, introduce the subject of sexuality to the client? (*Trainer note:* The health worker/counsellor will need to ask if the client has any questions about her sexuality. The client may be uncomfortable, but to put the client at ease, first the health worker/counsellor needs to become comfortable discussing the subject.)
 - How can you make this session more comfortable for the client? (*Trainer note:* It may help for them to think about how they themselves would feel discussing these issues with their health worker. Refer to Participant Handouts 4.1, p. 106, and 4.2, p. 109.)

- Where might a client get other forms of support regarding sexuality and sexual health in your local area?

Key Ideas to Convey

- Sexuality and sexual health are directly linked to RH. It is not possible to counsel a client on her SRH without discussing sexuality.
- For a health worker to successfully counsel a client, she or he must first feel comfortable using the vocabulary of sexuality and sexual practices.
- If HIV-positive women's and adolescent girls' sexual and reproductive rights are not upheld, they are limited in their ability to protect their SRH.
- HIV-positive women and adolescent girls are sexual beings and have the right to express their sexuality free of violence and coercion.
- Health workers have an opportunity and responsibility to raise HIV-positive women's and adolescent girls' awareness of their sexual and reproductive rights and to explore with them the ways of protecting and maintaining her sexual and reproductive health and well-being.
- After being diagnosed as HIV-positive, a woman or adolescent girl may have a number of concerns about her sexuality and sexual health that she should feel free to explore with the health worker. However, she may also be reluctant to talk about these issues. It is important that the health worker introduce the topic in a sensitive, nonjudgemental manner.

Training Steps

Note: Be aware that participants may feel uncomfortable talking about this issue in front of colleagues and members of another sex. Group work could be done in single-sex groups or split by age bracket—or, ideally, both.

Activity A: Brainstorm/Discussion (20 minutes)

1. Review with the group the definition of sexuality from Session 5.
2. Ask participants to give examples of some of the dimensions of sexuality, for example:
 - menstruating, being pregnant, or having sexual intercourse, sexual pleasure, sexual health (anatomy, physiology, and biochemistry);
 - being attracted to another person, including sexual orientation and sexual desire and pleasure. (*Note:* Examples are not always exclusive to one category—e.g., thoughts, feelings);
 - behaving in ways that are expected by one's community, based on whether one is male or female. (*Note:* This includes gender roles, decision making and power in sexual relationships, and violence and fear of violence—e.g., cultural and social factors.)
3. Facilitate a discussion by asking the participants the following questions:
 - How are the above examples experienced differently by a woman or a man? By an adolescent girl or boy? (*Note:* The trainer might need to point out that only menstruation

and pregnancy are exclusive to one sex; however, age, gender roles and dynamics, and cultural practices influence how both sexes experience and express their sexuality.)

- What are some of the differences in how an HIV-positive woman or adolescent girl may experience or express her sexuality as a result of the above factors? For example, HIV-positive women may feel that by continuing to want and have sex, they have less bargaining power in a sexual relationship or may experience greater levels of violence. Many people turn to sex as comfort in times of any kind of stress, so for HIV-positive women and men, wanting to have sex can be a natural desire and can be something healing. But also many HIV-positive women and adolescent girls believe what others have told them—that once positive, you must not have sex—which can be very stressful if they have sexual desire.
- What questions might an HIV-positive woman or adolescent girl want to ask a counselor concerning her sexuality? For example, what constitutes “safer sex” and what does not? Is it acceptable to still have sexual desire? Is it normal to desire (or not desire) sex since finding out about one’s HIV status? Is one’s sex drive affected, either from untreated health concerns or from side effects of ARV medications?²⁸

Activity B: Role-Play Practice (40 minutes)

1. Divide the participants into groups of three. Give each group three cards with sexual practices/customs written on them. Provide the following instructions on how to conduct the role-play:
 - Ask the participants to choose one person to play an HIV-positive woman or adolescent girl, one person to play the woman’s or girl’s partner, and one person to serve as an observer who will help with developing the role-play and provide feedback.
 - Ask the groups to role-play an encounter based on the practices described on their cards, taking turns so that each person has a chance of playing an HIV-positive woman or adolescent girl and each has a turn at playing the partner.
 - Ask the participants to refer to Participant Handouts 4.1, p. 106, and 4.2, p. 109, for a review of communication and counselling skills they should be practising.
2. After 30 minutes, debrief the role-players by facilitating a discussion based on the following questions:
 - What was difficult to discuss?
 - What methods did people playing the role of the HIV-positive woman or adolescent girl find to communicate with their partners?
 - How were partners able to negotiate their needs/desires with each other?

Activity C: Discussion (30 minutes)

1. Facilitate a large-group discussion, based on the key questions below:
 - What does this exercise tell us about how HIV-positive women and adolescent girls might feel when health workers ask them about their sexual practices?

²⁸ UNFPA and WHO. 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*. Retrieved 27 June 2006 at www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf.

SESSION 12

- How do you think health workers' and counsellors' values and attitudes about the sexual practices of HIV-positive women and adolescent girls affect their work?
 - How can health workers and counsellors feel more comfortable in addressing sexuality issues with HIV-positive women and adolescent girls?
 - How can health workers and counsellors make HIV-positive women and adolescent girls feel more comfortable and safe discussing sex?
2. Provide the participants with a summary of the essential ideas to convey.

12.1 Trainer's Resource

Examples of Sexual Practices and Customs

Note to trainers: Some of these only apply to certain cultures; omit the ones that are not appropriate in your setting.

- My partner always initiates sex.
- I do not enjoy sex with my partner.
- My partner forces me to have sex.
- My boyfriend threatens to leave or have sex with other women.
- If I refuse to have sex with him, the mood of the house becomes intense.
- If I don't have sex with him, I don't get money.
- He might leave or won't talk to me.
- I am able to ask him to use a condom, but sometimes he refuses.
- I sometimes have sex after injecting drugs and do not feel in control of the sexual encounter.
- He is financially stable and I am not working. I owe him sex for supporting me.
- Men are the head of the house—that is it.
- There will be a time when he'll refuse to use a condom. He will say, "Why are we using a condom after all these years?"
- I was having a problem with men, so I changed my sexuality.
- When you know their status and want to use a condom, you have to initiate the conversation. Men will not suggest using a condom.
- When you introduce a condom, they [men] say you are looking fine, you are okay.
- Maybe we put the condom aside—that's our problem, we have to make our own decisions.
- In-laws are a problematic bunch—if the father has two wives, then they encourage the son to have two wives.
- He says "you are HIV-positive. Who else will have you?"
- If my husband wants to have sex with me, I have to anytime he wants.
- We have to marry anyone who is able to pay *lobola* (a form of bride price, used in certain cultures). When they have paid *lobola*, they can do whatever they want.
- A man will say "I paid lobola, why do you want to use a condom? You are there to make children".
- When he has more than one wife, the man decides where he will sleep tonight; you have to play by his rules.
- My brother-in-law wanted to take my husband's place; he didn't want to marry, he wanted a sexual relationship. He said "If you don't do this we won't support the child" (where it is the practice for brothers-in-law to have sex with or "inherit" their widowed sister-in-law).
- Parents and in-laws get together to decide; the woman isn't part of the meeting, especially where *lobola* is paid. She is property; they just find someone who will marry her.
- If he rapes her and the wife goes to the granny—she says that's your job and you must have children.

12.1**Trainer's
Resource****Examples of Sexual Practices and Customs (*cont.*)**

- Young women are supposed to remain “virgins” (not have sex).
- When it comes to being sexually active, if you are not married you cannot discuss it.
- Sometimes positive women are not allowed to get married.
- His status is HIV-positive, and I tested negative, but he says that if I love him, I won’t worry about getting HIV.
- He says it doesn’t feel good with a condom.
- He’s my teacher; I have to do what he says.
- I just had a baby. I don’t want another one so soon, but my husband wants a big family.
- If an HIV-positive man has sex with a virgin, he is cured of HIV.
- He’s my “sugar daddy”—he gives me whatever I want. I owe him!
- My husband is on the road for work for months at a time. When he comes home, I know he’s been having sex with other partners, but he won’t use a condom.
- We are both HIV-positive, so what’s the point of using condoms?
- He says he’ll “pull out” (remove penis from vagina prior to ejaculation), and I won’t get infected.
- Sometimes I want to have sex, but I’m ashamed of it.
- I love having sex with my husband, and we feel better when using condoms.

Improving a Client's Perception of Risk

13

Objectives

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

- define risk *assessment* and explain why and how it is used in counselling;
- identify three reasons that prevention strategies are important for people living with HIV;
- identify three reasons for why it is difficult for HIV-positive women and adolescent girls to be aware of their own risks;
- describe two ways in which health workers can help clients be aware of their own risks for STI/RTI acquisition, HIV transmission to partners, HIV reinfection, and unintended pregnancy.

Time

75 minutes

Materials

- flipchart paper
- markers
- masking tape
- Trainer's Resource 13.1: REDI—Phase 2, p. 63
- Participant Handout 13.1: Overview of Risk Assessment, p. 135
- Participant Handout 7.2: Testimonies of HIV-Positive Women and Adolescent Girls, p. 122
- Participant Handout 4.2: Overview of REDI Counselling Model, p. 109

Advance Preparation

1. Prepare a flipchart with the definition of risk assessment and why we do it (Activity A), found in Participant Handout 13.1, p. 135.
2. Prepare a flipchart with the three reasons why prevention strategies are needed for people living with HIV (Participant Handout 13.1).
3. Review Participant Handout 13.1 for guidelines to use for the presentation (Activity B), plus Step 3 of the Exploration phase of REDI, with a focus on steps for this session (see Trainer's Resource 13.1, p. 63).
4. Prepare a flipchart with the six reasons that clients underestimate their risk (Activity B), found in Participant Handout 13.1.
5. Review testimonies (Participant Handout 7.2, p. 122).

Key Ideas to Convey

- Risk assessment is a counselling process to help clients understand the risk associated with sexual and/or IDU practices that they or their partners engage in, and how they can reduce their own level of risk by changing their behaviour.
- In counselling, health workers must respect that HIV-positive women and adolescent girls and their partners have different understandings about what risk means in their life. For a variety of reasons, people tend to think they are at less risk than they actually are. Therefore, health workers need to develop skills to help clients see and understand their risks.
- Prevention for and with HIV-positive women and adolescent girls encompasses a set of actions that help them protect their sexual health, avoid other STIs, or reinfection with another strain of HIV, delay HIV/AIDS disease progression, avoid passing HIV infection on to others, and prevent unintended pregnancies.
- HIV-positive women and adolescent girls from hard-to-reach populations, such as sex workers and IDUs, partners of sex workers and IDUs, and men who have sex with men, should be counselled on their increased risk for STIs/RTIs.
- Health workers can help HIV-positive women and adolescent girls assess their own risk and can use this understanding to reduce their risk through developing and implementing risk reduction plans.
- An important matter to stress during counselling is that successful ARV treatment does not prevent HIV transmission. The client needs to be advised on preventive measures, such as the use of condoms and safer sex practices, and (if an IDU) on the necessity to use clean needles and other harm-reduction strategies.
- Women, who are traditionally givers rather than receivers of care, tend to neglect their own health needs. Health workers must make clear to such women that “care for oneself” is integral to effective STI/RTI prevention and prevention of HIV disease progression.
- After learning that they are HIV-positive, most HIV-positive women and adolescent girls try to adopt safer sex practices; however, where the partner has not been told of the infection, such changes can be very difficult to start and continue. The client may need ongoing counselling to cope with these challenges, and at all times the health worker must be supportive and nonjudgemental.
- Appropriate and prompt treatment of STIs/RTIs at the first contact between HIV-positive women and adolescent girls and health workers can prevent gynaecological and obstetrical complications associated with STIs/RTIs, decrease their severity, and (in some cases) improve the response to standard treatment.
- Women with HIV should be encouraged to go for cervical cancer screening if such services exist, since they are more vulnerable for human papillomavirus (HPV) infection. Cytology screening is as effective in women with HIV as in uninfected women. There is no evidence to support a recommendation that women and adolescent girls newly diagnosed with HIV should be referred for colposcopy or that they should be screened more frequently than uninfected women.²⁹

²⁹ “Women living with HIV/AIDS should be offered cervical cancer screening at the same frequency and with the same screening test as women not infected with HIV.”—Source: UNFPA and WHO. 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*. Retrieved 27 June 2006 at www.who.int/hiv/pub/guidelines/sexualreproductivehealth.pdf.

- With advances in treatment of HIV infection and the better prospects for health in the long term, clients show a renewed interest in sexual activity and procreation. Successful HIV treatment lowers the viral load and may thus reduce the risk of HIV transmission to an HIV-negative partner or unborn children; however, the risk is not totally eliminated.
- In HIV-discordant couples (one person HIV-positive, the other HIV-negative), there is compelling evidence that consistent condom use (and, for IDUs, consistent use of clean needles) protects the HIV-negative partner against HIV infection; such couples, therefore, must be counselled on the crucial importance of safer sex and the proper use of condoms and clean needles. In cases where both partners are HIV-positive, the adoption of safer sex practices and safer injection drug use practices is recommended to prevent STIs/RTIs and reinfection with new or mutated strains of HIV.

Training Steps

Activity A: Brainstorm (20 minutes)

1. Explain to the participants that in their day-to-day work they discuss different categories of risk and the behaviours and the underlying social factors that influence risk and that this session focuses on the health worker's role in helping the client to assess her own risk.
2. Ask the participants:
 - What does risk assessment mean to you?
3. After getting a couple of responses, post the flipchart showing the definition of risk assessment and briefly explain it.
4. Explain that most prevention strategies to date have been targeted at HIV-negative people or people of unknown status to prevent them from becoming HIV-positive. Historically, there has been a perception that the concept of prevention for people already living with HIV is inherently contradictory. There have also been concerns about further stigmatizing people living with HIV. In addition, some have been reluctant to acknowledge that people with HIV have sex and to come to grips with the complex ethical issues surrounding HIV regarding disclosure, partner notification, etc.
5. Ask the participants :
 - What are important reasons for considering prevention strategies that meet the particular needs of people living with HIV?
6. After getting a couple of responses, post the flipchart showing the three reasons that prevention strategies for people living with HIV are important, and briefly explain each one.

Activity B: Discussion (25 minutes)

1. Explain that most people generally underestimate their own risks in life, and that this includes risks for STI/RTI acquisition, for HIV transmission to uninfected partners, for reinfection with other strains of HIV, and for unintended pregnancy. Ask the participants to give a few reasons why HIV-positive women and adolescent girls may have difficulty in perceiving these risks.

2. Post the flipchart showing the six reasons why clients underestimate their risk. Briefly explain each reason.
3. Facilitate a brief discussion by asking the following questions:
 - Why is a client’s perception of his or her own risk so important?
 - Considering the reasons why clients underestimate their risk, which reasons apply to HIV-positive women and adolescent girls? Why?
4. Ask the participants to refer to Session 4, Participant Handout 4.2, p. 109 (REDI—Phase 2: Exploration, Step 3); also in Trainer’s Resource 13.1 (“Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk”). Ask the large group to brainstorm how they would actually ask the questions in the first two bullets.
5. Discuss each suggestion briefly to see if people agree with the questions, and then write them on a flipchart.

Activity C: Role-Play Practice/Discussion (30 minutes)

1. Explain that the participants will now have an opportunity to practice Step 3 of the Exploration stage of REDI through role-plays.
2. Divide the participants into groups of three and give each group one of the testimonies from Participant Handout 7.2: Testimonies of HIV-Positive Women and Adolescent Girls. Provide the participants with the following additional instructions:
 - Ask the participants to choose one person to play an HIV-positive woman or adolescent girl, one person to play health worker or counsellor, and one person to serve as an observer who will help develop the role-play and provide feedback.
 - Ask the groups to role-play an encounter based on the testimony they were given so that each person has a chance of playing an HIV-positive woman or adolescent girl and each has a turn at playing the health worker or counsellor.
 - Ask the participants to refer to Participant Handout 4.2, p. 109 (REDI—Phase 2: Exploration, Step 3) to help in developing and practising their role-plays.
3. After 20 minutes have passed, debrief the role-players by facilitating a discussion using the following questions:
 - How did you explain the risks of STI/RTI acquisition, of HIV transmission to uninfected partners, of reinfection with other strains of HIV, and of unintended pregnancy to the client in your testimonial?
 - What questions could you ask to help an HIV-positive woman or adolescent girl relate these risks to her own situation?
 - What are some of the ways in which health workers can help HIV-positive women and adolescent girls perceive and understand their own risks?
4. Provide the participants with a summary of the essential ideas to convey.

REDI–Phase Two: Exploration

1. Explore the client's needs, risks, sexual life, social context, and circumstances.
2. Assess the client's knowledge and give information, as needed.
3. Assist the client to perceive or determine his or her own pregnancy or HIV and STI risk:
 - Ask the client if he or she feels at risk for unintended pregnancy or for HIV and STI transmission, and explore why or why not.
 - Ask the client if he or she thinks that his or her partners may be at risk for unintended pregnancy or HIV and STI transmission, and explore the reasons.
 - Explain HIV and STI transmission and pregnancy risks (as necessary), relating them to the individual sexual practices of the client and his or her partners.
 - Help the client to recognize and acknowledge his or her risks for HIV and STI transmission or unintended pregnancy.

Adolescent Sexuality, Pregnancy, and HIV/AIDS

14

Objectives

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

- describe common values and beliefs about adolescent sex, sexuality, and pregnancy, and from where these values and beliefs originate;
- describe the psychological and social changes that adolescent girls experience as they develop;
- explain the pressures that HIV-positive adolescent girls face to conform to certain social and cultural norms about sex, sexuality, and pregnancy.

Time

90 minutes

Materials

- flipchart
- markers
- masking tape
- coloured paper (six sheets)
- Participant Handout 14.1: Stages of Adolescent Development, p. 139

Advance Preparation

1. Write each of the following terms on coloured paper, one term per sheet:
 - early adolescence
 - middle adolescence
 - late adolescence
2. Make enough sets of the above terms for two teams.
3. Make enough copies of Participant Handout 14.1 for the number of participants.

Key Ideas to Convey

- Sexuality is a component of human psychological and social development and therefore is not only determined by biological factors.
- Through misinformation, difficulty in discussing the subject with a partner (particularly if it is the first time they are having sex), and lack of access to SRH services, adolescents can become pregnant without any previous planning.
- HIV/STI vulnerability is heightened during adolescence, partly as a result of the limited information and support that adolescent girls and boys receive about the psychological,

social, and physical changes they are experiencing. It is also not unusual for adolescent behaviour to be motivated by feelings of low self-esteem and a desire to belong to their peer group.

- An adolescent girl's attitudes towards her situation may in some cases lead her to make decisions that put her own health at risk, as well as the health of others. Vulnerability is not only created by personal actions but by circumstances often largely beyond the control of the individual including whether there is comprehensive sex education in schools; whether specific HIV/STI prevention programmes are being implemented in schools (if there is sufficient funding); whether there is access to health services and condoms; whether funding is available for these programmes; and whether adolescent girls have the same rights and opportunities as boys, among others.
- For HIV-positive adolescent girls, their HIV diagnosis may be a major factor influencing how they see themselves in relation to their peers and in how they make decisions based on the information they have received about preventing pregnancy and HIV/STIs.
- There are many powerful influences on HIV-positive adolescent girls that impact their views on pregnancy, sex, and sexuality in general, as well as how their own sexuality develops and manifests itself. Some issues that HIV-positive adolescent girls face may include: coming to terms with the prospect of death at a very young age; lack of adolescent-friendly services; judgemental attitudes towards adolescent sexuality; risk at a time of life known for feelings of invulnerability; and pregnancy seen as an assertion of normalcy and life affirmation.
- As a result of HIV/AIDS stigma and discrimination, some HIV-positive adolescent girls are likely to have lower self-esteem and are also likely to experience concerns about their sexuality and fertility that require ongoing support and sensitivity.

Training Steps

Activity A: Small-Group Activity (60 minutes)

1. Explain to the participants that they will be making wall murals about the stages of adolescent development.
2. Divide the participants into two groups. Explain that Group A will create a living wall mural about the life of Mary and that Group B will create a wall mural about the life of John. (The trainer or participants can substitute local names.)
3. Distribute Participant Handout 14.1 and provide the group with the following instructions:
 - Each group will create a story about their character's transition from early adolescence through middle and late adolescence into adulthood. The group will review the handout and decide which developmental stages and behaviours they want to highlight in the story about their character.
 - Each group is to choose a wall in the room.
 - Each story should be put together like a living wall mural of statues, with the group remaining static, against the wall, in total silence.

- In each group, one member volunteers or is chosen to stay out of the mural to tell the story. One participant from each group will strike a physical pose (including facial expressions) to illustrate a particular stage and behaviour in the character’s adolescent development. Another member of the same group then places himself or herself to the right of the first participant, illustrating the next moment in the character’s life. The participant should keep at least one part of the body (hand, foot, abdomen, back, etc.) in contact with the wall and another in contact with the previous participant.
 - One by one, all the members of group A (except the narrator) are to link up against the wall until their story is completed.
 - At the end, the narrator, who is not part of the mural, interprets the “statues” and tells the story of the character’s growth from early adolescence to adulthood.
 - Group B proceeds in the same way in relation to its character.
4. After the two groups have presented their stories, “dismantle” the murals and ask if their stories and murals would be any different if Mary were pregnant or John’s female partner had become pregnant or had a child when they were adolescents.
 5. Then ask the groups if their stories or murals would be any different if Mary or John had been diagnosed with HIV when they were adolescents.

Activity B: Discussion (30 minutes)

1. Debrief the participants in the wall mural activity by asking the following questions:
 - What caught your attention in Mary’s story? (Substitute local name.)
 - What caught your attention in John’s story? (Substitute local name.)
 - What are the differences between John’s and Mary’s stories?
 - Thinking back to your own adolescence, was HIV/AIDS a public health issue then? If so, how did it affect the way you and your friends thought about and talked about sex, sexuality, and pregnancy? If not, how has adolescence changed since then because of HIV/AIDS?
 - What messages do the media (TV, radio, movies, news, magazines) give about adolescence and sex, sexuality, pregnancy, and HIV/AIDS?
 - Thinking about adolescent girls you know now, how do you think their decisions about sex, sexuality, and pregnancy would be affected if they were HIV-positive?
 - Where do HIV-positive adolescent girls go for information, care, treatment, and support around sex, sexuality, and pregnancy?
2. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

Throughout the above exercises, encourage participants to think about their own awareness of their sexuality and sex as adolescents, and who or what were the main influences on their values, beliefs, and attitudes around sex, sexuality, pregnancy, and HIV/AIDS. You can ask them in what ways they feel that values and beliefs around these issues have changed since they were teenagers.

SESSION 14

If there is sufficient time, you may consider asking the two groups to recreate the mural in Activity A, based on whether the character is pregnant or has children, and whether the character is HIV-positive.

Counselling HIV-Positive Adolescent Girls on Sexual and Reproductive Health

15

Objectives

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

- explain ways of ensuring that the SRH needs of adolescent girls are addressed in a safe and respectful environment;
- describe strategies to successfully provide SRH services to HIV-positive adolescent girls;
- describe at least two skills needed for effective communication with and counselling of HIV-positive adolescent girls on their SRH needs.

Time

90 minutes

Materials

- flipchart paper
- markers
- Trainer's Resource 15.1: Role-Plays for Counselling HIV-Positive Adolescent Girls, p. 72

Advance Preparation

1. Make copies of the role-play scenarios found in Trainer's Resource 15.1, p. 72, and cut the copies into horizontal strips—separating the client roles from the health worker's roles.
2. Prepare a flipchart with the following instructions for role-play feedback.

Role-Play Feedback

- * "Health worker": Which counselling skills are you trying to apply? What do you think you are doing well? What do you think you can improve on?
- * "Client": Is the "health worker" addressing your needs? Do you feel that you are being heard? Are there questions that you want to ask or things that you need to say that you do not feel you can? Why?

Key Ideas to Convey

- Adolescent girls often feel powerless in health care settings; therefore, suggestions from health workers can easily be taken as commands.

- Adolescents are extremely aware of and sensitive to nonverbal messages. Improving health worker communication and counselling skills will contribute to the quality of services for youth.
- HIV-positive adolescent girls are heavily constrained and impacted by others when they make SRH-related decisions, and they often lack the power to make and exert their own decisions even when they have accurate/unbiased information on hand.
- It is important to ensure that services dedicated to adolescents are youth-friendly and better integrated to meet the needs of HIV-positive adolescent girls. Health workers need to be trained in counselling skills that address the needs of HIV-positive adolescent girls, including HIV disclosure, sexuality, safe motherhood, paediatric treatment and care, FP, self-image, confidentiality, etc.
- It is important to build trust with HIV-positive adolescent girls and make them feel comfortable during their first visit. Encouraging them to come for other visits if needed and following up with them in a confidential manner is also important to improving their care.

Training Steps

Activity A: Discussion (15 minutes)

1. Ask the participants the following questions to get them thinking about the issues faced by HIV-positive adolescent girls when accessing health services:
 - What do you believe HIV-positive adolescent girls think about health care settings?
 - Under what circumstances do adolescent girls find out their HIV-positive status? (For example, when pregnant or suffering symptoms of an opportunistic infection or an STI/RTI.) (*Note:* Adolescents are likely to delay as long as possible before seeking help for an opportunistic infection or STI.)
 - Under what circumstances does an HIV-positive adolescent girl come to be sitting in front of a health worker and what particular considerations need to be taken into account? For example:
 - She was sent by a health worker, a parent, or partner/husband.
 - She is seeking advice on sexual health or contraceptives and/or abortion.
 - She has an STI/RTI or symptoms of an opportunistic infection.
 - She has just been diagnosed with HIV.
 - She is pregnant.
 - She is being sexually exploited or abused.
 - She is seeking counselling after an abortion.
 - She has a child and is concerned for its welfare.
 - What might prevent HIV-positive adolescent girls from using SRH services that would benefit their well-being?

Activity B: Role-Play Practice/Feedback (40 minutes)

1. Divide the participants into groups of three and tell them they will be developing a role-play around counselling a young HIV-positive woman about her SRH needs.
2. Distribute the role-play scenarios to each group (show the client strip only to the client and the health worker strip only to the health worker) and provide the following additional instructions:
 - As in the previous role-plays, they should decide in their group who will first play the health worker, play the client, or be the observer.
 - Refer them back to REDI (Participant Handout 4.2, p. 109), and briefly review the four phases of the counseling framework. Explain that this exercise focuses on REDI, Phase 1, Rapport-building: (1) Welcome the client; (2) Make introductions; (3) Introduce the subject of sexuality; (4) Ensure confidentiality. Ask them to consider the following issues in developing their role-play:
 - how a health worker can ensure that a counselling session addresses the SRH needs and situation of HIV-positive adolescent girls;
 - physical factors that can ensure that HIV-positive adolescent girls feels safe and able to access counselling services (e.g., she may not want to be alone in a room with a male counsellor);
 - additional sources of information and support that can be offered to HIV-positive adolescent girls.
 - Remind the participants to switch roles so that everyone has a turn at being the client and the health worker.
3. After 15–20 minutes have passed, ask one of the groups to volunteer to show their role-play to the larger group.
4. Have the group conduct the role-play.
5. Facilitate feedback, referring first to the “health worker” and “client” role-play feedback flipchart. Then refer to the following questions for comments from other participants:
 - How did the person playing the health worker ensure that the session addressed the needs and situation of the adolescent girl?
 - Did the person playing the client feel heard? Supported?
 - Was anything missing from the session?
 - How could it be improved?
6. Repeat Steps 3, 4, and 5 for as many groups as possible in the remaining time.

Notes for the Trainer/Training Options

The health workers should consider all factors that influence a young person’s ability to access her sexual and reproductive rights and health—for example, whether she is being sexually exploited and abused. Health workers should be aware that the client is unlikely to want to talk about many issues related to her sexual health and also may not tell the truth. In such instances, the health worker needs to look for certain signs, such as anxiety or depression, and act accordingly.

Scenario 1: Client

You are an HIV-positive, pregnant 19-year-old woman. You do not want to have a child at this stage and requested your pregnancy to be terminated. The doctors agreed to the termination (abortion is legal in this scenario) only on condition that you consent to being sterilized. You feel you have no option but to put up with the judgemental attitude of the health care staff, including their disbelief that a woman with HIV would get pregnant.

Scenario 1: Health worker

A pregnant 19-year-old woman has come to see you. She seems nervous and upset. Your task is to make her feel comfortable so she will talk to you about her concerns.

Scenario 2: Client

You are an HIV-positive 17-year-old girl who has been hospitalized for pneumonia. It seems that they know in the hospital that you are HIV-positive. Health workers want to keep away from you as much as possible. You are ill and need care, but the health workers leave you alone and don't like to touch you. You feel abandoned.

Scenario 2: Health worker

An HIV-positive 17-year-old girl, who is hospitalized in your facility, has come to see you. She seems very weak and withdrawn. Your task is to make her feel comfortable so she will talk to you about her concerns.

Scenario 3: Client

You are an 18-year-old young woman with two children. The nurses advised you not to have any more children. You became pregnant again recently, but your partner became ill and died of AIDS soon after. Now you are worried that you and your child might be infected with HIV. The nurses shout at you every time they see you, "Why did you not listen to our advice?"

Scenario 3: Health worker

A pregnant 18-year-old woman living with HIV has come to see you. She seems suspicious. Your task is to make her feel comfortable so she will talk to you about her concerns.

Scenario 4: Client

You are 14 years old. You only know your school and local community. You are not allowed out alone because it is considered too dangerous for an adolescent girl to be out unchaperoned. You are concerned about HIV/STIs because a lot of your friends at school are talking about them, but you have never had an HIV test. You don't know what to ask for at the clinic. You can't assert your rights because you do not know what your rights are.

Scenario 4: Health worker

A 14-year-old girl has come to see you. She seems confused and scared. Your task is to make her feel comfortable so she will talk to you about her concerns.

Scenario 5: Client

You are a 15-year-old girl who was diagnosed with HIV six months ago when you came to the clinic for treatment of an STI. You are very embarrassed and uncomfortable to talk to a doctor about your sexual needs and desires, especially when the doctor is a man. You don't know how to assert your right for information and the right to make decisions for yourself.

Scenario 5: Health worker

A 15-year-old girl who was recently diagnosed with HIV has come to see you. She seems shy and embarrassed. Your task is to make her feel comfortable so she will talk to you about her concerns.

Comprehensive SRH Care of HIV-Positive Women and Adolescent Girls

16

Objectives

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

- describe the components of comprehensive SRH care for HIV-positive women and adolescent girls;
- name at least four health and social services that are necessary to meet HIV-positive women's and adolescent girls' SRH needs and to know where these services are provided in the community.

Time

60 minutes

Materials

- flipchart
- markers
- pens
- cards (8½ x 11 inches or A4)
- Participant Handout 16.1: Provider Checklist: Comprehensive SRH Care and Counselling of HIV-Positive Women and Adolescent Girls, p. 140
- Participant Handout 16.2: Algorithm for SRH Counselling of HIV-Positive Women and Adolescent Girls, p. 146
- self-adhesive notes (e.g., “Post-Its”), in multiple colours

Advance Preparation

1. Write the components of comprehensive SRH care of HIV-positive women—taken from the last bullet of the Key Ideas, below—on 8½ x 11 inch or A4 cards.

Key Ideas to Convey

- Comprehensive SRH care is an integrated approach to identifying the interrelated issues of contraception, disease prevention and treatment, reproduction, and experience with sexual intimacy and pleasure through a comprehensive assessment of the individual's SRH context and concerns, regardless of the reason for the visit. In many cases, subsequent visits will need to be scheduled or referrals will have to be made to other service sites.
- The goal of comprehensive SRH care is to provide holistic and integrated health services to HIV-positive women and adolescent girls through creating and strengthening linkages and referral mechanisms between SRH and HIV/AIDS services on-site or with other ser-

vices off-site. Although your health facility may not be able to offer all of the health and social services that an HIV-positive woman or adolescent girl may need, health workers can recognize and discuss with the client her range of needs and know where to refer her for further help.

- The crucial components of comprehensive SRH care are:
 - promoting sexual health and safer sex;
 - preventing violence against women with HIV;
 - diagnosing HIV infection in women and providing prevention counselling;
 - providing HIV/AIDS treatment, care, and support;
 - providing FP education, methods, and support;
 - improving antenatal, intrapartum, postpartum, and newborn care (including education and assistance with infant-feeding choices);
 - eliminating unsafe abortion;
 - preventing and managing STIs/RTIs;
 - diagnosing and treating cancer;
 - providing psychosocial support;
 - providing financial/legal support.

Training Steps

Activity A: Brainstorm/Discussion (20 minutes)

1. Distribute 5–7 self-adhesive notes to each participant and ask them to think of other SRH services that HIV-positive women and adolescent girls need apart from FP services and write them on the notes.
2. While the participants are working on their answers, tape on the wall the cards showing the various components of comprehensive SRH care of HIV-positive women and adolescent girls.
3. After 15 minutes have passed, ask the participants to stick their answers underneath the headings on the wall that most closely correspond to the services they have written on the notes.
4. Ask the participants to stand in front of the wall with the cards and facilitate a discussion using the following questions:
 - Are you surprised by any of the services that have been posted on the wall?
 - Are there any other services that are missing?
 - What does this tell us about the SRH needs of HIV-positive women and adolescent girls?
 - Are their needs different from those of HIV-negative women and adolescent girls? If so, in what way(s)?
 - Given that the majority of HIV-positive women and adolescent girls do not know their status, how can health workers ensure that their SRH needs are met?

Activity B: Small-Group Activity/Discussion (40 minutes)

1. Divide the participants into five groups and assign each group 1–2 of the service categories on the wall. (*Note:* The group assigned STI/RTI prevention and management should not be given another category, given the scope of this topic.)
2. Referring the participants to Participant Handouts 16.1 and 16.2, provide the following additional instructions:
 - Choose a note-taker and a person to report back to the larger group in 25 minutes.
 - For your assigned SRH service categories, discuss the important information and recommendations a health worker should discuss with an HIV-positive woman about this particular SRH issue.
 - Consider how the information/recommendations differ depending on knowing the woman’s HIV status.
 - Consider who should provide the service and where it should be offered.
 - Consider what other referrals you may need to make to ensure that the woman’s needs are met.
 - Consider the barriers that HIV-positive women and adolescent girls may face when acting upon the information given to her. Are there additional (support) services available that address these barriers?
 - Using the checklist (Participant Handout 16.1, p. 140), have the groups make sure they have covered all topics in their assigned service categories.
3. Facilitate a report back from each group, clarifying and correcting any misinformation presented by each group.
4. Provide the participants with a summary of the essential ideas to convey.

Notes for the Trainer/Training Options

Consider inviting an SRH expert to help facilitate this session. Ensure that the person is briefed beforehand about the session objectives and activities, as well as provided copies of the Participant Handouts. Given that the following session is devoted to the FP needs of HIV-positive women and adolescent girls, you may choose not to assign this topic to one of the small groups. Either way, let the participants know that an entire session will be focusing on FP.

Family Planning Needs of HIV-Positive Women and Adolescent Girls (Including Dual Protection, Pregnancy, and Safe Motherhood)

17

Objectives

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

- describe the reasons why some HIV-positive women and adolescent girls may choose *to have* a child and the options available to them to prevent perinatal transmission;
- describe the reasons why some HIV-positive women and adolescent girls may choose *not to have* a child and the options available to them to prevent unintended pregnancies;
- explain the eligibility criteria for safe contraceptive use by HIV-positive women and adolescent girls;
- explain the components of safe motherhood, including PMTCT through avoidance of exposure to STIs/RTIs, re-exposure to HIV, safe labour and delivery practices, safe infant-feeding practices, and avoidance of unintended pregnancies;
- explain “dual protection”—methods of safer sex that include prevention of unintended pregnancies and infection with STI/RTIs or reinfection with HIV.

Time

90 minutes

Materials

- flipchart paper
- markers
- masking tape
- Participant Handout 17.1: WHO Medical Eligibility Criteria for Contraceptive Use by HIV-Positive Women and Adolescent Girls, p. 147
- Participant Handout 17.2: HIV and Safe Motherhood, p. 151
- Participant Handout 17.3: Overview of Dual Protection, p. 156

Advance Preparation

1. It can be very effective to invite someone from the FP unit of a local hospital to give a one-hour presentation on FP and HIV-positive women and adolescent girls (45 minutes to present; 15 minutes for Q & A) or to facilitate the entire session. Provide the guest speaker with an overview of the session objectives and activities and copies of Participant Handouts 17.1, 17.2, and 17.3, pp. 147–156) in advance of the session—with adequate time to read and review them.
2. If one of the trainers conducts the presentation, be sure that all of the Participant Handouts are reviewed beforehand. EngenderHealth and Family Health International (FHI) have also developed a training module (*Contraception for Women and Couples with*

HIV) that can be used to assist with this presentation. It can be retrieved at www.fhi.org/training/en/modules/ARV/default.htm.

3. Prepare a flipchart showing the reasons that some HIV-positive women and adolescent girls consider pregnancy, including:
 - desire to have more children
 - pressure to have children
 - fear that older children may die
 - concern about infertility
 - reassurance regarding PMTCT
 - optimism about ARV therapy
 - avoidance of generating suspicions about HIV status
 - apprehension about disclosing HIV status
 - lack of knowledge of choices for avoiding unintended pregnancies.
4. Prepare a second flipchart showing the reasons that some HIV-positive women and adolescent girls avoid pregnancy, including:
 - economic status
 - desired family size
 - ideal spacing
 - concerns about health and quality of life
 - fear of transmitting HIV
 - anxiety about leaving orphans
 - concerns about limited access to care for family due to stigma and discrimination.
5. Tape the flipcharts to the wall, with the writing facing the wall.

Key Ideas to Convey

- FP recommendations from a health worker should not turn into pressure for or against a certain FP option. Health workers need to be aware that many clients perceive health workers to be in a position of authority, and therefore recommendations may be perceived as instructions. For this reason, it is important to provide accurate information on the full range of options and ensure client consent through informed decision making.
- A range of factors (social, economic, and medical) affect an HIV-positive woman's and adolescent girl's ability to take up a particular FP option. These should be explored by the health worker and client together to ensure the client makes the best choice for themselves.
- Pregnancy in HIV-positive women and adolescent girls does not accelerate progression of HIV disease. However, it may carry some consequences for the infant. Without interventions, including safer labour and delivery, safer infant feeding, and ARV drugs, about one-third of HIV-positive mothers will pass HIV to their newborns. Some evidence suggests that pregnancy in HIV-positive women and adolescent girls increases the risk of stillbirth and low birth weight. Nonetheless, the benefits of having another child may outweigh the risk of adverse pregnancy outcomes for some HIV-positive women and adolescent girls.

- Becoming newly infected with HIV *during* pregnancy or *during the breastfeeding period* greatly increases the risk of transmission of HIV from mother to child. Therefore, HIV-positive pregnant and breastfeeding postpartum women and adolescent girls should take even greater precautions against transmitting HIV to their infant.
- A healthy mother is as important as a healthy child. Evidence shows that ARV therapy can improve the overall health of an HIV-positive woman or adolescent girl during pregnancy (if she would be eligible for ARV therapy anyway).
- With minor exceptions, HIV-positive women and adolescent girls can use most modern contraceptive methods.
- Emergency contraception is an important intervention for HIV-positive women and adolescent girls in situations where condoms have broken or the woman has experienced sexual violence.
- It is important to counsel HIV-positive women and adolescent girls on dual protection, as it can help them perceive and reduce their risks for STI/RTI acquisition, HIV transmission to their partner, reinfection with another strain of HIV, and unintended pregnancy. It can also help them develop risk-reduction plans, including dual-method use (condom along with another family planning method), to protect themselves and their partners.

Training Steps

Activity A: Brainstorm (15 minutes)

1. Begin the brainstorm activity by asking the group to provide reasons why some HIV-positive women and adolescent girls consider pregnancy. Write their suggestions on flipchart paper.
2. Next ask the group for the reasons why some HIV-positive women and adolescent girls avoid pregnancy. Write their suggestions on a separate piece of flipchart paper.
3. Tape the participants' flipcharts up next to the prepared flipcharts and turn the prepared flipcharts around so that the writing is visible.
4. Ask the group to compare their responses to the ones prepared before the session. Point out any similarities or differences.

Activity B: Presentation on Family Planning (45 minutes)

Option A: Presentation by Invited Guest Speaker

Introduce the guest speaker and explain that he or she will provide an overview of FP considerations for HIV-positive women, including contraceptive methods for HIV-positive women, pregnancy, safe parenthood, and dual protection. Specifically, these include: an overview of WHO eligibility criteria for contraceptive methods for HIV-positive women; the impact of HIV on pregnancy (including ARV prophylaxis); delivery care (including safer obstetrical practices); postpartum care (including safer infant feeding and STI/RTI prevention); infant care; and dual protection.

Option B: Presentation by Trainer

Tell the participants that you will provide them with an overview of FP considerations for HIV-positive women, including contraceptive methods, pregnancy, safe parenthood, and dual protection. Referring to Participant Handouts 17.1, 17.2, and 17.3, these include: an overview of WHO eligibility criteria for contraceptive methods for HIV-positive women and adolescent girls; the impact of HIV on pregnancy (including ARV prophylaxis); delivery care (including safer obstetrical practices); postpartum care (including safer infant feeding and STI/RTI prevention); infant care; and dual protection. Tell them that the presentation will be followed by a question-and-answer period.

Activity C: Small-Group Activity (30 minutes)

1. Following the presentation, divide the participants into 4–5 groups and give each group 1–2 of the following questions to discuss:
 - What issues do health workers have to consider when discussing FP options with HIV-positive women and adolescent girls?
 - What issues need to be considered if an HIV-positive woman and adolescent girl is seeking advice on having a baby or has tested positive during her pregnancy?
 - How can health workers help clients deal with external socioeconomic factors such as violence and lack of power in relationships?
 - Does the FP information that you provide to a client differ depending on her HIV status? If so, in what ways?
 - Given that the majority of women and adolescent girls do not know their HIV status, how would you approach discussing FP options with a woman of unknown status?
 - What is meant by dual protection?
 - Why is an HIV-positive woman or adolescent girl particularly susceptible to acquiring an STI/RTI, transmitting HIV to her partner, or getting reinfected with another strain of the virus during pregnancy or in the postpartum period?
 - Why is an HIV-positive woman or adolescent girl more likely to transmit HIV to her infant if she acquires HIV during pregnancy or in the postpartum period?
2. Instruct the groups to discuss their assigned questions and choose a note-taker and reporter for their group. Refer the groups to Participant Handouts 17.1, 17.2, and 17.3 for additional information regarding their questions.
3. After 15 minutes have passed, ask the reporter from each group to share the responses to their questions. Correct any wrong responses or misinformation.
4. Provide the participants with a summary of the essential ideas to convey.

Integrated SRH Counselling for HIV-Positive Women and Adolescent Girls

18

Objectives

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

- explain principles of integrated SRH counselling for HIV-positive women and adolescent girls;
- describe how to use the provider checklist on comprehensive SRH care of HIV-positive women and adolescent girls;
- describe strategies for addressing common SRH issues for HIV-positive women and adolescent girls.

Time

90 minutes

Materials

- flipchart paper
- markers
- masking tape
- Trainer’s Resource 18.1: Role-Play Scenarios for Integrated SRH Counselling, p. 87
- Participant Handout 18.1: Key Concepts and Guiding Principles of Integrated SRH Counselling, p. 159
- Participant Handout 16.1: Provider Checklist: Comprehensive SRH Care and Counselling of HIV-Positive Women and Adolescent Girls, p. 140
- Participant Handout 16.2: Algorithm for SRH Counselling of HIV-Positive Women and Adolescent Girls, p. 146
- Participant Handout 4.2: Overview of REDI Counselling Model, p. 109.

Advance Preparation

1. Prepare a flipchart with the definition of integrated SRH counselling provided in Participant Handout 18.1, p. 159.
2. Make a copy of Trainer’s Resource 18.1 (p. 87), and cut it into strips—one strip for each client and health worker scenario.
3. Review the scenarios, and select 2–3 role-plays from it. Keep the client and health worker strips for each of the selected scenarios separate, to distribute to the role-play participants.
4. Prepare two flipcharts: one with feedback guidelines for the “health worker” and one with feedback guidelines for the “client” in the role-plays (see p. 84).

Role-Play Feedback

- * “Health worker”: Which counselling skills are you trying to apply? What do you think you are doing well? What do you think you can improve on?
- * “Client”: Is the “health worker” addressing your needs? Do you feel that you are being heard? Are there questions that you want to ask or things that you need to say that you do not feel you can? Why?

Key Ideas to Convey

- Integrated SRH counselling is a critical component of programme interventions linking SRH and HIV/AIDS and helps clients make the best use of the range of services available. However, integrated SRH counselling can be offered in any service-delivery setting. Thus, a health worker can discuss the full range of SRH issues about which the client may be concerned, regardless of the types of SRH services actually provided at that site.
- Meeting the client’s needs may require referring her to services either onsite or off-site, or may require problem-solving to determine what the client can do about a situation for which services simply do not exist locally.
- Integrated SRH counselling can be a vital part of outreach services, as a means of helping HIV-positive women and adolescent girls identify their needs both for clinical care and support in developing risk reduction plans for changing their behaviour.
- Integrated SRH counselling for HIV-positive women adolescent girls upholds the concept of informed decision making by ensuring that women are knowledgeable about all of their choices and are not judged or directed while making SRH decisions.
- Integrated SRH counselling for HIV-positive women and adolescent girls does not depend on knowing the HIV status of the individual, as the goal is to provide information in an integrated manner that anticipates clients’ needs, whether or not they have been tested for HIV.
- For fertile couples in which both partners are HIV-positive or in which one is positive and the other is negative (i.e., serodiscordant couples), counselling and assisted reproductive technologies are available that protect both partners from either infection or reinfection with HIV/STIs.
- For infertile women and couples in which one or both partners are HIV-positive, counselling and assisted reproductive technologies are available that can help the couple conceive a child safely.

Training Steps

Activity A: Discussion (30 minutes)

1. Introduce the activity by telling the participants that they will be applying principles of integrated SRH counselling to comprehensive SRH care of HIV-positive women.
2. Refer the group to the definition of integrated SRH counselling provided on the first day of training:

Integrated SRH counselling is a two-way interaction between a client and a health worker, to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service they are working within or what service the client has requested.

3. Briefly present the principles of integrated SRH counselling covered in Participant Handout 18.1, p. 159.
4. Answer any questions that the group may have at this point, and refer them to the handout.
5. Ask participants to look back at Participant Handout 16.1: Provider Checklist: Comprehensive SRH Care and Counselling of HIV-Positive Women and Adolescent Girls.
6. Review the main categories of services in the list, and facilitate a discussion using the following questions:
 - What SRH services in the checklist for HIV-positive women and adolescent girls do you provide at your health facility?
 - What other SRH services are available in your community?
 - Where are these other services located in the community?
 - How do you refer HIV-positive women and adolescent girls to other SRH services?

Activity B: Role-Play Practice/Feedback (60 minutes)

1. Tell the participants that they will be doing role-plays to practise their counselling skills and apply the technical knowledge about comprehensive SRH care of HIV-positive women and adolescent girls that they have gained throughout the four-day training. Encourage them to refer to Participant Handouts 4.2, 16.1, and 16.2 in developing and practising their role-plays. Provide the following instructions:
 - In the role-play, the role of the “health worker” will be rotated, but the “client” will remain the same throughout. (Be sure to inform the group that not everyone will have an opportunity to act as a client or health worker.)
 - Ask for a volunteer to serve as the first client. This person will be provided with information about the client that he or she will be playing (from the relevant “client strip” from Trainer’s Resource 18.1), and is not to show this information to any of the other trainees playing health workers.
 - Ask for a volunteer with some counselling experience who will act as the first “health worker”, and give this person the corresponding “health worker strip” (which gives very limited information about the client).

- Once the role-play is under way, stop it every 3–5 minutes to allow another trainee to step in as the “health worker” (with the client remaining the same). The person playing the “health worker” can also ask for help if he or she wishes, and another trainee will step into the role-play as the “health worker” and pick up where the previous person left off.
 - The participants should draw upon their experience, the REDI counselling model that was discussed, or other counselling models with which they are familiar, and the technical information pertaining to comprehensive SRH care of HIV-positive women and adolescent girls that they gained in the previous sessions.
 - While the health workers are practising in the front of the room, ask the other participants to pay attention to what has been covered and to think about what questions have not yet been asked in the current role-play.
2. After 3–5 trainees have had an opportunity to play the health worker, solicit reactions from the participants about how the client scenario was role-played, referring to flipcharts for health worker/client feedback.
 3. After about 15–20 minutes, select a new client scenario and ask for a volunteer to serve as the second “client” with a new “health worker”. Repeat the instructions above, and select additional client scenarios as time and interest permit.

Activity C: Discussion (15 minutes)

1. Debrief the role-players by leading a discussion based on the following key discussion questions:
 - For those who played the health worker, what were the most challenging aspects of doing a practice session on integrated SRH counselling?
 - What aspects did you feel most comfortable with, and why?
 - What aspects did you feel most uncomfortable with, and why?
 - Why is it important to integrate a wide range of SRH issues into a counselling session, even if the client says she came in for one specific reason?
 - What obstacles to providing dual-protection counselling might come up in your clinic setting? (See Session 17 for details on “dual protection”.)
 - What strategies could you employ to overcome these obstacles?
 - Are the strategies any different for HIV-positive women vs. HIV-positive adolescent girls?
2. Provide the participants with a summary of the essential ideas to convey.

Scenario 1: Client

You are a 14-year-old girl. You only know your school and local community. You are not allowed out because it is considered too dangerous for an adolescent girl to be out unchaperoned. You are concerned about HIV/STIs because a lot of your friends at school are talking about them. You don't know what to ask for at the clinic. You can't assert your rights because you do not know what your rights are. You don't know your HIV status and are concerned that you may be HIV-positive because you did not use a condom when you had sex recently with your boyfriend. You have come to see your doctor about getting an HIV test, but you are too scared to ask.

Scenario 1: Health worker

A 14-year-old girl has come to see you. She seems nervous and scared. Your task is to find out why she has come to see you and address her concerns.

Scenario 2: Client

You are an HIV-positive 23-year-old woman who uses intravenous drugs from time to time. You have not sought treatment because of the negative attitudes of health workers. You feel like they think you are unworthy of care and you fear losing your children. You are facing pressure from your partner to have another child. You don't want to have another child, at least not at this point in your life. You know that your partner sees other women, but you cannot leave him because you are financially dependent on him. You have come to talk to the provider about getting some type of contraception.

Scenario 2: Health worker

An HIV-positive 23-year-old woman has come to see you. She is not presently using any form of contraception. Your task is to find out why she has come to see you and address her concerns.

Scenario 3: Client

You are a 35-year-old woman who has been living with HIV for one year. You have been using oral contraceptives for the last three years. The health programmes you have attended push you to disclose your status and you feel threatened and are afraid that people in your community will find out. Health workers tell you that you are killing others and that you may have to go to court and prison. You want to have another child; however, recently the leader of your local HIV support group told your friend, "HIV-positive women who have children are no better than murderers". Your partner is HIV-negative and is very worried about having a child with you.

Scenario 3: Health worker

An HIV-positive 35-year-old woman has come to see you about having another child. She seems nervous. Your task is to find out why she has come to see you.

Scenario 4: Client

You are a 20-year-old woman with two children. You have been on ARV therapy for one year. The nurses advised you not to have any more children. You and your partner have only been using condoms for birth control. You became pregnant again recently, but your partner became ill and died of AIDS soon after. The nurses shout at you every time they see you, “Why did you not listen to our advice?” You are being pressured by your nurse to abort the pregnancy. You have to continue having sex for money to support your kids, even though all you want is to be abstinent.

Scenario 4: Health worker

A 20-year-old pregnant woman with HIV has come to see you. She has been on ARV therapy for one year. She seems distant and a little timid. Your task is to find out why she has come to see you and address her concerns.

Scenario 5: Client

You are an HIV-positive 27-year-old woman. You have been to a hospital, and were told to have an IUD fitted. When you went for the fitting, they did not allow you to have it because you do not live permanently with your sex partner. They asked you why you should bother using it. Then, when they checked your medical file and learned that you have HIV, they said, “Oh! This one was infected! The HIV-infected should not use it”. You now have lower abdominal pain and have returned to see a provider because you are concerned that you have an STI.

Scenario 5: Health worker

An HIV-positive 27-year-old woman has come to see you complaining of lower abdominal pain. Your task is to find out why she has come to see you and address her concerns.

Objectives

By the end of this session, the trainers should have:

- administered the posttest questionnaire and participant evaluation form;
- obtained the participants' impressions of the training and received suggestions for improving future trainings;
- formally thanked all involved in the training, wished everyone well, and close the proceedings.

Time

60 minutes

Materials

- posttest questionnaire, Appendix B
- Participant Evaluation Form, Appendix D
- certificates of participation for each participant

Advance Preparation

1. Identify and invite guests for closing ceremony.
2. Make enough copies of the posttest questionnaire.
3. Make enough copies of the Participant Evaluation Form.
4. Prepare a certificate of participation (as appropriate for each setting) for each participant.
5. Prepare a contact list of all participants and trainers to distribute.

Training Steps

1. Distribute the posttest questionnaire. Allow the participants 30 minutes to complete it and collect all copies.
2. Distribute the Participant Evaluation Form. Allow the participants 15 minutes to complete it and collect all copies.
3. Distribute the participant/trainer contact list and encourage participants to keep in touch following the training to support one another as they apply their new knowledge and skills.
4. Conduct a closing ceremony appropriate to the setting. Thank the participants and all trainers, hosts, and guest speakers; distribute certificates of completion and celebrate the completion of the training.
5. As time allows, invite participants to speak and express their appreciation.

APPENDICES

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A	Sample Four-Day Training Agenda 93
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Sample Four-Day Training Agenda

Appendix

A

Day 1
Morning
<p>Session 1: Overview (90 minutes)* Break (15 minutes) Session 2: Basic HIV and AIDS Information (30 minutes) Session 3: Exploring Beliefs, Values, and Attitudes about HIV and AIDS (90 minutes)</p>
Afternoon
<p>Session 4: Basic Counselling Skills and Approaches (90 minutes) Break (15 minutes) Session 5: SRH Vulnerability of HIV-Positive Women and Adolescent Girls (90 minutes) Closing (15 min.)</p>
Day 2
Morning
<p>Checking In: Participants' insights from the previous day's sessions (15 minutes) Session 6: Addressing HIV and AIDS Stigma and Discrimination in the Health Care Setting (90 minutes) * Break (15 minutes) Session 7: Sexual and Reproductive Rights of HIV-Positive Women and Adolescent Girls (90 minutes)*</p>
Afternoon
<p>Session 8: Supporting Clients' Informed and Voluntary Decision Making (75 minutes) Session 9: Ethical Issues in Counselling (75 minutes) Break (15 minutes) Session 10: Providing Psychosocial Support for a Positive Diagnosis (75 minutes) Closing (15 minutes)</p>
Day 3
Morning
<p>Checking In: Participants' insights from the previous day's sessions (15 minutes) Session 11: HIV Disclosure (90 minutes)* Break (15 minutes) Session 12: Addressing Sexuality with HIV-Positive Women and Adolescent Girls (90 minutes)</p>
Afternoon
<p>Session 13: Improving a Client's Perception of Risk (75 minutes) Break (15 minutes) Session 14: Adolescent Sexuality, Pregnancy, and HIV/AIDS (90 minutes) Closing (15 minutes)</p>

Page 1 of 2

* These sessions are particularly relevant for programme managers. We encourage managers to attend the overview and closing session in addition to the other sessions, to demonstrate their support for their staff and their commitment to the importance of the training.

Sample Four-Day Training Agenda (*cont.*)

Appendix

A

Day 4
Morning
<p>Checking In: Participants' insights from the previous day's sessions (15 minutes)</p> <p>Session 15: Counselling HIV-Positive Adolescent Girls on Sexual and Reproductive Health (90 minutes)</p> <p>Session 16: Comprehensive SRH Care of HIV-Positive Women and Adolescent Girls (60 minutes)</p> <p>Break (15 minutes)</p> <p>Session 17: Family Planning Needs of HIV-Positive Women and Adolescent Girls (120 minutes, total)—Start (60 minutes)</p>
Afternoon
<p>Session 17: Family Planning Needs of HIV-Positive Women and Adolescent Girls (120 minutes, total)—Finish (60 minutes)</p> <p>Break (15 minutes)</p> <p>Session 18: Integrated SRH Counselling for HIV-Positive Women and Adolescent Girls (90 minutes)</p> <p>Session 19: Closing Session (60 minutes)*</p>

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* These sessions are particularly relevant for programme managers. We encourage managers to attend the overview and closing session in addition to the other sessions, to demonstrate their support for their staff and their commitment to the importance of the training.

Pretest and Posttest Questionnaire

Appendix

B

Please write the last four digits of your telephone number as a means of anonymously matching your pretest and posttest responses.

This questionnaire will take approximately 30 minutes to complete. It is voluntary and completely confidential. Thank you for your time.

Beliefs, Values, and Attitudes (Please check one response for each of the questions below.)

1. I believe it is easy for clients to express their feelings and desires about sexuality, even with strangers.
 Agree Somewhat agree Somewhat disagree Disagree
2. I believe telling people that certain behaviours put them at risk for unintended pregnancies and sexually transmitted infections/reproductive tract infections (STIs/RTIs) is generally enough to cause them to change their behaviour.
 Agree Somewhat agree Somewhat disagree Disagree
3. I believe giving too much information about sexuality and reproduction to HIV-positive adolescent girls will make them promiscuous.
 Agree Somewhat agree Somewhat disagree Disagree
4. I feel it is important for every HIV-positive woman and adolescent girl to be counselled about her sexual and reproductive health (SRH).
 Agree Somewhat agree Somewhat disagree Disagree
5. I feel that I am at high risk of acquiring HIV from working at a public health facility.
 Agree Somewhat agree Somewhat disagree Disagree
6. I feel that providing SRH services for HIV-positive women and adolescent girls stops us from providing good health services to the general population.
 Agree Somewhat agree Somewhat disagree Disagree

7. I feel that clients from groups such as sex workers and injecting drug users have a right to access the highest quality of health services in my facility.

- Agree Somewhat agree Somewhat disagree Disagree

8. I feel uncomfortable providing health services to HIV-positive women and adolescent girls.

- Agree Somewhat agree Somewhat disagree Disagree

9. I don't worry about being exposed to HIV when I'm working with a colleague who is HIV-positive.

- Agree Somewhat agree Somewhat disagree Disagree

Now we are going to ask you some true/false questions. For each of the following questions circle either true or false.

HIV and AIDS

10. Following "standard precautions" is the best way to ensure prevention of HIV transmission in a clinical setting.

- True False

11. Health workers have a professional obligation to remain objective and nonjudgemental with clients, whether they are HIV-positive or HIV-negative.

- True False

Sexual and Reproductive Health Vulnerability of HIV-Positive Women and Adolescent Girls

12. In many cultures, women at all stages of life often lack power, which prevents them from protecting themselves from SRH problems.

- True False

13. SRH needs are the same at any stage of an HIV-positive woman's or adolescent girl's life.

- True False

Rights of HIV-Positive Women and Adolescent Girls

14. HIV-positive women and adolescent girls have the same sexual and reproductive rights as women and girls not affected by HIV; for example, they have the right to have a safe and satisfying sex life.

- True False

15. HIV-positive adolescent girls are more likely to access SRH services tailored to the needs of youth.

True False

Addressing HIV and AIDS Stigma and Discrimination

16. To prevent stigma and discrimination in the health care setting, staff must treat all clients with respect and in a welcoming manner whether they are known or believed to be HIV-positive or not.

True False

17. HIV-positive women and adolescent girls are often subject to more HIV stigma and discrimination by partners, friends, and family members than HIV-positive men and because they are more likely to be get an HIV test.

True False

Basic Counselling Skills and Approaches

18. The social context is not really important when considering client risk; all clients experience the same factors when making decisions about their SRH needs.

True False

19. It is the counsellor's responsibility to persuade HIV-positive women and adolescent girls into making SRH decisions that represent the healthiest choices about sexuality and family planning.

True False

Supporting Clients' Informed and Voluntary Decision Making

20. The right of an HIV-positive woman or adolescent girl to make choices about her reproduction and sexuality has little meaning if there are not SRH services in the community that respect and support her decisions.

True False

Providing Psychosocial Support for a Positive Diagnosis

21. In situations where some women and girls feel they already have limited control over their lives, an HIV-positive diagnosis can add another layer of perceived disadvantage including a perceived reduction in their power to negotiate safer sex.

True False

22. When giving an HIV-positive diagnosis, the health worker can frame the information the same way for each client, regardless of her situation.

True False

HIV Disclosure

23. Disclosure of one's HIV status to partners, families, friends, communities/neighbours, and the public is not a one-time event, but often an ongoing process.

True False

24. The advantages of HIV disclosure always outweigh the disadvantages; therefore, counselling on disclosure should be geared towards encouraging the client to disclose.

True False

Ethics in Counselling

25. Women and adolescent girls can be tested for HIV without their knowledge if the health worker thinks it would be good for her to know her status.

True False

26. Positive HIV test results must not be used to deny treatment to anyone or to segregate them from other patients (unless it is clinically warranted).

True False

Addressing Sexuality with HIV-Positive Women and Adolescent Girls

27. If a health worker is uncomfortable about discussing sexuality with a client, she or he can just give general advice without getting into specific sexual practices.

True False

28. Health workers should wait for the client to take the initiative in introducing sexuality-related issues in counselling.

True False

Improving a Client's Ability to Perceive Risk

29. Risk assessment is a counselling process to help clients understand the risks associated with sexual and/or injecting drug use practices that they or their partners are engaging in, and how this level of risk may change depending on changes in their circumstances.

True False

30. Appropriate and prompt treatment of STIs/RTIs is recommended for HIV-positive women to prevent the gynaecological and obstetrical complications associated with STIs/RTIs.

True False

Adolescent Sexuality, Pregnancy, and HIV/AIDS

31. It is the responsibility of health workers to ensure that HIV-positive adolescent girls have sufficient information about preventing STI/RTI acquisition, HIV transmission to partners, HIV reinfection, and prevention of unintended pregnancies.

True False

32. The physical, social, and cognitive changes associated with adolescence may be intensified for HIV-positive adolescent girls as a result of feelings of shame and low self-esteem associated with their diagnosis.

True False

Counselling HIV-Positive Adolescent Girls on SRH

33. Adolescent girls often feel powerless in health care settings, and therefore suggestions from health workers can easily be taken as commands.

True False

Comprehensive SRH Care of HIV-Positive Women and Adolescent Girls

34. Screening for cervical cancer is a key component of SRH care of HIV-positive women and adolescent girls.

True False

Family Planning Needs of HIV-Positive Women and Adolescent Girls

35. An HIV-positive woman's or adolescent girl's desire to get pregnant is an obstacle to discussing family planning options.

True False

36. With few exceptions, HIV-positive women and adolescent girls can use most modern contraceptive methods.

True False

37. "Dual protection" refers to simultaneous protection against both unplanned pregnancy and acquisition of STIs and HIV.

True False

38. If a woman acquires HIV during her pregnancy or during breastfeeding, her risk of passing HIV to her infant is greater.

True False

Integrated SRH Counselling of HIV-Positive women

39. Integrated SRH counselling is a two-way interaction between a client and a health worker, to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service the client is accessing.

True False

Answer Key for Pretest and Posttest Questionnaire

The agree and disagree questions in the pretest and posttest questionnaire measure changes in trainees attitudes and beliefs and there are no wrong answers. The following answer key therefore provides the correct responses for the true and false questions only.

10. True
11. True
12. True
13. False
14. True
15. True
16. True
17. True
18. False
19. False
20. False
21. True
22. False
23. True
24. False
25. True
26. True
27. False
28. False
29. True
30. True
31. True
32. True
33. True
34. True
35. False
36. True
37. True
38. True
39. True

Participant Handouts

Appendix

C

Session	Handout Title
2	2.1: Basic HIV and AIDS Information 104
4	4.1: Communication Skills of an Effective Counsellor 106
4	4.2: Overview of REDI Counselling Model 109
5	5.1: Key SRH Concepts and Definitions 113
7	7.1: Overview of Sexual and Reproductive Rights 117
7	7.2: Testimonies of HIV-Positive Women and Adolescent Girls 122
8	8.1: Informed and Voluntary Decision Making 129
9	9.1: Laws and Policies Constraining HIV-Positive Women's and Adolescent Girls' Access to SRH Care 132
11	11.1: Disclosure Guidelines 134
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HIV

- The human immunodeficiency virus (HIV) is one of a family of viruses known as retroviruses.
- HIV can infect and destroy special white blood cells called CD4+ lymphocytes.
- These cells are an important part of the immune system, which is the body's defence against infection.
- Immune deficiency means that the immune system is weakened and is less able to fight disease.
- HIV can lead to a range of specific opportunistic infections and tumours, so called because they take advantage of the opportunity posed by the weakened immune system.

AIDS

- Acquired immunodeficiency syndrome (AIDS) is the late stage of HIV disease.
- HIV weakens the body's ability to fight other infections and diseases.
- A person is said to have AIDS when the virus has weakened the body's immune system to such an extent that he or she develops one or more specific infections and cancers. The World Health Organization (WHO) considers an adult or an adolescent (someone older than 12 years of age) to have AIDS if a test for the antibody gives a positive result and if one or more of the following conditions are present:
 - >10% body-weight loss or cachexia, with diarrhoea or fever or both, intermittent or constant for at least one month, not known to be due to a condition unrelated to HIV infection;
 - cryptococcal meningitis;
 - pulmonary or extrapulmonary tuberculosis;
 - Kaposi's sarcoma;
 - neurological impairment that is sufficient to prevent independent daily activities, not known to be due to a condition unrelated to HIV infection;
 - candidiasis of the oesophagus (which may be presumptively diagnosed based on the presence of oral candidiasis accompanied by dysphagia);
 - clinically diagnosed life-threatening or recurrent episodes of pneumonia, with or without aetiologic confirmation;
 - invasive cervical cancer.

Source: WHO. 1994. *Weekly epidemiological record*, No. 37, p. 274. Geneva.

Other Key Points

- HIV and AIDS are not the same.
- For most of the duration of HIV illness, people who have HIV look like everyone else.
- The majority of HIV-positive people in the world do not realize that they are infected.
- While people living with HIV are potentially infectious to others, HIV infection can only be transmitted in very specific ways. These include:
 - vaginal/anal intercourse
 - needles
 - mother-to-child transmission
 - unscreened blood products
- From the time of initial infection with HIV, it takes up to 10 years to develop symptoms of AIDS.
- There is no known cure for HIV and AIDS, although antiretroviral (ARV) drugs can significantly improve the quality and length of life of a person living with HIV or AIDS.
- Since the presence of other STIs can increase people's susceptibility to HIV infection,* efforts to diagnose and treat curable STIs have become a major strategy in combating the HIV epidemic. HIV and STI diagnosis and treatment efforts include counselling to ensure proper treatment and strategies for notifying partners for treatment.
- There are a number of different tests for detecting the HIV virus by looking for antibodies in the blood against the virus.
- Transmission of HIV and other STIs through sexual activity can be prevented by the consistent and correct use of condoms, both male and female.
- A woman infected with HIV can pass the virus to her baby during pregnancy, during labour and delivery, or during breastfeeding. This is called mother-to-child transmission (MTCT), or vertical transmission.

* WHO. 1999. *STD case management: The syndromic approach for primary health care settings*. Training Guide. Geneva; Silva, G., et al. 2002. Sexually transmitted infections as facilitators of HIV infection—experiment in Brazil. Abstract from XIV International AIDS Conference, 7–12 July; and Taha, T. E., and Gray, R. H. 2000. Genital tract infections and perinatal transmission of HIV. *Annals of the New York Academy of Sciences* 918:84–98.

4.1 Participant Handout

Communication Skills of an Effective Counsellor

(Adapted from: EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum. Participant Handbook*. New York.)

1. Rapport Building

Welcoming the Client

The four steps of “welcoming the client” are:

- Welcome the client.
- Make introductions.
- Introduce the subject of sexuality.
- Assure confidentiality.

Aspects of welcoming the client include being friendly, nonjudgemental, and respectful, and showing interest in the client’s situation and needs.

Respect

Different cultures have different customs for showing respect between individuals. It is important for health workers to consider how they show respect for their clients. They should also consider the power imbalances that may exist between themselves and clients because of socioeconomic status or education, and how such imbalances may affect communications between health workers and clients.

Showing respect supports clients’ right to dignity in their interactions with health workers. In many cultures, genuine praise and encouragement for clients will show respect for their efforts as individuals who are trying to deal with their health problems, even if their efforts have been uninformed or misguided. In addition, praise and encouragement are usually effective in helping clients to acknowledge and solve their problems.

Praise

Praise is the expression of approval or admiration. In the health care setting, to give praise is to reinforce good behaviour—that is, identify and support the health-seeking behaviour of clients. Examples include:

- showing that you respect their concern for their health;
- acknowledging difficulties they may have overcome to be at the facility;
- looking for something to approve of rather than to criticize.

Encouragement

Encouragement is giving courage, confidence, and hope. In the health care setting, to give encouragement means letting clients know that you believe they can overcome their problems and helping them find ways to do so. Examples include:



- pointing out hopeful possibilities;
- focusing on what is good about what they have done and urging them to continue;
- telling them they are already helping themselves by coming to the health facility.

2. Asking Open-Ended Questions

Open-ended questions are useful for exploring the client's opinions and feelings and usually require longer responses. These questions are more effective in determining what the client needs (in terms of information or emotional support) and what he or she already knows. Examples include:

- How can we help you today?
- What do you think could have caused this problem?
- What have you heard about this family planning method?
- [For postabortion care clients] How did you feel when you first found out you were pregnant? How do you feel now?
- What questions or concerns does your husband/partner have about your condition?
- What do you plan to do to protect yourself from getting a sexually transmitted infection again?
- What made you decide to use the same method as your sister?

3. Effective Listening

Listening skills can be improved by:

- maintaining eye contact with the speaker (within cultural norms);
- demonstrating interest by nodding, leaning towards the client, and smiling;
- sitting comfortably and avoiding distracting movements;
- paying attention to the speaker (e.g., not doing other tasks at the same time, not talking to other people, not interrupting, and not allowing others to interrupt);
- listening to your client carefully, instead of thinking about other things or about what you are going to say next;
- listening to what your client says and how he or she says it, and noticing the client's tone of voice, choice of words, facial expressions, and gestures;
- imagining yourself in your client's situation as you listen;
- keeping silent sometimes, and thus giving your client time to think, ask questions, and talk;
- paraphrasing what the client has said as a way of showing you understand what he or she has said, as well as clarifying that you have understood correctly.

4. Using Language the Client Understands

Language and Sexuality

- One challenge that people confront in discussing matters related to sexuality and sexual and reproductive health (SRH) is in choosing the words to use. Sometimes the words that come to mind seem either too clinical or too offensive. However, to communicate effectively, you as a health worker must know the words that a client would understand.
- You should not feel obliged to use words that you consider offensive throughout the counselling session. However, it is important to identify the word a client uses for a particular body part or activity and then explain to the client that, when a particular medical term is used, it refers to that body part or activity.
- If you are comfortable enough to use local words as a bridge for understanding, it will help the client to overcome his or her own embarrassment at discussing these subjects. An important part of this training process is for you to say the words out loud, so you begin to feel more comfortable about using them or hearing them from clients.

Using Simple Language

- For effective communication, it is essential to explain issues of SRH in ways that clients understand. Even when we feel that we know something very well, it can be hard to find simple ways to explain it. This gets easier with practice.
- Asking what the client already knows is essential. It lets you know what level of terminology (for example, slang, common words, or medical terms) the client will understand. This also gives you a starting point, by reinforcing the client's current knowledge and correcting inaccuracies.
- Not finding out first what the client already knows can lead to two common errors: explaining at a level beyond his or her comprehension, or wasting time explaining what he or she already knows (perhaps insulting the client in the process).
- There is rarely enough time in counselling to adequately explain everything that the client needs to know. This process is much more efficient if the basic information about anatomy and physiology and key medical terms are explained in group education sessions prior to counselling. Then, during counselling, you can quickly review the information to see what the client did or did not understand and what questions he or she might have, and then move on to counselling the client about his or her individual risks for HIV, for sexually transmitted or reproductive tract infections, or for pregnancy risks, as well as the decisions that need to be made regarding testing, SRH choices, and possible behaviour change.

(Adapted from: EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum. Participant Handbook*. New York.)

REDI: Rapport-Building, Exploration, Decision Making, and Implementing the Decision

<p>Phase 1: Rapport-Building</p> <ul style="list-style-type: none"> • Welcome the client • Make introductions • Introduce the subject of sexuality • Assure confidentiality <p>Phase 2: Exploration</p> <ul style="list-style-type: none"> • Explore the client's needs, risks, sexual life, social context, and circumstances • Assess the client's knowledge and give information, as needed • Assist the client to perceive or determine his (his partner's) or her own pregnancy or HIV and sexually transmitted infection (STI) risk 	<p>Phase 3: Decision Making</p> <ul style="list-style-type: none"> • Identify what decisions the client needs to make in this session • Identify the client's options for each decision • Weigh the benefits, disadvantages, and consequences of each option • Assist the client to make his or her own realistic decisions <p>Phase 4: Implementing the Decision</p> <ul style="list-style-type: none"> • Make a concrete, specific plan for carrying out the decision • Identify skills that the client will need to carry out the decision • Practise skills, as needed, with the health worker's help • Make a plan for follow-up
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Note: The bullets below are suggestions for areas to address in each phase of REDI. They are not meant as a checklist to follow in strict order, nor are they to be read or recited to the client. The interaction should always be tailored to the client's situation.

Phase 1: Rapport-Building

1. Welcome the client:
 - Greet the client warmly.
 - Help the client to feel comfortable and relaxed.
2. Make introductions:
 - Identify the reason for the client's visit.
 - Ask general questions, such as name, age, number of children, etc.
3. Introduce the subject of sexuality:
 - Explain the reasons for asking questions about sexuality.

4.2 Participant Handout

Overview of REDI Counselling Model (*cont.*)

- Put it in the context of HIV and sexually transmitted infections (STIs), and assure the client that you discuss HIV and STIs with all clients.
 - Explain that the client does not have to answer all of your questions.
4. Assure confidentiality:
- Explain the purpose of and the policy on confidentiality.
 - Create an atmosphere of privacy by ensuring that no one can overhear your conversation, even if you are not able to use a separate room.

Phase 2: Exploration

1. Explore the client's needs, risks, sexual life, social context, and circumstances:
 - Assess what the client understands about his or her sexual and reproductive health (SRH) condition or situation, what worries or concerns he or she might have, and what he or she specifically hopes to accomplish through the visit.
 - Explore the context of the client's sexual relationships:
 - What sexual relationships is he or she in, what is the nature of the relationships (including any violence or abuse), and how does he or she feel about it?
 - How does he or she communicate with partners about sexuality, family planning, and HIV and STIs?
 - What does he or she know about his or her partners' sexual behaviour outside of the relationship?
 - Explore the client's pregnancy history and knowledge of and use of family planning methods, including condoms.
 - Explore the client's HIV and STI history, present symptoms, and knowledge of partners' HIV and STI history.
 - Explore other factors about the client's circumstances that may limit his or her power or control over decision making, such as financial dependence on partners, tensions within an extended family, and fear of violence, among others.
2. Assess the client's knowledge and give information, as needed:
 - Assess the client's knowledge of pregnancy-related care (if appropriate), postabortion care (if appropriate), family planning, HIV, and STIs.
 - Correct misinformation and fill in gaps, as needed.
3. Assist the client to perceive or determine his or her own pregnancy (or partner's pregnancy) risk or HIV and STI risk:
 - Ask the client if he or she feels at risk for unintended pregnancy or for HIV and STI transmission, and explore why or why not.
 - Ask the client if he or she thinks that his or her partners may be at risk for unintended pregnancy or HIV and STI transmission, and explore the reasons.

4.2 Participant Handout

Overview of REDI Counselling Model (*cont.*)

- Explain HIV and STI transmission and pregnancy risks (as necessary), relating them to the individual sexual practices of the client and his or her partners.
- Help the client to recognize and acknowledge his or her risks for HIV and STI transmission or unintended pregnancy.

Phase 3: Decision Making

1. Identify what decisions the client needs to make in this session:
 - Help the client to prioritize the decisions, to determine which are the most important to address today.
 - Explain the importance of the client's making his or her own decisions.
2. Identify the client's options for each decision:
 - Many health workers and clients feel that in most areas of SRH, the client's decision-making options are limited. An important role of the health worker is to lay out the various decisions that a client could make, to explore the consequences of each. This empowers the client to make his or her own choice, which is a key element of supporting the client's sexual and reproductive rights.
3. Weigh the benefits, disadvantages, and consequences of each option:
 - Make sure the discussion centres on options that meet the client's individual needs, taking into account his or her preferences and concerns.
 - Provide more detailed information, as necessary, on the options that the client is considering.
 - Consider who else would be affected by each decision.
 - Explore with the client how he or she thinks that partners or family members may react to the course of action (e.g., suggesting condom use or discussing sexuality with partners).
4. Assist the client to make his or her own realistic decisions:
 - Ask the client what is his or her decision (i.e., what option he or she chooses).
 - Have the client explain in his or her own words why he or she is making this decision.
 - Check to see that this decision is the choice of the client, free of pressure from spouse, partner, family members, friends, or health workers.
 - Help the client to assess whether his or her decision can actually be carried out, given his or her relationships, family life, and economic situation, among other issues.

Phase 4: Implementing the Decision

1. Make a concrete, specific plan for carrying out the decision:
 - Be *specific*. If a client says that he or she is going to do something, find out when, under what circumstances, and what his or her next steps will be in each situation. Ask-

4.2 Participant Handout

Overview of REDI Counselling Model (*cont.*)

ing a client “What will you do next?” is important in developing a plan to reduce risk. For example, if a client says that he will start to use condoms, the health worker should ask, “How often?” “Where will you get the condoms?” “How will you pay for them?” “How will you tell your partner that you want to use them?” and “Where will you keep them so you will have them with you when you need them?”

- Ask about possible consequences of the plan: “How will your partner(s) react?” “Do you fear any negative consequences?” “How will the plan affect relationships with your partners?” “Can you communicate directly about the plan with your partners?” and “Will indirect communication be more effective at first?”
 - Ask about social supports. Who in the client’s life can help the client carry out the plan? Who might create obstacles? How will the client deal with a lack of support or with individuals who interfere with the client’s efforts to reduce risk?
 - Make a “Plan B”—that is, if the plan does not work, then what can the client do?
2. Identify skills that the client will need to carry out the decision (see number 3, below).
 3. Practise skills, as needed, with the health worker’s help:
 - Partner communication and negotiation skills:
 - Discuss the client’s fears or concerns about communicating and negotiating with partners about condom use, family planning, maternal health concerns, safer sex, or sexuality, and offer ideas for improving communication and negotiation.
 - For a client who feels that it may be difficult to negotiate condom use for HIV and STI prevention, discuss whether it might be easier to introduce condoms for pregnancy prevention.
 - Role-play with the client possible communication and negotiation situations.
 - Condom-use skills:
 - Demonstrate correct condom use on a penis model, describe the steps, and ask the client to repeat the demonstration to be sure that he or she understands.
 - Discuss strategies for making condom use more acceptable to partners.
 - Provide samples of condoms (if possible) and make sure that the client knows where and how to obtain more.
 - Skills in using other family planning methods:
 - Make sure that the client understands how to use other family planning methods that he or she has selected by asking the client to repeat back basic information and by encouraging him or her to ask for clarification.
 4. Make a plan for follow-up
 - Invite the client to return for a follow-up visit to provide ongoing support with decision making, negotiation, and behaviour change.
 - Explain timing for medical follow-up visit or contraceptive resupply.
 - Make referral for services not provided at your facility.

5.1 Participant Handout

Key SRH Concepts and Definitions

(Adapted from: EngenderHealth. 2003. Comprehensive counseling for reproductive health: An integrated curriculum. Participant Handbook. New York; and International Conference on Population and Development [ICPD]. 1994. Programme of action. Retrieved 26 June 2006 at: www.unfpa.org/icpd/icpd_poa.htm#ch7.)

Sex

Sex can mean the biological characteristics (anatomical, physiological, and genetic) that make us male or female.

Sex also can mean sexual activity, including sexual intercourse.

Sexuality

Sexuality is the way in which an individual experiences being male or female. This includes physical and biological aspects of one's life (e.g. menstruating, having wet dreams, being pregnant, or having sexual intercourse), as well as emotional aspects (such as being attracted to another person, including sexual orientation) and social aspects (such as behaving in ways that are expected by one's community, based on whether one is male or female; this includes gender roles).

Sexuality:

- involves the mind and the body;
- is shaped by our values, attitudes, physical appearance, beliefs, emotions, personality, likes and dislikes, and ways in which we have been socialized;
- is influenced by social norms, culture, and religion;
- involves giving and receiving sexual pleasure, as well as enabling reproduction;
- spans our lifetimes.

Gender

Gender is how an individual or society defines “female” or “male”. Gender roles are socially and culturally defined attitudes, behaviours, expectations, and responsibilities for males and females. Gender identity is the personal, private conviction each of us has about being male or female; it defines the degree to which each person identifies himself or herself as male, female, or some combination of the two.

Sexual Orientation

Heterosexuality is an erotic or romantic attraction to people of the opposite sex. Homosexuality is an erotic or romantic attraction to people of the same sex. Bisexuality is an erotic or romantic attraction to people of both sexes.

Reproductive Health

According to a definition agreed to at the International Conference on Population and Development (ICPD), held in Cairo, Egypt, in 1994:

Reproductive health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when, and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice ... and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems (see: www.unfpa.org/ipcd/summary.htm#chapter7).

Sexual Health

The term sexual health includes aspects of sexuality not necessarily related to reproduction. It recognizes the fact that people may have sex for the purposes of pleasure, not just reproduction, and that people have health needs related to such sexual activity.

According to the International Women's Health Coalition (IWHC):

Sexual health means having a responsible, satisfying, and safe sex life. Achieving sexual health requires a positive approach to human sexuality and mutual respect between partners. By recognizing sexual health—and sexual rights—health and education systems can help prevent and treat the consequences of sexual violence, coercion, and discrimination, and can ensure that healthy human sexuality is enjoyed by all people and is accepted as part of their overall well-being (see: IWHC. 2001. *Sexual Health*. New York. Retrieved at www.iwhc.org/docUploads/FWCW/%5FSexHealthfactsheet.PDF).

The IWHC describes the basic elements of sexual health as:

- a sexual life free from disease, injury, violence, disability, unnecessary pain, or risk of death;
- a sexual life free from fear, shame, guilt, and false beliefs about sexuality;
- the capacity to enjoy and control one's own sexuality and reproduction.

Sexual and Reproductive Health

Definitions of sexual health and reproductive health overlap. To avoid confusion and to ensure that all areas are covered, many providers, planners, and policymakers now use the term

5.1 Participant Handout

Key SRH Concepts and Definitions (*cont.*)

sexual and reproductive health, which includes everything encompassed in both sexual health and reproductive health.

The term *sexual and reproductive health* can refer to a state of health and well-being, types of services, or an “approach” to service delivery, as follows:

A state of health and well-being:

- physical, mental, and social well-being related to sexuality and reproduction;
- freedom to enjoy sexual relations without fear of pregnancy, disease, or abuse of power, sexual coercion, or violence;
- equal balance of power in sexual relations;
- respect for bodily integrity and the right to control one’s own body.

Types of services:

- pregnancy-related services (antenatal, postpartum, and emergency obstetrical care);
- HIV and sexually transmitted infection (STI) prevention and services;
- family planning;
- postabortion care;
- integrated services (e.g., family planning and HIV and STI prevention).

Approach to services:

- the *way* in which services are provided
- the *issues* that are taken into account or addressed when services are provided
- new ways of providing *existing* services
- the *mentality* and *attitude* behind the way in which services are provided.

Some examples of an “approach” to services include:

- taking a holistic, integrated approach to reproductive health and to service provision;
- focusing on partner involvement and communication;
- promoting sensitivity to gender issues;
- promoting awareness of sexuality;
- taking into account the context of people’s decision making (e.g., gender power dynamics, poverty, domestic violence, and other vulnerabilities);
- incorporating a human rights perspective in counselling and other services;
- fostering community involvement.

Components of Sexual and Reproductive Health Care

According to the Programme of Action adopted at the ICPD in 1994 (Paragraphs 7.2, 7.3, and 7.6), the following are components of reproductive rights and reproductive health care:

- family planning information, counselling, and services;
- prevention and treatment of STIs and reproductive tract infections;
- diagnosis and treatment of HIV and AIDS;
- antenatal, postpartum, and delivery care;
- health care for infants;
- management of abortion-related complications;
- prevention and treatment of infertility;
- information, education, and counselling on human sexuality, sexual and reproductive health, and parenthood;
- diagnosis and treatment of cancers of the reproductive system.

7.1 Participant Handout

Overview of Sexual and Reproductive Rights

Global Perspective

- In 1993, the World Conference on Human Rights declared in Vienna that women's rights were human rights.
- The Cairo Programme of Action adopted at the International Conference on Population and Development (ICPD) in 1994 refined the Vienna affirmations and committed participating governments to ensuring that human rights, whether in national constitutions or human rights treaties, should be applied to promote reproductive and sexual rights.
- The sexual and reproductive rights of people living with HIV (PLHIV) and other vulnerable key populations, including sex workers, injecting drug users (IDUs), men who have sex with men, youth, migrants, prisoners, etc., are no different from those rights of people who are not directly affected by HIV.
- This recognition of human rights is grounded in international human rights law, through all the international and regional instruments, which guarantees rights and freedoms to everyone without distinction of any kind, such as race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.

Key International Agreements and Commitments

- The ICPD Programme of Action (United Nations, 1994) is the major international consensus document that elaborates sexual and reproductive health (SRH) and reproductive rights (www.unfpa.org/icpd/icpd_poa.htm, last retrieved 21 August 2006).
 - The ICPD Programme of Action includes sexual health under the definition of reproductive health. Thus, by implication, rights related to sexual health are covered by the definition of reproductive rights.
 - The Platform for Action agreed to at the Fourth World Conference on Women in Beijing in 1995, went further to define sexual rights (www.un.org/womenwatch/daw/beijing/fwcw.htm, last retrieved 21 August 2006).
 - The 1989 Convention on the Rights of the Child and other international human rights agreements adopted over the last 15 years also uphold adolescents' reproductive health and rights.
- Over the last decade, the human rights vocabulary has been used to hold governments accountable for failing to protect SRH.
 - Some conservatives around the world now see view this language as an obstacle to some fundamental issues they oppose, including abortion rights, adolescents' rights to information and services on sex-related matters, nontraditional sexual orientations and families, and greater equality for women.

7.1

Participant
HandoutOverview of Sexual and Reproductive Rights (*cont.*)**Examples of sexual and reproductive rights:**

Sexual rights are the rights of all people to:
say “No” to sex
practise safer or protected sex
decide who we have sex with without being judged
decide on the type of sex practised (“genital”, oral, penetrative, etc.)
sex education and information on sexual rights and health
take legal action against any sexual abuse or harassment
sexual pleasure
access to treatment for sexual health problems and services to ensure sexual health is maintained
not undergo harmful traditional practices
not be forced into marriage

Reproductive rights are the rights of all people to:
decide whether and when to conceive without being judged
safe abortion or sterilisation without requiring the consent of another person
keep the baby
adopt
education and accurate unbiased information on reproductive health options (labour, delivery, breast feeding, and prevention of mother-to-child transmission of HIV)
access quality antenatal care (with or without being accompanied by a partner)
equal access to SRH care, regardless of social, economic, or political status
family planning information and decision making over the type and use of contraception
access to preventive methods of contraception such as microbicides
safe delivery, how and where we want
assisted conception or artificial insemination

Adapted from: ICW. 2004. Young women’s dialogue: Swaziland workshop report.



Operationalizing SRH Rights of PLHIV

- There is a need to move from rhetoric to action and to operationalize the SRH rights of PLHIV and other key vulnerable populations at international and national levels.
- Formulating a conceptual framework, which is based on standards and principles in existing international treaties and agreements and is comprehensive in scope, can provide some practical guidance to policymakers, program developers, program managers, advocates, and providers for achieving a rights-based approach to the SRH care of HIV-positive women.
- International and national SRH-related policies and programmes must take into account the rights, needs, and aspirations of HIV-positive women and men. Based on human rights norms and the effectiveness of these approaches, the most important of these principles are outlined below:

Guiding Principles for Addressing the SRH Rights and Needs of PLHIV

- HIV-positive women, men, and young people must be able to make noncoerced and autonomous decisions regarding sexuality and fertility.
- Through the health system, HIV-positive women, men, and young people must have access to relevant information, counselling, and services tailored to their SRH-related needs.
- HIV-positive women, men, and young people must be entitled to confidentiality, and their fully informed consent must be sought in all service provision.
- Whenever possible, HIV-positive women, men, and young people should be given the opportunity to involve their partners in decision making and action regarding sexuality, reproductive health, and child care.
- The needs of both HIV-concordant and HIV-discordant couples should be taken into account, as well as the needs of those who are not living in couples and who may or may not have one or more regular sexual partners.
- Caregivers and health professionals who deliver SRH services to HIV-positive women, men, and young people must have sufficient good-quality equipment, supplies, and training for universal precautions that can protect them and their patients from (re-)infection with HIV and other blood-borne infections, such as hepatitis.

Adapted from: de Bruyn, M. 2000. *Gender, adolescents and the HIV/AIDS epidemic: the need for comprehensive sexual and reproductive health responses*. Report from Expert Group Meeting on the HIV/AIDS Pandemic and its Gender Implications, 13–17 November 2000, Windhoek, Namibia. Retrieved 7 September 2006 at: www.un.org/womenwatch/daw/csw/hivaids/De%20bruyn.htm.

7.1

Participant
HandoutOverview of Sexual and Reproductive Rights (*cont.*)

- A key challenge lies in generating political commitment, action, and accountability among international bodies and national governments for such a framework, including ensuring the effective flow of resources to address policy and programmatic gaps. It is this which will, finally, secure the rights of PLHIV and other key vulnerable populations to the standard of SRH care they need.
 - Controversial for some national governments is addressing sexual rights in the context of SRH, as this is linked to other sensitive issues, including homophobia, same-sex marriage, the rights of sex workers, the rights of IDUs, etc.
 - Competing for resources with other needs, including antiretroviral therapy, the provision of comprehensive SRH care for PLHIV is a low priority for most countries with high HIV rates. Consequently, these services are often characterized by a narrow range of services, poor integration with other HIV services, low quality of client-provider interaction, high levels of stigma and discrimination, and limited access, particularly by vulnerable groups such as IDUs, sex workers, and men who have sex with men.
- Efforts to operationalize SRH programs for PLHIV are fundamentally inhibited by distinct funding and administrative mechanisms that reinforce separateness through discrete reporting requirements for monitoring, evaluation, and funding accountability.
 - Even within departments such as maternity services, staff of antenatal, labour and delivery, and postnatal wards often do not communicate across units, and rarely do they communicate with related outpatient units, such as family planning, antenatal, postnatal, and child health. In addition, lack of orientation among staff to seeing the value of and learning how to collaborate with related units further impedes integration of services and communication between HIV and family planning providers.
 - Monitoring SRH policy implementation at the international and national levels, as well as governments' adherence to international treaties and agreements, represents major challenges, given competing demands on scarce resources, the myriad national laws, policies, and guidelines intersecting in the area of SRH of HIV-positive women and adolescent girls, and the level of stigma and discrimination towards HIV-positive women and adolescent girls in many countries.
 - Also, few policy-level indicators have been developed to monitor the quality of care of HIV-positive women. Ipas, in collaboration with the International Community of Women Living with HIV/AIDS (ICW) and other partners, developed a tool for monitoring the achievement of the Millennium Development Goals (MDGs) relevant to the sexual and reproductive rights of HIV-positive women. Two of the United Nations–endorsed MDGs are directly related: MDG 5 aims to improve maternal health by reducing the maternal mortality ratio by 75%, while MDG 6 aims to halt and begin to reverse the spread of HIV/AIDS (www.unfpa.org/icpd/about.htm, retrieved 21 August 2006).
- Emphasis should be placed on evidence-based advocacy to inform policymakers, program managers, health care workers, and community members about the SRH needs and con-

7.1**Participant
Handout****Overview of Sexual and Reproductive Rights (*cont.*)**

cerns of PLHIV and other key vulnerable populations. Examples of issues that advocacy should focus on include:

- Introducing laws that criminalize domestic and sexual violence, including marital rape and incest, give women the possibility of bringing legal action against perpetrators. Regulations that establish minimal services for violence survivors, such as postexposure prophylaxis (for women who are HIV-negative), emergency contraception, legal abortion, access to legal aid, and referrals to rape crisis counseling and shelters, can help women cope with the consequences of violence.
- Amending laws that criminalize drug use, sex work, and abortion can enable women to better access treatment services that will enhance their SRH. Passage of laws that guarantee women's rights in the areas of health care, education, employment, property rights, and family matters all serve to promote women's resources, and hence their well-being. The same is true for specific laws prohibiting discrimination against PLHIV.
- Ensuring that PLHIV and key vulnerable populations are engaged in a meaningful way can inform and direct policies and programs.
- Reassessing health budgets to determine reallocation of funds can contribute to linkages and integration of HIV/AIDS and other SRH services.
- Promoting dialogue among civil society organizations, PLHIV and other key vulnerable populations, and health workers can improve the health system's ability to address the unmet SRH needs and concerns of PLHIV, sex workers, IDUs, men who have sex with men, youth, migrants, etc.
- Engaging community leaders can raise community awareness about the SRH needs of these key vulnerable populations.

Note: Adapted from EngenderHealth, Harvard University, ICW, Ipas, and UNFPA. 2006. Rights-based approach to sexual and reproductive health for HIV-positive women and adolescent girls. Draft paper prepared for EngenderHealth and for UNFPA.

A Testimony from South Africa

I learned about my HIV status in 1995 when I went for my tuberculosis check-up. I was pregnant at the time. I was 20 years old at the time. (I think that I was infected when I was 15 years old because my first child, who is now 12, is also living with HIV/AIDS. The doctors speculate that she was infected at birth.) I was pregnant. I happily agreed to have an HIV test at the time, never thinking that the result would be positive. When I received my result, I was shocked and angry. I had been part of an HIV/AIDS project while at school. I knew about AIDS, but I just didn't think it would happen to me. I had one sexual partner, was from a religious family, and was not sleeping around.

I found it very difficult to disclose my HIV status. After much soul-searching, I came to terms with the fact that I was HIV-positive and that I could do nothing to change the situation. I accepted myself as a woman living with HIV/AIDS. I told my partner and my family. My partner was shocked and found it hard to believe. My family was supportive.

Anger led me to attend AIDS meetings. I wanted to change the way AIDS work was being done. After all, if AIDS prevention were working, I would not have been infected. Five months after learning I was HIV-positive, I began to speak openly about living with HIV/AIDS in an effort to prevent others from becoming infected. My parents were not happy about my speaking openly about living with HIV/AIDS. They are staunch Catholics and felt that my openness would impact negatively on the family in the eye of the church.

At eight months, the baby I was carrying died in utero. Three days after I discovered that my baby was no longer breathing I was induced, and I gave birth to my stillborn child. This was a horrifying experience for me. One day later my partner lost another child that he had with another woman. This child was also stillborn and the cause was also an in-utero infection. I began to realize that HIV was really in my body and was causing slow damage.

Losing two babies also made my partner worried. Up to that point, he had been denying that he might be infected. He started to question how he could be HIV-positive, and he began to blame me for bringing HIV to his life. It did not stop there. My partner went to his family and told them about my HIV status, but neglected to tell them that he was HIV-positive too. He told them that if anything happened to him, I would be responsible.

The abuse began growing daily. He beat me because he was HIV-positive and frustrated. I had to accept the way he was treating me—if I challenged his actions, it meant that I did not care for him. He demanded that I support him despite his abuse of me. It was at this

(cont.)

7.2 Participant Handout

Testimonies of HIV-Positive Women and Adolescent Girls (*cont.*)

A Testimony from South Africa (*cont.*)

time that I married him. We'd been living together for a while; he had paid *lobola* (bride wealth) to my parents. Although I knew the relationship was abusive, I felt I had no choice but to marry him.

Marriage changed nothing. He became more and more angry with me for attending AIDS meetings and giving talks about my personal story. He was jealous of my meeting other people who are HIV-positive, saying that I cared for and supported other people at his expense. Although we were both receiving counselling and information about the necessity to practise safer sex in order not to reinfect each other, he forced me into unprotected sex because I was his wife and he had paid *lobola* for me. My life became an endless circle of beatings and unprotected sex, especially if he was drunk. I could not take it any longer and I left him, despite the cultural disgrace and shame that it caused.

Three months after leaving him, I became sick. The doctors diagnosed a cervical cyst. I was hospitalized so that the cyst could be removed. However, the doctors also found out that I was pregnant. I did not want to have a child at this stage and requested the pregnancy to be terminated. The doctors agreed to the termination only on condition that I consent to being sterilized. I had no option. Because of the attitude of the nursing sisters, it took three days for my termination to be performed. I had to put up with the judgemental attitude of the health care staff, including their disbelief that a woman with HIV would get pregnant.

My story highlights some of the negative aspects and issues of being a woman living with HIV/AIDS. However, things are not all negative. It is possible to live a positive life with HIV and its stigma and discrimination; the obstacles can be overcome.

Source: ICW member, 2006, published with permission of ICW.

A Testimony from Thailand

If there really are “good women” and “bad women” as society defines and then divides us, I proclaim that I was a “good woman” who always behaved in whatever ways a “good woman” is supposed to. I grew up in a family in which the father had absolute power in the house. Following Chinese family culture, and because I was a daughter, I didn’t go on to higher education, as I would belong to another family when I married. Nonetheless, I was raised with strict controls from my parents as they were afraid that a daughter might besmirch the family honour. As an ancient saying goes: “Having a daughter is like having a toilet in front of the house”. I behaved myself in order to meet the standards of a high class toilet—clean and no smell. I adhered strictly to the Thai maxim of keeping your virginity until marriage. My first sex was when I got married at 28 to a man whom I considered a responsible and loving husband.

We Thought We Were Safe

Before getting married, I asked my boyfriend to take a blood test and show me the result. At the time, there was a tremendous campaign by the government. I remember clearly one TV ad saying that “It’s not important how much the dowry is, but the HIV test result is a must”. However, what we didn’t know was that taking a blood test did not tell you anything about your HIV status if you didn’t specify that you wanted an HIV test. My boyfriend went for a blood test and found out that he had no health problems. Therefore, we had our wedding in 1995. He had to borrow money for both the dowry and the expenses for the wedding.

Then early in 1996, when I was four months pregnant, I went to the hospital for antenatal care service. It was there that a nurse told me I had HIV. My life fell apart. Abortion was the only solution I could think of. I thought my baby would also be infected, and even if the baby was fine, I didn’t know how long I would stay alive. I found out it cost 3,000 Baht (US\$75) for an abortion at four months. It might seem a small amount for many, but I couldn’t afford it, as I still had wedding debts. I decided to take some drugs to cause a miscarriage, but I didn’t succeed. I had no choice but to keep the baby.

I Tried Suicide

Meanwhile, my husband became sick. His discouragement at discovering he had HIV and guilt for passing the virus to me contributed to his illness. I was furious. However, I had no choice but to stand by him and encourage him that we had to face the situation together. I was under stress and desperate about my baby, taking care of my ill husband, and doing his janitor work at the school. I tried to commit suicide three times by taking all kinds of drugs, but it never worked.

(cont.)

7.2 Participant Handout**Testimonies of HIV-Positive Women and Adolescent Girls (cont.)****A Testimony from Thailand (cont.)**

My husband died when my daughter was 15 months old. After he'd gone, the insurance benefit freed me from debts. I also kept some savings for my daughter's future—the daughter I didn't feel “love” for at all. After she was born, every time I looked at her, I could only think of all the sadness and misery in my life. I would have continued being a strange mother, except one day, my daughter—who by then could talk—said, “I love and care about you; I want to have a mother”. I was speechless and could feel what she needed. At that moment I realized I must live on because she needed me. While watching her, I asked myself, “Is this the little one I once wanted to kill?”

Ten Years On

It has been almost 10 years now that I have lived with HIV. Bad dreams turned into an understanding that AIDS is not fearful, nor sinful. I have gained more understanding of life after sharing my sorrows, tears, and happiness with my positive friends, most of whom are widows like me. I became a committee member of the Thai National Network of People Living with HIV/AIDS. At present, I work full-time for the network on a project aiming at strengthening [such] groups in order to be part of the [antiretroviral] treatment and comprehensive health care system. I have joined the Thai Women and HIV/AIDS Task Force, for I myself have seen and faced gender bias and the nonsense of inequalities.

I have learned more about HIV/AIDS. I understand that when my husband went for a blood test, it was a general health check-up, not an HIV test. I think perhaps there are many people out there who still don't know about HIV/AIDS. Just like me. I want them to know more. I want them to know it is never too late.

Source: ICW. 2004. *ICW News*, #26, July/August.

A Testimony from Bolivia

When I was younger, no one ever spoke to me honestly about anything related to sex and sexuality, so I learned most of what I know in secrecy.

When I was 20 years old, I was raped. I suspect the two men responsible for doing this also infected me, but they were strangers and I never met them again. Being a rape survivor damaged my self-image for a long time, and the impact of that experience on my sexual life was enormous. I felt destroyed, and I engaged in sex without any caution or care for myself. I wanted to die. Three years after I was raped, I discovered I had HIV.

I have never been pregnant, so I don't know what it feels like, but I am conscious that for me, becoming a mother is more complex than for women who are not living with HIV. Some people have said to me that women who are HIV-positive will automatically put their babies at risk. In fact, all pregnancies involve risk, whether the woman is HIV-positive or not. HIV does not take away my right to become a mother.

I want very much to have a baby, but I want to be confident he or she will be okay in every sense. One consequence I still carry as a rape survivor is that I am unable to trust men—I simply don't believe what they say. But I am working on this. I want to make sure I am with the baby and the baby's father. Then if I fall sick the father will be there to take care of the baby.

I have many fears around having a child, and at the moment I don't have a partner to support me in this choice. It's difficult because most men don't want to be with a woman who might become sick. Traditional gender roles are still quite rigid in our society, so men want someone who will always take care of them and be a good wife. If I ever find a man who is prepared to live with me and to love the baby we would hope to create together, I would consider him a gift from God. The possibility of one day being a mother fills me with happiness, but it feels far from my reach right now.

Because of the HIV infection, I am beginning to feel physically weaker. One of my fears is that my strength will not last until the possibility of getting pregnant becomes a reality. I think all sexual and reproductive health organizations and family planning clinics have to accept and understand fully how HIV/AIDS affects women. Organizations need to stop the denial and involve HIV-positive women in their programmes. They should promote HIV/AIDS awareness for prevention, treatment, care, and support for positive women as a matter of urgency.

The future feels uncertain and I do not dwell on it. I prefer to concentrate on the present—I am alive today and I will live today to the full. Tomorrow will bring its own problems. In my ideal future, I dream of being the mother of two beautiful babies, married to a loving husband, and working in a relevant HIV organization.

(Source: International Planned Parenthood Federation (IPPF)/ICW. 2004. *Dreams and desires: Sexual and reproductive health experiences of HIV-positive women*. London.)

7.2 Participant Handout

Testimonies of HIV-Positive Women and Adolescent Girls (*cont.*)

A Testimony from Nigeria

When I was with my husband I had no rights over my body. I couldn't negotiate safer sex, even though I knew he was unfaithful and that I would ultimately have to pay the price. Eventually we had to deal with HIV infection. The thought of being labelled an HIV-positive divorcee scared me, so I stayed for four years in a miserable, unhappy marriage. Finally, I had to choose my life and sanity over my marriage and the fear of what people would say. Now I am separated. I made a choice to survive and right now, [name withheld] is the most important person in my world.

When you are HIV-positive, doctors make you feel guilty for wanting a child. For years after my diagnosis I was totally confused about whether or not I could give birth to a healthy baby. The thought of having an HIV-positive child paralysed me but I was receiving mixed messages from the health professionals about the risks involved. As an HIV-positive woman, people say you have no business becoming pregnant, and a single HIV-positive pregnant woman is treated worse than a criminal in the health centres. But I really want to have a baby! Now, knowing treatment is available, I have regained my hope of being pregnant some day.

Being on treatment makes you feel less contagious, less like a vector of transmission. It enables you to take back your life. But I am not on antiretrovirals (ARVs). I don't need them, since my immune system can still cope. In spite of the health improvements I have seen other Nigerian women benefit from, I am not psychologically ready to begin taking medications. If I start, I will need to continue taking them every day for the rest of my life. Because I work in treatment advocacy, I am also mindful of the side effects these drugs can cause.

What do you do about fulfilling your sexual needs and desires when you keep getting gynaecological infections as I do? What makes things worse is that these infections are constantly referred to as sexually transmitted infections. It makes you feel totally undesirable. With treatment you have fewer episodes and things eventually become normal. You can have healthy, pleasurable, nonviolent sexual activity, which is what we all desire.

I am currently establishing an HIV treatment information and advocacy organization in Nigeria. The work we are doing has a very strong gender focus, as there is little or nothing said or done about positive women and HIV in my country. I want to share what I have learned and transfer the skills I have acquired to other positive women. Family planning clinics in Nigeria should subsidize the female condom, as it gives women the power to take more control over their sexual lives. They should begin to talk about sexuality and family planning for positive women. And they should approach these issues from a balanced perspective, taking into consideration the wider context in which we live our lives. This would include economic, social, and gender constraints and how these impact on HIV-positive women's sexual and reproductive health options and choices.

(Source: International Planned Parenthood Federation (IPPF)/ICW. 2004. *Dreams and desires: Sexual and reproductive health experiences of HIV-positive women*. London.)

A Testimony from Ukraine

I started to use drugs 10 years ago. My first drug was alcohol. Basically I drank because I didn't like myself and I found it difficult to relate to other people. My parents were divorced when I was five and it upset me terribly. At the age of 18, I started injecting opiates. Drugs and alcohol helped me to change my reality. By the time I was 21, I was married and had a baby. My husband and I drifted into theft to support our addictions.

After we split up, I joined my mother in Russia, and eventually ended up in prison. I had my first HIV test in Russia. But once I received a negative result I went back to my old ways. In prison I had another test. This time it was positive.

After I was released, the head of police told me that if he saw me in town he would kill me. I ended up in Odessa, went back to prison, and continued to use drugs. I was waiting for death. Finally I made the decision to live—to try to feel life, feel the wind and the air, feel the difference of the colours. I started going to NA [Narcotics Anonymous] meetings. Slowly I started to feel better. I started to work at an organization called Hope and Love in Odessa, which works around prevention of HIV/AIDS and other diseases. I've been totally clean, off drugs, and going to NA meetings for six months. Now I can see how I used drugs to dull the pain inside of me, but in the end the drugs didn't take the pain away.

I met a positive man through my organization who was open about his HIV status and I started talking about my own situation. I now live with my mother and my daughter and they both know about me. Although sometimes I still get frightened about disclosing my status, I've had my story published in a book.

I hope to live a long time, but mainly I'd like to use whatever time I have left to the maximum. This is the first conference I have attended in Russia, and it has been an opportunity to get to know new people, make friends, and meet others with the same problems who work in the same field. When I'm with other people who also talk about their status, I feel better, easier in myself. When I'm open, I feel like another dark corner of my soul lights up and I can dust off a corner of it.

Source: ICW. 2000. *ICW News*, #15, December.

8.1 Participant Handout

Informed and Voluntary Decision Making

Conceptual Framework for Informed and Voluntary Decision Making

The following basic elements or conditions support informed choice and voluntary sexual and reproductive health (SRH) decision making:

1. Service options are available.
2. The decision making process is voluntary.
3. Individuals have appropriate information.
4. Good client-provider interaction (CPI), including counselling, is ensured.
5. The social and rights context supports autonomous decision making.

The framework suggests indicators that one can look for to assess whether or not these elements or conditions are in place.

1. Service options are available.

- Services are available where and when individuals need them.
- A choice of methods/services/options is offered.
- Options are affordable.
- Referral mechanisms are in place for other services.
- Links exist with other health services.

2. The decision-making process is voluntary.

- Individuals are free to decide whether or not to use services, without coercion or constraint.
- Clients are free to choose among available methods/services/options, without coercion or constraint.
- A range of service options is accessible to all categories of clients, including adolescents and unmarried individuals.
- Health workers are objective regarding all clients and methods.
- The individual's right to choose is respected and supported.

3. Individuals have appropriate information.

- Individuals have access to appropriate and accurate information about services and options.
- Individuals understand their risk and the protection that services/options/methods provide.
- Health workers assess clients' knowledge, fill any gaps, and correct any misinformation.
- Comprehensible posters and flipcharts are clearly in clients' view.
- If relevant, samples of methods (e.g., family planning methods) are available for clients to see and touch.
- Clients understand their options, the essential information about their chosen method or treatment (including benefits and risks, conditions that would render it inadvisable for use, and common side effects), and the way their choice may affect their personal circumstances.

8.1

Participant Handout

Informed and Voluntary Decision Making (*cont.*)

4. Good CPI, including counselling, is ensured.

- Clients and health workers have dynamic, two-way interaction.
- Clients actively participate in discussions and are encouraged to ask questions.
- Staff have good communication skills (talking, listening, eliciting, probing, assessing).
- Counselling staff provide individualized care, tailoring the CPI and information to what clients want and need, and addressing individual circumstances and concerns.
- All staff use language and terms that clients can understand.
- Counselling staff have complete and correct information about SRH and available services.
- Staff answer clients' questions fully and clearly.
- All staff are empathetic, respectful, nonjudgemental, and sensitive to power imbalances and gender differences between clients and health workers.
- All staff maintain clients' privacy and confidentiality.
- Trained staff are assigned to counsel clients as a routine component of service delivery.
- Counselling serves as the checkpoint to ensure informed and voluntary decision making.
- Memory aids are used by staff and provided to clients.
- The service setting is organized, clean, and cheerful to put clients at ease.
- Auditory and visual privacy are ensured for counselling, regardless of the setting.
- Adequate seating is available during counselling for counsellors, clients, and anyone else the clients choose to include.

5. The social and rights context supports autonomous decision making.

Laws, policies, and social norms support the following:

- gender equity;
- individuals' rights to decide whether and when to have children, and how many (International Conference on Population and Development [ICPD] Programme of Action, 1994);
- clients' right to access SRH information and services regardless of age, sex, marital status, or sexual orientation (ICPD Programme of Action, 1994);
- clients' right to make decisions and to exercise control over their sexuality and reproduction free of discrimination, coercion, and violence;
- clients' right to protect their health and prevent disease;
- clients' right to privacy, confidentiality, dignity, and safety.

Three Levels to Consider and Discuss

Multiple factors within and beyond the service setting affect clients' ability to make informed and voluntary SRH decisions:

- individual/community factors
- service-delivery factors
- policies

8.1

Participant
HandoutInformed and Voluntary Decision Making (*cont.*)

Individual/community factors include all of the family, educational, religious, and social norms that individuals experience living in a particular community, as well as the unique ways that individuals process and interpret all of these factors. An individual's sense of what he or she needs and wants in terms of his or her own SRH is a very personal experience that is heavily influenced by community values and expectations. These influences are particularly powerful in determining desired family size, sexual behaviour, whether or not to seek health care and ways to do so, family planning method preferences, and what topics individuals feel that they can or cannot talk about, and with whom. Such communication opportunities and/or constraints are key to the "informed" element of informed and voluntary decision making. The community also plays a powerful role in determining who is expected, or allowed, to make decisions about SRH, as well as which kind of decisions are acceptable. Both of these elements have a direct bearing on the voluntary nature of decisions.

Service-delivery factors describe what actually exists and happens in practice, regardless of what is supposed to happen according to policy. Factors at this level that influence client decision making include the service options offered; the availability of trained personnel; health workers' skills, attitudes, and comfort in addressing SRH issues; the organization of services; and supervisor and management support for client-centred care. Health workers' awareness of their clients' rights and circumstances, and of the power imbalances between them and their clients, has a direct bearing on the quality of CPI and on SRH decision making. Similarly, health workers' self-awareness regarding their own values, and the recognition that they themselves are subject to the social and cultural context in which they live and provide services, are important factors that influence whether or not they support clients' right to make informed and voluntary decisions.

Policies can include international conventions (e.g. the ICPD Programme of Action, 1994), donor requirements, government policies, laws, rules, regulations, programme goals, protocols, and service-delivery guidelines. Policies are influenced by politics, economics, demographic pressures, religion, cultural expectations, and public opinion. Some policies foster a supportive environment for client-centred care, sexual and reproductive rights, autonomous decision making in SRH, and informed choice for services. Others limit access to information or services, thus hindering individuals' ability to make informed and voluntary decisions. Policies related to service programmes are meant to guide programme managers and health workers by clarifying roles, responsibilities, and performance expectations. Sometimes good policies exist but are not implemented in practice because of inadequate dissemination, misunderstanding, or poor communication, or constraints that impede staff from putting policies into effect as intended.

Adapted from: EngenderHealth. 2003. *Realizing rights in sexual and reproductive health services: Choices in family planning: informed and voluntary decision making.* New York.

9.1

Participant Handout

Laws and Policies Constraining HIV-Positive Women's and Adolescent Girls' Access to SRH Care

National Law and Policies

- While human rights in theory encompasses the sexual and reproductive rights of people living with HIV and AIDS (PLHIV) and other key vulnerable populations, in practice there are many examples of national laws and policies that forcibly restrict these rights.
- Human rights provide the legal framework within which national laws, policies, and services should be formulated and monitored, as well as an approach to designing policy and programmes.
- Most countries around the world have adopted some laws and policies related to HIV and AIDS; however, some of these have been known to severely restrict or impede the rights of PLHIV, sex workers, injecting drug users (IDUs), men who have sex with men, youth, prisoners, migrants, etc.

HIV and Marriage

Mandatory premarital HIV testing, coupled with the denial of a marriage licence to those infected with HIV and prohibition of marriage between individuals known or suspected to be HIV-infected, interferes with the right to marry and found a family. A public health rationale does not provide sufficient justification for violating this right, because such a restriction does not serve as an effective means of preventing either sexual or perinatal transmission of HIV. Extramarital and premarital sexual activity are common.

- Criminalization of certain behaviours impacts on the ability of key vulnerable populations to access and use sexual and reproductive health (SRH) services due to stigma and discrimination, even if such services are made available.

Criminalization of Sex Work

Due to the criminalization of sex work in most countries, stigma and discrimination, and the routine violence sex workers face from their clients and the police, many sex workers are reluctant to access existing SRH services, due to discriminatory attitudes of health providers and for fear that their name, HIV status, and other personal information will be made available to the police or some other government agency.

- Other laws and policies constrain the use of SRH services for key vulnerable populations:

Laws Affecting Migrants

A number of countries have policies entitling an individual to obtain health care only in his or her place of birth. Should an individual leave the countryside to seek work in the capital city, he or she would not be able to obtain health care there. Similarly, undocumented migrants living in border countries are often unable to access health services in their “host” country.

9.1

Participant Handout

Laws and Policies Constraining HIV-Positive Women's and Adolescent Girls' Access to SRH Care (*cont.*)

Gender-Based Violence, Family Law, and the Rights of Women and Girls

Some civil laws restrict women's and girls' rights in the areas of education, employment, property ownership, and housing, and this has an economic impact on their ability to take care of their SRH. In other cases, the absence of laws protecting women and girls from traditional practices, such as widow cleansing and female genital cutting/mutilation, constrains their ability to make informed decisions about their SRH.

These circumstances are further compounded by being HIV-positive, as many women and girls are blamed for bringing HIV into the family, and some have been beaten or thrown out of the family after disclosing their HIV status.

- Many rights issues of PLHIV and other key vulnerable populations go beyond SRH.

Children's Access to Antiretroviral Treatment

Until recently, laws in South Africa prevented children's access to life-saving medicine and antiretroviral treatment. Until the government expanded the definition of a caregiver or institutional representative, children were not allowed to receive enhanced medical treatment and antiretroviral drugs.

Criminalization of Same-Sex Sexual Activity

Laws that criminalize same-sex sexual activity are not only discriminatory, but they also impede access to HIV/AIDS and SRH programmes. The lack of information and services available in countries where same-sex sexuality is illegal undermines both the health of men who have sex with men and public health in general.

Laws Criminalizing Drug Use

Many needle-exchange programmes and other services for IDUs require that the name and other personal information of the person is made available to the police or to some other government agency. Stigmatization of and discrimination against IDUs entrenched through existing legislation can also constrain IDUs' access to harm-reduction programmes and SRH services.

Laws Affecting Adolescents

Many constraints on adolescents' access to and use of SRH services exist in laws and policies, as well as societal and cultural attitudes. Many countries legally require the consent of a parent or legal guardian for an adolescent to receive certain SRH services, as well as the routine disclosure of HIV test results or SRH concerns to parents or guardians. Adolescents also are often denied the most basic SRH care due to provider bias about whether they should be sexually active.

Adapted from: Gruskin, S., and O'Malley, J. 2006. Reproductive choices for women and men living with HIV: Policy and programmatic guidance. Draft paper prepared for WHO; and EngenderHealth and UNFPA. 2006. Rights-based approach to sexual and reproductive health for HIV-positive women and adolescent girls. Draft paper prepared for EngenderHealth and for UNFPA.



Steps towards facilitating the disclosure process:

- Help the client to take time to think things through and make sure that any decisions made to disclose or not to disclose are what he or she wants to do.
- Assess the person's ability to cope and establish his or her sources of support.
- Identify sources of support, such as groups of people living with HIV/AIDS, church members, friends, and/or counselling organizations.
- Provide support and reassurance to the client and help him or her to accept himself or herself positively.
- Discuss the implications fully to help the person consider in advance the possible reaction of his or her father, mother, best friends, sexual partner(s), colleagues, school teachers, priests, and others. Counsellors should try and discuss the HIV status of sexual partners, as this can influence the information and advice that a client needs. Disclosure is a process, and it may be easier to start with someone they are close to and trust. However, it can also be better for someone to disclose to people who are further away from him or her (for example, support workers, who understand the issues better, though they may not know the client so well).
- If a person feels that he or she wants to disclose to somebody, help him or her plan how to go about it. This will include any preparations that he or she will need to make before disclosure, as well as who, when, how, where, and the level of disclosure.
- The client will need to assess how much the person he or she plans to disclose to knows and understands about HIV and AIDS. This will help the client decide what he or she needs to tell the person and how to tell him or her so it is less traumatic for both of them.
- Role-plays and “empty chair” enactment techniques could be used to help the client prepare for disclosure.
- The counsellor needs to work with the client on the implications of disclosing to inappropriate persons or groups.
- Even if a person is not in a sexual relationship at the time of counselling, addressing these issues for future relationships is important.
- Discuss how disclosure can be outside the individual's control or partially outside his or her control and ways of protecting the client's confidentiality. Counsellors should protect their clients from undue pressure to disclose.
- Arrange to see the client again at a time and date agreed to by both of you to review the process.

Adapted from: Canadian International Development Agency (CIDA) and Canadian Health Association. 2001. *Counseling guidelines on survival skills for people living with HIV*. Harare, Zimbabwe: Southern African AIDS Training Programme. Retrieved 13 October 2006 at: www.unicef.org/aids/files/aids_counseling_survival_skills_PLHA.pdf. This should not be seen or presented as the “best” or only eventual outcome for all people living with HIV and AIDS—disclosure should always be undertaken as an informed and voluntary decision on the part of the individual.

Risk Assessment

What Is It?

Risk assessment is a counselling process to help clients understand the risk (i.e., the chance of getting pregnant or contracting a sexually transmitted infection [STI] or reproductive tract infection [RTI]) that is associated with sexual practices in which they or their partners are engaging, and how this level of risk may increase or decrease depending on changes in circumstances. For example, your risk could increase if:

- your uninfected partner becomes infected
- you had one partner and now you have more than one
- you have a new partner and you do not know his or her sexual history
- your partner changes his or her mind and decides that he or she does not want to use condoms
- you develop side effects to a contraceptive method and discontinue its use
- you are sick from a suppressed immune system
- you have an STI or RTI.

Why Do We Do It?

We help clients to assess their own risk so they can use this understanding to reduce their risk, with a focus on behaviour change.

How Do We Use It in REDI?

Exploration

We use exploration as a guide for asking questions, to learn about clients' relationships and sexual practices and other factors that may put them at risk, and for providing information that clients will need to make a decision about reducing risk.

Decision making

We use decision making to help clients choose risk-reduction plans, family planning methods, or medical treatments that will reduce their risk.

Implementing the decision

We use implementation to help clients make a plan for how they will decrease their risk, how they will communicate with partners, how they will cope with the problems or challenges they might encounter, and how they will deal with changes in their life circumstances.

Three Reasons Prevention Strategies Are Needed for People Living with HIV

(Adapted from International HIV/AIDS Alliance. 2003. *Positive prevention: Prevention strategies for people with HIV/AIDS*. Brighton, UK.)

Most prevention strategies to date have been targeted at uninfected people to prevent them from becoming infected with HIV. Historically, programmes have been reluctant to work on HIV/STI prevention with people with HIV because of perceptions that the concept of prevention for people already infected is inherently contradictory. There have also been justifiable concerns about victimizing an already stigmatized group. In addition, programmes have been reluctant to acknowledge that people with HIV have sex, and also to grapple with the complex ethical issues surrounding the responsibilities towards others of people living with HIV.

On the other hand, there are very compelling reasons for considering prevention activities that meet the particular needs of people with HIV. These include:

1. **People living with HIV have the right to live well with HIV.** From a human rights perspective, people with HIV have a right to know their HIV serostatus. Whether aware of his or her status or not, a person living with HIV has the right to live well with HIV, which includes having a healthy sex life. This requires strategies that support HIV-positive women, men, and young people to protect their sexual health, to avoid new STIs, and to delay the progression of HIV/AIDS disease.

Having an STI can increase the risk of passing HIV onto a partner through sex. For women, it can also increase the risk of developing certain cancers of the cervix related to the human papillomavirus (HPV). There is also a growing body of evidence that prevention strategies are required to protect people with HIV from HIV reinfection or superinfection (that is, becoming infected a second time with another “strain” of HIV, including drug-resistant strains).

People living with HIV have specific prevention requirements that require prevention strategies to be tailored to their specific needs. For instance, HIV-positive women and adolescent girls have the right to make informed decisions about pregnancy planning, which has implications for STI/HIV prevention. These needs must also be met through strategies that reduce stigma and discrimination.

2. **One positive person is involved in each case of HIV transmission.** From an epidemiological and public health perspective, it is also important to address the HIV/STI needs of people who are already living with HIV, in order to reduce HIV/STI transmission to their partners.
3. **HIV prevention, treatment, care, and support are interrelated.** The prevention-treatment-care continuum reinforces the rationale for supporting prevention interventions for people with HIV. For example, HIV-positive women and adolescent girls need access to

medical care and psychosocial support services, and also support to build their skills for adopting and maintaining safer behaviour.

Barriers to Clients' Perception of Risk

Whether the client *perceives* that she is actually at risk for unintended pregnancy, HIV reinfection, STI/RTI infection, or infecting a partner, it is a crucial starting point in helping her to be willing to take some steps towards reducing risk. In many cases, people perceive themselves to be at less risk than they actually are. HIV-positive women and adolescent girls may have many reasons for underestimating their own risk.

Some reasons HIV-positive women and adolescent girls underestimate their risk include:

- **Stereotyped beliefs about who is at risk.** Some HIV-positive women and adolescent girls may still mistakenly believe that sex workers and injecting drug users are the only people who are at risk for STI/RTIs or reinfection with another strain of HIV. They think that because they are in a marriage or monogamous relationship, they can trust that their partner will not have any other partners. For many women and adolescent girls, in particular, messages about “being faithful” may give a false sense of safety, since they are most often at risk due to the behaviour of their partners rather than their own behaviour
- **The illusion of invulnerability.** Some HIV-positive women and adolescent girls may have a personal belief that they are immune to risk regardless of their behaviour. People generally tend to underestimate their own personal risk compared with the risk faced by others engaging in the very same behaviour. An example would be an adolescent girl who thinks she will not get pregnant even if she has sex without using a method of family planning: “It will not happen to me”. Adolescents, in particular, as part of their emotional development, often think of themselves as invulnerable to many things.
- **Fatalism.** Fatalism is a belief that circumstances are beyond one’s control: Nothing a person does will change what is going to happen anyway. An example of this would be an HIV-positive woman or adolescent girl who believes that spiritual forces determine her circumstances and she may not have any control over what happens to her.
- **Bigger or more urgent problems.** Some HIV-positive women and adolescent girls may have other concerns that need immediate attention and that put the threat of HIV reinfection and STI/RTI infection or unintended pregnancy into the background. People who live in communities where hunger, violence, or poverty are widespread, for example, are more likely to prioritize other issues, such as feeding their families and protecting their children from harm.
- **Misconceptions about risk.** Mistaken beliefs may interfere with some HIV-positive women and adolescent girls’ understanding of what is actually risky. For example, a woman or adolescent girl might not have a clear understanding of how HIV is transmit-

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Overview of Risk Assessment (*cont.*)

ted; an HIV-positive woman might believe that because she already has HIV she cannot be reinfected with another strain of HIV; or an HIV-positive adolescent girl might mistakenly believe that she cannot get pregnant the first time she has sex.

- **Traditional gender roles and societal expectations.** Different societal expectations and social norms often influence clients' perceptions of risk. For example, an HIV-positive woman or adolescent girl might suspect that her partner is having extramarital relationships, but it may not be acceptable within her social or cultural role to confront him about this or ask him to use condoms. Therefore, it is easier for her to not acknowledge or to minimize the potential risk, when there is little or nothing she feels she can do about it.

Adapted from: STD/HIV Prevention Training Center. 1998. *Bridging theory and practice: Participant manual*. Berkeley.

Adolescent Psychological and Social Development

The process of adolescent psychological and social development is characterized by a range of normal adolescent behaviour (see the chart below). The designated age groups below may also vary from country to country depending on social and cultural norms.

Characteristic Behaviours of Adolescence

Developmental Stage	Early Adolescence (10–13 years) <ul style="list-style-type: none"> Begins transition to adolescence Is characterized by puberty 	Middle Adolescence (14–16 years) <ul style="list-style-type: none"> Is the essence of adolescence Experiences strong peer-group influence 	Late Adolescence (17–19 years) <ul style="list-style-type: none"> Begins transition to adulthood Assumes adult roles
Independence	<ul style="list-style-type: none"> Challenges authority, parents, and other family members Rejects things of childhood Desires more privacy 	<ul style="list-style-type: none"> Moves away from parents and towards peers Begins to develop own value system 	<ul style="list-style-type: none"> Is emancipated: begins to work or pursue higher education Enters adult life Reintegrates into family as emerging adult
Cognitive Development	<ul style="list-style-type: none"> Finds abstract thought difficult Seeks to make more decisions Has wide mood swings 	<ul style="list-style-type: none"> Starts to develop abstract thought Begins to respond based on analysis of potential consequences Has feelings that contribute to behaviour but do not control it 	<ul style="list-style-type: none"> Firmly establishes abstract thought Demonstrates improved problem solving Is better able to resolve conflicts
Peer Group	<ul style="list-style-type: none"> Has intense friendships with members of the same sex Possibly has contact with members of the opposite sex in groups 	<ul style="list-style-type: none"> Forms strong peer allegiances Begins to explore ability to attract partners 	<ul style="list-style-type: none"> Is less influenced by peers regarding decisions and values than before Relates to individuals more than to peer group
Body Image	<ul style="list-style-type: none"> Is preoccupied with physical changes Is critical of appearance Is anxious about menstruation, masturbation, breast or penis size 	<ul style="list-style-type: none"> Is less concerned about body image than before Is more interested in looking attractive 	<ul style="list-style-type: none"> Is usually comfortable with body image Accepts personal appearance
Sexuality	<ul style="list-style-type: none"> Begins to feel attracted to others May begin to masturbate May experiment with sex play Compares own physical development with that of peers 	<ul style="list-style-type: none"> Shows an increase in sexual interest May struggle with sexual identity May initiate sex inside or outside of marriage 	<ul style="list-style-type: none"> Begins to develop serious intimate relationships that replace group relationships as primary relationships

Adapted from: The Center for Continuing Education in Adolescent Health, Division of Children's Medicine, Children's Hospital Medical Center, 1994; PHN Center FOCUS on Young Adults project, 2001.

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Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls

(Note: This checklist has been adapted from: UNFPA and WHO. 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. Last retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=297&filterListType=1.)

The following checklist is meant to help you in deciding what sexual and reproductive health (SRH) services and information you should provide to an HIV-positive woman or adolescent girl. It is recommended that all health workers, regardless of their specialization or where the client accesses care, provide the information and services under “General SRH Services and Information” for each client. Depending on the nature of the client’s needs, they can then decide what other specialized information and services they can offer the client, based on their own skills, training, and experience, or if they need to refer the client for information and services listed under the “Specialized SRH Services and Information” section of this checklist.

General SRH Services and Information Health workers should offer these general SRH services and information to every HIV-positive woman and adolescent girl. Much of this information is also relevant to women who do not know their HIV status.	
Type of Service and Information	Check
Promoting SRH	
Provide information about HIV/AIDS and, for clients who do not know their HIV status, offer voluntary counselling and testing (VCT) or refer them to the nearest VCT centre.	
Offer counselling on sexual needs and desires, including a discussion about the woman’s context and conditions.	
Assess client for physical symptoms or psychological stress that could interfere with sexual function.	
Offer counselling on fertility needs and desires, including asking whether or not the woman is pregnant and if she is presently using any form of contraception.	
Offer counselling on emergency contraceptive pills, and if available, provide them if the woman meets the eligibility criteria.	
If the client is not considering having any more children, offer counselling on effective contraceptive methods, including dual protection, and provide condoms, pills, or injectables. Refer her to a family planning clinic if she desires an intrauterine device (IUD) or counselling on noncoerced sterilization.	
If the woman desires to have more children, provide information on fertility options, including fertility treatment (e.g. sperm washing/artificial insemination, if available), and adoption.	
Provide information on potential drug interactions with hormonal methods.	
Provide information on interactions between pregnancy and HIV.	
Offer counselling on prevention of sexually transmitted infections (STIs) and reproductive tract infections (RTIs), on HIV transmission, and on HIV reinfection, including the importance of early management of STIs/RTIs.	

(checklist continues on p. 141)

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Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls (*cont.*)

General SRH Services and Information (<i>cont.</i>)	
Health workers should offer these general SRH services and information to every HIV-positive woman and adolescent girl. Much of this information is also relevant to women who do not know their HIV status.	
Type of Service and Information	Check
Promoting SRH (<i>cont.</i>)	
Provide male and female condoms and demonstrate their consistent and correct use.	
Provide information on risk for perinatal transmission and effectiveness of antiretroviral (ARV) prophylaxis in preventing perinatal transmission.	
Preventing Violence against Women	
Conduct assessment of risk for violence, including nonconsensual sex.	
Offer counselling on domestic violence and support the woman's decision regarding HIV disclosure and any problems she faces with violence at home or in the community.	
Treat physical injuries and SRH problems associated with violence.	
Refer to other relevant services, including psychosocial counselling, pregnancy testing, STI treatment and prophylaxis, social welfare, legal aid, and safe shelters for women.	
Diagnosis of HIV Infection	
Offer VCT for clients who do not know their HIV status.	
Offer STI/HIV prevention counselling and support for negotiating safe and consensual sex, including dual protection.	
Provide male and female condoms and demonstrate their consistent and correct use.	
Provide information on effects of disease progression and effectiveness, availability, and cost of ARV treatment.	
Stress importance of planning care for herself, her children, and family, should she become ill.	
Offer counselling on advantages and disadvantages of disclosing HIV status.	
Refer to prevention of mother-to-child transmission (of HIV) (PMTCT) and HIV/AIDS treatment, care, and support services.	
Specialized SRH Services and Information (<i>cont.</i>) After providing an HIV-positive woman or adolescent girl with the above general services and information, health workers should offer the following specialized services and information based on the client's needs and their own skills, training, and experience, or refer the client to other services on-site or off-site.	
Providing HIV/AIDS Treatment, Care, and Support	
Screen for tuberculosis if there is a persistent cough, and treat if test is positive.	
Provide information on dietary needs and nutritional considerations.	
Refer to community and home-based care programmes.	

(checklist continues on p. 142)

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Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls (cont.)

Specialized SRH Services and Information (cont.) After providing an HIV-positive woman or adolescent girl with the above general services and information, health workers should offer the following specialized services and information based on the client's needs and their own skills, training, and experience, or refer the client to other services on-site or off-site.	
Type of Service and Information	Check
Providing HIV/AIDS Treatment, Care, and Support (cont.)	
Treat opportunistic infections (OIs).	
Ensure access to ARV treatment for women who need it.	
Provide information on avoiding ARV regimens that include efavirenz for women who are trying to conceive or using unreliable contraception.	
Provide counselling on risk reduction and support woman's risk-reduction plan.	
Refer to services for STI screening and management.	
Providing Family Planning Education, Methods, and Support	
Provide information on interactions between HIV and pregnancy.	
Offer counselling on fertility needs and desires, including asking whether the woman is pregnant and if she is presently using any birth control.	
Offer counselling on emergency contraceptive pills and, if available, provide them if the woman meets the eligibility criteria.	
Offer counselling on contraceptive choices to support voluntary, informed decision making.	
Provide information on WHO eligibility criteria for different contraceptive methods.	
If the woman is not considering having any more children, offer counselling on effective contraceptive methods, including dual protection, and provide condoms, pills, injectables, Norplant implants, IUDs, and noncoerced sterilization.	
If the woman desires to have more children, provide information on fertility options, including fertility treatment (e.g. sperm washing/artificial insemination, if available), and adoption.	
Provide information on potential drug interactions with hormonal contraceptives or birth defects associated with some ARV drugs.	
Conduct STI/RTI risk assessment and provide information on best contraceptive methods.	
For staff working in family planning services, provide information about HIV/AIDS and offer VCT for clients who do not know their HIV status.	
Refer to PMTCT and HIV/AIDS treatment, care, and support services.	

(checklist continues on p. 143)

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Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls (*cont.*)

Specialized SRH Services and Information (*cont.*)

After providing an HIV-positive woman or adolescent girl with the above general services and information, health workers should offer the following specialized services and information based on the client's needs and their own skills, training, and experience, or refer the client to other services on-site or off-site.

Type of Service and Information	Check
Improving Antenatal, Intrapartum, Postpartum, and Newborn Care	
Offer VCT if the client does not know her HIV status.	
Offer STI/HIV prevention counselling and support for negotiating safe and consensual sex, including the importance of dual protection in the postpartum period, and access to male and female condoms.	
Screen and treat tuberculosis, malaria (if prevalent in region), and anaemia.	
Provide information on risks and benefits of ARV drug regimens in preventing perinatal transmission.	
Provide information on interactions between HIV and pregnancy.	
Screen for syphilis.	
Conduct assessment of HIV-related signs and symptoms, including evidence of OIs.	
Provide ARV treatment if woman is eligible.	
Treat OIs.	
Provide ARV prophylaxis to women who do not have indications for ARV treatment or if treatment is not offered.	
Offer counselling and support on ways of achieving weight gain during pregnancy, prevention and management of anaemia, and the importance of an adequate diet to support pregnancy and lactation.	
Provide nutritional assistance, if available.	
Stress the importance of delivering with a skilled attendant and support the woman in developing a birth plan.	
Avoid artificial rupture of membranes during childbirth and invasive procedures such as fetal monitoring and episiotomy.	
Offer ongoing infant feeding counselling and support for the women's infant feeding choice.	
Offer postpartum family planning counselling, or refer to nearest family planning clinic.	
Eliminating Unsafe Abortion	
Offer nondirective, nonjudgemental, and confidential counselling on the option of termination of pregnancy, to the extent allowed by law.	
Offer referrals to abortion (if legal) and postabortion care services if requested by woman.	
For staff working in abortion or postabortion care services, provide information about HIV/AIDS and offer VCT.	
Provide antibiotics at time of abortion to minimize postprocedure risk of infection.	
Stress importance of seeking immediate medical care in the event of excessive bleeding, pelvic pain, fever lasting more than one day, or other symptoms of infection.	
Provide contraceptive information and counselling and offer different contraceptive methods, including dual protection, based on eligibility criteria for postabortion women.	
Refer woman to HIV/AIDS-related treatment, care, and support services, including psychosocial support services.	

(checklist continues on p. 144)

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Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls (cont.)

Specialized SRH Services and Information (cont.) After providing an HIV-positive woman or adolescent girl with the above general services and information, health workers should offer the following specialized services and information based on the client’s needs and their own skills, training, and experience, or refer the client to other services on-site or off-site.	
Type of Service and Information	Check
Prevention and Management of STIs/RTIs	
Staff working in STI services should provide information about HIV/AIDS and offer VCT, if client does not know her HIV status.	
Conduct assessment for risk of STIs/RTIs, including inquiring about partner’s practices and symptoms.	
Conduct physical examination to detect signs of STIs/RTIs.	
Screen for syphilis, and if resources permit, gonorrhoea and chlamydia.	
Stress importance of preventing STIs/RTIs during pregnancy.	
Treat STIs/RTIs according to standard treatment protocols.	
Stress that prolonged treatment of candidiasis is usually required.	
Stress that the frequency and severity of genital episodes due to herpes are associated with immunosuppression.	
Stress greater likelihood of becoming infected with HPV; longer persistence of HPV over time; greater likelihood of becoming infected with multiple HPV types, including increased cancer-associated HPV types; and having higher HPV viral loads.	
Conduct a biopsy of genital warts when the diagnosis is uncertain, lesions worsen during therapy, or warts appear atypical (e.g. pigmented, indurated, fixed, or ulcerated).	
Offer STI/HIV prevention counselling and support for negotiating safe and consensual sex, including dual protection, and access to male and female condoms.	
Offer counselling and support for notification of partners.	
Provide clinical follow-up as necessary.	
Diagnosis and Treatment of Cancer	
Stress importance of cervical cancer screening, at least once a year, due to greater risk for precancer and cancer.	
Screen for abnormal cytology.	
Avoid treating low-grade lesions due to increased risk of complications and HIV shedding.	
Treat high-grade lesions and stress importance of follow-up due to persistence and recurrence.	
Conduct surgery or attenuated treatment with radiation or chemotherapy for invasive cancer in women with a CD4 count below 200 10 ⁶ cells/L.	
Providing Psychosocial Support	
Conduct assessment of emotional and social needs.	
Offer psychosocial support and counselling for bereavement, future planning, stigma and discrimination, suicidal ideation, and pregnancy-related concerns	
Refer to other relevant services, including ongoing psychosocial counselling and support groups.	

(checklist continues on p. 145)

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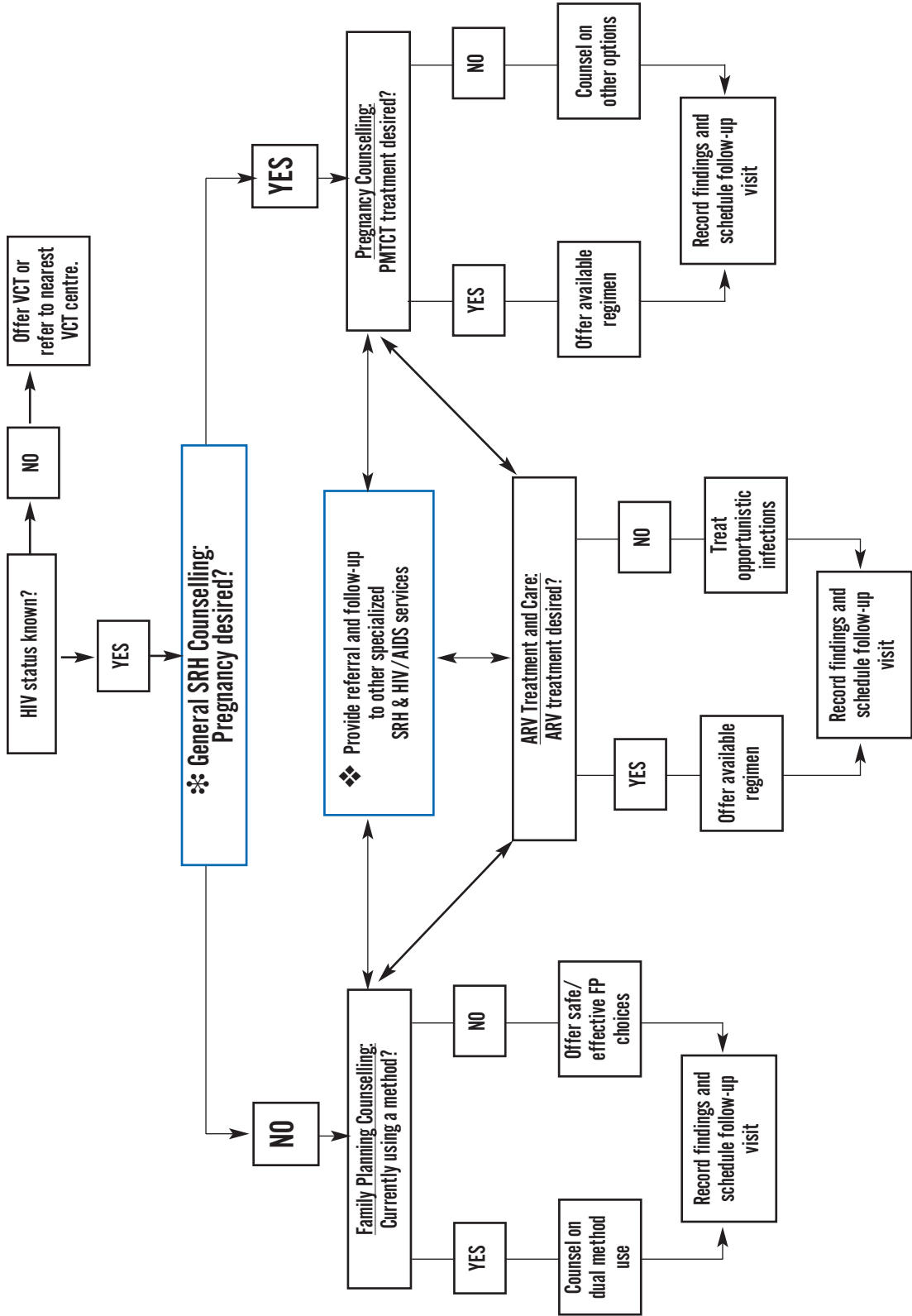
Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls (*cont.*)

Specialized SRH Services and Information (*cont.*)

After providing an HIV-positive woman or adolescent girl with the above general services and information, health workers should offer the following specialized services and information based on the client's needs and their own skills, training, and experience, or refer the client to other services on-site or off-site.

Type of Service and Information	Check
Providing Financial/Legal Support	
Conduct assessment of financial situation and livelihood strategies.	
Offer counselling and support for changing lives and relationships following HIV diagnosis, as well as physical effects of virus on ability to earn income.	
Provide information on subsidies for medical care and treatment (if they exist) and/or free medical services in the community.	
Refer to other relevant services, including ongoing financial counselling, legal advice, income generating programmes, microfinance programs, and financial aid programmes.	

Algorithm for SRH Counselling of HIV-Positive Women and Adolescent Girls



- Possible referrals include:**
- Family planning
 - Antenatal, intrapartum, postpartum, and newborn care
 - Abortion and postabortion care
 - ARV treatment and care
 - Prevention and management of STIs/RTIs
 - Diagnosis and treatment of cancer
 - Tuberculosis screening
 - Ongoing psychosocial support
 - Nutritional support
 - Financial/legal support

- General SRH counselling topics to cover include:**
- Sexual and reproductive health
 - Screening for gender-based violence
 - Fertility needs and desires
 - Emergency contraception
 - Effective contraceptive methods, including dual protection
 - Potential drug interactions with hormonal methods
 - Interactions between pregnancy and HIV
 - STI/RTI prevention
 - Risk for perinatal transmission and effectiveness of ARV prophylaxis

The World Health Organization (WHO) defines family planning as “the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility”.² As the United Nations Population Fund (UNFPA) describes it, “Family planning enables individuals and couples to determine the number and spacing of their children—a recognized human right”.³

WHO has developed medical eligibility criteria for the safe use of various contraceptive methods. Health workers use these criteria to decide whether it is appropriate for a woman with a particular medical condition to use the contraceptive method in question. A woman’s infection with HIV, the presence of AIDS, and use of antiretroviral (ARV) therapy are all medical conditions that may affect her eligibility for a contraceptive method.

For each contraceptive method, medical conditions are classified into categories based on the risks and benefits associated with use of the method among women with those conditions. The WHO eligibility criteria use four categories to classify medical conditions:

Category 1: For women with these conditions, the method presents no risk and can be used without restrictions.

Category 2: For women with these conditions, the benefits of using the method generally outweigh the theoretical or proven risks. Women with Category 2 conditions generally can use the method, but follow-up by the health worker may be appropriate in some cases.

Category 3: For women with these conditions, the theoretical or proven risks of using the method generally outweigh the benefits. Women with Category 3 conditions generally should not use the method. However, if no better options for contraception are available or acceptable, the health worker may judge that the method is appropriate, depending on the severity of the condition. In such cases, ongoing access to clinical services and careful follow-up by the health worker are required.

Category 4: For women with these conditions, the method presents an unacceptable health risk and should not be used.

¹ The contents of this handout are adapted from: WHO. 2004. *Medical eligibility criteria for contraceptive use, third edition*. Geneva.

² Working definition used by WHO Department of Reproductive Health and Research. Retrieved 27 June 2006 at: www.who.int/topics/family_planning/en/.

³ UNFPA. No date. Reproductive health and family planning: Family planning and sexual health. Retrieved 27 June 2006 at: www.unfpa.org/swp/2004/english/ch6/index.htm.



In some cases, a particular condition is assigned to one category for initiation and another for continuation of the method. In other words, for certain conditions the category depends on whether a woman with the condition wishes to initiate a contraceptive method or was already using that method when she developed the condition.

The table on pages 149–150, adapted from WHO’s *Medical Eligibility Criteria for Contraceptive Use*, provides an overview of medical conditions classified into the above categories, based on the risks and benefits associated with HIV and AIDS for those conditions. For example, condoms are assigned to Category 1 for women and adolescent girls who:

- have a high risk of HIV or are HIV-positive;
- are diagnosed with AIDS but are not on antiretroviral therapy (ART);
- are diagnosed with AIDS and presently are on ART.



WHO Medical Eligibility Criteria for Contraceptive Use and HIV/AIDS (cont.)

Method	Category 1 No risk, use without restrictions	Category 2 Benefits generally outweigh risks	Category 3 Risks generally outweigh benefits	Category 4 Level of risk is unacceptable	Comments
Condom	<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no antiretroviral (ARV) therapy AIDS diagnosis, on ARV therapy 				<ul style="list-style-type: none"> Should be used even when HIV infection is controlled by ARVs
Dual method use (depends on what other method besides condoms is being used. See below.)	<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy 				<ul style="list-style-type: none"> Use condoms to protect against sexually transmitted infections (STI)/HIV and another method to prevent pregnancy, as shown below.
Oral contraceptive	<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy 	<ul style="list-style-type: none"> AIDS diagnosis, on ARV therapy 			<ul style="list-style-type: none"> ARVs may reduce effectiveness of method or increase side effects Not best choice for women who forget to take pills on time
Injectables/implant	<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy 	<ul style="list-style-type: none"> AIDS diagnosis, on ARV therapy 			<ul style="list-style-type: none"> Nevirapine reduces blood progesterin level by ~18%
Intrauterine device (IUD)		<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy AIDS diagnosis, on ARV therapy 	<ul style="list-style-type: none"> AIDS-related symptoms (initiate) 		<ul style="list-style-type: none"> Insertion in women with AIDS may increase risk of IUD-related complications, unless on ARV



WHO Medical Eligibility Criteria for Contraceptive Use and HIV/AIDS (cont.)

Method	Category 1 No risk; use without restrictions	Category 2 Benefits generally outweigh risks	Category 3 Risks generally outweigh benefits	Category 4 Level of risk is unacceptable	Comments
Spermicides				<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy AIDS diagnosis, on ARV therapy 	<ul style="list-style-type: none"> Women with HIV are at increased risk for STIs/RTIs or reinfection when using spermicides HIV status makes spermicide use inappropriate
Diaphragm			<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy AIDS diagnosis, on ARV therapy 		<ul style="list-style-type: none"> Women with HIV should generally not use diaphragm because of spermicides
Surgical sterilization	<ul style="list-style-type: none"> High risk of HIV or HIV-positive AIDS diagnosis, no ARV therapy AIDS diagnosis, on ARV therapy 				<ul style="list-style-type: none"> Good option for couples who want no more children No medical reason to deny sterilization to clients with HIV Counsel about condom use, particularly if couple is discordant
Lactational amenorrhea method					<ul style="list-style-type: none"> Breastfeeding women with HIV can infect children (risk ~16%). Use formula or other substitutes. When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, avoidance of all breastfeeding by HIV-positive mothers is recommended Should be encouraged to use condoms.
Fertility awareness methods					<ul style="list-style-type: none"> Women who have HIV with/ without AIDS and those on ARV therapy can use without restrictions as long as menstrual cycles are regular. Should be encouraged to use condoms.

(Adapted from: UNFPA and WHO. 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. www.unfpa.org/publications/detail.cfm?ID=297.)

General Information

- Most pregnant women who seek antenatal care (ANC) worldwide are not aware of their HIV serostatus.
- Since ANC represents an important entry point to the health care system for many women and adolescent girls, the importance of voluntary counselling and testing in HIV prevention, treatment, and care should be emphasized with programme managers, health workers, and clients.
- The following considerations associated with HIV testing during pregnancy and postpartum should also be discussed with clients, and appropriate risk reduction strategies should be incorporated into their overall care plan:
 - Disclosure of HIV diagnosis during pregnancy in the absence of adequate support may bring about the devastating psychosocial consequences of stigma and discrimination, as well as the potential for gender-based violence.
 - The HIV status of women and adolescent girls needs to be kept confidential and their medical records made available only to health workers with a direct role in their care or care for their infants.
 - Offering women and adolescent girls the option of being counselled and tested with their partners (couple counselling) may address some of the sensitive issues associated with disclosure and partner notification.
 - Besides emotional support during pregnancy, couples (both or one of the partners) being identified as HIV-positive during pregnancy should receive counselling and health education that covers:
 - o information on the interactions between HIV and pregnancy, including a possible increase in certain adverse pregnancy outcomes;
 - o the effects of progression of HIV disease on the woman's health and the effectiveness, availability, and adverse effects of antiretroviral treatment;
 - o the potential for HIV transmission to her baby and sexual partner, even while she is receiving antiretroviral therapy;
 - o encouragement to use condoms during pregnancy to prevent the acquisition of other sexually transmitted infections (STIs) or other strains of HIV, as well as the transmission of HIV and other STIs to uninfected sexual partners;
 - o information about infant feeding and support to cope with non-breast-feeding options, including stigma and discrimination.¹

¹ WHO, UNICEF, UNAIDS, and UNFPA. 2003. *HIV and infant feeding: A guide for health-care managers and supervisors*. Geneva. Retrieved 21 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=203&filterListType=1

Skilled Counselling during Pregnancy, Childbirth and the Postpartum Period

- Many HIV-positive women and adolescent girls lack accurate information and compassionate counselling to alleviate their fears about pregnancy.
- Many of them may also experience violence during pregnancy (between 4% and 20% of pregnant women), with consequences both for them and/or their babies, such as spontaneous abortion, preterm labour and low birth weight.
- Counselling and health education during pregnancy for HIV-positive women and adolescent girls should cover:
 - the importance of using condoms during pregnancy to prevent the acquisition of other STIs and strains of HIV, as well as the transmission of HIV and other STIs to uninfected sexual partners;
 - information on the interactions between HIV and pregnancy, including a possible increase in certain adverse pregnancy outcomes;
 - the effects of the progression of HIV disease on women's health and the effectiveness, availability, and cost of antiretroviral therapy;
 - the importance of delivering with a skilled attendant;
 - a woman's risk of transmitting HIV to her infant and the risks and benefits of antiretroviral prophylaxis and safer labour and delivery practices in reducing transmission;
 - the risks and benefits of various infant-feeding options and support for her choice.

Impact of HIV on Pregnancy

- Though pregnancy is believed to constitute an immensely complex physiologic and immunologic state, it does not appear to accelerate HIV disease progression.
- Interventions aiming at the prevention of mother-to-child transmission of HIV (PMTCT) must take into account the fact that mother-to-child transmission (MTCT) may occur at different stages during pregnancy.
- The risk of MTCT is 15–30% in nonbreastfeeding populations; breastfeeding by a woman with HIV increases the risk by 5–20%, to a total of 20–45%.²
- Long and short courses of single, dual, or triple antiretroviral prophylaxis have been shown to reduce HIV transmission to infants.
- The WHO guidelines on antiretroviral drugs for treating pregnant women and preventing HIV infection among infants provide further details on the safety of short-term exposure to antiretroviral drugs to prevent MTCT and on the issue of viral resistance and its potential implications for subsequent antiretroviral therapy.³

² De Cock, K. M., et al. 2000. Prevention of mother to-child HIV transmission in resource-poor countries: translating research into policy and practice. *Journal of the American Medical Association* 283(9):1175–1182.

³ WHO. 2004. *Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants. Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings*. Geneva. 2004. Retrieved 6 September, 2006 at: www.who.int/hiv/pub/mtct/en/arvdrugswomenguidelinesfinal.pdf.

- Recommended measures for PMTCT include:
 - suppression of HIV replication with consequent undetectable plasma viral load during pregnancy and suppression of HIV genital shedding during pregnancy through administration of antiretroviral therapy;
 - intrapartum antiretroviral administration and antiretroviral use by the infant;
 - avoidance of premature rupture of the membranes and of episiotomy during labour;
 - selective caesarean section before labour starts, if local conditions meet quality standards;
 - avoidance of breastfeeding and provision of alternative infant feeding strategies;
 - assurance that mothers and infants return for postnatal follow-up visits;
 - special attention to the provision of nutritional assessment and support for pregnant HIV-positive women and adolescent girls;
 - increased male involvement and a focus on the couple, not exclusively on the woman.

Skilled Care during Pregnancy

- HIV-positive women and adolescent girls require the same antenatal care as women not infected with HIV, but certain additional components should be strengthened or modified.
- Care of HIV-positive women and adolescent girls during pregnancy also involves assessing HIV-related sign and symptoms, including evidence of opportunistic infections.
- Clinical staging and, where feasible, immunological staging of HIV-positive women and adolescent girls is recommended to assess prognosis and determine eligibility for antiretroviral therapy. An estimated 15% of pregnant women experience a life-threatening complication during pregnancy or childbirth. In addition to these risks, HIV-positive women and adolescent girls have a greater risk of certain adverse pregnancy outcomes, including spontaneous abortion and stillbirth.
- Evidence, mostly from industrialized countries, indicates that pregnancy does not have a major effect on the progression of HIV disease or mortality.
- HIV-positive women and adolescent girls may be at increased risk for malnutrition, and anaemia during pregnancy is more common and often more severe. Wasting during pregnancy also occurs more frequently.

Skilled Care during Childbirth

- Universal precautions to reduce the risk of transmission of bloodborne pathogens through exposure to blood or body fluids among patients and health care workers are essential in all settings, and not only for HIV-positive women and adolescent girls.
- Further, the safe and appropriate disposal of all sharps, of the placenta, and of other blood-soaked articles is especially important.

- Care during childbirth needs to be modified to reduce the risk of MTCT, including:
 - leaving the membranes intact for as long as possible and reserving artificial rupture of the membranes for cases of fetal distress or delay in progress of labour;
 - avoiding routine vaginal cleansing as a means of reducing HIV transmission;
 - avoiding as far as possible invasive fetal monitoring, such as the use of penetrating fetal scalp electrodes, fetal scalp blood sampling, or other procedures that break the infant's skin;
 - performing elective caesarean section before the onset of labour and before the membranes rupture, as this can reduce the risk of transmission of HIV to infants (although this benefit has to be balanced against the risk to the woman of the surgical procedure);
 - performing routine caesarean section for PMTCT in some cases, such as pregnancies in which labour is likely to be prolonged or in which obstetric complications may be associated with an increased risk of MTCT (although routine use of caesarean delivery would tax already-stretched health care resources).

Skilled Care during the Postpartum Period

- Comprehensive postpartum follow-up and care for women living with HIV/AIDS and their infants extend beyond the traditional six week postpartum period and are increasingly important in expanding access to treatment and care for HIV.
- The postpartum period is part of the continuum of chronic care and support for HIV-positive women and adolescent girls.
- HIV-exposed infants require antiretroviral prophylaxis according to WHO guidelines. Children born to HIV-positive women and adolescent girls have specific follow-up and care needs, in addition to routine care and immunization.
- Postpartum care for HIV-positive women and adolescent girls includes:
 - assessing maternal healing after delivery and evaluating for postpartum infectious complications, which may be more common among HIV-positive women and adolescent girls;
 - providing postpartum family planning counseling (Women who do not want to conceive postpartum need information and counselling on appropriate contraceptive methods, including condoms, and several factors are likely to affect their choice, including the physiological processes of the puerperium, the return of ovulation and fertility, infant feeding practices, and the women's or girls' resumption of sexual activity. Women and adolescent girls wanting to have more children are advised to wait at least two to three years between pregnancies.)
 - Ongoing infant feeding counselling and support for the woman's infant feeding choice.

Infant Care

- Early diagnosis of children born to HIV-positive parents is recommended, with the aim of minimising the risk of HIV acquisition, recognising HIV infection as early as possible, preventing opportunistic infections (OIs), and addressing psychosocial issues that might be related to impairment of child's development.
- Important interventions in this regard include:
 - HIV serologic monitoring until the age of 18 months to rule out infection.
 - Serologic monitoring may sometimes not be feasible, as follow-up is needed to rule out passive transfer of anti-HIV maternal antibodies. In this context, detection of viral nucleic acids may be an alternative that enables the recognition of HIV-infected infants at earlier age. Recently, the use of new techniques, such as HIV-RNA detection on dried blood spots on filter paper, have been used in some settings.
 - Pneumocystis pneumonia prophylaxis after the age of 6 weeks of age for at least four months, regardless of negative viral results, is recommended.
 - Clinical and laboratory monitoring of the child's growth and development should include screening for other perinatal infections and immunization, as well as searching for evidence of zidovudine-associated anaemia.
 - Organizing appropriate social support for bottle-feeding and for feeding options that may reduce the risk of HIV acquisition and ensure adequate and safe nutrition should be considered a priority at infant care settings and at the community level.
- Despite recent advances in reducing in utero and postpartum transmission with the use of antiretroviral therapy, there is still a critical need to make infant feeding safer, as is laid out in current UNAIDS/WHO/UNICEF guidelines.⁴

⁴ WHO, UNICEF, UNAIDS, and UNFPA. 2003. *HIV and infant feeding: A guide for health-care managers and supervisors*. Geneva. Retrieved 6 September 2006 at: www.unfpa.org/publications/detail.cfm?ID=203&filterListType=1; and WHO, UNICEF, UNAIDS, and UNFPA. 2003. *HIV and infant feeding: Guidelines for decision makers*. Geneva. Retrieved 6 September 2006 at: www.unfpa.org/publications/detail.cfm?ID=204&filterListType=1.

(Adapted from: EngenderHealth and UNFPA. 2004. *HIV Prevention in maternal health services: Training guide*. New York.)

What is dual protection?

Dual protection can be defined as a strategy for preventing both transmission of HIV or sexually transmitted infections (STIs) and unintended pregnancy, through (1) the use of condoms alone, (2) the use of condoms combined with other methods (dual-method use), or (3) the avoidance of sexual activities considered high risk.

Many sexually active people need dual protection: protection against unintended pregnancy and against STIs, including HIV. Those contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, simultaneous condom use for disease prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently, but are associated with higher pregnancy rates than condoms used together with another contraceptive method.

More specifically, dual protection can include:

- 1) Use of condoms alone:
 - using a condom (male or female) alone for both purposes.
- 2) Dual-method use:
 - using a condom plus another contraceptive method for extra protection against pregnancy;
 - using a condom plus emergency contraception, should the condom fail;
 - selectively using condoms plus another family planning (FP) method (for example, using the pill with a primary partner, but the pill plus condoms with secondary partners).
- 3) Avoidance of unsafe sexual practices through one of the following options:
 - abstaining;
 - avoiding all types of penetrative sex without a condom;
 - practising mutual monogamy between uninfected partners, combined with using a contraceptive method (for those wishing to avoid pregnancy);
 - delaying sexual debut (for young people).

Why is condom promotion so important for dual protection?

- The male latex condom, when used correctly and consistently, is the only technology that has been proven to be highly effective at preventing both the sexual transmission of HIV and other STIs and pregnancy.
- Conclusive evidence from extensive research on heterosexual couples in which one partner is infected with HIV shows that correct and consistent condom use significantly reduces the rate of HIV transmission both from men to women, and from women to men.¹

¹ Holmes, K., Levine, R., and Weaver M. 2004. Effectiveness of condoms in preventing sexually transmitted infections. *Bulletin of the World Health Organization* 82(6):454-461.

- The female condom can provide women with more control in protecting themselves. However, HIV-positive women and adolescent girls will remain highly vulnerable to STI/RTIs and reinfection with another strain of HIV until men and women share equal decision-making powers in their interpersonal relationships².

Why is it important to legitimate condoms as an effective FP method for HIV-positive women and adolescent girls?

- In some cases, preventing pregnancy can be a greater motivator for condom use than is preventing transmission of STIs and reproductive tract infections (RTIs), transmission of HIV to partners, or reinfection with another strain of HIV.
- If FP programmes promoted condoms as an effective method for pregnancy prevention, this would have the added benefit of reducing the stigma of the condom as a method to prevent only HIV and other STIs/RTIs.
- In general, many FP health workers believe that condoms are not as effective for pregnancy prevention but are effective for HIV and STI prevention. In part, this bias is based on the fact that some other FP methods, such as sterilization, the intrauterine device, the injectable, and the Norplant implant, are more effective than the condom in “perfect” and “typical” use. But if condoms are used correctly and consistently, they are highly effective against pregnancy. This fact needs to be communicated to health workers and HIV positive women and adolescent girls alike.
- Condoms and those who use them are sometimes stigmatized because they are currently associated with HIV and STI prevention and condom use implies that partners may have other sexual partners. This stigma, which arises from the association of condom use with sex work or sexual promiscuity, can be addressed by promoting condoms as effective methods for preventing unintended pregnancy and preventing STI/RTI transmission, HIV transmission to partners, and HIV reinfection.

Why is dual-protection counselling so important in addressing the sexual and reproductive health (SRH) needs of HIV-positive women and adolescent girls?

- Dual-protection counselling can help HIV positive women and adolescent girls perceive their own risk of infection and unintended pregnancy and help them develop strategies to protect themselves.
- Meeting clients’ needs for dual protection improves the quality of SRH services by addressing clients’ multiple concerns.
- Pregnancy prevention and STI/RTI prevention needs are related to a client’s sexuality and/or reproductive intentions and can be addressed holistically in counselling HIV-positive women and adolescent girls about their SRH needs.

² UNAIDS, UNFPA, and WHO. 2004. *Position statement on condoms and HIV prevention*. Geneva.

How does dual-protection counselling relate to the concept of “informed choice”?

- Dual-protection counselling upholds the concept of informed choice by making sure that HIV-positive women and adolescent girls are knowledgeable about and aware of their risks for acquiring STIs/RTIs, infecting partners, acquiring another strain of HIV, and unintended pregnancy while they are making FP decisions.
- HIV-positive women and adolescent girls cannot make a truly informed choice about an FP method unless they are aware of their risks for STIs/RTIs and know how effective the various FP methods are at preventing these infections. Dual-protection counselling ensures that clients are aware, knowledgeable, and informed.

What are some key strategies for dual protection in addressing the SRH needs of HIV-positive women and adolescent girls?

- Providing information to HIV-positive women and adolescent girls about the full range of FP methods.
- Supporting HIV-positive women and adolescent girls who do not want to have more children in following dual protection, including dual-method use (using a condom plus another contraceptive method for extra protection against pregnancy).
- Working with HIV-positive women and adolescent girls on partner communication and condom negotiation skills.
- Involving male partners in counselling and education, and addressing their concerns about condoms.
- Making condom use acceptable to both partners.
- Helping HIV-positive women and adolescent girls consider the implications of their decisions (both positive and negative) and recognizing the limitations that many women may experience in negotiating condom use (e.g., insisting on condom use may lead to violence, abandonment, etc.).
- Promoting the female condom as an alternative to the male condom (where it is available).

18.1 Participant Handout

Key Concepts and Guiding Principles of Integrated SRH Counselling

(Adapted from: EngenderHealth. 2003 *Comprehensive counseling for reproductive health: An integrated curriculum: Trainers' manual*. New York.)

Definitions

Integrated Sexual and Reproductive Health Counselling

Integrated sexual and reproductive health (SRH) counselling is a two-way interaction between a client and a health worker, to assess and address the client's overall SRH needs, knowledge, and concerns, regardless of what health service they are working within or what service the client has requested.

In integrated SRH counselling, the provider's tasks or responsibilities are to:

- help clients assess their own needs for a range of SRH services, information, and emotional support;
- provide information appropriate to clients' identified problems and needs;
- assist clients in making their own voluntary and informed decisions;
- help clients develop the skills necessary to carry out those decisions.

How Does Integrated SRH Counselling Relate to Integrated SRH Services?

Integrated SRH counselling relates to integrated SRH services in several ways:

- The goal of integrated SRH services is to provide comprehensive health care on-site and to promote linkages between these services. Integrated SRH counselling is a critical component of integrated SRH and among services that helps clients make best use of the range of services available.
- However, integrated SRH counselling can be offered in any service-delivery setting. Thus, a provider can discuss the full range of SRH issues about which the client may be concerned, regardless of the types of SRH services actually provided at that site. Meeting the client's needs may require referring him or her to services off-site or may require problem solving to determine what the client can do about a situation for which services simply do not exist locally.

Integrated SRH counselling can be provided anywhere and at any time. It does not even need to be directly linked with a clinic setting, because many prevention strategies (e.g., for preventing transmission of HIV or sexually transmitted infections) involve social or behavioural change rather than clinical care. Thus, integrated SRH counselling can be a vital part of outreach services, as a means of helping individuals identify their needs both for clinical care and for nonclinical strategies for changing their counselling.

Participant Evaluation Form

Appendix

D

Instructions: Please complete the following evaluation form on the training in which you just participated. We are interested in learning about your views of the training sessions so we can improve the sessions in the future. Please complete all sections of this evaluation form, using the reverse side for comments, if needed. Please answer the questions from the point of view of the services you offer. Thank you for your time.

1. Overall Evaluation

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

II. Achievement of Objectives

The general objectives of the training are to ensure that you have the knowledge, attitudes, and skills needed to carry out basic tasks of HIV/STI prevention. For each task (below), please circle the appropriate number to indicate the degree to which you feel that objective was: totally achieved (5); mostly achieved (4); somewhat achieved (3); hardly achieved (2); or not at all achieved (1).

For any objectives given a rating of 1, 2, or 3, please indicate in the Comments/Suggestions column why you feel that it was somewhat, hardly, or not at all achieved, and please offer any suggestions you might have about how to improve it.

Key Integrated SRH Tasks	Score					Comments/Suggestions
	5	4	3	2	1	
Help clients assess their own needs for a range of HIV and STI services, information, and emotional support.						
Provide clear and correct information appropriate to clients' identified concerns and needs.						
Assist clients in making their own voluntary and informed decisions about HIV and STI risk reduction.						
Help clients develop the skills they will need to carry out those decisions.						

III. Other Aspects of the Training

For each of the following questions, circle the response that best represents your opinion. Please add any other comments you have.

1. How well did the course content meet your expectations?

- | | | | | |
|-----------|--------|----------|------------------|--------------------|
| 5 | 4 | 3 | 2 | 1 |
| Very well | Mostly | Somewhat | Not very
Very | Not at
all well |

For the next two questions, please refer to your agendas for the names of the sessions or topics in this workshop.

2. Which three sessions were the **most** useful, and why?

- a. _____

- b. _____

- c. _____

3. Which three sessions were the **least** useful, and why?

- a. _____

- b. _____

- c. _____

4. How well did the training methods contribute to achieving the workshop objectives?

- | | | | | |
|--------------|--------|----------|------------------|--------------------|
| 5 | 4 | 3 | 2 | 1 |
| Very
well | Mostly | Somewhat | Not very
well | Not at
all well |

Comments:

5. Please check any of the following that you feel could have improved the workshop.

- Use of more realistic examples and applications
- More time to become familiar with theory and concepts
- More time to practise skills and techniques
- More effective group interaction
- More effective training activities
- Concentration on a more limited and specific topic
- Consideration of a broader and more comprehensive topic
- Other

Comments:

6. What three things could the organisers of this training have done to make the training more effective for you?

- a.

- b.

- c.

Additional Resources

Appendix

E

- Centre for Development and Population Activities (CEDPA). 2003. *Adolescent sexual and reproductive health: A training manual for program managers*. Available at: www.phishare.org/documents/cedpa/2483/.
- EngenderHealth. 2002. *Youth-friendly services: A manual for health workers*. New York. Available at: www.engenderhealth.org/res/offc/qi/yfs/index.html.
- EngenderHealth. 2003. *Choices in family planning: Informed and voluntary decision making*. New York. Available at: www.engenderhealth.org/res/offc/ic/choices/index.html.
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- WHO, UNFPA, UNAIDS, and IPPF. 2005. *Linking sexual and reproductive health and HIV/AIDS: An annotated inventory*. Available at: www.who.int/reproductive-health/stis/docs/inventory_linkages_shr_hiv.pdf.
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- WHO. 2001. *Transforming health systems: gender and rights in reproductive health manual*. Geneva. Available at: www.who.int/reproductivehealth/publications/transforming_healthsystems_gender/text.pdf.

Sexual and Reproductive Health Fact Sheets for HIV-Positive Women and Adolescent Girls

Appendix



The following fact sheets can be photocopied and distributed to HIV-positive women and adolescent girls as additional information they can take with them after a counselling session regarding common sexual and reproductive health (SRH) concerns:

- Thrush
- Preventing sexually transmitted infections (STIs)/reproductive tract infections (RTIs)
- Human papillomavirus (HPV) and cervical cancer
- Assisted conception
- Pregnancy, childbirth, and feeding your baby
- Family planning

Thrush

What is thrush (*Candida albicans*)?

Many women and some adolescent girls develop thrush at some time in their lives. It is common in adults who are stressed or have damaged immune systems because of HIV infection. Many babies also get it. Thrush is caused by a tiny yeast-like organism called *Candida albicans*, which normally lives quite harmlessly on your skin and in your mouth and gut.

Thrush is more likely to develop if you:

- are pregnant;
- are taking certain antibiotics;
- have diabetes;
- are unwell or ill;
- are taking the contraceptive pill;
- have unprotected penetrative sex with someone who has thrush;
- eat lots of sugar or sugar-based products;
- wear very tight jeans or trousers or nylon underwear.

If you have more than one of the following symptoms, you may have thrush:

- sore spots or thick white fur on the tongue, mouth, or gums;
- itching, soreness, and redness around your vagina, vulva, or anus;
- thick white discharge from your vagina that looks white and lumpy and smells like yeast;
- swollen vulva;
- pain when you have penetrative sex;
- pain when you urinate.

Treatment

Medical treatment for thrush is easy, usually consisting of cream and pessaries (suppositories), or tablets.

You can try some of the following to relieve symptoms of thrush yourself:

- At the first sign of irritation, stop using soap and clean yourself with water.
- Stop wearing tight pants or jeans—it helps to let as much air circulate as possible.
- Don't be tempted to have frequent baths or to wash yourself more often. It may feel soothing for a short while, but it tends to make the irritation worse.
- Don't put disinfectant or bubble bath in the water. However, you can put some vinegar in your bath, or 10 drops of tea tree oil. In places where live yoghurt is available, some women with thrush have applied it to the outside of the vagina, where it soothes the irritation. Some women also put live yoghurt into their vagina with a syringe or on a tampon. The beneficial bacteria found naturally in live yoghurt are thought to destroy thrush. It works for some women, but not for all. Garlic is an alternative that may work for you. Peel a clove of garlic, slit it, and dip it in oil. Insert it into the vagina. Insert a clove once in the morning. Remove and insert a new clove in the evening. Repeat the next day or until the symptoms improve.
- If symptoms persist, see a nurse or a doctor.

Thrush (cont.)

Can you prevent thrush?

There are no simple solutions. But there are a number of things you can do to prevent getting it so frequently:

- For thrush in the mouth, avoid sugar at all times, particularly when you have an attack.
- If you have an attack of thrush, avoid fruit, honey, and yeast until you are clear of the thrush for at least three weeks.
- Avoid wearing tights, underwear made with nylon, tight jeans, or trousers.
- Use sanitary pads rather than tampons if you are menstruating.
- Avoid perfumed soaps, genital sprays and deodorants, and disinfectants. Also, avoid vaginal douching with chemical mixtures. All of these upset the beneficial balance inside the vagina.
- After defecating, always reach from behind and wipe away from the vagina. You want to avoid getting faecal matter in your vagina.
- If you are prescribed an antibiotic for some other infection, remind your doctor that you tend to get thrush.

Can you have sex while having treatment?

It is best not to have penetrative vaginal or anal sex or oral sex until you have had your final check-up with your health worker. If you have thrush in your mouth, stop kissing until you are well again. Hugging and cuddling are always fine.

Source: ICW. 1999. A positive woman's survival kit. London.

Sexually Transmitted Infections and Reproductive Tract Infections (STIs/RTIs)

STIs/RTIs

Many people have STIs or RTIs without being aware of it, because these infections are often not symptomatic. This means that the infected people may not feel any pain or discomfort. STIs/RTIs are important to know about because if they are not treated, they can have very damaging effects, such as chronic pain, infertility, and cervical cancer. If you are pregnant and have an untreated STI/RTI, the risk of infecting the baby with HIV and other infections increases. It is now understood that the presence of an STI/RTI makes sexual transmission of HIV from one partner to another much more likely.

Protect yourself

It is important to protect yourself against STIs/RTIs, and practising safer sex and using condoms during penetrative sex is the only effective way to avoid STIs. STIs/RTIs can really affect your health and may make HIV disease progress more rapidly.

Diagnosing an STI/RTI

Diagnosing an STI/RTI if you have no symptoms is not easy in many countries, as screening is not always widely available. However, it is now recognized that screening for STIs/RTIs and treating them is an effective way to slow down the numbers of new cases of HIV or reinfection with more than one strain of HIV virus. This means that treatment is now increasingly being offered in antenatal clinics, maternal and child health clinics, and family planning services. If your partner has symptoms of an STI but you don't, you should still go and get treatment. Both partners should be treated if one has an STI, to avoid reinfection.

Treatment

Treatment of STIs/RTIs can be fairly cheap and simple. Sometimes it is just one dose of antibiotics. However, different infections need different treatments, so it is important to get medical advice. If you are pregnant or planning to get pregnant, it is important to have antenatal care and to treat and clear up any existing STIs. STIs can infect the baby at birth and cause serious damage. It is also important to tell your health practitioner if you are pregnant, because this may affect the treatment you get.

Many HIV-positive women and adolescent girls have herpes in their bodies already. If an HIV-positive woman's or adolescent girl's doctor gives her 400 mg a day of acyclovir to take all the time, she can stop getting repeated herpes outbreaks, except for maybe occasionally, when she is really run down. This can make a huge difference to her quality of life and also reduces her risk of catching other STIs through open herpes sores. Because of the way herpes works, this regular use of acyclovir does not affect its effectiveness in curing a herpes outbreak.

STIs/RTIs—What to look out for:

Although many HIV-positive women and adolescent girls do not have symptoms, you may have an STI if you have had sex and you notice:

- unusual bleeding from the vagina;
- unusual stuff coming out of the vagina or your partner's penis (“discharge”);
- sores, lumps, or a rash on or around the vagina, anus, or your partner's penis;

Sexually Transmitted Infections and Reproductive Tract Infections (STIs/RTIs) (cont.)

- a burning feeling when you urinate;
- upper abdominal pain with no discharge;
- itching around the vagina or anus or your partner feels it around the penis.

Important: *If you have or suspect you have an STI/RTI, you can seek advice and treatment at a health centre.*

What about having sex if I am being treated for an STI/RTI?

With any STI, the best way to avoid infection is to use condoms and practise safer sex every time you have sex. Avoiding oral sex during an outbreak of sores or blisters and avoiding touching any open sores, warts, or blisters will reduce the risk of infection.

Common STIs/RTIs

Chancroid

Chancroid is a bacterial infection that is common in tropical countries. It causes painful ulcers on the genitals. Chancroid can be identified by a laboratory test and cured with antibiotics.

Chlamydia

Chlamydia is an infection that affects the genitals. It is one of the most common STIs. Most women have no symptoms. It can be treated simply once diagnosed, with antibiotics.

Gonorrhoea

Gonorrhoea is caused by bacteria and, again, many women will have no symptoms. Gonorrhoea is passed from one person to another through penetrative vaginal, anal, and oral sex. It is very easy to catch. It can also be passed on to babies during birth, causing eye infections and blindness. To diagnose gonorrhoea, a swab is taken from the cervix, urethra, or throat. Treatment is usually with antibiotics. If you do not have treatment, gonorrhoea can lead to pelvic inflammatory disease (PID), which can make it impossible to have a baby.

Genital Warts

Genital warts are small pinkish/white fleshy growths that may appear anywhere in the genital or anal area. They are caused by a virus called human papillomavirus (HPV). Women and adolescent girls with untreated genital warts may be at increased risk of developing genital cancers.

Warts are spread through skin-to-skin contact. If you have unprotected vaginal or anal sex or genital contact with someone who has genital warts, you may develop them. After being infected with the wart virus, it usually takes between one and three months for warts to appear on the genitals of women and men. They may itch, but they are usually painless. There are several methods used to treat genital warts. The most common one is to treat them with chemicals, which can be done by a doctor or nurse. Other methods include freezing them with liquid nitrogen, injecting them, or burning them off with a laser.

Genital Herpes

Genital herpes is caused by the herpes simplex virus (HSV). It causes painful tingling or itching blisters or ulcers. Some people have aching muscles and fever. Herpes Type I causes sores around the nose and mouth. Herpes Type II causes sores or blisters around the genital and anal area.

Sexually Transmitted Infections and Reproductive Tract Infections (STIs/RTIs) (cont.)

Herpes is passed on through direct contact with the infected part of the person's body. Herpes sores on your mouth or your partner's mouth can infect the genital area of the other person. Several things that you can do to avoid spreading herpes include:

- Avoid sharing towels and wash cloths (face flannels) with partners, family members, or friends. Unlike HIV, HSV can be passed on in this way.
- Always wash hands with soap after touching the sores.

Is there anything you can do to help yourself when you have genital herpes?

There are several things you can do to soothe the affected area:

- If the pain is severe, try taking painkillers (aspirin/paracetamol), if they are available.
- Keep the affected area as dry and clean as possible. Try gently bathing the sore areas with a salt solution (half a teaspoon of salt to half a pint of warm water). You can add five drops of tea tree oil in warm salt water too. It may soothe and help dry up the sores.
- Put gentian violet onto the sores to prevent secondary infection.
- Honey applied to herpes sores will burn for a minute and then soothe and help them to heal.
- Take 50mg zinc and 500mg vitamin E daily from the moment the herpes pimple appears. (Taking 50mg zinc and 200mg vitamin E all of the time helps to prevent reoccurrence of a herpes attack.)
- If you can get it, Zovirax (acyclovir) will shorten and ease a herpes attack. Take it with the zinc and vitamin E.
- Wear loose clothing so that air can circulate around the sore areas.
- Place an ice pack wrapped in a clean cloth or towel on the affected area.
- Get plenty of rest.
- Drink plenty of fluids.

Syphilis

Syphilis is a bacterial infection. It is usually transmitted through vaginal, anal, or oral sex. It can also be passed from an infected mother to her unborn baby. The signs and symptoms are the same in both men and women, and usually a sore appears on the penis or vagina, anus, or mouth about 10 days to three weeks after sex with an infected person. The sore disappears in a week or two, but the bacteria remain in the body. However, most women and adolescent girls do not see the sore and may not have any symptoms. The only way to be sure is to have a blood test. During the secondary stage, which may occur during the next two years, a rash may appear on the hands and feet, the face, and other parts of the body. Treatment at any time during these first two stages of syphilis will cure the infection. But if it is left untreated, a later stage will occur some years later which will cause very serious damage to your health.

Source: ICW. 1999. A positive woman's survival kit. London.

Human Papillomavirus (HPV) and Cervical Cancer

HPV Infection in HIV-Positive Women and Adolescent Girls

HPV is the most common sexually transmitted organism worldwide, and most women and adolescent girls are exposed to HPV in early sexual activity. Some strains of HPV cause genital warts, and others can cause cervical and anal dysplasia (abnormal tissue changes), which can progress to cervical and anal cancer if left untreated. However, most HPV infections resolve on their own; if they become chronic or persistent, they may lead to the development of precancer and/or cancer. There are several important differences in HPV infection among HIV-positive women and adolescent girls compared with those not infected with HIV. HIV-positive women and adolescent girls:

- have a higher prevalence of persistent HPV infection;
- have 2–6 times increased risk of precancerous lesions of the cervix (dysplasia);
- have a greater likelihood of infection with multiple HPV types, including increased cancer-associated HPV types;
- develop invasive cervical cancer more quickly.

These differences are most marked among women and adolescent girls with advanced HIV disease.

HIV-positive women and adolescent girls have a higher incidence and prevalence of genital warts—in particular, women and adolescent girls with advanced HIV disease, who also may have a poorer response to treatment and frequent recurrences. Treatment options are the same as for women and adolescent girls without HIV infection and depend on the preference of the client, available resources, and the experience of the health care provider. Biopsy of genital warts is recommended when the diagnosis is uncertain, lesions worsen during therapy, or warts appear atypical (e.g., pigmented, indurated, fixed, or ulcerated). Genital warts and the HPV strains that cause them are not associated with cervical cancer.

Cervical dysplasia is a term used to describe the abnormal growth of cells on the surface of the cervix, the part of the uterus that opens into the vagina. These changes in cervical tissue are classified as mild, moderate, or severe, or low grade/high grade (depending on what classification system is used). While dysplasia itself does not cause health problems, it is considered to be a precancerous condition. Left untreated, dysplasia sometimes progresses to an early form of cancer known as cervical carcinoma in situ, and eventually to invasive cervical cancer. Dysplasia can be detected from a Pap smear. Detecting and treating dysplasia early is essential to prevent cancer.

Anal HPV and Anal Dysplasia

Anal HPV is common in HIV-positive women and adolescent girls, especially those who have had genital warts, anal sex, or cervical dysplasia. Although anal sex is the most direct way to get anal HPV, you can have anal HPV even if you have never had anal sex.

If a woman or adolescent girl has HPV, has ever had cervical dysplasia, or has ever had anal sex, she can consider asking her health worker about the need to do an anal Pap smear to check for anal HPV. Anal Pap smears are like cervical Pap smears—cells are collected to screen for lesions in the anus. If any other abnormalities are found, health workers should use an anoscope (similar to a colonoscope) to look inside the anal canal and identify any lesions, warts, or abnormal tissue that might need treatment.

Despite possibly high rates of anal dysplasia in HIV, no comparable screening guidelines exist for anal abnormalities. An anal screening and treatment program, similar to cervical screening, could help prevent anal cancer in both HIV-positive women, men, and young people.

Human Papillomavirus (HPV) and Cervical Cancer (*cont.*)

Cancers of the Lower Genital Tract

The primary underlying cause of cervical cancer is infection with one or more high-risk types of HPV. Women and adolescent girls with HIV have an increased risk of developing cervical cancer, although this has not been seen in all countries.

Signs and symptoms

Early cervical cancer generally produces no signs or symptoms. As the cancer progresses, these signs and symptoms may appear:

- bleeding from your vagina after intercourse, between periods, or after menopause
- watery, bloody discharge from your vagina that may be heavy and have a foul odour
- pelvic pain or pain during sexual intercourse.

Women and adolescent girls with HIV receiving therapy for invasive cervical cancer require antiretroviral (ARV) treatment for HIV. Current guidelines for screening and treatment of cervical cancer do not need to be modified for women receiving ARV treatment. It is unknown whether ARV treatment substantially affects the natural history of precancerous cervical lesions, and the role of ARV treatment in the management of cervical disease is unclear; a beneficial effect on cervical lesions has been seen in some studies but not in others.

Cervical Screening

Cervical screening is acknowledged as currently the most effective approach for cervical cancer control. Experience in several countries has shown that well-planned, organized screening programmes with high coverage can significantly reduce the number of new cases of cervical cancer and mortality rates. No woman should be denied treatment for precancer or invasive cancer because she is HIV-positive. Furthermore, screening for control of cervical cancer should not be linked to or be dependent on HIV testing.

WHO and UNFPA recommend that HIV-positive women and adolescent girls should be offered cervical cancer screening at the same frequency and with the same screening test as women not infected with HIV.

Many countries with high HIV prevalence lack cytology services or adequate treatment services. A viable option in such settings is visual inspection and treatment with cryotherapy, which can be done on an outpatient basis.

Treatment for Precancerous Lesions

Treatment for low-grade lesions in HIV-positive women and adolescent girls should be avoided, due to the increased risk of complications and HIV shedding during healing after treatment. However, high-grade lesions require treatment, as there is a greater likelihood of progression to cancer. HIV-positive women and adolescent girls are more likely to have persistent disease and more rapid progression. Further, recurrence of dysplasia is strongly associated with the degree of immunosuppression, occurring in approximately 90% of women with CD4 cell counts below 200. More frequent follow-up is recommended (every six months), with prompt retreatment of persistent or recurrent high-grade lesions. Women and adolescent girls who receive treatment for cervical dysplasia need to be informed of the need for follow-up visits and possible retreatment, as well as the potential for increased HIV shedding during healing.

Human Papillomavirus (HPV) and Cervical Cancer (*cont.*)

Management of Invasive Cancer

HIV-positive women and adolescent girls present with invasive cervical cancer (i.e., cancer that has spread from the surface of the cervix to tissue deeper in the cervix or to other parts of the body) up to 10 years earlier than average, have more advanced disease, and have a poorer prognosis. For women with a CD4 count below 200, surgery is the preferable option when appropriate, although treatment with radiation or chemotherapy is also used. Women and adolescent girls with advanced HIV disease have a poor prognosis with all treatment modalities. Comprehensive, nonjudgemental palliative care programmes are essential in improving the quality of life of people with cancer.

Sources: UNFPA and WHO. 2006. *Reproductive and sexual 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. Available at: www.who.int/hiv/pub/guidelines/rhr/en/index.html; The Women's Health Channel, www.womenshealthchannel.com/cervicaldysplasia; The Body, www.thebody.com; Cable News Network (CNN), www.cnn.com; and Centers for Disease Control and Prevention (CDC) web site, www.cdc.gov.

Assisted Conception

Assisted Conception and HIV

Conception carries transmission risks in serodiscordant couples (where one partner is HIV-positive and one is HIV-negative) and reinfection risks where both partners are HIV-positive. Even if viral load is low or undetectable in blood, the viral load in semen and genital fluids may be greater. Any “pregnancy attempt” (that is, sex without using contraception) is unsafe sex and carries the risk of transmission or reinfection. The following factors help to reduce the risk, but not eliminate it:

- Pregnancy attempts involving unprotected sex that are made only during the woman’s fertile days, with undetectable levels of viral load in blood, carry a relatively low risk. (However, people can be infected by as little as one exposure to HIV.)
- Circumcised men are less susceptible to infection and are also less likely to transmit HIV to an HIV-negative female partner.
- Screening and treatment for any genital tract infections and any other sexually transmitted infections (STIs) should be carried out in both partners before they make any attempt to conceive.
- The male partner should have a semen analysis to check for any infections and to make sure he has a healthy sperm count.
- Couples who have unprotected sex while trying to conceive are less likely to return to regular condom use afterwards. This will significantly increase the risk of the HIV-negative partner’s being infected.

Assisted reproduction techniques can make it possible for couples to have pregnancies while protecting the HIV-negative partner against infection or an HIV-positive couple against reinfection with resistant strains of HIV. These include:

- sperm washing and artificial insemination
- intrauterine insemination
- in vitro fertilization (IVF)

Sperm Washing and Artificial Insemination

- Sperm washing provides a safe method of conception in serodiscordant couples where the man is HIV-positive and the woman is HIV-negative.
- The treatment involves separating the sperm from the seminal fluid, which carries the virus in infected white blood cells. The washed sperm is tested for HIV, and if it is clear, can be injected into the woman’s uterus using a catheter.
- Washed sperm can also be used for IVF if the sperm count is low.
- So far, there have been no cases of HIV transmission to women from sperm washing.
- It is not very easy to obtain this procedure through government hospitals or fertility clinics in many countries, and cost is a significant barrier, both to couples’ being able to access this service and to health services’ being able to offer it.

Intrauterine Insemination

- When the woman is HIV-positive and the man is HIV-negative, artificial insemination can be used.

Assisted Conception (*cont.*)

- Do-it-yourself artificial insemination, or “self insemination” using a plastic syringe, carries no risk to the man and is an inexpensive and simple procedure. This is the safest way to protect the man from HIV.
- Around the time of ovulation, you need to put the sperm of your partner as high as possible into your vagina. Ovulation takes place in the middle of your cycle, about 14 days before your period.
- Different clinics may recommend different methods for collecting the sperm. One way is to have protected intercourse with a spermicide-free condom. Another is for your partner to ejaculate into a container. In both cases, you then insert the sperm into your vagina with a syringe.
- Clinics should be able to provide the container and syringe. They can also give detailed instructions on how to do this, including advice on timing the process to coincide with ovulation.

In Vitro Fertilization (IVF)

- IVF is a method that involves combining an egg with sperm in a laboratory dish. If the egg fertilizes and begins cell division, the resulting embryo is transferred into the woman's uterus, where it will likely implant in the uterine lining and further develop. IVF may be performed in conjunction with medications that stimulate the ovaries to produce multiple eggs, to increase the chances of successful fertilization and implantation.
- IVF is recommended when the man's sperm count is low and can be used in conjunction with sperm washing, as above.
- IVF can also be used in situations where both partners are HIV-positive to reduce the risk of reinfection with a different strain of HIV.
- It is not very easy to obtain this procedure through government hospitals or fertility clinics in many countries, and cost is a significant barrier both to couples' being able to access this service and to health services' being able to offer it.

Adoption

- People living with HIV/AIDS (PLHIV) have the right to adopt children.
- In some settings where assisted reproduction techniques are unavailable or too costly, adoption can provide another option for PLHIV who are considering having children.

Sources: Ipas et al. 2004. *Fulfilling reproductive rights for women affected by HIV: A tool for monitoring achievement of Millennium Development Goals*; Center for Health and Gender Equity (CHANGE); International Community of Women Living with HIV/AIDS (ICW), Ipas, Pacific Institute for Women's Health (PIWH); I-base website, www.i-base.info/guides/pregnancy/planning.html.

Pregnancy, Childbirth, and Feeding Your Baby

This is a short summary of a much longer document, which is available by e-mail from info@icw.org. Or you can download it from www.icw.org/.

HIV-positive women who want to have children should be able to access the treatments and care that they need to have healthy pregnancies and healthy HIV-negative babies. This fact sheet explains how the risk of transmitting HIV from mother to child can be greatly reduced. The information is as up-to-date as possible (as of August 2006), but research is still going on and we suggest that you should, if possible, *consult a health worker* about your pregnancy, to learn about your best options. If you have access to the Internet, you can also check www.aidsmap.com/web/pb3/eng/1a3edd95-c60b-4bff-83d5-ce706aa88191.htm or www.unaids.org for the latest available information.

Preventing Perinatal Transmission

HIV can be passed to babies from their mothers' bodies during pregnancy, during childbirth, or through breastfeeding. Around 50–60% of children born to HIV-positive women are likely not to be HIV-positive themselves. With some basic precautions, transmission rates during pregnancy, childbirth, and breastfeeding can be considerably reduced. The possibility of passing on the virus can be reduced to as low as 2% in many settings. Understanding of these issues is constantly improving, but there are many parts of the world where women are still not able to gain access to the information, care, or treatment that is their right.

Reducing the Risk of Perinatal Transmission

If you are able to keep healthy, this will be better for you as well as for your baby. There are a number of ways that you may be able to reduce the risk of infection being passed to your baby during pregnancy, during childbirth, and if you breastfeed.

- **Know your HIV status.** If you know your status, this will help you to decide what steps you might be able to take to reduce the risk of transmitting HIV to your baby.
- **Seek medical advice.** Contact with health workers before or early in your pregnancy means that they can monitor your health and advise you about reducing the risk of transmission to your baby. If you are HIV-positive, it is best that your delivery is attended by a trained health professional who is aware of your status and who is therefore able to take the necessary steps to reduce the risk of HIV transmission.
- **Try, if you can, to look after your health.** Pregnant or breastfeeding women who are sick because of HIV are more likely to transmit HIV to their babies than are women who are well.
- **Use condoms, especially if you have sex during your pregnancy and while you are breastfeeding,** to protect yourself against other strains of HIV and other sexually transmitted infections, which can otherwise affect your own health and affect your baby too. If using condoms is a problem for your partner, it may help if you or a health professional can explain to him that using condoms may reduce the risk of HIV transmission to the baby.
- **Try to eat a healthy balanced diet,** including, for instance, red meat and eggs, green vegetables, fruit, and cereals.
- **Rest** is also important.
- **Take antiretroviral (ARV) medicine** (if you have access to it and you meet the criteria for starting ARVs) (carefully following medical advice about what to take and when) in order to reduce the amount of virus in your blood. These can both reduce the progression of HIV in your own

Pregnancy, Childbirth, and Feeding Your Baby (cont.)

body and reduce the chances of transmission of HIV to your baby. There is more about ARVs below.

Note: All babies are born with their mother's antibodies in their blood; therefore, it can take up to 15 months before an HIV antibody test is able to show whether the baby is HIV-positive or HIV-negative. According to a recent report from the WHO, "HIV infection can be definitively diagnosed in infected infants only by using viral diagnostic assays (detection of HIV by DNA or RNA polymerase chain reaction [PCR]). These assays may not be available in resource-limited settings...If available, virologic testing should be performed between six weeks and six months of age...HIV infection can be reasonably excluded among children with two or more negative virologic tests performed between six weeks and six months of age in non-breastfed infants and six weeks after complete cessation if breastfeeding. In the absence of viral diagnostic assays, HIV antibody testing is used".¹ HIV infection can be definitively excluded in a non-breastfeeding child if the HIV antibody is negative at 18 months of age. A persistent HIV-positive test result 18 months after delivery confirms HIV infection regardless of breastfeeding.

More about Pregnancy

All HIV-positive pregnant women ideally need to have regular follow-up and care during pregnancy. Seeking early antenatal care means that tests can be carried out, illnesses identified (such as malaria or intestinal worms, which can cause anaemia) and, where necessary, treatment given. Maintaining your own health, by eating well, avoiding illness, using condoms, resting, and taking ARVs, is one of the most effective ways of staying well, of looking after yourself, and of reducing the risk of transmitting HIV to your baby.

More about Childbirth

Strategies to reduce transmission of HIV during childbirth include:

- providing ARVs to women before and during delivery (and usually zidovudine or nevirapine to the baby after delivery);
- preventing prolonged and/or difficult labours (birth attendants should not break the waters artificially);
- avoiding interventions that cause bleeding, such as episiotomy, forceps-assisted delivery, or application of electrodes to the baby's scalp;
- having a caesarean section if you are HIV-positive but not on long-term combination therapy and if it is available where you live;
- if you are HIV-positive and have a caesarean section, you should be provided with antibiotics to reduce the risk of infection.

Feeding Your Baby

Breast milk is the best food for a new baby. However, breastfeeding is a route of HIV transmission. This sheet highlights issues to consider when deciding whether or not to breastfeed. For

¹ WHO Regional Office for the Western Pacific. 2005. Antiretroviral therapy for children with HIV infection in resource-limited settings. *HIV/AIDS Antiretroviral Newsletter*, Issue No. 11, p. 3. Retrieved 28 June 2006 from www.wpro.who.int/NR/rdonlyres/33C36F11-6EFC-4255-A3212CC6D5466FE0/0/ARV_Newsletter_Issue_11.pdf.

Pregnancy, Childbirth, and Feeding Your Baby (cont.)

more information, see the longer ICW information sheet for HIV-positive women, *Pregnancy, childbirth and feeding your baby*, and try to discuss the matter with a health provider.²

- Some HIV-positive women are now expressing their breast milk regularly and then pasteurizing it, by heating it just until it starts to bubble round the edge of the pan, then letting it cool before feeding it to their baby. Preliminary research suggests that this might be a safe way of destroying the HIV in the milk. You can read more about this in the longer ICW information sheet.
- If you would prefer not to breastfeed, assess how easy will it be for you to prepare a safe alternative to breast milk:
 - Do you have access to safe, clean water?
 - Can you afford a replacement milk supply for six to 12 months?
 - Do you have access to adequate utensils for feeding?
 - Do you have access to fuel for sterilizing equipments and heating the milk?
- Also try to think about the social and cultural implications if you do not breastfeed.
 - Will people guess that you are HIV-positive?
 - Will that cause problems for you?
 - Can you think of another reason to say to people who ask why you are not breastfeeding? (For instance, that it hurts your breasts too much. Quite a few women find this anyway.)

More about ARVs

(See an additional resource on ARVs and pregnancy, noted below.)³

A healthy mother is more likely to produce a healthy baby. If a woman needs ARV therapy for her own health, then giving these drugs to her is more likely to result in a) her own continued good health and, in addition, b) a reduced risk of transmitting HIV to her baby. In some situations when a mother does not require therapy at present, “monotherapy” (normally, zidovudine [also known as AZT] or nevirapine) can be given to her before and during delivery and to the baby after delivery. Monotherapy can also be given in situations where combination therapy is not available. (However, where combination therapy normally is available, the mother ideally should receive it.) Although this reduces risk of transmission to the baby, it does have drawbacks for the mother’s health.

How do they work? ARVs reduce the amount of virus in the bloodstream and therefore reduce the risk of transmission to a baby during pregnancy, during delivery, or through breastfeeding. ARVs may have side effects for both you and/or your baby. Many women believe that the benefits of having an HIV-negative baby outweigh the risk of complications in pregnancy or of the very low possible risk of birth defects.

² *Note:* Because HIV can be transmitted through breast milk, the guidelines around infant feeding for women who are HIV-positive differ from those for women who are HIV-negative. See the following resources for the ways in which they differ: UNFPA. *HIV and infant feeding: Framework for priority action*. Geneva. Retrieved at: www.unfpa.org/publications/detail.cfm?ID=156&filterListType=1; UNICEF. No date. *Infant feeding and HIV: Nutrition*. Retrieved 28 June 2006 at: www.unicef.org/nutrition/23964_infantfeeding.html; WHO. No date. *HIV and infant feeding: Guidelines for decision-makers: Mother-to-child transmission*. Retrieved 28 June 2006 at: www.unaids.org/en/Issues/Affected_communities/mothertochild.asp.

³ Department of Health and Human Services. 2006. *HIV and pregnancy*. AIDInfo. Retrieved at: www.aidsinfo.nih.gov/ContentFiles/HIVandPregnancy_FS_en.pdf.

Pregnancy, Childbirth, and Feeding Your Baby (cont.)

Why should I take more than one set of ARVs? A single drug (“monotherapy”—normally zidovudine or nevirapine) can reduce the risk of transmission to the baby during labour/delivery, but it is not as effective as combination therapy. Ask your doctor about this. Monotherapy may also lead to the development of drug resistance in the mother. Again, it’s best to ask your doctor about this.

If I am already on combination therapy, should I continue it when I become pregnant? Yes. Although taking drugs in the first three months of pregnancy is generally not advised, if you are already using combination therapy, it is best to continue, because if you stop it, the amount of virus in your blood may increase and the risk of transmission to your baby would also increase. Some combination therapy drugs are not recommended during pregnancy, so you may need to change them. Ask your doctor about this.

There are many things that you can do that can help you and your baby stay healthy. If you can, try to find a group of other HIV-positive women with whom you can discuss the ideas and suggestions in this information sheet. Many HIV-positive women have found that it really helps to do this. There are still no simple answers to many of these difficult and challenging issues, but ICW will continue to try to keep you informed about new research as it emerges.

Sources: ICW. 1999. *A positive woman’s survival kit*; London; UNFPA and WHO. 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.

Family Planning

HIV-positive women and adolescent girls have the right to make noncoerced and autonomous decisions about family planning, based on unbiased information. They should have a variety of contraceptive methods to choose from and be given their method of choice.

Contraceptive Methods and Dual-Method Use

With minor exceptions, HIV-positive women and adolescent girls can use most of the following modern contraceptive methods:

Condoms (male and female)

- Condoms protect against both pregnancy and sexually transmitted infections (STIs) and reproductive tract infections (RTIs), including HIV reinfection or transmission of HIV to a partner (dual protection).
- Condoms are effective when used consistently and correctly every time you have sex.
- Condoms can be used alone or with other family planning methods (dual-method use).
- Female condoms are more expensive than male condoms and hard to find.
- Female condoms are inserted by the woman.
- Usually, partners need to discuss use of either male or female condom.

Dual-method use

- Dual-method use addresses some of the limitations of the single-method approach.
- However, condoms are more effective at preventing STIs/RTIs and HIV than they are at preventing pregnancy.
- The dual-method approach refers to using condoms to prevent STIs/RTIs, reinfection with HIV, or infecting a partner, and using another contraceptive method to prevent pregnancy.

Emergency contraception

- Emergency contraception prevents pregnancy when a contraceptive method fails, when no method was used, or when sex was forced.
- Emergency contraceptive pills (ECPs) can be used by women within five days of unprotected intercourse, though they are more effective the sooner they are taken after unprotected sex.
- Emergency contraception might cause nausea, vomiting, spotting, or bleeding.
- Emergency contraception does not prevent pregnancy the next time you have sex.
- Emergency contraception also does not prevent STIs/RTIs, including reinfection with HIV.

The pill

- Oral contraceptives are very safe and effective.
- One pill is taken every day.
- The pill helps reduce menstrual bleeding and cramps.
- Women can use the pill when taking antiretroviral (ARV) drugs.
- The pill does not protect against STIs/RTIs or against reinfection with HIV.
- Most common pill-related side effects include nausea, spotting, and headaches.
- Pill users are recommended to use a condom too (dual-method use).

Family Planning (*cont.*)

Long-acting injectables

- Injectables are very safe and effective.
- One injection is needed every two or three months.
- It often takes longer to get pregnant after stopping use of injectables than after discontinuation of other methods.
- Injectables do not protect against STIs/RTIs, including reinfection with HIV.
- Injectable users are recommended to use a condom too (dual-method use).

Female sterilization

- Female sterilization is very safe and effective.
- It is a surgical procedure.
- Sterilization is a permanent method for women who do not want more children.
- Users still have menstrual periods, as the womb is not removed.
- Sterilization does not protect against STIs/RTIs, including reinfection with HIV.
- Sterilized women are recommended to use a condom too (dual-method use).

Male sterilization (vasectomy)

- Vasectomy is very safe and effective.
- It is a simple surgical procedure.
- Vasectomy is a permanent method for men who do not want more children.
- Vasectomy has no effect on a man's sexual ability.
- Vasectomy does not protect against STIs/RTIs, including reinfection with HIV.
- Vasectomy users are recommended to use a condom too (dual-method use).

Hormonal implants

- Hormonal implants are very safe and effective.
- They consist of six small plastic tubes placed under skin of the upper arm.
- Implants last for 4–7 years, depending on the user's weight.
- Women can get pregnant soon after implants are removed.
- The implant usually changes monthly bleeding patterns.
- Implants do not protect against STIs/RTIs, including reinfection with HIV.
- Implant users are recommended to use a condom too (dual-method use).

Copper IUD

- The IUD is very safe and effective.
- It is a small device that fits inside the womb.
- The IUD keeps working for at least 10 years.
- It can be removed whenever you want.
- The IUD might increase menstrual bleeding and cramps.
- The IUD does not protect against STIs/RTIs, including reinfection with HIV.
- IUD users are recommended to use a condom too (dual-method use).

Family Planning (*cont.*)

Lactational amenorrhoea method (LAM)

- LAM is a method based on breastfeeding.
- It involves breastfeeding often, day and night, and giving the infant little or no other food.
- LAM is effective for six months after giving birth.
- LAM does not protect against STIs/RTIs, including reinfection with HIV.
- LAM users are recommended to use a condom too (dual-method use).

Drug Interactions

- Some ARVs can either increase or decrease hormones levels, thereby reducing the effectiveness of hormonal contraceptive methods or increasing side effects.
- It is not clear that the effectiveness of contraceptive hormones is appreciably affected by the decreased concentrations.

At this point in time, concerns about unfavourable results of interactions between hormonal contraceptives and ARV drugs are theoretical.

Abortion and Postabortion Care

- In countries where abortion is legal, the technique of vacuum aspiration is the preferred method of inducing abortion over dilatation or curettage for HIV-positive women and adolescent girls.
- Routine use of antibiotics can help reduce the postprocedural risk of infections.
- Medical abortion may be the preferred option for HIV-positive women and adolescent girls, given that the rate of infection is lower than with surgical procedure.

Sources: WHO. 2004. *Medical Eligibility Criteria for Contraceptive Use, third edition.* Geneva; WHO and UNFPA. 2006. *Reproductive and Sexual Health of Women with HIV: Guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings.* Geneva.

Page	Session Title
187	Introduction to the Programme Planning Workshop
189	Sample Two-Day Workshop Agenda
191	Session 1: Overview
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Introduction to the Programme Planning Workshop

The commitment of the international community to intensify linkages between sexual and reproductive health (SRH) and HIV/AIDS at the policy and programme level was expressed in the June 2005 UNAIDS policy position paper “Intensifying HIV prevention”. It builds upon the New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health,¹ the Glion Call to Action on Family Planning and HIV/AIDS in Women and Children,² and the Abuja Call to Action: Towards an HIV-Free and AIDS-Free Generation.³ These policy statements call upon both the SRH and HIV/AIDS communities to strengthen programmatic linkages between SRH and HIV/AIDS.

Stronger linkages between SRH and HIV/AIDS programmes should lead to a number of important public health benefits. Much remains unknown, however, about which linkages will have the greatest impact, and how best to strengthen selected linkages in different programme settings.

The following planning steps can be used to facilitate a group of stakeholders in designing programme interventions linking SRH with HIV/AIDS. It is recommended that programme managers and health workers invited to this workshop have already completed the four-day training on Sexual and Reproductive Health for HIV-Positive Women and Adolescent Girls.

Planning Steps

- Assemble a team of HIV/AIDS and SRH programme managers and health workers from public and community-based health facilities within your district to participate in a two-day workshop to develop an action plan for linking HIV/AIDS and SRH services. (Be sure to include representation from people living with HIV/AIDS.)
- Compile and distribute existing data and information, including relevant country-specific policies and strategic plans on HIV/AIDS and SRH, country-specific HIV/AIDS and contraceptive prevalence rates, and other national surveys or studies pertinent to the SRH of HIV-positive women and adolescent girls, such as barriers to accessing existing family planning and SRH services.
- Conduct a rapid assessment⁴ of the situation by completing Activity 1, pages 199–200.
- Review the levels and types of programme interventions linking SRH and HIV/AIDS and set priorities for your interventions by completing Activity 2, pages 209–210.

¹ UNFPA. 2004. *New York call to commitment: Linking HIV/AIDS and sexual and reproductive health*. 7 June 2004. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=195&filterListType=1.

² UNFPA. 2004. *Glion call to action on family planning and HIV/AIDS in women and children*, Glion, May 3-5, 2004. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=199&filterListType=1.

³ UNFPA. 2005. *Call to action: Towards an HIV-free and AIDS-free generation*. Report of the Prevention of Mother to Child Transmission (PMTCT) High Level Global Partners Forum, Abuja, Nigeria, December 3, 2005. Retrieved 31 August 2006 at: www.unfpa.org/publications/detail.cfm?ID=259&filterListType=1.

⁴ A rapid assessment aims to identify the extent and nature of health risk behaviours and associated health consequences and to identify existing resources and opportunities for intervention.

APPENDIX G: Workshop Introduction

- Based on the results of Activities 1 and 2, develop an action plan for implementing and monitoring the programme interventions linking SRH and HIV/AIDS by completing Activity 3, pages 215–217.
- Identify one person or several people who will be responsible for monitoring the action plan's progress, for recommending changes or improvements to the plan, and for ensuring that all people responsible for recommendations in the plan carry them out.
- Provide ongoing facilitative supervision support and monitoring of staff performance in relation to the introduction of any new programme interventions linking SRH and HIV/AIDS.

Sample Two-Day Workshop Agenda

Day 1
<p style="text-align: center;">Morning</p> <p>Session 1: Overview (60 minutes) Session 2: Linking SRH and HIV/AIDS Programmes (60 minutes) Break (15 minutes) Session 3: Completing a Rapid Assessment of the Current Situation (60 minutes)</p> <p style="text-align: center;">Afternoon</p> <p>Session 3 Cont'd: Completing a Rapid Assessment of the Current Situation (120 minutes) Break (15 minutes) Session 3 Cont'd: Completing a Rapid Assessment of the Current Situation (60 minutes) Session 4: Determining Priorities for Programme Interventions Linking SRH and HIV/AIDS (60 minutes) Closing (15 min.)</p>
Day 2
<p style="text-align: center;">Morning</p> <p>Checking In: Participants' insights from the previous day's sessions (15 minutes) Session 4 Cont'd: Determining Priorities for Programme Interventions Linking SRH and HIV/AIDS (120 minutes) Break (15 minutes) Session 5: Developing an Action Plan (60 minutes)</p> <p style="text-align: center;">Afternoon</p> <p>Session 5 Cont'd: Developing an Action Plan (120 minutes) Break (15 minutes) Session 5 Cont'd: Developing an Action Plan (60 minutes) Session 6: Closing Session (60 minutes)</p>

Overview

1

Objectives

- to officially welcome all participants and introduce the participants, any guests, and trainers;
- to describe the purpose and agenda for this workshop;
- to create a set of “ground rules” or “group norms” by which the group and facilitator(s) agree to work throughout the training.

Time

60 minutes

Materials

- copies of the daily agenda
- a flipchart showing the daily agenda (optional)

Advance Preparation

1. Any guest speakers should be thoroughly briefed in advance, to explain the purpose of the training and to be clear about the length and subject desired for their opening remarks.
2. Prepare and photocopy the training agenda for all guests and participants. It is also helpful to have the daily agenda written up on a flipchart and posted on the wall throughout the day. It might be preferable to avoid having precise times listed next to the activities, so the trainers can have flexibility, as needed.
3. Prepare and photocopy the pretest questionnaire for the number of participants in the group.

Training Steps

1. A representative of the local “host” organization should formally open the workshop by welcoming the participants, explaining the purpose of the workshop, and introducing the trainers.
2. After this, the trainers should go around the room and have each participant *briefly* state his or her name, clinic, and job title, the number of years each has been working in this field, and one thing he or she hopes to gain from participating in this training. Record these ideas on a flipchart and post it. (You may refer back to the list during the second day’s closing session.)

3. One trainer will provide an overview of the training by reviewing the goal and overall objectives for the workshop, including:
 - Assisting regional- and district-level programme planners, managers, and health workers to determine the most appropriate approach to linking HIV/AIDS and sexual and reproductive health (SRH) services in their setting by:
 - completing basic planning activities that can be adapted for collecting relevant baseline information, organizing and synthesizing the information, setting priorities, developing relevant plans, and making sound programming decisions;
 - reviewing and discussing options and considerations that must be taken into account in tailoring programme interventions for linking SRH and HIV/AIDS to best fit their locale.
4. The trainers can then distribute the agenda, go through it with the participants, and respond to any questions.
5. Create a set of ground rules or group norms with the participants. A trainer can ask whether anyone in the group has been to a training before, and if so, whether they developed ground rules or group norms at the beginning. If so, have the participant explain the purpose of ground rules. If not, explain why ground rules are set up:
 - to ensure that everyone feels they can participate openly, without judgements
 - to create a safe learning environment for everyone involved
 - to have written expectations of how the group will work together during the training.
6. Ask the group to brainstorm ground rules and write these on a flipchart. Suggested ground rules include:
 - Show respect, especially for differences of opinion.
 - Speak one at a time, so that we can all hear what everyone else is saying.
 - Avoid side conversations, because they distract people around you from hearing what someone else is saying.
 - Start and end on time.
 - Use “I” statements when expressing your opinion. For example, try saying “I believe it is important to address HIV prevention in pregnancy” instead of “We all believe it is important to address HIV prevention in pregnancy”.
 - If possible, participate fully and equally. Mention the participants’ right to “pass” (i.e., if people feel uncomfortable with something, they can choose to “pass” from participating in the discussion).
 - Promise confidentiality. (Even though this will have been discussed during the introductory session, it is a good idea to have it on the ground rules list.)
 - Have fun. (This is an important issue: Let the participants know that while they will be discussing very serious topics, they will be doing so in a dynamic way, so the hope is that everyone will have fun while working together.)

Linking SRH and HIV/AIDS Programmes

2

Objectives

- to introduce a conceptual framework for linking sexual and reproductive health (SRH) and HIV/AIDS programmes;
- to provide working definitions of key concepts relevant to linking SRH and HIV/AIDS programmes.

Time

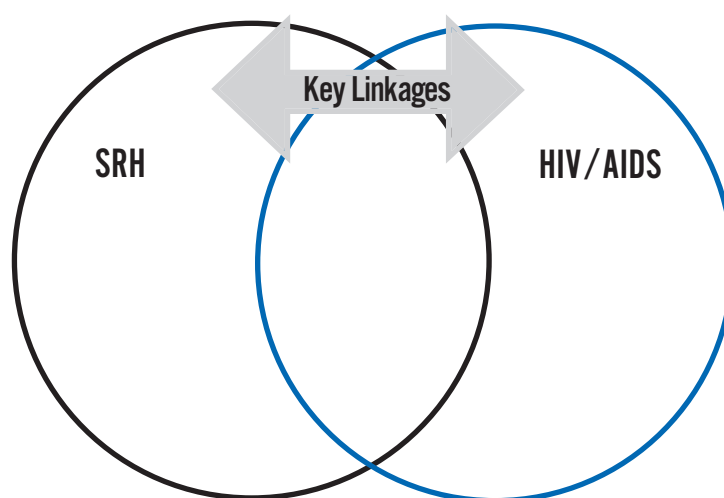
60 minutes

Materials

- flipchart paper
- markers
- masking tape
- Participant Handout 2.1: A Framework for Priority Linkages, p. 196
- Participant Handout 2.2: The Forms and Levels of Linkage and Integration, p. 197

Advance Preparation

1. On a piece of flipchart paper, draw the framework for priority linkages found in Participant Handout 2.1, p. 196, omitting the accompanying text as illustrated below.



- Write the following definitions of linkage and integration on flipchart paper:

Linkage

Linkage is a term that pertains to the conceptual and strategic levels. It refers to the understanding of synergies that can be created when seeking common approaches to addressing specific health issues. Linkage seeks to answer the question of the value that can be added by the linking of the two issues. For example, linkage would assess the value from adding family planning services to AIDS treatment centres for HIV-positive women, or joining antenatal syphilis screening and treatment with services for the prevention of mother-to-child transmission (of HIV) (PMTCT).

Integration

In contrast, integration has come to be known as the operational, concrete process of implementing linkages. As such, integration denotes how linkage can occur in its various forms and at different levels, ranging from referrals to full integration. No matter how “informal” or “formal” the form or level of integration, it will always require some added implementation process. This can be as simple as creating a way to alert another programme of your intention to refer clients.

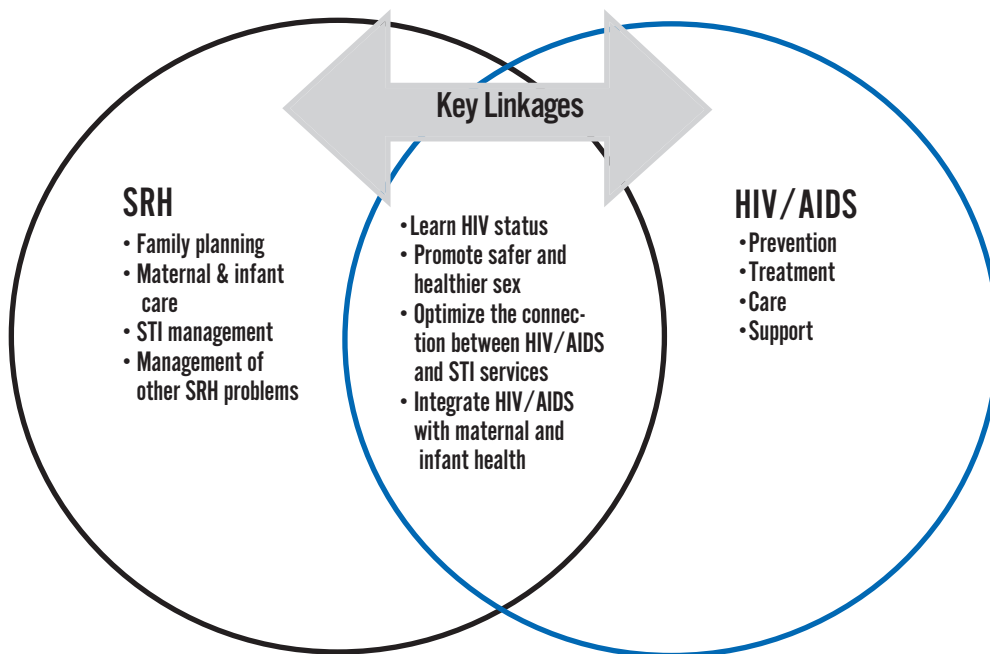
Training Steps

- Conduct a brainstorming activity with the following instructions:
 - Referring participants to the flipchart with the framework for priority linkages, ask them what services they think should be included in the SRH circle. Write their responses in the SRH circle on the flipchart paper.
 - Then ask them what services they think should be included in the HIV/AIDS circle. Again, write their responses in the appropriate circle.
 - Please ensure that all services included in Participant Handout 2.1 are identified by participants. If not, write down the services they missed.
 - Next ask the participants what they think some of the key linkages are between SRH and HIV/AIDS services. Write their responses in the area on the flipchart where the two circles overlap. Again, ensure that all linkages shown in Participant Handout 2.1 are included.
 - Distribute copies of Participant Handout 2.1 and summarize the framework by explaining:
 - This framework proposes a set of key policy and programme actions to strengthen linkages between SRH and HIV/AIDS programmes.
 - The linkages work in both directions, by integrating HIV/AIDS interventions into ongoing SRH programmes and, conversely, by integrating SRH interventions into HIV/AIDS programmes.
 - Based on experience and programming realities, stronger linkages between SRH and HIV/AIDS programmes should lead to a number of important public health benefits.

- Ask the participants what they think some of the important public health benefits are. Write their ideas onto flipchart paper. Ensure that they identify all of the following benefits:
 - improved access to and uptake of key HIV/AIDS and SRH services;
 - better access for people living with HIV (PLHIV) to SRH services tailored to their needs;
 - reduced HIV/AIDS-related stigma and discrimination;
 - improved coverage in SRH services of underserved and marginalized populations, such as injecting drug users, sex workers, or men who have sex with men;
 - greater support for dual protection against unintended pregnancy and sexually transmitted infections (STIs), including HIV, for those in need, especially young people;
 - improved quality of care;
 - enhanced programme effectiveness and efficiency.
 - Summarize the brainstorm activity by explaining that with careful priority-setting and judicious programme planning and implementation, all of the above benefits can be achieved.
2. Conclude the session by asking one of the participants to read the definitions of linkage and integration written on the flipchart paper. Ask the participants if they think these are good working definitions and if they have any suggestions as to how they would change it or add to them. Refer the participants to Participant Handout 2.2 for an overview of the form and levels of linking and integration.

2.1 Participant Handout

A Framework for Priority Linkages



Adapted from: WHO, UNFPA, UNAIDS, and IPPF. 2006. Sexual and reproductive health & HIV/AIDS: A framework for priority linkages. Available at: www.who.int/reproductive-health/stis/docs/framework_priority_linkages.pdf.

2.2 Participant Handout

The Forms and Levels of Linkage and Integration

Motivation for linkage and integration should focus on meeting the needs of the client. That is, linkage and integration should serve the client in such a way that care appears seamless, respects client rights, is provided free of discrimination and stigmatization, and is culturally sensitive. This does not imply that all linkage and integration efforts should take the form of a “one-stop comprehensive health service”, where all services are delivered to all people under one roof. An initial assessment of the context in which programmes are being linked, and the stated objectives motivating linkage and integration, would guide an appropriate configuration for the linkage and integration of services—be it an informal linking of services through a referral system or a formal integration of one service into an established health program. What is clear is that linkage and integration must be realistically designed to meet client needs and situated positively within the country or local context.

The forms of linkage and integration can vary considerably. The WHO¹ describes the following forms of integration:

1. Integration of service tasks within a given setting:
 - at the point of delivery of services;
 - multipurpose clinics instead of special-purpose clinics;
 - multipurpose staff (e.g., nurses capable of family planning, treatment of STIs, and HIV prevention).
2. Integration of management and support functions:
 - planning (e.g., comprehensive, intersectoral planning, and development of programmes, rather than separate planning of single-purpose programmes);
 - budget and financial processes;
 - information systems, which include data on both inputs and outcomes, and reporting on all services delivered;
 - training (e.g., in-service staff training designed to upgrade staff skills in several areas of service responsibilities, including communication skills);
 - supervisory visits that are multipurpose and deal with all elements of the services.
3. Integration of organizational components:
 - integration of the efforts of different resource providers (government, private, non-governmental organizations) operating at various administrative levels (community, district, provincial, national) through coordinating mechanisms such as health committees or councils;

¹ WHO. 1996. *Integration of health care delivery*. WHO Technical Report Series 861. Geneva.

2.2 Participant Handout

The Forms and Levels of Linkage and Integration (*cont.*)

- establishment of the district hospital as an integral part of the district health service instead of a discrete institution, serving not only as a referral centre but as a resource for support services;
- integration of health and other development efforts across several sectors (e.g., joint efforts to support development of health care, education, transport, communications, housing, water, and agriculture);
- integration of health care into community and family activities

Briggs et al.² state that integration is relevant to the health system at various levels:

- Level 1: Integration of services at the point of delivery, making the product coherent.
- Level 2: Integration of resource management, making the local management systems efficient.
- Level 3: Integration of organization and policy, making the service structure consistent with policy.

² Briggs, C. J., et al. 2001. Strategies for integrating primary health services in middle- and low-income countries: effects on performance, costs and patient outcomes. *Cochrane Database Syst Rev* 4: CD003318.

Completing a Rapid Assessment of the Current Situation

3

Objectives

- to learn about the policy and service-delivery requirements of programme interventions linking SRH and HIV/AIDS;
- to discuss the advantages and challenges of introducing programme interventions linking SRH and HIV/AIDS.

Time

240 minutes

Materials

- paper and pens
- flipchart paper and markers

Advance Preparation

1. Review the question guide, Worksheet 1 on page 201, to become familiar with each of the main topic headings and questions under each topic.
2. Make enough copies of the question guide for the number of participants.
3. Create small groups (5–7 people in each group) with good representation of HIV/AIDS and sexual and reproductive health (SRH) participants and public health and private/non-governmental organization participants in each group.
4. Based on the number of small groups, assign an adequate number of topic headings from Worksheet 1 to each group to ensure that all topics in the question guide get discussed.
5. Contact a representative of the Ministry of Health to provide a short presentation on SRH and HIV/AIDS in your country, including epidemiological data.

Detailed Steps

1. Introduce the guest speaker and explain that he or she will present some SRH- and HIV/AIDS-related background information about HIV-positive women and adolescent girls. Tell them that the presentation will be followed by questions and answers.
2. Divide the participants into small groups and distribute the question guide.
3. Provide a brief overview of the question guide, pointing out the topic headings and questions under each topic heading.

4. Assign each group its topic headings and provide the following additional instructions:
 - Each group will have approximately 2 1/2 hours to answer each question for the topic headings they were assigned and discuss the implications of their answers. Explain that “no” answers represent potential problems with introducing SRH-HIV/AIDS-linked programme interventions and they should discuss these fully before going on to the next question.
 - Each group should choose a note-taker and presenter. The note-taker should record the “no” answers to the questions on a flipchart paper, as well as a summary of the key implications they discussed under each “no” answer. The presenter will provide a 15-minute summary of their discussion.
5. During the last 1 1/2 hours of this activity, facilitate a report back. Post each group’s flipcharts on the wall where everybody can see. After each group presents, ask the entire group if they have any questions or need anything clarified.

3 Worksheet 1

Question Guide for Completing a Rapid Assessment

For each question, answer yes or no. For each yes or no answer, go to the appropriate column and discuss the implications that are listed. The “no” responses indicate a likely problem or gap in linking SRH and HIV/AIDS services. For each “no” response, identify and discuss any further implications for your setting in addition to those provided.

Questions	Yes/Implications	No/Implications
1. Community Partnerships and Resources		
1.1 The community's attitude about linking sexual and reproductive health (SRH) and HIV/AIDS services: Does the community believe or understand the benefits of linked services?	<ul style="list-style-type: none"> Engage the community in planning and monitoring linked services. 	<ul style="list-style-type: none"> Requires creating awareness regarding SRH-HIV/AIDS-linked services, the benefits and challenges, and engaging the community in deciding the scope of linked services.
1.2 Are there organizations of people living with HIV/AIDS (PLHIV)?	<ul style="list-style-type: none"> Include representatives of PLHIVs to contribute their perspective in planning and monitoring linked services. 	<ul style="list-style-type: none"> Explore what support groups exist for PLHIV in the community and assess the possibility of starting your own support group.
1.3 Are there community organizations providing SRH (family planning) or HIV-related services, such as voluntary counselling and testing (VCT), prevention of mother-to-child transmission of HIV (PMTCT), anti-retroviral (ARV) treatment and care, or home- and community-based care?	<ul style="list-style-type: none"> Explore possibilities for coordinating services to support referral linkages 	<ul style="list-style-type: none"> If there are none, explore if organizations exist in neighbouring towns or at the district or regional level and what opportunities exist for collaboration.
1.4 Are there existing services or programmes in the area linking SRH and HIV/AIDS?	<ul style="list-style-type: none"> Determine the possibility of referral linkages or identifying a service gap that the service could fill. 	<ul style="list-style-type: none"> Requires determining with the community the scope of integration that would be possible for the facility to provide.
1.5 Are there influential persons who can be allies in promoting behaviour change?	<ul style="list-style-type: none"> Sensitize influential individuals as a resource to endorse health-promoting sexual and reproductive behaviour and to promote use of linked services. 	<ul style="list-style-type: none"> Requires finding potentially supportive influential or popular figures and preparing them for promoting behaviour change and use of linked services.
2. Rights-Based Approach		
2.1 Is there a process that systematically solicits the views of vulnerable populations, such as young girls, sex workers, injecting drug users (IDUs), migrants, etc., about the quality of existing services?	<ul style="list-style-type: none"> Review feedback regularly and apply in developing relevant policies and guidelines and ongoing quality improvement activities. 	<ul style="list-style-type: none"> Requires creating a system for gathering feedback from vulnerable populations on a regular basis, such as conducting focus groups, client satisfaction surveys, etc.
2.2 Are hospital and health clinic management boards inclusive by inviting PLHIV representatives, women representatives to participate in decision making, or is there any form of community participation?	<ul style="list-style-type: none"> Review membership and selection criteria regularly to ensure they reflect the diversity of people affected by HIV/AIDS 	<ul style="list-style-type: none"> Requires creating an advisory body and a system for ensuring equity, selection of criteria, and target setting for the numbers of people to be included on the advisory body, paying particular attention to young girls, sex workers, IDUs, men who have sex with men (MSMs), and migrants.
2.3 Are there measures in place and sanctions to prevent violence against women and to punish those responsible?	<ul style="list-style-type: none"> Review monitoring data regularly and apply them to the development of relevant policies and staff training to address gender-based violence. 	<ul style="list-style-type: none"> Requires creating a system for monitoring incidents of violence and holding management accountable for punishing those who violate the sanctions.

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (cont.)

Questions	Yes/Implications	No/Implications
2. Rights-Based Approach (cont.)		
2.4 Are there facilities, legal assistance, medical care, and psychological support programmes for women and girls who have experienced sexual abuse and violence?	<ul style="list-style-type: none"> • Monitor and evaluate programmes regularly and conduct ongoing quality improvement activities. 	<ul style="list-style-type: none"> • Requires conducting a rapid assessment of existing programmes and services, and advocating for resources to establish needed services.
2.5 Is there an HIV/AIDS workplace policy?	<ul style="list-style-type: none"> • Review policy regularly to ensure it reflects changes/revisions to national laws and policies. 	<ul style="list-style-type: none"> • Requires management to understand legal/ethical issues associated with HIV/AIDS in the workplace, including the rights of PLHIVs, and create a policy that protects the rights of both clients and health workers
2.6 Are there measures in place and sanctions to prevent stigma and discrimination against PLHIVs?	<ul style="list-style-type: none"> • Review monitoring data regularly and apply to the development of relevant policies and staff training to address stigma and discrimination against PLHIVs. 	<ul style="list-style-type: none"> • Requires creating a system for monitoring incidents of stigma and discrimination and holding management accountable for punishing those who violate the sanctions.
3. Policy		
3.1 Do national policies facilitate linking services (e.g., age requirements for accessing services, forcible restriction of SRH rights of positive women, inappropriate interpretation of policies, unclear partner notification guidelines, etc.)?	<ul style="list-style-type: none"> • Orient staff to current policies to ensure they are interpreted appropriately and implemented consistently. 	<ul style="list-style-type: none"> • Requires identifying health system stakeholders to revise and/or develop policies and guidelines and to address any barriers that constrain HIV-positive women’s access to SRH services.
3.2 Are guidelines in place that delineate health personnel tasks for service delivery linking SRH and HIV/AIDS?	<ul style="list-style-type: none"> • Disseminate widely and orient managers, supervisors, health workers/service providers, and community to the SRH standards of care for HIV-positive women. 	<ul style="list-style-type: none"> • Requires identifying health system and community stakeholders to contribute to the development of policies that support linked services.
3.3 Are there service-delivery guidelines (SDGs) for SRH to be included in VCT, for SRH to be included in highly active anti-retroviral therapy (HAART), and for HIV prevention, reproductive rights, and referral for VCT to be included in SRH services?	<ul style="list-style-type: none"> • Disseminate widely; review periodically to maintain currency with rapidly changing scientific recommendations; orient staff to current SDGs. 	<ul style="list-style-type: none"> • Requires identifying health system stakeholders to develop SDGs for linked services, and to develop a dissemination and orientation plan within the health sector and in the communities being served.
3.4 Do programme and donor priorities support effective linking of SRH and HIV/AIDS services?	<ul style="list-style-type: none"> • Disseminate donor strategies and guidelines pertaining to SRH-HIV/AIDS—linked services. 	<ul style="list-style-type: none"> • Orient programme managers and key staff to donor guidelines.
3.5 Has a budget line for SRH commodities, instruments, and ARV drugs, equipment, and supplies been established?	<ul style="list-style-type: none"> • Disseminate budget guidelines within the health care system; review periodically against cost assessment reviews to ensure adequate funding to support linked services. 	<ul style="list-style-type: none"> • Facilitate the development of a budget based on cost assessment evidence, if feasible.

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (*cont.*)

Questions	Yes/Implications	No/Implications
4. Information, Education, and Communication/Behaviour Change Communication		
4.1 Do client brochures reflect SRH-HIV/AIDS–integrated messages?	<ul style="list-style-type: none"> • Include materials in service delivery, information sharing, and community outreach. 	<ul style="list-style-type: none"> • Requires identifying material development resources to incorporate SRH-HIV/AIDS–integrated messages.
4.2 Do the facility’s posters reflect SRH-HIV/AIDS–integrated messages visibly?	<ul style="list-style-type: none"> • Periodically update and rearrange to attract clients’ attention. 	<ul style="list-style-type: none"> • Requires determining effective placement of posters in service delivery for use during information sharing, and community outreach.
5. Counselling		
5.1 Do health workers/providers protect the client’s right to privacy during service delivery (counselling, procedures)?	<ul style="list-style-type: none"> • Periodically assess effectiveness of privacy measures. 	<ul style="list-style-type: none"> • Requires determining ways to protect client privacy—auditory and visual.
5.2 Do existing health workers (SRH and HIV) have adequate knowledge, counselling skills, and comfort level to address the SRH needs of HIV-positive women, including young women; male partners; women from key vulnerable populations (e.g., IDUs, sex workers, migrants etc.)	<ul style="list-style-type: none"> • Assess periodically through facilitative supervision using standardized SRH-HIV/AIDS–linked service performance tool. 	<ul style="list-style-type: none"> • Requires assessing needs and determining most cost- and learning-effective mode of performance improvement.
5.3 Does existing SRH counselling cover HIV/STI prevention, risk-reduction assessment and planning, and condom demonstration, including counselling on dual protection?	<ul style="list-style-type: none"> • Assess periodically through supervision using standardized SRH-HIV/AIDS–linked service performance tool. 	<ul style="list-style-type: none"> • Requires incorporating HIV prevention, risk-reduction assessment, and effective referral to other services based on client’s needs.
5.4 Do existing HIV services (such as VCT, PMTCT, HAART, and treatment of opportunistic infections [OIs]) provide counselling on fertility decision making and sexual health, family planning method provision and dual protection, cancer screening, STI/RTI management, and safe motherhood?	<ul style="list-style-type: none"> • Assess periodically through supervision using standardized SRH-HIV/AIDS–linked service performance tool. 	<ul style="list-style-type: none"> • Requires identifying points in HIV services for integrating SRH counselling, including method provision and monitoring of method use.
5.5 Are staff capable of handling an increased volume of clients as a result of expanded HIV-prevention counselling and VCT?	<ul style="list-style-type: none"> • Assess periodically through supervision using standardized SRH-HIV/AIDS–linked service performance tool. 	<ul style="list-style-type: none"> • Requires identifying points in SRH services for integrating HIV-prevention counselling and VCT.
6. Diagnostics		
6.1 Are the existing laboratory services capable of handling increased volume for HIV testing?	<ul style="list-style-type: none"> • Assess periodically using national guidelines for ensuring quality test results. 	<ul style="list-style-type: none"> • Requires determining the location; transportation access; rapidity of test results; storage of testing materials; communication; quality control mechanism; cost; rapidity of supply following requisition.
6.2 Are the existing laboratories capable of handling increased volume for ARV monitoring?	<ul style="list-style-type: none"> • Assess periodically to ensure equipment is functioning properly and providing quality test results. 	<ul style="list-style-type: none"> • Requires determining the location; transportation access; rapidity of test results; storage of testing materials; communication; quality control mechanism; cost; rapidity of supply following requisition.

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (cont.)

Questions	Yes/Implications	No/Implications
7. Referral Network		
7.1 Are referral options currently available for provision of programme interventions linking SRH and HIV/AIDS?	<ul style="list-style-type: none"> Periodically assess the gaps in the referral system. 	<ul style="list-style-type: none"> Requires determining the degree your services could fill the identified gaps.
7.2 Is there a functional referral network (standardized forms, resource directories, etc.) between SRH (STI/RTI, family planning, cancer screening, etc.) and HIV (VCT, PMTCT, antiretroviral therapy [ART], OI, etc.) services?	<ul style="list-style-type: none"> Review and update information and hours for referral services. 	<ul style="list-style-type: none"> Requires identifying key staff to create a directory of existing resources and services in catchment area, developing joint SRH-HIV client referral and consent forms, orienting staff on services in referral network and importance of following up on clients who have been referred.
7.3 Are there referral sites for other SRH- and/or HIV-related needs within the referral network (e.g. within 5 km) of this facility?	<ul style="list-style-type: none"> If yes, ensure staff are familiar with location of these services and hours of operation. 	<ul style="list-style-type: none"> Requires identifying resources for SRH service provision (e.g., long-acting and permanent methods) and establishing a referral link with these sites.
8. Community Outreach		
8.1 Are there currently any outreach services for hard-to-reach populations, including young girls, sex workers, IDUs, migrants, etc.?	<ul style="list-style-type: none"> Regularly monitor and evaluate outreach services to ensure they reflect the needs of people most affected by HIV and AIDS. 	<ul style="list-style-type: none"> Requires conducting rapid assessment of needs of hard-to-reach populations and mapping where the populations are located.
8.2 Are there ongoing community outreach activities into which programme interventions linking SRH and HIV/AIDS can be incorporated?	<ul style="list-style-type: none"> Collaborate with community outreach programs to incorporate awareness creation activities and to develop a referral mechanism. 	<ul style="list-style-type: none"> Requires collaborating with community resources to develop a mechanism for creating awareness of linked services and to create referral mechanisms.
8.3 Are there health workers in the community who can be utilized for supporting HIV-positive women and adolescent girls in accessing the SRH services they need?	<ul style="list-style-type: none"> Ensure health workers are regularly updated with relevant technical information and accurate information about existing SRH services in the community. 	<ul style="list-style-type: none"> Requires hiring and/or training health workers who can support HIV-positive women and adolescent girls in accessing SRH services.
8.4 Are there currently mobile services that can assist in delivering supplies and providing basic SRH care to HIV-positive women and adolescent girls in remote areas?	<ul style="list-style-type: none"> Ensure health workers/providers in mobile services have updated technical information and relevant SRH supplies/commodities. 	<ul style="list-style-type: none"> Requires hiring and training mobile team of health workers and purchasing necessary equipment and SRH supplies/commodities.
9. Physical Structure		
9.1 Does the physical structure allow for privacy (auditory, visual) and confidentiality of client records?	<ul style="list-style-type: none"> Provide sufficient staff supervision to promote client confidentiality and privacy. 	<ul style="list-style-type: none"> Requires assessing resources for making equipment and structural changes beyond the site's ability to rearrange the space.
9.2 Do the structure, time, and staff welcome male involvement? Services for youth? Services for key vulnerable populations (e.g., sex workers, IDUs, etc.)?	<ul style="list-style-type: none"> Provide sufficient staff supervision to ensure adequate hours of coverage to meet demand. 	<ul style="list-style-type: none"> Requires determining reasons for "no"; deciding what is possible and identifying resources for male, youth services, and services for other key populations.

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (cont.)

Questions	Yes/Implications	No/Implications
10. Staffing		
10.1 Is sufficient staffing available to provide SRH counselling and family planning method provision throughout the range of HIV services (e.g., VCT, ART)?	<ul style="list-style-type: none"> • Are staff adequately supervised to provide quality counselling and care? 	<ul style="list-style-type: none"> • May limit the extent of method provision and increased reliance on referral.
10.2 Are VCT (or ART) staff trained in SRH counselling and family planning method provision?	<ul style="list-style-type: none"> • Conduct periodic updates to maintain currency with rapidly changing science. 	<ul style="list-style-type: none"> • Training needs consideration should include when, where, how, and by whom training will be provided; cost and training approach that will be used.
10.3 Are VCT (or ART) staff trained in the system for maintaining a supply of SRH commodities, instruments, and supplies?	<ul style="list-style-type: none"> • Assess periodically for adequacy of stock. 	<ul style="list-style-type: none"> • Requires orientation of staff and supervisors to use the system effectively to maintain adequate supplies for integrated service delivery.
10.4 Are SRH staff trained in VCT counselling/counselling skills?	<ul style="list-style-type: none"> • If yes, periodically assess and monitor performance. 	<ul style="list-style-type: none"> • Requires facilitating VCT counselling/counselling training if considering expansion to provide VCT.
10.5 Would staff attitudes facilitate programme interventions linking/integrating SRH and HIV/AIDS?	<ul style="list-style-type: none"> • Monitor and conduct interventions as indicated. 	<ul style="list-style-type: none"> • Would require interventions to foster positive attitudes for SRH-HIV integration.
10.6 Do SRH health workers/service providers/counsellors demonstrate respect for the rights of HIV-positive women and adolescent girls to make decisions about their fertility?	<ul style="list-style-type: none"> • Monitor and conduct interventions as indicated. 	<ul style="list-style-type: none"> • Would require orientation of staff to the rights of the client to make independent fertility decisions regardless of HIV status.
10.7 Are SRH health workers/service providers/counsellors aware of the current guidelines for contraceptive use by HIV-positive women and adolescent girls and by HIV-positive women and adolescent girls taking ART?	<ul style="list-style-type: none"> • Monitor and conduct updates, as indicated. 	<ul style="list-style-type: none"> • Requires conducting updates for staff to new guidelines and dissemination of new guidelines.
10.8 Are ART providers aware of the current information about ARV and OI drug interactions with hormonal contraceptives? With current guidelines for contraceptive use by HIV-positive women and adolescent girls and by HIV-positive women and adolescent girls taking ART?	<ul style="list-style-type: none"> • Monitor and conduct updates, as indicated. 	<ul style="list-style-type: none"> • Requires conducting updates for staff to new guidelines and dissemination of new guidelines.
10.9 Are HIV and SRH staff performing infection prevention procedures to standard?	<ul style="list-style-type: none"> • Monitor and conduct refreshers, as indicated. 	<ul style="list-style-type: none"> • Requires conducting refresher and supervisory monitoring of infection prevention practices.

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (cont.)

Questions	Yes/Implications	No/Implications
11. Drugs, Equipment, Supplies		
11.1 Emergency contraceptive pills	<ul style="list-style-type: none"> • Ensure correct storage and distribution of current stock. • Prevent stock-outs by conducting regular stock reviews to facilitate forecasting and placement of orders. 	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.2 Combined oral contraceptives	Same as above.	Same as above.
11.3 Progestin-only oral contraceptives	Same as above.	Same as above.
11.4 Implants (Norplant)	Same as above.	Same as above.
11.5 Injectables (Depo provera/DMPA)	Same as above.	Same as above.
11.6 IUD	Same as above.	Same as above.
11.7 Cotton wool	Same as above.	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.8 Absorbent cotton gauze (plain)	Same as above.	Same as above.
11.9 Surgical tape	Same as above.	Same as above.
11.10 Small adhesive bandages	Same as above.	Same as above.
11.11 Disposable gloves	Same as above.	Same as above.
11.12 Tincture of iodine	Same as above.	Same as above.
11.13 Glove powder	Same as above.	Same as above.
11.14 Antiseptic solution	Same as above.	Same as above.
11.15 Soap	Same as above.	Same as above.
11.16 Disinfectant solution	Same as above.	Same as above.
11.17 Alcohol	Same as above.	Same as above.
11.18 Hand towel	Same as above.	Same as above.
11.19 Disposable syringes	Same as above.	Same as above.
11.20 HIV Rapid Tests, according to National Protocols (e.g., Capillus)	Same as above.	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.21 Lancets (for HIV Rapid Test)	Same as above.	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.22 HIV screening and confirmatory tests, according to National Protocol	Same as above.	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.23 Timer (for HIV Rapid Test)	<ul style="list-style-type: none"> • Conduct regular maintenance on equipment and replace as needed. 	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (cont.)

Questions	Yes/Implications	No/Implications
11. Drugs, Equipment, Supplies (Cont.)		
11.24 ARVs for PEP (at least two doses)	<ul style="list-style-type: none"> • Ensure correct storage and distribution of current stock. • Prevent stock-outs by conducting regular stock reviews to facilitate forecasting and placement of orders. 	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.25 Vacutainer tubes (pack of 100)	Same as above.	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.26 Vacutainer needles (pack of 100)	Same as above.	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.27 Suction tubes	Same as above.	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.28 Goggles	<ul style="list-style-type: none"> • Review stock regularly to prevent stock-outs. 	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.29 Condoms (male)	<ul style="list-style-type: none"> • Ensure correct storage and distribution of current stock. • Prevent stock-outs by conducting regular stock reviews to facilitate forecasting and placement of orders. 	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.30 Condoms (female)	Same as above.	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.31 Anatomical models (male) for condom demonstration	<ul style="list-style-type: none"> • Review stock regularly to prevent stock-outs. 	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.32 Anatomical models (female) for female condom demonstration	<ul style="list-style-type: none"> • Review stock regularly to prevent stock-outs. 	<ul style="list-style-type: none"> • If commodity is registered for use in the country, requires working with commodities officer to order supplies.
11.33 Educational pamphlets	<ul style="list-style-type: none"> • Review stock regularly to prevent stock-outs. 	<ul style="list-style-type: none"> • Requires developing pamphlets in-house with available resources or working with commodities officer to order supplies from other organizations.
11.34 Syphilis test kits	<ul style="list-style-type: none"> • Ensure correct storage and distribution of current stock. • Prevent stock-outs by conducting regular stock reviews to facilitate forecasting and placement of orders. 	<ul style="list-style-type: none"> • Requires working with commodities officer to order supplies.
11.35 Others		
11.36 Others		

3

Worksheet 1

Question Guide for Completing a Rapid Assessment (*cont.*)

Questions	Yes/Implications	No/Implications
12. Management & Supervision		
12.1 Have supervisors been trained in the skills that they need for supporting their staff taking on new roles and responsibilities?	• Requires periodically monitoring supervisors' performance.	• Requires orientating supervisors to facilitate integration and maintenance of quality services.
12.2 Do supervisory tools reflect staff performance in programme interventions linking SRH and HIV/AIDS? For monitoring of service systems?	• Requires ensuring supervisors are adequately trained and updated on tools.	• Requires modifying tools to reflect the level of integrated services.
12.3 Do service statistics reflect programme interventions linking SRH and HIV/AIDS?	• Requires monitoring for maintenance of completeness and accuracy of documentation.	• Requires modifying management information system forms to reflect the level of integrated services.
12.4 Do supervisors review client records and service statistics as an aspect of monitoring programme interventions linking SRH and HIV/AIDS?	• Requires periodically monitoring supervisors' performance.	• Requires supervisors to be knowledgeable about the standards for documenting integrated services in client records and services statistics.
12.5 Does management/supervision have a written plan for monitoring the proposed programme interventions for linking SRH and HIV/AIDS?	• Requires periodically reviewing and revising plan based on changes in services.	• Requires developing monitoring plans consistent with the degree of integration.
12.6 Does management/supervision have a succession plan for replacing staff trained on programme interventions linking SRH and HIV/AIDS, if they are transferred or retire?	• Requires periodically reviewing and revising plan based on changes in services.	• Requires developing a succession plan, including recruitment and training of new staff who can perform roles and responsibilities required for SRH-HIV/AIDS-linked services.
13. Logistics		
13.1 Have SRH commodities, instruments, and supplies been added to the standardized list?	• Monitor periodically for consistency with recommended standards of care.	• Requires review of standardized equipment, supplies, and drug list to provide the determined integrated family planning—HIV services.
13.2 Is there a mechanism for maintaining a reliable supply of SRH and HIV/AIDS service commodities?	• Requires monitoring procurement mechanism and anticipating shortfalls in supplies.	• May require accessing supplies from alternative sources or not providing services for which supplies cannot be reliably obtained.
14. Cost		
14.1 Does the health system's financing mechanism cover programme interventions linking SRH and HIV/AIDS?	• Requires monitoring current budget to ensure covers costs of ongoing services.	• Requires policy-level advocacy and interventions for health financing coverage.

Adapted from: Farrell, B. 2006. Family planning integrated HIV services: A framework. New York: The ACQUIRE Project. Draft.

Determining Priorities for Programme Interventions that Link SRH and HIV/AIDS

4

Objectives

- to consider factors in your setting influencing the best programmatic approach to linking SRH and HIV/AIDS services;
- to determine priorities and select feasible programme interventions for linking SRH and HIV/AIDS.

Time

180 minutes

Materials

- paper and pens
- flipchart paper and markers
- Participant Handout 16.1: Provider Checklist: Comprehensive SRH Care and Counselling for HIV-Positive Women and Adolescent Girls, p. 140
- Worksheet 2, p. 211

Advance Preparation

1. Review Worksheet 2, p. 211, and become familiar with the instructions, each of the programme interventions linking SRH and HIV/AIDS, and the criteria for determining priority interventions.
2. Make enough copies of the Participant Handout 16.1 and Worksheet 2 so that all participants can have one, and extras so that there is one for each group.

Detailed Steps

1. Ask the participants to break into small groups according to the health facility or organization where they work. (*Note:* If there are only one or two representatives from some health facilities or organizations, ask them to join one of the other groups. In some settings, depending on the current level of integration within service-delivery network, it may make more sense to organize the small groups by mixing participants from different health facilities or organizations.) Distribute copies of Participant Handout 16.1 and Worksheet 2.
2. Provide the following additional instructions:
 - Each group will have approximately two hours to complete the worksheet.

- Each group should choose a note-taker and presenter. The note-taker should record the group's ratings on one worksheet. The presenter will provide a 10-minute overview of the group's top three priorities.
 - Each group should refer to Participant Handout 16.1, p. 140, from the training manual, for an overview of key counselling and service provision tasks for the interventions listed in the worksheet.
3. During the last hour of this activity, facilitate a report back. Write each group's priorities on flipchart paper and post the flipchart. After each group presents, ask the entire group if they have any questions or need anything clarified. Conclude by identifying and summarizing the top 3–5 priorities identified by all of the groups.



Worksheet 2

Determining Priority Programme Interventions for Linking SRH and HIV/AIDS

Instructions for completing the worksheet:

- The far-left column on Worksheet 2 lists potential programme interventions for consideration that link SRH and HIV/AIDS. The rows along the top of the worksheet list criteria to consider in selecting or prioritizing these intervention(s).
- You can use the following criteria illustrated in the worksheet while completing this activity, as well as developing other criteria that are relevant to your particular setting:
 - **Available resources (material/human):** Which activities can you do now or with few additional resources? Which options can be done with existing staff? Which options are most cost-effective and affordable?
 - **Potential impact:** Which activities will have the greatest impact on the quality of services for clients?
 - **Building on strengths:** Do any of these activities build on or improve upon existing programmes or projects?
 - **Greatest needs:** Which activities are designed to address clients' greatest needs (as perceived by the clients and assessed by the staff)?
 - **Feasibility:** Which activities are most realistic, given internal or external barriers, such as a conservative culture and limited resources and staffing, among others?
- Consider each of the interventions on the worksheet and rate them, from 1 (low priority) to 5 (high priority), for each of the criteria. For example, if a facility has abundant resources, it would be assigned a rating of 5 under the resource column for a given intervention.
- Add the points for each activity and write the total in the far right-hand column. The activity with the lowest total score has the lowest priority, while the activity with the highest total score has the highest priority.
- Many sexual and reproductive health (SRH) interventions for HIV-positive women and adolescent girls do not require abundant resources or a complex infrastructure. When developing national and local plans, consider integrating the following basic SRH interventions that can be offered to all HIV-positive women and adolescent girls, regardless of where they access health care, and making referrals to more specialized services, such as family planning methods requiring insertion or surgery, services for the prevention of mother-to-child transmission of HIV (PMTCT), tuberculosis (TB) screening, treatment of opportunistic infections (OIs), antiretroviral (ARV) treatment and clinical care, home- and community-based care, emergency obstetrical care, safe abortion (where legal), etiological diagnosis of and treatment for sexually transmitted infections (STIs) and reproductive tract infections (RTIs), screening and treatment of cancers, assisted reproductive technologies, counselling and support related to domestic violence, financial assistance, and legal support:
 - Provide information, education, and communication (IEC) materials on SRH needs of HIV-positive women and adolescent girls.



Worksheet 2

Determining Priority Programme Interventions for Linking SRH and HIV AIDS

- Counsel on SRH, including sexual desires and needs, reproductive health intentions, dual protection, and risk-reduction planning for STIs/RTIs.
- Provide STI/RTI syndromic diagnosis and treatment.
- Demonstrate correct and consistent use of condoms, including dual protection, and distribute both male and female condoms.
- Offer voluntary counselling and testing for HIV.
- Screen for gender-based violence.
- Treat consequences of sexual violence, including providing postexposure prophylaxis (PEP) following rape.
- Counsel on family planning methods, including information about possible drug interactions and provision of emergency contraception pills, condoms, pills, and injectables.
- Provide information on fertility options, including assisted reproductive technologies.
- Provide information on preventing perinatal transmission, including ARV prophylaxis, infant feeding options, and safe parenthood.
- Based on the needs in your setting and your current capacity, review and discuss the following options and considerations, in prioritizing your programme interventions for linking SRH and HIV/AIDS:
 - address the comprehensive SRH needs of HIV-positive women and adolescent girls (e.g., offer general SRH information and services with referral to other specialized services vs. offering the full package of SRH information and services)
 - examine various approaches and models for integrating service tasks (e.g., multipurpose staff vs. specialized staff, multipurpose clinics vs. single-use clinics)
 - explore a phased-in approach to integrating services (e.g., begin with integrated services that can have greatest impact vs. trying to integrate everything)



Worksheet 2

Determining Priority Programme Interventions for Linking SRH and HIV AIDS

Programme interventions linking SRH and HIV/AIDS	Available resources	Potential impact	Building on strengths	Greatest needs	Feasibility	Other factors	Total priority rating
Provide information, education, and communication (IEC) materials on sexual and reproductive health (SRH) needs of HIV-positive women and adolescent girls.							
Counsel on SRH, including sexual desires and needs, reproductive health intentions, dual protection, and risk-reduction planning for sexually transmitted infections (STIs)/reproductive tract infections (RTIs).							
Provide STI/RTI syndromic diagnosis and treatment.							
Demonstrate the correct and consistent use of condoms, including dual protection, and distribute both male and female condoms.							
Offer voluntary counselling and testing if the client does not know her HIV status.							
Screen for gender-based violence.							
Facilitate male involvement							
Treat consequences of sexual violence, including providing postexposure prophylaxis (PEP).							
Counsel on family planning methods, including information about possible drug interactions and provision of emergency contraceptive pills, condoms, pills, and injectables.							
Provide information on fertility options, including assisted reproductive technologies.							

4

Worksheet 2

Determining Priority Programme Interventions for Linking SRH and HIV/AIDS (cont.)

Programme Interventions linking SRH and HIV/AIDS	Available resources	Potential impact	Building on strengths	Greatest needs	Feasibility	Other factors	Total priority rating
Provide information on preventing perinatal transmission, including antiretroviral (ARV) prophylaxis, infant feeding options, and safe motherhood.							
Strengthen links and referral mechanisms to the following specialized services based on needs of client: <ul style="list-style-type: none"> • Family planning methods requiring insertion or surgery. • Prevention of mother-to-child transmission (PMTCT) • Tuberculosis screening • Treatment of opportunistic infections (OIs) • STI/RTI etiological diagnosis and treatment • ARV treatment and clinical care • Community- and home-based care • Emergency obstetrical care • Safe abortion, where legal • Screening and treatment of cancers • Assisted reproductive technologies • Counselling and support related to gender-based violence • Financial support • Legal support 							
Provide training to health workers on comprehensive SRH care and integrated SRH counselling of HIV-positive women and adolescent girls.							
Provide training to programme managers on facilitative supervision.							
Build capacity of midwives, traditional birth attendants, and community health workers.							
Other							

Creating an Action Plan

5

Objectives

- to develop recommendations based on the information gathered in Sessions 3 and 4;
- to create an action plan for implementing the priority programme interventions for linking SRH and HIV/AIDS.

Time

240 minutes

Materials

- paper and pens
- flipchart paper and markers

Advance Preparation

1. On flipchart paper, draw an action plan format, as follows:

Problem	Cause(s)	Recommendations	By Whom	By When

2. Review the sample action plans and Tables A and B on page 217, to become familiar with the parts of an action plan, as well as examples of clear and unclear action plans.

Detailed Steps

1. Referring the group to the flipchart of the action plan template, explain:
 - that an action plan is a written plan developed to help resolve problems identified during a planning exercises;
 - that participants identify problems and root causes and recommend solutions—all of them recorded in an action plan format.

- Keep the participants in the same groups (by facility or organization) for this activity. (*Note:* If you chose to mix participants from different facilities/organizations in Session 4, keep the participants in the same groups for this session.)
2. Explain that the participants should review the group’s responses to Worksheet 1 and identify all of the “no” responses that they think should be included as problem statements in their action plan.
 3. Explain that participants must state the problem clearly with respect to the programme interventions linking SRH and HIV/AIDS that they selected as priorities in Worksheet 2, note the root cause(s) of the problem, and write recommendation(s) that address the problem’s root causes, not just its symptoms.
 4. Explain that for each problem identified, they should use the “multiple whys” technique to get to the root cause. By asking “WHY?” at least three times and then asking “Are there any other causes?” staff will identify the underlying causes of the problem.
 5. Point out that each recommendation must include the name of a *specific person* (not a job title) to follow up on the recommendation (“by whom”) and a specific date by which it should be carried out (“by when”). This person is not necessarily the one who will carry out the recommendation; it is the person who will make sure that it is carried out. Writing the person’s name rather than his or her job title helps to personalize the action plan.
 6. Be sure to make the following key points:
 - Working in small groups, each group will develop its *own* draft action plan for the top 3–5 priority interventions they selected in Worksheet 2, using the action plan format previously referred to above. (*Note:* If conducting this workshop with staff from the same facility, assign one of the 3–5 top priority interventions they selected in Worksheet 2 to each small group and tell them that their draft plans will then be consolidated into one master plan for the facility at a follow-up meeting or by a monitoring implementation team that will be formed prior to the end of the workshop.)
 - Do not make the same person responsible for too many recommendations. Solutions may be identified more quickly when responsibility for different problems is shared among many staff members. Rather than assign many recommendations to one person, find other staff members who can help carry out recommendations.
 - Do not make senior staff or members of external organizations responsible for most of the recommendations. All staff have something to contribute. Think first about which recommendations lower-level staff can carry out. Even if external support is needed, consider which staff member can be responsible for seeking external support.
 - For each recommendation, list only one name in the “by whom” column. When more than one person is listed, individual responsibility for ensuring that a problem gets solved is lost. Some solutions may need to be broken into smaller steps, with different individuals named for each step.
 - Set realistic deadlines for carrying out recommendations. It is better to set a later date by which the facility can surely carry out the recommendations than to set an earlier date that cannot be met. In addition, the participants should choose specific dates that can be met, not vague deadlines such as “ongoing”, “as soon as possible”, or “tomorrow”. Give an example for one problem. (Either ask the staff for an example from the facility, or refer to Table B, p. 217.)

7. Provide the following additional instructions:
- Each group will have approximately 2 1/2 hours to complete the worksheet.
 - Each group should choose a note-taker and a presenter. The note-taker should record the group's problems, root causes, recommendations, etc., in the action plan format. The presenter will provide a 15-minute overview of the group's action plan.
8. During the last 1 1/2 hours of this activity, facilitate a report back. Post each group's action plans. After each group presents, ask the entire group if they have any questions or need anything clarified.

Table A: Example of Action Plan with an Unclear Problem Statement

Problem	Cause(s)	Recommendations	By Whom	By When
HIV-positive pregnant women are lost to follow-up.	Clients are not interested in services.	Make clients more interested in services.	All staff.	Immediately

Table B: Example of Action Plan with a Clear Problem Statement

Problem	Cause(s)	Recommendations	By Whom	By When
Pregnant clients testing positive for HIV do not return for follow-up SRH services.	(1) Staff are not trained to discuss the range of SRH services available.	(1) Conduct a training for health workers on integrated SRH care and counselling of HIV-positive women.	L. Karisa (clinic nurse)	July 1, 2007
	(2) Clients feel unwelcome and stigmatized by staff.	(2) Conduct HIV and stigma awareness/sensitivity training for all staff.	J. Samanda (ward nurse)	July 30, 2007
	(3) HIV-positive clients are afraid that others will find out their status and harm them.	(3) Review/revise protocols on client confidentiality and orient all staff.	Dr. Ware (clinic director)	August 30, 2007

Closing Session

6

Objectives

By the end of this session, the facilitators should have:

- established an implementation monitoring team;
- formally thanked all involved in the workshop, wished everyone well, and closed the proceedings.

Time

60 minutes

Materials

- flipchart paper

Training Steps

1. Discuss the roles and responsibilities of an implementation monitoring team by explaining:
 - The implementation monitoring team plays a critical role in monitoring progress in carrying out the action plan recommendations.
 - The committee should represent different levels of personnel at the facility or facilities, including managers, supervisors, and staff members. The group could be newly formed or could be an existing committee at the facility, possibly with a few adjustments. Generally, the monitoring committee consists of about five to eight staff members, though at facilities with eight or fewer staff members, the entire staff should serve on the committee. Explain that the monitoring committee can be formed in several ways:
 - **To form a new team**, ask for volunteers from among the participants. If no one volunteers or if the volunteers do not represent a mix of levels of staff, ask each department or unit to choose a representative for the team. Alternatively, ask each type and level of staff (for example, doctors, nurses, and clerks) to choose a representative for the team.
 - **If the facility has an existing implementation monitoring team or committee** that can take on the responsibility of following up on the action plan, ensure that the committee includes representatives of different units and staff levels. If it does not, work with the committee to expand its membership.
 - Some facilities choose to assign **formal roles** to committee members, such as chairperson or secretary, while other facilities' committee members have informal roles. In either case, someone must be responsible for scheduling and facilitating committee meetings.

2. Encourage staff to remember their strengths and continue to build on them. Ask staff if they have any questions about next steps. Clarify that as soon as the action plan is finalized, they should begin to carry out their assigned recommendations. Managers and staff should report the status of the solutions to the implementation monitoring team.
3. Conduct a plus/delta exercise or some other closing activity. Thank the participants for their time, effort, and enthusiasm.
4. After the exercise is over, meet briefly with the implementation monitoring committee and set a date for a follow-up meeting (generally within one month of the workshop).
5. Ask the participants for a copy of the action plan for use in following up with the facility over time. Ensure that the results of the exercise are kept confidential, however.
6. Write a letter or contact the facility managers and staff, as appropriate, to thank them for their hard work and enthusiasm.