

PREVENTING HIV, PROMOTING REPRODUCTIVE HEALTH



HIV PREVENTION IN MATERNAL HEALTH SERVICES TRAINING GUIDE

HIV Prevention in Maternal Health Services: Training Guide



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Introduction: How to Use This Training Guide

Overview of Adult Learning and Participatory Training

This training guide has been designed using participatory training approaches, which means that the exercises require the active involvement of all participants. The role of the facilitator is to guide the participants through learning activities rather than to lecture or just provide information to a passive audience. Underlying this approach is the belief that every participant has abilities, ideas, and experiences that are invaluable to the learning experience.

Participatory methods, such as brainstorming or role-play exercises, have been shown to be a critical feature of successful adult learning. In general, it is desirable to have as much interactivity as possible, both to reduce the amount of lecture time and to engage the participants more fully. The facilitator can employ principles of adult learning by relying on the participants to discuss issues and generate solutions based on their own experiences.

The training guide has been developed for use by skilled, experienced trainers who are familiar with the content and objectives of each exercise. While the training guide contains information to help trainers understand each exercise, it is assumed that the trainer knows about adult learning concepts, employs a variety of training methods and techniques, and knows how to adapt materials to meet the participants' needs.

How to Use This Guide

The Training Guide consists of this introduction, a detailed curriculum with session guides, and a series of appendices containing additional materials.

The sessions in the curriculum have eight basic components:

1. **Objectives**—A short description of the learning objectives for the exercise
2. **Time**—A guideline for the anticipated length of the exercise to help a facilitator plan a workshop
3. **Materials**—A list of materials needed to carry out the exercise
4. **Advance preparation**—Preparatory steps that the trainers should complete prior to conducting the exercise
5. **Training steps**—Detailed directions that guide the trainer through the order of activities within the exercise
6. **Key discussion points**—A series of questions that the trainers can raise with the participants to promote productive discussion
7. **Considerations for the facilitator/training options**—Notes and suggestions about how to conduct activities, different versions of exercises to try, and things to keep in mind while conducting an exercise

8. **Essential ideas to convey**—A summary of relevant points that the participants should retain from the exercise (These should be conveyed during the course of the exercise and discussion; the trainers can use these points to summarise at the end of each exercise.)

The appendices contain explanatory materials and tools that will help the trainers conduct the training activities as effectively as possible. Curriculum appendices are as follows:

- **Appendix A: Sample Three-Day Training Agenda.** The trainers can adapt this agenda according to the needs of their participants.
- **Appendix B: Participant Evaluation Form.** The trainers must make and distribute copies of this form at the end of the training.
- **Appendix C: Participant Handouts.** You can make and distribute copies of all of the resources, as a handbook, at the beginning of the training, or you can make and distribute copies of a particular handout at the end of the relevant session. If the entire handbook is distributed at the beginning, the participants may be advised to refrain from reading the handouts until a particular session is over.

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 exercises are offered and to understand the purpose, content, and approach of the training guide. Trainers can then select the specific content areas and exercises that are most appropriate to the needs of their training participants.

The trainers should also confirm the institutional commitment to the training by meeting with administrators at the service sites requesting the training, to clarify the purpose of the training and confirm the time committed for the workshop.

Purpose

The goal of this training is to build the capacity of programme managers and staff to address pregnant and postpartum clients' HIV and STI needs by offering integrated HIV and STI services within their own particular service-delivery setting. 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 prevention tasks:

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

More in-depth ongoing training is recommended, after this basic orientation, for managers and staff who will be responsible for HIV and STI services. Please refer to Chapter 3 of the accompanying programming guide for an overview of these training topics.

Cross-Cultural Adaptability

This training guide is intended for a wide variety of cultural settings. Therefore, trainers are encouraged to adapt the exercises, 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 guide recognises that inequalities between women and men, as well as different norms for women's and men's sexual behaviour, all increase women's vulnerability to HIV and other STIs. While specific sessions here explore the relationship between gender inequalities and women's HIV vulnerability, integrated throughout the guide is an overall philosophy of empowering women and promoting male involvement, to reduce the social, gender, cultural, economic, and legal barriers to effective prevention, treatment, care, and support of women, their children, and partners.

Climate Setting **1**

Objectives

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

Essential 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 three days will be an interactive process during which we will learn from each other, not just from the trainers.
- The overall purpose of this training is to prepare participants to provide HIV and sexually transmitted infection (STI) services 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 three days.
- By focusing on the client as an individual and by considering factors both inside and outside the clinic setting that influence a client’s sexual behaviours and decision making, including gender dynamics, providers will be better able to assess and meet a client’s informational, decision-making, and emotional needs. This will help the client to make decisions that will be more likely to be carried out.

Time

45 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 daily 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 the precise times listed next to the activities, so the trainers can have flexibility, as needed.

Training Steps

1. A representative of the local “host” organisation 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 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 goal and overall objectives for the workshop. (See the Introduction, pages vii–ix, 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 three-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 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
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 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.)

Values Clarification **2**

Objectives

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

- Talk about their attitudes and values concerning a range of potentially sensitive issues in HIV prevention and maternal health care, including sexual taboos and HIV/AIDS and other STIs
- Explain some of the issues associated with the diversity of opinions both within the group and between the provider and the client

Essential Ideas to Convey

- Beliefs and attitudes about sexuality, pregnancy, and HIV may be difficult for clients to express, particularly with strangers. Health providers have a professional obligation to remain objective and nonjudgemental with clients and to avoid letting their personal beliefs and attitudes become barriers to communicating with clients.
- By exploring and becoming aware of personal beliefs about sensitive topics, providers can learn how to stay neutral during their interactions with pregnant and postpartum clients.
- Health providers cannot make decisions for their clients. Clients' right to make decisions must be respected, even if providers do not personally support their choices or do not personally condone their behaviour.

Time

1 hour

Materials

- Facilitator's Resource: Sample Values Statements, by Topic (page 8)
- Flipchart paper
- Markers
- Masking tape

Advance Preparation

1. Prepare three flipcharts, by writing either "Agree," "Disagree," or "Unsure" on one of the pieces of paper. Post the signs on opposite sides of the room or on one large wall, a few body-lengths apart.

2. Select a list of value statements (see Facilitator’s Resource: Sample Values Statements, by Topic, page 8) or create new statements, depending on the needs and particular interests of your training group.
3. Arrange the training room so there is enough open space for the participants to assemble on different sides of the room and in the middle.

Training Steps

1. Explain that this exercise will help us understand both our values and viewpoints that differ from our own, as well as consider how this affects our effectiveness in working with pregnant and postpartum women. State that there are no “right” or “wrong” answers and that we are all entitled to our own opinions. Ask the participants to brainstorm a definition for the term “value statement.” Possible responses may include:
 - A statement of something’s desirability
 - An expression of the ethical appropriateness of something (e.g., whether it is right or wrong)
 - An expression or statement of one’s personal values
 - An expression or statement of organisational values
2. Ask the participants to gather in the centre of the open area. Direct their attention to the “Agree,” “Disagree,” and “Unsure” 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 or if they are unsure of their response. Those who agree will move and stand by the “Agree” sign. Those who disagree will move and stand by the “Disagree” sign. Those who are unsure will move and stand by the “Unsure” sign. Let the 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.
4. Read a statement out loud. Ask the participants to move to the appropriate area of the room, according to their opinion. Invite one or two participants from each location to explain why they have chosen to stand where they are. The trainer should remain neutral, but can share factual information to clarify matters, as needed. After hearing a representative from each position, give the participants the option of switching positions if they wish. When the participants move, ask them what prompted their decision to change position.
5. Repeat this process until you have posed all statements that you wish the group to consider.
6. Ask the participants to return to their seats for a group discussion. Facilitate a discussion based on the following key discussion questions:
 - * How did you feel during this exercise? What was it like for you?
 - * Which statements were the most controversial, and why?
 - * How did you feel when other people expressed values and beliefs that differed from yours?

- * How did it feel to hold a minority opinion?
- * How did it feel to hold a majority opinion?
- * How can you explain the differences of opinion within the group?
- * What differences would you expect to find between the values of providers and clients in your workplace?
- * How might such differences affect your work with pregnant clients?
- * How can providers help pregnant women to make difficult decisions when they disagree about fundamental values?
- * How can we keep our own values from influencing work in a negative way?

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

Considerations for the Facilitator/Training Options

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

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

If the dynamics or conditions of the group are not right for individuals to state their own opinions publicly (e.g., if staff are not comfortable stating their opinions in front of supervisors), provide prepared statements on pieces of paper, making sure that each participant has a copy of all statements. Instruct the participants to anonymously write their opinion about each statement by writing or checking off whether they agree, disagree, or are unsure. Before reading each statement aloud, tell the participants that they can place their responses to that particular statement face down in a pile. After the responses are mixed up, a participant can select a piece of paper and discuss whatever position is indicated on it for that particular statement, even if it does not reflect his or her own opinion.

Do not clarify the meaning of the statements, as this may influence the results. Simply read the statement again if a participant asks for clarification.

If there is no division of opinion in the group, you can ask the group how a person with the opposite opinion might defend their position. Or, to enrich the exercise, trainers can play the role of an advocate of an opposing opinion.

Sexuality and Pregnancy

- During pregnancy, it is more acceptable for a man to have an extramarital sexual partner than for a woman to do so.
- It is a man's responsibility to provide and use a condom.
- Condom use within marriage means that there are problems in the relationship.
- Most pregnant women who get STIs are promiscuous.
- Most pregnant women want sex less often than their partners do.
- There is no such thing as rape in marriage.
- A man has a right to extramarital sex if his wife is not sexually available during pregnancy or the postpartum period.
- A pregnant woman who suspects that her husband has an STI or HIV has the right to refuse to have sex with him.
- A pregnant woman should not have sex.
- Women are less sexually active postpartum.
- Women are less sexually active during pregnancy.
- A couple should abstain from sex during pregnancy and the postpartum period.

HIV/AIDS and Other STIs

- A pregnant woman who does not use condoms can only blame herself for getting HIV.
- A health care provider has the right to know the HIV status of a pregnant woman.
- A woman who knows that she is infected with HIV should not have a baby.
- It is wrong for a man who is infected with HIV to have sexual relations without informing his partners.
- A postpartum woman has a higher risk for acquiring HIV or other STIs.
- A woman who gets HIV through sex during pregnancy or the postpartum period deserves it because her behaviour goes against cultural practises.
- A woman who is not yet well-educated about HIV must be ignoring health messages already told to her.
- Life is hopeless and not worth living if you have AIDS.
- People with AIDS should be isolated from the rest of the community.
- A pregnant woman thought to be at risk for HIV should be tested for HIV, whether or not she agrees to it.
- A woman should exclusively breastfeed for the first six months.

Essential Knowledge about HIV/AIDS and Key Prevention Messages during Pregnancy and Postpartum

3

Objectives

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

- Describe the basic information pertaining to HIV infection and transmission in pregnant and postpartum women
- Identify at least three key messages for preventing HIV infection among pregnant and postpartum women

Essential Ideas to Convey

- Information about HIV is subject to change as scientists discover new details about the infection and treatment processes. As providers, it is important to keep up with information, to respond to clients' questions as accurately as possible.
- It is essential that providers understand the key concepts about HIV, AIDS, general transmission of HIV, specific transmission of HIV in pregnant and postpartum women, and mother-to-child transmission, and the important link between HIV and other STIs.
- It is important for providers to understand local HIV and STI transmission patterns and how they may directly affect the pregnant and postpartum women in their care.
- Practising how to convey factual information about HIV transmission and prevention to pregnant and postpartum clients can help providers feel more comfortable when they work with such clients on these issues.
- Developing and incorporating key prevention messages into working with pregnant and postpartum women can help reinforce behaviour change in pregnant women over time.
- Grasping the importance of HIV prevention in the perinatal period will help providers understand the rationale for more integrated services at maternal health facilities.

Time

1 hour

Materials

- Facilitator's Resource: Basic HIV and AIDS Information (pages 12–13)
- Participant Handout: Key HIV/STI Prevention Messages for Pregnant and Postpartum Women (Appendix C, pages 88–90)
- Flipchart paper
- Markers
- Masking tape
- A collection of background information about HIV and AIDS

Advance Preparation

1. **Important:** Trainers will need to assess the training group’s level of knowledge regarding HIV and other STIs prior to structuring this exercise. Trainers will also need to supply the participants with factual information about HIV and other STIs, including information about pregnant women and HIV and other STIs, to help them prepare for this exercise. Some good sources of basic information about HIV and other STIs are EngenderHealth’s online minicourses on HIV/AIDS and other STIs (<http://www.engenderhealth.org/res/onc/trh-index.html>), which are also available on CD-ROM. Trainers are encouraged to use local sources of information on HIV and other STIs such as ministries of health, non-governmental organisations 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. Participants will need to receive the background information identified by the trainers prior to the training workshop. If possible, the participants should receive the background information at least one week before the workshop, so they can familiarise 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 before this activity takes place.
3. Make for each participant a copy of the factual information about HIV and other STIs from the resources that you identified.

Training Steps

1. Tell the participants that you will provide them with some basic information about HIV transmission among pregnant women, and that they will then work in small groups on key messages about HIV or AIDS prevention and transmission for pregnant women.
2. Give the participants a short presentation on the basics of HIV and AIDS. Cover the points in the Facilitator’s Resource—Basic HIV and AIDS Information (pages 12–13).
3. Distribute to the participants the copies of the factual information about HIV/AIDS and other STIs.
4. Give the following directions to the participants:
 - They will work in small groups.
 - Each group’s task is to come up with key prevention messages for pregnant and postpartum women, based on the participants’ experience in working with pregnant and postpartum women as well as on the information just presented to them.
 - Each group should record its prevention messages on a flipchart. Feel free to draw pictures or write key phrases on the flipchart as a way of communicating the key messages clearly and concisely to pregnant and postpartum women.
 - Each group should choose a reporter to explain its key prevention messages to the larger group.
5. Divide the participants into groups of four to five people, and give each group a blank sheet of flipchart paper and a variety of colourful markers.

6. After 15 to 20 minutes, reconvene the larger group. Ask each group's reporter to post the key prevention messages and present them to the larger group. Allow 10 to 15 minutes for completion.
7. Once all of the teams have presented their messages, distribute the Participant Handout: Key HIV/STI Prevention Messages for Pregnant and Postpartum Women (Appendix C, pages 88–90) and facilitate a large-group discussion based on the key discussion questions below. Save the flipcharts with each group's key prevention messages for the final activity on Day 3.
 - * How did it feel to summarise detailed information into concise messages?
 - * How do your messages compare with those in the handout? Are there any messages not covered by either your messages or the messages in the handout?
 - * After viewing all of the different types of presentations, which techniques did you find helpful for conveying the information?
 - * How can we feel more prepared to respond to pregnant clients' inevitable concerns and questions about HIV and other STIs?
 - * How would you respond to pregnant clients if they raise issues that you are unsure of or that you feel you do not know enough about?
8. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

If feasible and appropriate, invite an outside expert on HIV and other STIs to give a talk to the participants as a part of this exercise or prior to it.



HIV

- The human immunodeficiency virus (HIV) is one of a family of viruses known as retroviruses.
- There are different types of HIV: HIV-1 is the most common type, and is found worldwide; HIV-2 is found mostly in West Africa.
- HIV can infect and destroy special white blood cells called CD4+ or T4 cells.
- These cells are an important part of the immune system, which is the body's defence against infection.
- Infection with HIV progressively weakens the immune system, making an individual increasingly susceptible to a range of specific infections and tumours. The WHO clinical staging system for HIV disease recognizes this disease progression as a sequence of four stages.
- In early HIV disease (stages 1 to 3), individuals can develop tuberculosis, malaria, pneumococcal pneumonia, shingles (herpes zoster), staphylococcal skin infections and septicaemia (WHO. 2004. *Prevention and treatment of HIV-related infections*, Geneva; accessed at <http://www.who.int/hiv/topics/opportunistic/infections/en/> on March 25, 2004). While these diseases can also occur in individuals with healthy immune systems, in HIV-positive individuals they occur at much higher rates.

AIDS

- Acquired immune deficiency syndrome (AIDS) is the advanced stage of HIV disease (stage 4). With advanced HIV disease, opportunistic infections such as pneumocystis, toxoplasma, and cryptococcus cause disease because the HIV-positive person's immune system is weakened and damaged (WHO. 2004. *Prevention and treatment of HIV-related infections*, Geneva; accessed at <http://www.who.int/hiv/topics/opportunistic/infections/en/> on March 25, 2004).
- Opportunistic infections are illnesses caused by a germ that might not cause illness in a healthy person but that will cause illness in a person with a weakened immune system.
- Ordinary infections also present in atypical ways (e.g., tuberculosis disseminated from the lung, and recurrent non-typhi salmonella septicaemia). Kaposi's sarcoma and other cancers also occur (WHO. 2004. *Prevention and treatment of HIV-related infections*, Geneva; accessed at <http://www.who.int/hiv/topics/opportunistic/infections/en/> on March 25, 2004).

Other Points to Cover

- 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 realise that they are infected.

3

Facilitator's Resource

Basic HIV and AIDS Information

- 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 or other sharp instruments
 - Mother-to-child transmission
 - Unscreened blood products
 (Tell the participants that the next session will cover HIV transmission in greater detail.)
- 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.
- WHO recommends that in ARV treatment programs in resource-limited settings, HIV-infected adolescents and adults should start ARV therapy when they have confirmed HIV infection and one of the following conditions:
 - Clinically advanced HIV disease (i.e., WHO Stage 4 HIV disease irrespective of CD4 cell count, or WHO Stage 3 disease with consideration of using CD4 cell counts of $<350/\text{mm}^3$ to assist decision making)
 - WHO Stage 1 or 2 HIV disease with CD4 cell counts of $200/\text{mm}^3$
(WHO. 2004. *Scaling up antiretroviral therapy in resource-limited settings, October 2003 Revision*. Geneva)
- Since the presence of other STIs can increase people's susceptibility to HIV infection (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; 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), efforts to diagnose and treat curable STIs have become a major strategy in combatting 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 or antigens. (Tell the participants that HIV testing will be covered in greater detail in one of the next day's sessions.)
- Transmission of HIV and other STIs through sexual activity can be prevented by means of the consistent and correct use of condoms, both male and female.
- A woman infected with HIV can pass the virus to her infant during pregnancy, during labour and delivery, or during breastfeeding. This is called mother-to-child transmission (MTCT), or vertical transmission.
- This guide focusses on women infected with HIV-1 for two reasons:
 - HIV-1 is more prevalent worldwide.

- Given the relatively low rate of perinatal transmission of HIV-2, the risks versus the benefits for short-course ARV prophylaxis have not been established (WHO. 2004. PMTCT—Generic training curriculum: Participant guide. Draft. Geneva.)
- While this guide focuses primarily on the *prevention of HIV among prospective parents*, given the gap in the literature and training/programming guidelines for addressing prevention during pregnancy, a number of sessions later in the training will also provide an overview of comprehensive programmes for preventing mother-to-child transmission (PMTCT), including safer delivery practises and infant feeding options.

HIV and STI Risk Continuum for Pregnant and Postpartum Women

4

Objectives

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

- Describe at least three factors that influence HIV risk during pregnancy and the postpartum period
- Identify and explain at least three myths about HIV and STI transmission for pregnant and postpartum women

Essential Ideas to Convey

- Variations in sexual behaviours, relationships, and social factors can influence HIV and STI risk for pregnant and postpartum women. Risk of transmission depends on the context in which a particular behaviour occurs, as well as on other factors, such as cultural practises and gender dynamics.
- It is important for health care providers to help pregnant and postpartum clients understand the relationship between HIV and other STIs and how STI treatment and prevention can be an important tool in limiting the spread of HIV infection.
- While we can definitively determine the level of risk for some activities, with others it is less clear-cut (i.e., oral sex); this can be confusing for both providers and their clients.
- Providers who are also counsellors must understand and respect that pregnant women have different understandings about what risk means in their lives, based on cultural and sociocultural norms and gender dynamics. Some people are willing to take risks, while others may not think they are at risk. Providers must work with pregnant women to help them better understand their perception of HIV and STI risk and to help them find ways to reduce the risk in their life during pregnancy and the postpartum period.
- It is crucial for pregnant and postpartum women to understand that their own behaviours may not be putting them at risk, but that their partners' behaviours may increase their risk for acquiring HIV and other STIs.
- Due to gender inequalities, women often are not empowered to negotiate safer sex with their partners, including condom use. Efforts should be made to address the underlying gender dynamics. For example, couples counselling on voluntary counselling and testing can provide women with an opportunity to address risk-reduction with their partner in a supportive environment.
- Once people perceive their risk, and are empowered to make changes, most do so in incremental steps, over a period of time. Therefore, emphasising risk reduction (how clients can reduce rather than entirely eliminate their risk) is often a good strategy. For example, a pregnant woman may find it difficult to use condoms for every act of intercourse, but if she can increase the frequency of condom use, she may reduce her risk somewhat by decreasing her exposure.

- It is important for clients to know that there are sexual activities that are pleasurable and that pose little or no risk of infection. Safe sex can be pleasurable as well as healthy.
- Regardless of whether clients have HIV or other STIs, promoting good communication skills between partners is beneficial in maintaining healthy sexual lives.

Time

1 hour

Materials

- Facilitator’s Resource: Sample Behaviour/Myth cards (page 19)
- Participant Handout: HIV/STI Risk Continuum—Additional Considerations for Pregnant and Postpartum Women (Appendix C, pages 91–92)
- Flipchart paper
- Markers
- Masking tape
- Letter-sized coloured cards or paper

Advance Preparation

1. Using letter-sized coloured cards or paper, mark four cards with one of the following titles: “High risk,” “Medium risk,” “Low risk,” or “No risk” (see below)

High risk

Medium risk

Low risk

No risk

2. Post the cards high on a wall in the sequence shown above (to create a continuum from high risk to no risk), with plenty of space between each for the participants to post behaviour cards.
3. Prepare behaviour and myth cards by writing one behaviour or myth associated with HIV and STI transmission for pregnant and postpartum women (see Facilitator’s Resource: Sample Behaviour/Myth cards, page 19, or make your own) on a letter-sized card or piece of paper.
4. Make sure that the space in front of the wall is cleared so the participants have enough room to mingle as they post their cards.
5. Prepare many pieces of masking tape in advance for participants to use to stick the cards or pieces of paper to the wall rapidly.
6. Prepare a flipchart of the Overview of HIV Transmission for Pregnant and Postpartum Women (see page 18).

Training Steps

1. Distribute all of the cards with behaviours and myths to the participants, trying to ensure that each participant has the same number of cards. Provide the participants with pieces of tape—enough to post their behaviour or myth cards on the wall.
2. Instruct the participants to read their cards and to determine on their own what level of HIV or STI risk their card poses. Then ask the participants to go to the wall all at once and place each of their cards along the continuum, according to their assessment of the risk of what is written on the card.
3. Once all of the cards have been placed, facilitate a discussion based on the key discussion points below.
 - * Do you disagree with the placement of any cards? Where should they go instead and why?
 - * Are you confused by the placement of any cards? Why is a particular card placed where it is along the continuum?
 - * Which cards did you find most difficult to place along the continuum?
 - * Which cards can be categorised as myths? Are there other myths about HIV transmission that you have heard about in your community? Where do these myths come from and how can they be dispelled?
 - * How can we translate the information we learned in this session into simple, clear messages for clients to take home with them?
 - * How can you help pregnant and postpartum women explore the possibility of engaging in activities that are less risky but still sexually pleasurable?
 - * How will the information you learned in this exercise apply to your work as providers of maternal health care?

Be sure to allow the participants to answer their peers' questions and to share their knowledge of the relative risk of various behaviours. Affirm accurate responses and correct any misconceptions that do not get resolved in discussion among the participants.
4. Using a prepared flipchart (see page 18), conclude the session by presenting an overview of HIV transmission for pregnant and postpartum women.
5. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

Instead of providing prepared behaviour or myth cards, you can have the group, as a first step in the activity, brainstorm a list of sexual behaviours that are practised in their culture and of all the ways in which pregnant women can get HIV or other STIs. Once the list is determined, the different behaviours and factors can be written on separate cards and the exercise can be conducted as described below.

This exercise can be long and involved or it can be conducted quickly, depending on how long the group takes to analyse the risk continuum and to dispel myths. For example, when discussing the placement of the cards, you can either provide an overall summary of the risk continuum (when working with a more advanced training group) or discuss the placement of each card, one by one (for a less knowledgeable group). Also, you can provide fewer

cards—by, for example, concentrating on actual HIV and STI risks exclusively rather than incorporating myths as well.

It is recommended that the facilitator add cards with *local* myths to tailor this exercise to the needs of each group.

The risk continuum can also include the category “unknown” or “unsure of risk.” Participants can place cards in this category either because they are unsure of the level of risk or because the card itself does not provide sufficient information to make a judgement.

Note: Sometimes, participants begin the activity by classifying behaviours that they find offensive as high-risk, even if they present little risk of infection. If this happens in your group, discuss how attitudes and judgements can influence a counsellor’s assessment of risk.

Sample prepared flipchart

Overview of HIV Transmission for Pregnant and Postpartum Women

HIV is spread through three main modes, all associated with exposure to the bodily fluids (blood, semen, vaginal fluids, and breast milk) of infected individuals. Specifically, HIV can be transmitted through:

Sexual contact

- Vaginal sex
- Anal sex
- Oral sex

Blood contact

- Injections/needles (sharing needles, injecting drugs, or drug paraphernalia, or using contaminated needles or other sharp objects)
- Cutting tools (using contaminated skin-piercing instruments, such as scalpels, needles, razor blades, tattoo needles, and circumcision instruments)
- Transfusions (receiving infected blood or blood products) or transplant of an infected organ
- Contact with broken skin (exposure to blood through cuts or lesions)

Mother-to-Child Transmission

- During pregnancy, labour and delivery, or breastfeeding

[Note: Tell the participants that MTCT will be covered in more detail in a separate session on prevention of MTCT.]



Note: These behaviours and myths represent a wide range of types of sexual relations. Based upon the cultural setting, other behaviours and myths can be used in addition to or instead of those listed below.

Behaviours

Abstain from sexual relations during pregnancy.
 Abstain from sexual relations postpartum.
 Unprotected sexual relations with a monogamous, uninfected partner during pregnancy
 Unprotected sexual relations with a monogamous, uninfected partner postpartum
 Unprotected sexual relations with multiple partners during pregnancy
 Unprotected sexual relations with multiple partners postpartum
 Protected sexual relations with a monogamous, uninfected partner during pregnancy
 Protected sexual relations with a monogamous, uninfected partner postpartum
 Protected sexual relations with multiple partners during pregnancy
 Protected sexual relations with multiple partners postpartum
 Sexual relations using spermicides during pregnancy
 Sexual relations using spermicides postpartum
 Kissing during pregnancy and postpartum
 Sexual relations with withdrawal prior to ejaculation during pregnancy
 Sexual relations with withdrawal prior to ejaculation postpartum
 Using sharp instruments to cut the skin during labour and delivery
 Sharing injection needles through lay health practitioners during pregnancy or postpartum
 Receiving injections at a health facility during pregnancy or postpartum
 Sitting on a public toilet seat during pregnancy
 Sitting on a public toilet seat postpartum
 Exclusive breastfeeding
 Receiving a blood transfusion during pregnancy
 Receiving a blood transfusion postpartum
 Helping a pregnant women with a nosebleed
 Sharing eating utensils with an HIV-infected pregnant woman
 Having sex during pregnancy with someone who claims that he or she does not have HIV

Myths

Having sexual relations with a virgin can cure HIV.
 If you jump over a gutter, you can get HIV.
 If you get bitten by a mosquito, you can get HIV.
 If you have sexual relations during early stages of pregnancy, it can help fertilise the egg.
 If you eat fruit that a witch has sprinkled with HIV, you can get HIV.
 If you share food with someone who is HIV-positive, you can get HIV.

Values and Sexual Behaviour

5

Objectives

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

- Describe their own biases and value judgements concerning particular sexual behaviours during pregnancy and the postpartum period
- Explain the differences in individual, cultural, and gender perspectives pertaining to sexual behaviour during pregnancy and the postpartum period, including differences in what is considered “normal” or “acceptable”
- Explain the importance of being nonjudgemental about sexual behaviours when communicating with pregnant and postpartum women about sexual and reproductive health

Essential Ideas to Convey

- Although providers of maternal health care have offered services for many years with success, discussions about sexual practises with clients often are limited. HIV has heightened providers’ awareness of the need to address sexuality more frankly and directly with pregnant and postpartum clients.
 - Pregnant and postpartum women, in particular, may be uncomfortable with talking about sexual practises, due to cultural taboos associated with sexual abstinence during pregnancy and the postpartum period.
 - This exercise is meant to help providers not only see the difficulty of discussing sexual practises, on the part of both the client and the provider, but also understand how the provider’s biases might affect a client’s feelings about discussing such intimate issues.
 - The term “sex” is often thought to refer to penile-vaginal sex only, but sexual behaviours can be defined much more broadly. If providers assume that sex only means penile-vaginal intercourse, they may be missing important information.
 - All people make value judgements when it comes to sexual behaviours and the circumstances under which people engage in sexual practises; to be effective, providers must not impose personal values on pregnant and postpartum clients as they explore their individual needs and situations. Enhancing a provider’s comfort level so that pregnant and postpartum clients can discuss sexuality is an important goal towards which to strive.
 - If a provider does not address the issue of sexual practises, pregnant and postpartum clients may receive inadequate or inappropriate information and consequently may be unable to protect themselves from infection. Assumptions and misunderstandings about the sexual practises of pregnant and postpartum women can leave them without the information, skills, or methods they need to protect themselves.
-

Time

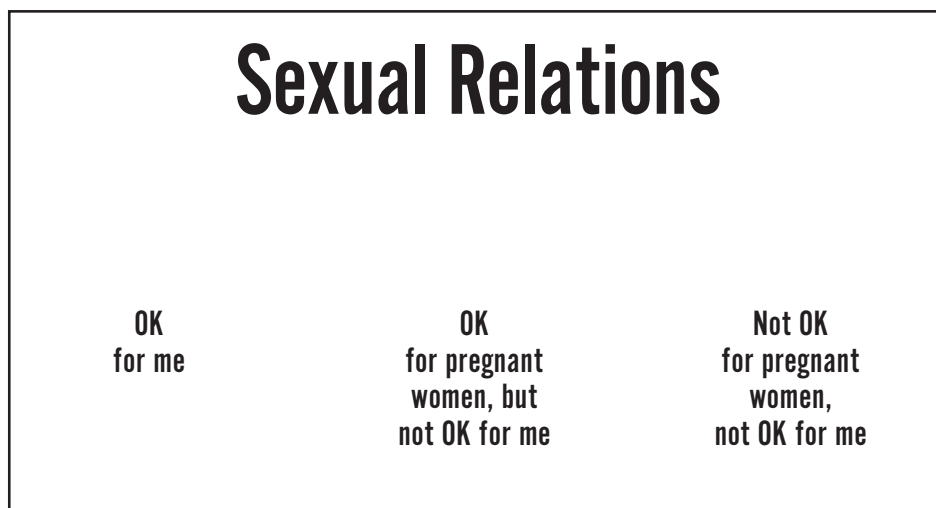
1 hour

Materials

- Facilitator’s Resource: Different Types of Sexual Behaviours (page 26)
- Flipchart paper
- Coloured paper (heavy paper or card stock, if available)
- Markers
- Masking tape

Advance Preparation

1. If using Option A (see page 23), have sheets of coloured paper (heavy paper or card stock, if available) on hand to supplement sexual behaviours listed in the brainstorm and be prepared to draw some behaviours from the Facilitator’s Resource: Different Types of Sexual Behaviours (page 26), if necessary.
2. If using Option B (see page 23), write one sexual behaviour on each sheet of letter-sized coloured paper (heavy paper or card stock, if available), using the Facilitator’s Resource: Different Types of Sexual Behaviours, page 26, for sample behaviours. Print using a large marker and large letters, or use a computer printer to print the pages in a large, bold font so the words can be read from a distance. Write the phrases “OK for me,” “OK for pregnant women, but not OK for me,” and “Not OK for pregnant women, not OK for me” in small letters at the bottom of each card (so the participants can circle their response).



3. Prepare three additional sheets, each with one of the three phrases (“OK for me,” “OK for pregnant women, but not for me,” and “Not OK for pregnant women, not OK for me”) written in large print. Use a different colour paper for these sheets, if possible. Post

them high on the wall, ensuring sufficient space between them for three to five vertical rows of cards to be placed beneath each.

4. Prepare many small pieces of tape ahead of time, enough to affix all of the prepared sheets to the wall.

Training Steps

1. Introduce the exercise by saying that the group will explore the range of sexual behaviours in which pregnant and postpartum women engage and the attitudes and values that we have about those behaviours. Explain that this is an interactive exercise that will allow the participants to examine their personal values about different sexual behaviours during pregnancy and postpartum, but in a completely confidential way.
2. There are two ways in which you can conduct this exercise:

Option A: Begin by asking the participants to brainstorm a list of all of the sexual behaviours that they can name in which pregnant and postpartum women might engage. (*Note:* This will take an extra 15 to 20 minutes.) Ask them to think broadly and include behaviours that are not very common or that are taboo in their community. The list should include both sexual behaviours and sexual dynamics or situations (e.g., sex with a sex worker, sex with someone older, etc.). Write all of the responses on a flipchart. If there are two trainers, one should lead the brainstorm while the second writes each sexual behaviour on a piece of paper or card as it is mentioned; if not, the facilitator may ask for one or two volunteer participants to handle this task. (*Note:* Be sure the phrases “OK for me,” “OK for pregnant women, but not OK for me,” and “Not OK for pregnant women, not OK for me” are written in small letters at the bottom of each card.) After the brainstorm, if the list of behaviours does not represent a wide range of sexual behaviours, some additional cards can be prepared from the list of sexual behaviours (see page 26) and added to the pile of cards before they are distributed to the participants.

Option B: Use the prepared sexual behaviour cards only. Be sure to review the Facilitator Resource: Different Types of Sexual Behaviours (page 26) first and add new behaviours or omit others, based on the local situation. (*Note:* It is important to include some behaviours that are outside of the mainstream or that are taboo, even if these behaviours are not generally acknowledged in the local setting.)
3. Tell the participants that you will give each person one or more cards with a sexual behaviour written on each. Instruct them to determine how they personally feel about pregnant and postpartum women’s engaging in each particular behaviour and indicate this by circling one of the phrases at the bottom of the card.
4. Explain to the participants that “OK for me” signifies a behaviour in which one personally would engage, “OK for pregnant women, but not for me” means a behaviour one personally would *not* engage in but would have no problem with a pregnant or postpartum woman doing, and “not OK for pregnant women, not OK for me” means a behaviour in which neither the participant nor a pregnant women should engage because it is morally, ethically, or legally wrong.

SESSION 5

5. Be sure to remind the participants that this exercise is meant to be completely confidential, so they should not communicate the behaviour on the card or their response with anyone. To ensure confidentiality, you may want to ask the participants to rearrange their seats or spread around the room before you distribute the cards, so no one can see the cards and the participants' responses.
6. Hand out the cards, attempting to give each participant the same number of cards, until all have been distributed. Repeat the meaning of the three categories and ask if everyone understands.
7. Tell the participants to mark their responses by circling one of the phrases. Instruct them *not* to write their names on the cards, and ask them to place the cards face down in a pile in the centre of the room once they have circled their responses.
8. Mix up the cards, and ask all of the participants to take as many cards as they put down.
9. Have the participants take turns, one by one, reading each of their cards aloud and then taping each card on the wall under the category indicated on the card. Remind them to put the card in the category that is circled, even if they personally do not agree with the classification. Encourage them to stay standing, line up (queue) to read their card, and move quickly one after the other.
10. Once all of the cards are posted, instruct the participants to gather around the wall and take a few minutes to observe the placement of the cards.
11. Facilitate a group discussion based on the key discussion points below. Do not move the cards if there is disagreement; simply acknowledge the difference of opinion and leave the cards as they are.
 - * Are you surprised by the placement of some of the cards? Which ones surprised you and why?
 - * How would you feel if someone had placed a practise that you engage in yourself in one of the "Not OK for me" categories?
 - * How would you feel if someone placed something that you feel is wrong or immoral in one of the "OK" categories?
 - * Does the placement of the cards imply that some behaviours are "right" and that others are "wrong"? How do you feel about that?
 - * Are there behaviours that are "Not OK for you or pregnant women" under any circumstances?
 - * How did you feel placing someone else's response card on the wall? Would you have felt comfortable placing your own responses in front of the group?
 - * What does this exercise tell us about how pregnant and postpartum clients might feel when providers ask them about their sexual practises?
 - * How do you think providers' and educators' values and attitudes about different sexual practises during pregnancy and postpartum affect their work?
 - * How can providers and educators feel more comfortable in addressing sexuality issues with pregnant or postpartum clients?
 - * How can providers and educators make pregnant and postpartum women feel more comfortable about discussing sex?
12. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

There may be behaviours on the cards that some participants do not understand. If necessary, you can stop to define the behaviours for the participants, or you can ask other participants to do so.

It is helpful to continually remind the participants that this exercise is not about HIV risk, but about *values* and *judgements* around *sexual behaviours*. Sometimes, participants have difficulty separating their ideas about disease risk from their value judgements about behaviours.

If some participants indicate that a particular sexual practise does not exist in their culture (e.g., abstinence during pregnancy and the postpartum period), ask other participants to verify whether this is true. Some participants may be more aware of variations in sexual behaviour and can help their colleagues understand.

Do not ask who placed any particular response in a particular category. If a participant would like to volunteer such information to explain his or her answer, he or she may do so, but to ask anyone to do so might make the participants uncomfortable and would take away the anonymity of the exercise.

5 Facilitator's Resource

Different Types of Sexual Behaviours

Note: These behaviours and myths represent a wide range of types of sexual relations. Based upon the cultural setting, other behaviours and myths can be used in addition to or instead of those listed below.

Kissing

Abstaining during pregnancy

Abstaining postpartum

Being faithful to one's partner

Having sexual relations with a person who is much younger than your partner

Having sexual relations with a person who is much older than your partner

Having sexual relations during pregnancy

Having sexual relations postpartum

Having sexual relations with multiple partners

Having sexual relations with people whom you do not know

Having sexual relations with your spouse

Initiating sexual encounters

Having sexual relations with multiple partners during pregnancy

Having sexual relations with multiple partners postpartum

Engaging in "dry sex" (can include the use of drying agents in the vagina, such as herbs, powders, etc.) [omit if not practised in your culture]

Engaging in "cleansing" rituals (sex with a relative of a deceased husband) [omit if not practised in your culture]

Refusing to have sexual relations with one's partner

Sexuality and HIV Risk during Pregnancy

6

Objectives

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

- Describe sexual practises during pregnancy that are culturally specific and gender-specific
- Explain the importance of demonstrating an increased awareness and empathy for the opposite sex’s viewpoint on culturally specific and gender-specific sexual practises during pregnancy

Essential Ideas to Convey

- As providers, we must be aware of the ways in which laws, customs, and gender inequities can affect people’s sexual and reproductive rights and freedoms and the expression of these rights and freedoms.
- Sexual practises and relationships are affected by the way we feel about sex, by what we think is proper and improper, and by what it means to relate to another person in a sexual way. These types of thoughts and feelings are often filled with emotions—including, for example, pleasure, but also sometimes fear, guilt, shame, or embarrassment. These feelings come from our personal experiences and also from the meanings that our culture attaches to sex, including gender norms.
- Providers who have a better understanding of the sociocultural factors and gender dynamics influencing women’s expression of sexual and reproductive rights and freedoms can assist pregnant and postpartum women to perceive their risk of HIV and other STIs and to develop strategies to reduce risk.
- To improve the client’s accuracy of risk perception, the provider must feel comfortable with engaging pregnant and postpartum women in a two-way conversation about their needs, relationships, sexual practises, gender-based vulnerabilities, other risks, and social context.

Time

1 hour

Materials

Facilitator’s Resource: Fishbowl Questions (page 29)

Advance Preparation

Arrange the chairs in the room so that there are two circles, one inside the other.

Training Steps

1. Introduce the exercise by saying that it will explore the range of viewpoints regarding sexual practises that are culturally specific and gender-specific. Explain that it is a “fishbowl exercise” that will allow the participants to examine their personal values about different sexual practises during pregnancy and postpartum and reflect on how these values are determined by culture and gender and are different for women and for men.
2. Divide the participants into a male group and a female group.
3. Ask the women to sit in a circle in the middle of the room and the men to sit around the outside of the circle, facing in.
4. Begin a discussion with the women by asking them the Questions for Women from the Facilitator’s Resource: Fishbowl Questions.
5. Once the women have talked for 20 minutes, close the discussion. Then ask the men to switch places with the women and lead a 20-minute discussion with the men while the women listen. (The Questions for Men are also listed in the Facilitator’s Resource for this session.)
6. Facilitate a large-group discussion after both groups have completed their fishbowl discussion, using the following key discussion points.
 - * Are you surprised by any comments or statements that you heard from either the men’s or the women’s group? Which ones surprised you, and why?
 - * How do you think women’s and men’s experiences of culturally specific sexual practises vary according to gender?
 - * How do these experiences shape our perceptions of these practises and individuals’ level of risk for HIV during pregnancy and the postpartum period?
 - * What does this exercise tell us about how these cultural practises might influence pregnant and postpartum clients’ perceptions of the level of HIV risk associated with these practises?
7. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

This activity works best with a mixed-gender group of participants. However, it can be conducted with an all-female or a predominantly female group. Simply divide the female participants into two smaller groups. Ask the second group to put themselves in the place of men and when it is their turn to be in the middle to think of how men would respond to the Questions for Men. When facilitating the group discussion at the end, be sure to ask this group how it felt to be in the men’s situation for this exercise.

If there is insufficient space, place the chairs in two semicircles so they are facing each other on opposite sides of the room. Ask the men and women to sit on the same side of the room during both discussions.



Questions for Women

- What do you think men need to better understand about women's sexual and reproductive health needs?
- What do you think is the most difficult thing about communicating with your partner?
- What do you find difficult to understand about men's sexual and reproductive health needs during pregnancy and postpartum?
- What kinds of messages were you given about sex and pregnancy when you were growing up as a girl?
- What was difficult about developing sexually as a teenage girl?
- What social and cultural factors make it difficult for women to express themselves sexually with their partner during pregnancy and the postpartum period?
- Do any of these factors have the potential to increase women's risk for infection with HIV or other STIs?
- How do you think men can better support and empower women during pregnancy and the postpartum period to reduce their risk for infection with HIV or other STIs?

Questions for Men

- What do you think women need to better understand about men's sexual and reproductive health needs?
- What do you think is the most difficult thing about communicating with your partner?
- What do you find difficult to understand about women's sexual and reproductive health needs during pregnancy and the postpartum period?
- What kinds of messages were you given about sex and pregnancy when you were growing up as a boy?
- What was difficult about developing sexually as a teenage boy?
- What social and cultural factors make it difficult for men to express themselves sexually with their partner during pregnancy or the postpartum period?
- Do any of these factors have the potential to increase your risk or your partner's risk for infection with HIV or other STIs?
- What kind of support during pregnancy and the postpartum period do men need to reduce their risk or their partner's risk for infection with HIV or other STIs?

Pregnant and Postpartum Women's Vulnerability to HIV and Other STIs

7

Objectives

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

- Explain at least three root causes and consequences of HIV infection for pregnant and postpartum women
- Describe the social, cultural, economic, gender, and political factors that may increase pregnant and postpartum women's vulnerability to HIV and other STIs

Essential Ideas to Convey

- In many cultures, inequitable gender relations result in a lack of power among women in sexual decision making, which prevents pregnant and postpartum women from protecting themselves from HIV, even if they are aware that their partner's behaviour may be putting them at risk. Many women may find it difficult, if not impossible, to negotiate safer sex with their partners or to control the circumstances under which they have sex. Because of their social and economic dependence on men, pregnant and postpartum women frequently have little power to refuse sex or to insist on the use of barrier methods, such as condoms, during intercourse.
- Cultural norms and/or taboos about sex during pregnancy and postpartum can increase pregnant and postpartum women's vulnerability to HIV infection. A combination of factors—including cultural practises regarding abstinence or decreased sexual activity for women during pregnancy or the postpartum period and the acceptability of male partners' having multiple partners during pregnancy or the postpartum period—contribute to women's increased vulnerability either during pregnancy or after resumption of sexual activity following pregnancy.
- Pregnant and postpartum women require equal access to information, education, and support either to remain HIV-negative or, if they are HIV-positive, to avoid transmitting HIV to their partner or to their children. Increasing pregnant and postpartum clients' awareness of their vulnerability to infection may help prevent HIV transmission.
- Pregnant and postpartum women often face stigma and discrimination from their communities, families, and partners if they seek voluntary counselling and testing for HIV infection. In addition to being emotionally painful, this social isolation can sometimes lead to gender-based violence and rejection.
- HIV-positive women and their children, some of whom may be infected themselves through mother-to-child transmission during pregnancy, labour, delivery, or breastfeeding, also suffer from the consequences of stigma and discrimination: poverty, isolation, and ill health. In addition, if a woman is rejected by her family and community, her children may be left without caretakers when she dies.

- Health care providers alone cannot address the root causes of health problems, particularly those forces that make pregnant and postpartum women vulnerable to HIV. However, if there is general awareness of these root causes, providers will better understand the context of their clients' lives and create a safe and supportive environment for pregnant and postpartum women to explore ways to reduce their risk for HIV and other STIs within a broader context. Providers and facility managers may have some influence on Ministry of Health staff and policy makers in the long term by recommending the integration of HIV and STI services in maternal health services.
-

Time

1 hour

Materials

- Facilitator's Resource: Sample Problem Tree (page 34)
- Flipchart paper
- Markers
- Masking tape

Advance Preparation

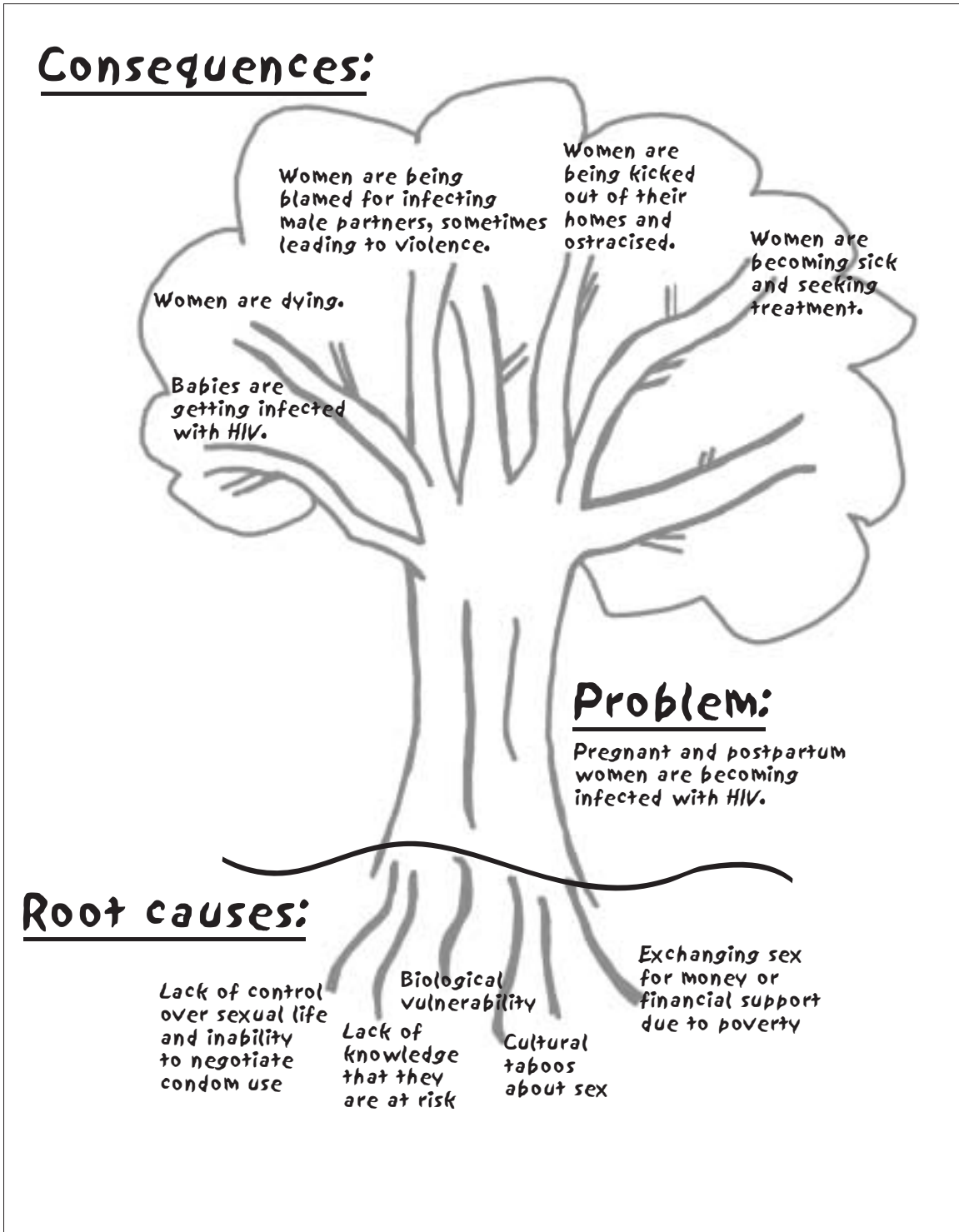
Draw the sample problem tree from page 34 (without the “consequences” and “root causes”) on four pieces of flipchart paper so that each small group will have one.

Training Steps

1. Divide the participants into four small groups. Introduce the exercise by telling them that they will explore the specific problem of HIV infection in pregnant and postpartum women by examining its root causes and consequences. Each small group will brainstorm the root causes and draw a tree to depict the problem.
2. Quickly demonstrate the exercise to the participants by drawing a sample tree on a flipchart in the front of the room. Use the following instructions for guidance:
 - First, draw the trunk of a tree in the centre of the blackboard or flipchart paper.
 - Write “Pregnant and Postpartum Women Infected with HIV” across the trunk; this represents the problem.
 - Draw roots leading out of the trunk and tell the participants that their small groups will brainstorm possible “root” *causes* for pregnant and postpartum women's being infected with HIV. These 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.).
 - Ask the participants to name as many causes as they can think of and show each one as a “root” on their tree.

- Tell the small groups that for each “root” cause, they should “dig deeper” to explore additional roots, going as far down into the “soil” as they can go. For example, the roots of “cultural taboos about sex” might be “cultural traditions about abstinence or decreased sexual activity during 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 roots of “abstinence” might be “cultural policies,” “lack of gender policies,” “legal restrictions on women’s rights,” or “religious traditions.”
 - Next, tell the participants that after the “roots” have been addressed, they should draw some branches going upwards from the trunk and brainstorm the *consequences* of the problem. 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 branches may be “Women are getting sick and seeking treatment,” “Women are dying,” “Babies are getting infected,” “Women are getting kicked out of their homes and ostracised,” or “Women are being blamed for infecting male partners, sometimes leading to violence.”
 - As with the “roots,” the small groups should examine each consequence and determine if other consequences stem from that particular problem. Draw more branches leading out of the consequences and write in additional ones. For example, some consequences of “Pregnant and postpartum women are dying” might be “Children are becoming orphaned,” “Communities are losing valuable members,” and “Families are losing sources of support.” Instruct the groups to follow through with as many branches they can think of.
3. Provide each group with one of the predrawn problem trees, allow them 30 minutes to complete their problem tree, and then have each small group present their “tree” to the large group.
 4. After each group has presented their problem tree, lead a group discussion based on the following key discussion questions.
 - * How do you view the problem of pregnant and postpartum women’s being infected with HIV now that we have done this exercise?
 - * Which of the roots do you think it is possible for us to address in our work?
 - * How, if at all, do you think addressing the “roots” will affect the “branches”?
 - * How can we address the consequences, or “branches,” through our work? Does it make sense to address consequences without addressing the roots?
 5. Provide the participants with a summary of the essential ideas to convey.

7



Voluntary Counselling and Testing for HIV

8

Objectives

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

- Describe voluntary counselling and testing (VCT) for HIV
- Explain how to support pregnant and postpartum clients in making their own decision about getting tested for HIV

Essential Ideas to Convey

- HIV testing should always be done voluntarily and confidentially and should never be mandated or coerced. If people have a desire to know whether they are infected, they have a right to be tested.
- For both HIV-positive and HIV-negative clients, discussing the HIV testing process and test results with their partners is apt to be difficult. Providers doing HIV counselling and testing should build skills to counsel clients effectively during the pretest and posttest stages of the process.
- Before providing an HIV test, providers should discuss the possibility of both a negative and a positive result with a pregnant or postpartum woman, addressing the potential social stigma that it carries. In some settings, people with HIV have been disowned by their families, fired from jobs, victimised in their community, and physically assaulted. In some settings, due to cultural taboos, pregnant women seeking an HIV test are viewed as immoral and are subject to shame, ridicule, and gender-based violence.
- Providers should be aware of any national guidelines pertaining to HIV testing of pregnant women and infants.
- VCT services are an important entry point for other HIV and AIDS services, which can benefit clients with either positive or negative test results. When they are well implemented, VCT services offer the possibility of benefitting the community by “normalising” the existence of HIV and AIDS, reducing stigma, and promoting awareness.
- Systems to ensure confidentiality and follow-up support, particularly postpartum, are critical components of VCT services, since women often do not return to a health care facility after the birth of their infant.
- Pregnancy and the postpartum period provide excellent opportunities to discuss VCT with women. A woman who has an HIV-negative test result can be counselled on appropriate prevention strategies and infant feeding options. An HIV-positive woman can receive early counselling and treatment (if available) to reduce the risk of mother-to-child transmission during pregnancy, labour, delivery, and breastfeeding. Systems to ensure confidentiality and follow-up support are critical components of VCT services.
- Pregnancy and the postpartum period also provide an excellent opportunity to involve men in VCT and in the prevention of HIV transmission.

Time

1 hour

Materials

- Participant Handout: Voluntary Counselling and Testing for HIV (pages 93–96)
- Flipchart paper
- Markers
- Masking tape

Training Steps

1. Inform the participants that you will be facilitating a large-group discussion about issues pertaining to VCT for HIV.
2. Ask the participants each of the key discussion questions below. Ask for their ideas and input for each question. Refer to the participant handouts for this session, to ensure that important content is covered in each of the participants' responses to the questions, as well as to correct any misinformation.
 - * What is an HIV test?
 - * What is pretest counselling?
 - * With HIV testing, what do voluntary, mandatory, anonymous, and confidential testing really mean?
 - * What happens if the test results are positive?
 - * What happens if the test results are negative?
 - * Can a person be tested for HIV without his or her permission?
 - * What are some advantages of VCT for pregnant and postpartum women?
 - * What are some disadvantages of VCT for pregnant and postpartum women?
 - * Why should male partners of pregnant and postpartum women be encouraged to participate in VCT services?
3. Following the large-group discussion, distribute copies of the handout—Voluntary Counselling and Testing for HIV—for the participants' reference. If specific points were not mentioned during the prior discussion, make sure to call attention to them now, before concluding the session.
4. Provide the participants with a summary of the essential ideas to convey.
5. Refer the participants to other resources pertaining to VCT. One excellent resource is: UNFPA and IPPF. 2004. *Integrating HIV voluntary counselling and testing services into reproductive health settings: Stepwise guidelines for programme planners, managers and service providers*. New York.

 **Considerations for the Facilitator/Training Options**

If it is feasible and appropriate, you might consider inviting an outside expert on VCT to talk with the training group prior to, or as a part of, this exercise.

Prevention of Mother-to-Child Transmission of HIV

9

Objectives

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

- Identify and explain at least three basic facts about preventing mother-to-child transmission (MTCT) of HIV
- Describe at least three things that they can do in their day-to-day work to address the prevention needs of pregnant and postpartum clients

Essential Ideas to Convey

- Preventing HIV transmission in pregnant women, mothers, and their children—often referred to as prevention of mother-to-child transmission (PMTCT)—has become a crucial intervention in the global fight against the HIV/AIDS epidemic. About 200 million women become pregnant each year and need effective maternal and child care. Ninety-nine percent of these pregnant women globally are HIV-negative and need counselling and services if they are to remain so. HIV-positive women also need counselling and support to access treatment and care for themselves and their families and to prevent transmission to their infant and to their partners.
- Preventing HIV infection in pregnant women protects the women themselves, as well as protecting their children and partners. (The most effective way to prevent MTCT is to ensure that women do not become infected in the first place.)
- Historically, there has been a tendency to view the “mother” in PMTCT as simply a vehicle for producing a healthy infant, with efforts directed mainly at providing antiretroviral prophylaxis to pregnant women to prevent transmission of the virus to the child. PMTCT programs include four critical components or elements that should be given equal weight to respect to both the woman’s and her child’s right to health:
 - Primary prevention of HIV, especially among pregnant women and young people
 - Prevention of unintended pregnancies among HIV-infected women
 - Prevention of HIV transmission from HIV-infected women to their children
 - Treatment, care, and support to HIV-infected women and their families
- Decreasing the vulnerability of pregnant and postpartum women to HIV infection is important for the sake of the woman herself and her partner and is the best way to prevent HIV transmission to infants and children. This includes providing counselling and services to clients on risk reduction plans for preventing HIV and other STIs, condom use, infant feeding, safer delivery practices, dual protection, etc.
- VCT is an important entry point to the comprehensive package of PMTCT services; pregnant and postpartum women cannot be appropriately referred to these services if they do not know their HIV status. VCT, however, should focus not only on identifying HIV-positive women but also on identifying HIV-negative woman and helping them to remain that way.

- Even without VCT, providers can do HIV prevention counselling. If a woman is HIV-negative, she can be counselled on appropriate risk-reduction plans.
 - If she is HIV-positive, a woman can receive available treatment and care to protect her own health, as well as to reduce the risk of MTCT during pregnancy, labour, delivery, and breastfeeding. Systems to reduce stigma and discontinuation and to ensure confidentiality and follow-up support are critical components of VCT services.
 - PMTCT programmes can benefit from men’s involvement. Some studies have shown that when women test positive for HIV and their male partners are not tested, the women are often blamed for introducing the infection into the couple. Such unfounded blame can lead to conflict, violence, and abandonment.
 - It is important to counsel HIV-negative as well as HIV-positive pregnant and postpartum women on various infant feeding options, to prevent MTCT and ensure the infant’s health.
 - Education at the community level about how to prevent MTCT is important to reduce stigma and to foster community concern.
-

Time

1 hour, 30 minutes

Materials

- Facilitator’s Resource: Prevention of Mother-to-Child Transmission Overview, page 41.
- Facilitator’s Resource: Key HIV Interventions for Preventing Mother-to-Child Transmission, page 42
- Participant Handout: Overview of Prevention of Mother-to-Child Transmission of HIV, (pages 97–98)
- Letter-sized paper or cards
- Markers
- Masking tape

Advance Preparation

1. Make a copy of the Key HIV Interventions for Preventing Mother-to-Child Transmission resource, page 42, for each group.
2. Prepare four letter-sized sheets of paper, marking them accordingly with one of each of the four elements of a comprehensive PMTCT programme:
 - Primary prevention of HIV, especially among young women and pregnant women
 - Prevention of unintended pregnancies among HIV-infected women
 - Prevention of HIV transmission from HIV-infected mothers to their children
 - Provision of treatment, care, and support to HIV-infected women and their families

3. Clear wall space so there is room to post all of the cards.
4. Arrange the room so that all of the participants will be able to stand by the wall where the cards are posted, for discussion.

Training Steps

1. Tell the participants that you will be providing them with some basic information about PMTCT and that they will then work in small groups on some questions about this topic.
2. Give the participants a short presentation on PMTCT, making sure to cover the information in the Facilitator's Resource: Prevention of Mother-to-Child Transmission Overview, page 41.
3. Split the participants into four small groups. Each group will brainstorm one of the four elements in the UN system's agreed-upon approach for PMTCT:
 - Group 1: Prevention of HIV, especially among young people and pregnant women
 - Group 2: Prevention of unintended pregnancies among HIV-infected women
 - Group 3: Prevention of HIV transmission from HIV-infected women to their infants
 - Group 4: Provision of treatment, care, and support to HIV-infected women and their families

Explain that each group should come up with as many interventions as they can that are relevant to the PMTCT element to which they were delegated and should write each one on a separate card or sheet of paper (20 minutes). Give each group a copy of the key HIV interventions for PMTCT.

4. Using a large, clear wall, post the sheets marked with the names of each element. Ask the groups to put their response cards under the appropriate element.
5. Keep the groups at the wall and have them review all of the cards written by the other groups.
6. Once all of the participants have had the time to review the cards, lead a group discussion (with the participants still standing by the wall), using the following questions:
 - * Do you agree with the placement of all of the interventions under the various elements?
 - * Are there some interventions that were not included under any of the elements that you think should have been? If so, what are they?
 - * Are the HIV-prevention needs of HIV-negative women and HIV-positive women different? If so, in what ways?
 - * What essential information about HIV prevention needs to be communicated to an HIV-negative pregnant or postpartum client to help her remain HIV-negative?
7. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

You may need to tailor the small-group questions to the needs and knowledge base of the group. For example, if the group is less knowledgeable about PMTCT, then you may need to lengthen the introductory minilecture and supplement it with facts contained in the handouts.

If it is feasible and appropriate, you might consider inviting an outside expert on PMTCT to talk with the training group prior to this exercise.

Be sure to cover the following points in your overview of PMTCT:

- HIV infection can be transmitted to infants during pregnancy, at labour and delivery, and in the postpartum period through breastfeeding.

| Estimated risk and timing of MTCT of HIV in the absence of interventions | |
|--|-------------------|
| Timing | Transmission Rate |
| During pregnancy | 5–10% |
| During labour and delivery | 10–20% |
| During breastfeeding | 5–20% |
| Overall, without breastfeeding | 15–30% |
| Overall, with breastfeeding to six months | 25–35% |
| Overall, with breastfeeding to 18 to 24 months | 30–45% |

Adapted from: 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.

- About 2.5 million children were living with HIV as of December 2003 (UNAIDS. 2003. *AIDS epidemic update*. Geneva.) According to UNAIDS, the vast majority of these children were born to mothers who were infected with HIV.
- Without any medical intervention, about one-third of HIV-positive women transmit the virus to their newborns.
- Several antiretroviral regimens have proven effective in reducing perinatal transmission of HIV and in treating HIV-positive women and mothers.
- The UN's system-wide approach to PMTCT consists of the following four elements:
 - Primary prevention of HIV, especially among young people and pregnant women
 - Prevention of unintended pregnancies among HIV-positive women
 - Prevention of HIV transmission from an HIV-positive woman to her child
 - Treatment, care, and support of HIV-positive women and their families
- As was stated earlier, while this guide primarily focusses on the first of the four elements—that is, the prevention of HIV—it also covers a number of HIV interventions that fall under the other elements, including safer delivery practises, counselling on infant feeding, universal precautions, etc.



Information, education, and communication/behaviour-change communication

Group education strategies

Prevention counselling (including dual protection)

Counselling on infant feeding

Condom provision and support for consistent and correct use (both male and female condoms)

VCT services

STI management services

Universal precautions

Safer delivery practises

Provision of antiretroviral therapy to pregnant women and infants to prevent vertical transmission

Treatment, care, and support services for HIV-positive mothers and their families

Expanded reliance on traditional birth attendant, midwifery, and community health worker programmes

Promotion of male involvement

Targeted outreach to vulnerable subpopulations of women

Community outreach to the general population

Safer Infant Feeding Practises

10

Objectives

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

- Describe the criteria for replacement feeding in the context of HIV, including acceptability, feasibility, affordability, sustainability, and safety of different infant feeding options
- Identify and explain key messages to communicate to pregnant and postpartum women about safer infant feeding options in the context of HIV
- Describe how the media can be utilised in communications strategies for increasing coverage and awareness of safer infant feeding practises

Essential Ideas to Convey

- The health of infants and children benefits from their being breastfed. However, HIV-positive woman can transmit the virus through breastfeeding; therefore, women should be counselled and supported in their decisions on the most appropriate infant feeding option for them.
- The risk of transmitting HIV through breastfeeding is increased if a woman becomes infected with HIV at the end of pregnancy or during breastfeeding, since the viral load is high during initial period of infectivity.
- HIV-negative mothers and those whose HIV status is unknown should be counselled to exclusively breastfeed for the first six months of life, to help the child achieve optimal growth, development, and health. Introduction of nutritionally adequate and safe complementary foods at six months should be recommended, even while breastfeeding continues for up to two years of age or beyond.
- HIV-positive mothers should be counselled to avoid breastfeeding when replacement feeding is acceptable, feasible, affordable, sustainable, and safe. Otherwise, exclusive breastfeeding is recommended for the first months of the infant's life and then should discontinue breastfeeding as soon as similar conditions are met. (This would normally imply the same conditions as for replacement feeding from birth—that is, that replacement feeding is acceptable, feasible, affordable, sustainable, and safe.) Complementary feeding should begin at six months.
- Women will face many obstacles to their infant feeding choices, which may be influenced by community and family norms, including possible stigma.
- All breastfeeding mothers should be supported in the prevention, diagnosis, and early treatment of breast problems, which can increase the chances of HIV transmission from an HIV-positive woman.
- Women's groups offer the opportunity for women to provide each other with support regarding breastfeeding decisions and with practical solutions for overcoming common problems associated with breastfeeding.

Time

1 hour

Materials

- Facilitator’s Resource: Safer Infant Feeding Practises (pages 46–48)
- Facilitator’s Resource: Safer Infant Feeding Topics (page 49)
- Participant Handout: Overview of Safer Infant Feeding Practises (pages 99–101)
- Flipchart paper
- Markers
- Tape

Advance Preparation

1. Prepare slips of paper with the topics written on them (see Facilitator’s Resource: Safer Infant Feeding Topics, page 49).
2. Obtain a basket or envelope for the slips of paper.

Training Steps

1. Tell the participants that you will provide them with some basic information about safer infant feeding practises for pregnant and postpartum women. Afterwards, they will work in small groups on some questions about safer infant feeding practises among pregnant and postpartum women.
2. Give the participants a short presentation on safer infant feeding practises. Cover the points in the Facilitator’s Resource: Safer Infant Feeding Practises.
3. Divide the participants into small groups of five each. Give them the following instructions:
 - Explain that each small group will receive two or three topics (depending on time and needs of the group) related to safer infant feeding practises.
 - These small groups will study and discuss the topics and will prepare one 5- to 10-minute presentation on their topic, to educate the rest of the participants in the large group.
 - The groups should approach the presentations as if they were doing an in-service training on their particular topic to other staff. Their presentations should be no more than 5–10 minutes in duration.
4. Instruct a volunteer from each group to pick two or three pieces of paper out of the basket or envelope. The topics that are written on the pieces of paper will be the subject of each team’s presentations.
5. Provide each team with extra copies of the factual information about safer infant feeding practises covered in the presentation by the trainers and ample pieces of flipchart paper and markers.

6. Instruct the teams both to use the extra copies of the information provided as reference materials and to draw on their previous knowledge to develop some key messages and information and educational materials on the most pertinent information relating to their topics. Encourage them to draw pictures or to write key phrases on a flipchart as part of the presentations. If props are provided, encourage the participants to incorporate them into their presentations. Clarify to the group that their colleagues are the intended audience for these presentations.
7. Once the teams have finished preparing the presentations, invite each group to present them. Stop after each presentation and facilitate a brief large-group discussion about the accuracy, thoroughness, and clarity of the information presented. Encourage other participants to ask any questions they may have. In addition, immediately after each presentation, make sure to correct any factual inaccuracies and add important pieces of information that may have been omitted.
8. After all of the teams have presented on all of their topics, refer the participants back to Message No. 8 of the key messages (Appendix C, page 88) and facilitate a large-group discussion based on the key discussion questions below.
 - * After viewing all of the different types of presentations, which techniques did you find helpful for conveying the information?
 - * What are some of the cultural challenges of or barriers to promoting exclusive breastfeeding in your community?
 - * How can we feel more prepared to respond to pregnant and postpartum clients' inevitable concerns and questions about safer infant feeding practises?
 - * How can the media become involved in promoting breastfeeding and use of breast milk in your community through various communication channels?
 - * How would you respond to pregnant and postpartum women when they raise issues associated with maintaining infant feeding options if you are unsure of the topic or do not know enough about it?
9. Provide the participants with a summary of the essential ideas to convey.

Be sure to cover the following points in your overview of safer infant feeding practises:

Between 5% and 20% of all infants born to HIV-positive mothers become infected during breastfeeding.

Breastfeeding is associated with better nutrition and fewer infections. In resource-constrained settings, failure to breastfeed an infant during the first two months of life is associated with a six-fold increase in mortality due to infectious diseases.

In many countries where HIV prevalence is high, uninfected women may think that they have the virus. In the absence of breastfeeding promotion, such women may stop breastfeeding, even though breastfeeding remains one of the most effective strategies for improving their infant's health and chances of survival.

In some countries, cultural beliefs that breastfeeding is an inferior method of infant feeding pose barriers to women's exclusive breastfeeding.

United Nations (UN) guidelines state that “when replacement feeding is acceptable, feasible, affordable, sustainable, and safe [see below], avoidance of all breastfeeding by HIV-infected mothers is recommended.”

Definitions from UN Guidelines

These terms should be adapted in the light of local conditions and formative research. The following may serve as a starting point:

Acceptable: The mother perceives no barrier to replacement feeding. Barriers may be cultural or social, or may relate to fear of stigma or discrimination. According to this concept, the mother is under no social or cultural pressure not to use replacement feeding; she is supported by family and community in opting for replacement feeding, or she will be able to cope with pressure from family and friends to breastfeed; and she can deal with possible stigma attached to being seen with replacement food.

Feasible: The mother (or family) has adequate time, knowledge, skills, and other resources to prepare replacement food and feed the infant up to 12 times in 24 hours. According to this concept, the mother can understand and follow the instructions for preparing infant formula and, with support from the family, can prepare enough replacement feeds correctly every day and at night, despite disruptions to prepare family food or for other work.

Affordable: The mother and family, with community or health system support, if necessary, can pay the cost of purchasing/producing, preparing, and using replacement feeding, including all ingredients, fuel, clean water, soap, and equipment, without compromising the health and nutrition of the family. This concept also includes access to medical care, if necessary, for diarrhoea and the cost of such care.

(continued)



Definitions from UN Guidelines (*continued*)

Sustainable: Availability of a continuous and uninterrupted supply and dependable system of distribution for all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, up to one year of age or longer. According to this concept, there is little risk that formula will ever be unavailable or inaccessible, and another person is available to feed the child in the mother's absence and can prepare and give replacement feeds.

Safe: Replacement foods are correctly and hygienically prepared and stored, and fed in nutritionally adequate quantities, with clean hands and using clean utensils, preferably by cup. This concept means that the mother or caregiver:

- Has access to a reliable supply of safe water (from a piped or protected well source)
- Prepares replacement feeds that are nutritionally sound and free of pathogens
- Is able to wash hands and utensils thoroughly with soap and to regularly boil the utensils to sterilise them
- Can boil water for at least 10 minutes for preparing each of the baby's feeds
- Can store unprepared feeds in clean, covered containers and protect them from rodents, insects, and other animals

Source: WHO, UNICEF, UNAIDS, and UNFPA. 2003. *HIV and infant feeding: A guide for health care managers and supervisors*. Geneva. p. 25.

Infant Feeding Guidelines

For HIV-negative mothers and mothers whose HIV status is unknown:

- Exclusive breastfeeding is recommended for the first six months of life, to ensure achievement of optimal growth, development, and health. Afterwards, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.
- The availability and use of voluntary counselling and testing for women whose status is unknown should be promoted.

For HIV-positive mothers who are considering their feeding options:

- Where mothers are using combinations of antiretrovirals for treatment, the infant feeding recommendations in this document still apply.
- When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, HIV-positive mothers are recommended to avoid all breastfeeding.
- When replacement feeding does not meet the above criteria, exclusive breastfeeding is recommended for the first months and should then be discontinued as soon as similar conditions are met. (This would normally imply the same conditions as for replacement feeding from birth—that is, that it is acceptable, feasible, affordable, sustainable, and safe.)
- Counsel clients on infant feeding options, including:
 - **Mixed feeding:** Feeding both breast milk and other foods or liquids (Studies suggest that exclusive breastfeeding during the first few months of life may be associated with

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Facilitator's
Resource

Safer Infant Feeding Practises

a lower risk of HIV transmission than is mixed feeding. Research is in progress to clarify this issue. Exclusive breastfeeding during the first 4–6 months of life carries greater benefits for the infant than does mixed feeding with respect to morbidity and mortality from infectious diseases other than HIV.)

- **Commercial infant formula:** A specially formulated powdered milk that is made specifically for infants and sold in shops and stores or provided by programmes to prevent HIV transmission to infants
- **Home-modified animal milk:** Fresh or processed animal milk that has been modified by the addition of water, sugar, and micronutrient supplements (Any water added should be boiled, regardless of its source.)
- **Exclusive breastfeeding:** The practise of providing only breast milk and no water, other liquids, or food, except prescribed medicine, to the baby for the first months of life
- **Wet-nursing:** The practise of having another woman breastfeed a baby—in this case, a woman who has tested as HIV-negative
- **Expressing and heat-treating breast milk:** The practise of removing milk from the breasts manually or with a pump, then heating it to kill HIV
- **Breast-milk banks:** Places where donor milk is pasteurised and made available for infants
- **Early cessation:** Helping the mother with transitioning from breastfeeding to replacement feeding by cup, using commercial or home-prepared infant formula

Note: For a more detailed presentation of the benefits and challenges of the above infant feeding options, see: WHO. 2004. *HIV and infant feeding: Guidelines for decision-makers*. Geneva.

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Facilitator's
Resource

Safer Infant Feeding Topics

- What kind of information about infant feeding practises should be made available for pregnant women accessing services at your facility?
- What are some of the cultural and social factors influencing pregnant and postpartum women's choices regarding infant feeding options?
- How can pregnant and postpartum women reduce the risk of transmitting HIV to their children through safer infant feeding practises?
- What community resources exist for safer infant feeding practises?
- What are some of the ways in which pregnant and postpartum women can communicate with their partners and families about safer infant feeding practises?
- What are the benefits for the child and the mother of exclusively breastfeeding for first six months? (Even though it may not be feasible in most settings, it is still important for providers to know the benefits of exclusive breastfeeding so they can counsel women about them.)
- What are some qualities of a good infant feeding counsellor?
- How can the media be involved in increasing coverage of and awareness about safer infant feeding practises?
- What is the role of infant feeding counselling in improving breastfeeding practises?
- What role can group discussions or support groups play in improving breastfeeding practises?
- What does the word "safer" mean in the expression "safer infant feeding practises"?

What Is Dual Protection and Why Talk about It with Pregnant and Postpartum Women?

11

Objectives

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

- Explain dual protection
- Describe at least three challenges of counselling pregnant and postpartum women on dual protection

Essential Ideas to Convey

- Dual protection can be defined as a strategy for preventing both transmission of HIV and other 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 unsafe sex.
 - Women's vulnerability for becoming infected both with HIV and with other STIs increases in the postpartum period.
 - Dual-protection can meet postpartum women's needs for protection against unintended pregnancy as well as infection with HIV or other STIs.
 - In some cases, postpartum clients may opt to use dual methods (i.e., condoms plus another family planning method), and providers can avoid stigmatising condoms as being a less-effective family planning method or a method solely for infection control.
 - When used consistently and correctly, condoms can be a highly effective family planning method, as well as the only method that is highly effective against the transmission of HIV and other STIs. To learn how to protect themselves effectively, pregnant and postpartum women need to have hands-on training in how to use condoms correctly.
 - Dual-protection counselling does a better job of meeting postpartum women's needs than traditional family planning counselling because clients also need protection from HIV and other STIs.
 - Dual-protection counselling upholds the concept of informed decision making by ensuring that pregnant and postpartum women are knowledgeable about and aware of their risks for HIV and other STIs and for unintended pregnancy while making family planning decisions.
 - Postpartum women are not making truly informed decisions about family planning unless they are aware of their risks for HIV and other STIs and are knowledgeable about how effective the various family planning methods are in preventing infection with HIV and other STIs. Dual-protection counselling ensures that postpartum clients are aware, knowledgeable, and informed.
-

Time

1 hour, 30 minutes

Materials

- Facilitator’s Resource: Dual-Protection Role-Play Scenarios (pages 54–55)
- Participant Handout: Introduction to Dual Protection (pages 102–103)
- Flipchart paper
- Markers
- Masking tape

Advance Preparation

1. Prepare a flipchart with the definition of dual protection provided in the Participant Handout: Introduction to Dual Protection (pages 102–103).
2. Make a copy of the Facilitator’s Resource: Dual-Protection Role-Play Scenarios (pages 54–55), and cut it into strips—one strip for each client and provider scenario.
3. Review the scenarios, and select two to three role plays from it. Keep the client and provider strips for each of the selected scenarios, for distribution to the role-play participants.

Training Steps

1. Introduce the activity by telling the participants that they will be exploring the concept of “dual protection” and thinking about ways to work with pregnant and postpartum women on meeting their needs for dual protection.
2. Present the group with the flipchart showing the definition of dual protection:

Dual protection can be defined as a strategy for preventing both transmission of HIV and other 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 unsafe sex.

Briefly present the elements of dual protection covered in the participant handout. Answer any questions that the group may have at this point, and distribute the handout.
3. Let the participants know that they will be doing role plays to practise the skills they have gained in previous exercises. Provide the following instructions:
 - In the role play, the role of “counsellor” 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 counsellor.)
 - A volunteer will serve as the first client. This person will be provided with information about the client he or she will be playing (from the relevant “client strip” from the Facilitator’s Resource: Dual-Protection Role-Play Scenarios), and is not to show this information to any of the counsellors.
 - A volunteer with some counselling experience will act as the first counsellor, and this

counsellor will be given the corresponding “provider strip” (which gives very limited information about the client).

- Once the role play is underway, it will be stopped at some point for another participant to step in as the counsellor (with the client remaining the same). The counsellor can also ask for help if he or she wishes, and another counsellor will step in.
 - The participants should draw upon their experience and/or any counselling models that they are familiar with or already use.
 - While the counsellors are practising in the front of the room, the other participants need to pay attention to what has been covered and to what questions have not yet been asked.
4. After a set period of time (around three minutes), stop the session momentarily and select a new counsellor to take over where the first one left off. Continue to stop and start until three to five counsellors have had a turn, keeping the same “client.”
 5. Switch role plays, selecting a new client scenario and a volunteer to serve as the second “client” with a new “counsellor.” Repeat step 3 above, and do additional client scenarios if time and interest permit.
 6. Lead a discussion of the following key discussion questions:
 - * For those who played the counsellor, what were the most challenging aspects of doing a practise session on integrated dual-protection counselling? What aspects did you feel most comfortable with, and why?
 - * Why is it important to integrate a wide range of reproductive health issues in a counselling session, even if the client says he or she came in for one specific reason?
 - * What obstacles to providing dual-protection counselling might come up in your clinic setting? How could you try to overcome these obstacles?
 7. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

When doing these role plays, it is best to allocate as much time as possible—an entire morning or afternoon, for example. While there are several sample role-play scenarios, it is likely that you will only get through one or two in the time allowed. Do not worry if this is the case.


Scenario 1: Client

You are a 35-year-old married woman who had a baby two months ago. You know that your husband wants to resume sexual relations as soon as possible. You have four children and you think that you probably do not want to have another child. You are very religious and active in your religious establishment. Your husband travels frequently for work and you suspect that he has other partners. You are very concerned about STIs, including HIV, because you know other married women like you who have gotten infected. You do not really want to discuss your fears with the provider, but you just might if the provider makes you feel comfortable.

Scenario 1: Provider

A 35-year-old woman has come to see you. She is married and just had her fourth child. She has been using the IUD for birth control and appears to be satisfied with the method. She seems nervous and upset. Why has she come to see you? Your task is to find out if there is anything else she would like to talk about besides birth control.

Scenario 2: Client

You are a 22-year-old woman who has been married for four years. You have two young children and recently found out that you are pregnant again. You know that your husband has other partners, and you have recently convinced him to use condoms as a form of birth control because you told him that you want to wait a while to have another child. You and he are still having sexual relations, even though the cultural practise is to abstain during pregnancy. The real reason you used condoms before you got pregnant was to protect yourself from STIs. Since you have been using condoms, however, your husband has been having problems during sex. He now refuses to use condoms since you got pregnant, because there is no danger of your getting pregnant. You are confused and worried about whether you should be having sex at all until after your baby is born. If you are going to continue having sex with him, you really would like him to use condoms, though. You would like to talk about this with the provider, but you are afraid. If the provider makes you feel comfortable, you will discuss your concerns.

Scenario 2: Provider

A 22-year-old woman has come to see you. She is married and has two young children. She is four months pregnant. She and her husband had been using condoms as their method of contraception until she got pregnant. Why has she come to see you? Your task is to find out why she has come to the clinic and to address any concerns that she may have.



Dual-Protection Role-Play Scenarios

Scenario 3: Client

You are a 30-year-old married woman and gave birth to your third child one month ago. You have been breastfeeding the newborn and have not been interested in having sexual relations since the baby was born. Your husband, however, has been forcing you to have sexual relations against your will. You are very upset about your husband's behaviour, but you cannot talk to him or to anyone about it because you think it is your own fault. You have come to the clinic seeking treatment for vaginal irritation and will only reveal the full story if you feel comfortable with the provider.

Scenario 3: Provider

A 30-year-old married woman comes to you complaining of vaginal irritation. She has three children, including a one-month-old infant whom she is breastfeeding. You have conducted a physical exam and find no signs of disease. She seems very shy and nervous. Your task is to determine what is going on with her and to address any concerns that she may have.

Scenario 4: Client

You are a 48-year-old married man who came to the clinic to ask for something to protect against HIV, but you do not want to use condoms. You are having sexual relations with women outside your marriage and you are concerned about getting infected and infecting your pregnant wife. You have tried condoms but do not want to use them and are reluctant to explain that the problem really is interference with sexual performance due to condom use.

Scenario 4: Provider

A 48-year-old married man, who is the partner of one of your pregnant clients, comes to you for protection against HIV. He does not want to use condoms, but is reluctant to say why. Your task is to find out why.

Condom Negotiation

12

Objectives

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

- Describe at least three reasons that pregnant and postpartum women and their partners might avoid condom use
- Explain how to develop effective responses to persuade pregnant and postpartum women and their partners to use condoms
- Describe at least three ways in which to help pregnant women respond to common excuses that partners might give for not wanting to use condoms

Essential Ideas to Convey

- Emphasise to the group that this is just a game with quick retorts that pregnant and postpartum women can try to use with their partners.
 - Pregnant and postpartum women and their partners think of many excuses for not wanting to use condoms. These can include personal preferences about what is pleasurable, lack of correct information about transmission and prevention of HIV infection and STIs, negative associations attached to condoms, challenges in resuming intimacy following a period of abstinence or decreased sexual activity, a wish to assert power, and the desire to become pregnant or cause a pregnancy.
 - The desire to remain in a relationship or to adhere to certain societal norms may outweigh a pregnant or postpartum woman's intentions to use condoms. Therefore, it is important not to minimise any of these excuses for the client. Expect that clients may have difficulty using the response lines developed during the game when they actually negotiate safer sex with partners.
 - Good communication in relationships is important for negotiating condom use. However, some people, particularly women, may not have the power in a relationship to insist on condom use with a partner. In fact, insisting on condom use can result in violence or other negative responses.
 - Do not expect pregnant and postpartum clients to use condoms consistently immediately. There may be many reasons for difficulty in using condoms consistently that have nothing to do with the woman. For example male partners may have an erectile dysfunction that is exacerbated by the use of condoms.
 - Providers can promote the female condom as an alternative to the male condom. Whenever possible, provide samples of the female condom and distribute printed information clients can take away with them.
-

Time

1 hour, 30 minutes

Materials

- Participant Handout: Responding to Excuses for Not Using Condoms (pages 104–105)
- Flipchart paper
- Markers
- Masking tape
- Bells
- Prizes (optional)

Advance Preparation

1. Obtain two or three bells or other signals, one for each team to use.
2. Buy some prizes to distribute during the game (optional).

Training Steps

1. Divide the participants into at least two (but no more than three) teams. Ask them to choose a name for their team; if they cannot think of anything or do not wish to, simply label them teams 1, 2, and 3.
2. On a flipchart, write out the team names, for the purpose of keeping score.
3. Let the group know that you will be reading a common phrase that pregnant and postpartum women might say when they do not want to use condoms. Their job, as a group, is to come up with a fast, effective response to the phrase. The first group to come up with a response should ring the bell provided or should shout out an agreed-upon word or phrase (such as “Got it” or “Done”). That small group should then share its response with everyone.

Scoring is as follows: The first group that responds gets one point for being the first to respond. Then ask the other group(s) for their responses. The one with the best response of the three receives two additional points. (The “best” response can be determined by audience cheering, through facilitator choice, or by other means.)

4. Using the “excuses” listed in the Participant Handout: Responding to Excuses for Not Using Condoms, play the game for at least 15 minutes. Then tabulate the scores and provide prizes to the first-place and second-place (and, if applicable, third-place) teams (optional).
5. Bring the teams back into one larger group. Distribute the Participant Handout: Responding to Excuses for Not Using Condoms and review it with the group. Highlight any responses that may not have been shared during the activity. Ask if the participants can think of any additional excuses that pregnant and postpartum women may have for not wanting to use condoms. Suggest that for future reference, the participants should write on their sheets the additional excuses and ideas for responses that they came up with during the game.

6. Lead a discussion based on the key discussion points below:
 - * What did you learn from doing this activity?
 - * Do you think pregnant and postpartum women could use these responses? Why or why not?
 - * In what ways do you think you might be able to use this exercise with your own pregnant or postpartum clients?
 - * What alternatives to using male condoms do pregnant and postpartum women have?
7. Provide the participants with a summary of the essential ideas to convey.
8. Refer participants to other resources on negotiating condom use. One excellent resource is: UNAIDS Interagency Task Force on Condom Programming for Prevention of HIV/AIDS. 2004. *Myths, perceptions, and fears: Addressing condom use barriers*. Geneva: UNAIDS.

Condom Use (Female and Male)

13

Objectives

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

- Explain the importance of communicating effectively with pregnant and postpartum clients about how to use female and male condoms correctly
- Demonstrate on a model the correct steps for using female and male condoms effectively
- Describe at least three common errors in condom use and how to correct them

Essential Ideas to Convey

- All clients should be educated about the dual-protection effects of condom use. The condom is still one of the most effective weapons against transmission of STIs, including HIV. When used correctly and consistently, it is also one of the most effective ways to prevent or delay pregnancy.
- Although negotiation between partners about condoms may be difficult or sensitive, providers with good skills in counselling either individuals or couples can help clients learn how to communicate about the benefits of condom use.
- It is important for providers of maternal health care to have skills in promoting and demonstrating correct condom use, especially given that most condom failure is due to improper use rather than flaws in the method itself.
- To explain condom use properly, it is important for providers to have experience with putting on a condom correctly. It is also important to talk to clients about condom failure, the most common reasons for it, and how to prevent it.
- In the event of condom failure, if a woman is concerned about pregnancy, instruct her to obtain emergency contraception (if available). If a man or woman is concerned about possible exposure to HIV or an STI as a result of condom failure, counsel him or her about such options as having an HIV test.
- Emphasise to clients that practise improves the correct use of condoms. Make sure that you are watching as clients use penis or pelvic models to practise putting on condoms, so you can encourage them and correct their mistakes.
- The postpartum period is a critical time in which women should consider using condoms, even if they have never used them before, due to the increased risk of HIV infection related to abstinence during pregnancy and the possible involvement of male partners with other sexual partners. Women may also be at greater risk biologically due to vaginal lesions and abrasions following delivery.
- After months of abstinence, many women will be dealing with intimacy issues related to resuming sexual relations with their partners. If using a condom adds yet another issue with which they must deal, this may complicate the resumption of intimacy with a partner and women may need extra support from counsellors and providers during this period.

- If the female condom is available, pregnant and postpartum women should know how to use it and should be encouraged to consider it as an alternative to the male condom. The female condom can be promoted as an option over which the woman may have more control than she has with the male condom.
 - The female condom is a good option for dual protection in relationships during the postpartum period when partners want to avoid both pregnancy and HIV/STIs, particularly if a male partner is less willing to use a male condom.
 - The female condom is a brand new concept to many clients. As with anything new, it is important to encourage them to try the female condom more than once, especially if they find insertion difficult or if they do not like how it looks at first.
 - For some women, the female condom offers a barrier method option that they can control (i.e., they can insert it themselves, as opposed to relying on the man to put on a condom). However, some studies have shown that the challenges women face in negotiating male condom use with their partners remain the same for the female condom. In counselling about female condom use, providers should help their female clients improve their communication and negotiation skills with male partners.
-

Time

2 hours

Materials

- Facilitator's Resource: Steps to Correct Use of the Male Condom (page 65)
- Participant Handout: Reducing Errors in Condom Use (pages 106)
- Participant Handout: Female Condom Overview (page 107)
- Participant Handout: Instructions for Using the Female Condom (page 108)
- Flipchart paper
- Writing paper
- Markers
- Masking tape
- Pens or pencils
- Enough female and male condoms for the number of participants
- Tissues for wiping the lubrication off the condoms
- Penis models (or substitutes, such as cucumbers, bananas, wooden sticks with a rounded end, etc.)
- Pelvic model (if available)
- A basket or envelope from which the participants can pull out written instructions

Advance Preparation

1. Obtain a plastic pelvic model and penis models, if available.
2. Obtain female and male condoms.

- Write the 13 steps to correct condom use, plus hints, on a flipchart. (See Facilitator’s Resource: Steps to Correct Use of the Male Condom, page 65.)

Note: The section of this session on male condom use was adapted from: Stacey, L. No date. Integrating STDs and AIDS services into family planning programs: Training community workers. Washington, DC: CEDPA.

Training Steps

- Divide the participants into five groups.
- Give each group writing paper and pens or pencils.
- Explain to the groups that they are going to participate in an activity in which they will discuss the correct steps for using a male condom effectively. While they are doing the exercise, they will also take turns practising proper condom use on a penis model. The goal of this exercise is to help them feel comfortable about discussing condom use with clients and about instructing clients on how to use condoms correctly.
- Give each group condoms and a penis model and tell them they will have 30 minutes to complete the following instructions:
 - Ask each group to make a list, in the proper order, of the steps that they think are necessary in correct condom use. Tell them that there are at least 13 steps. Give them a clue by informing them that the first step is “Check the manufacturing date on the condom to make sure that the condom is not expired.”
 - Ask them to write their instructions, with the numbered steps, as clearly and legibly as possible on the paper.
 - Ask them to take turns playing the role of the “counsellor,” demonstrating and explaining to the “client” how to put a condom on a penis model correctly, using the instructions on the flipchart. Tell the “clients” to ask questions if the instructions are vague or unclear.
- Walk around the room and monitor the participants as they practise to make sure they are taking turns.
- After 30 minutes, collect their written instructions, put them into a basket or envelope, and mix them up. Go around to each group and have one representative select a set of instructions out of the basket or envelope. If the instructions chosen are those created by that particular group, instruct the representative to return them and to select another set.
- Ask one group at a time to take turns following the set of written instructions that they have selected. Instruct each group to select a volunteer who will physically follow the instructions by placing the condom on the penis model, based on cues from the other members of the group who will read the instructions out loud. Each group will select one member to read the instructions to the participant who is conducting the demonstration. The other members of the group will help tell the volunteer what to do. Make sure to inform the participants that they should follow the instructions *as written* and do not alter them, even if they disagree with the order of steps or specific instructions.

8. After all of the groups conduct the demonstration, review what each group did correctly and make suggestions for improving the quality of the demonstrations.
9. Display the flipchart with the correct 13 steps plus helpful hints. Either ask a volunteer to conduct a demonstration based on these instructions, ask the entire group to individually do a demonstration (with models, fingers, or other implements), or conduct the demonstration yourself.
10. Ask the participants to brainstorm everything that they have heard about the female condom. Write these comments on the flipchart. Once they are done, provide a brief lecture on the female condom, using the Participant Handout: Female Condom Overview. Be sure to correct any misinformation that may have been mentioned.
11. Distribute the female condoms to everyone (or to pairs, if there are not enough female condoms for each person to have one). Using the Participant Handout: Instructions for Using the Female Condom (and the female pelvic model, if available), demonstrate how the female condom is inserted.
12. Invite the participants, if they feel comfortable, to open their female condoms and practise squeezing the flexible ring. Distribute tissues or towels so they can wipe the lubricant from their hands. Answer any questions they may have.
13. Facilitate a large-group discussion based on the following points:
 - * How does this experience give us insight into the feelings that pregnant and postpartum women may feel when using condoms for the first time?
 - * What fears or concerns do you have about demonstrating proper condom use to a pregnant or postpartum client? How can we address these?
 - * What are some of the most common mistakes people make when using condoms?
 - * How can we help pregnant women feel more comfortable with handling condoms and practising putting them on a penis model or inserting them in a pelvic model?
 - * What are some of the issues that may arise for pregnant women on using condoms postpartum?
 - * How likely do you think it is that your clients will be able to use a female condom?
 - * What are some of the ways in which you might be able to address clients' concerns and discomfort about the female condom?
 - * How easy do you think it will be for your clients to use the female condom with their partners? What barriers might they face? What are some of the advantages to their using it?
 - * How would you communicate with clients about the female condom's being a good method of dual protection (i.e., protection against unintended pregnancy and against HIV and STIs)?
 - * How did it feel to try to follow the instructions for using either the male or female condom?
14. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

Some participants may be uncomfortable with talking about or working with condoms. You may find it useful to conduct an exercise to desensitise the issue.



Steps to Correct Use of the Male Condom

Hint: Make sure condoms are stored properly and obtained from a good source.

1. Check the manufacturing or expiration date on the package.
2. Remove the condom from the package.

Hint: Do not use teeth or sharp objects to open the condom package.
3. Unroll the condom slightly to make sure it unrolls properly.
4. Place the condom on the tip of the erect penis.

Hint: If the condom is initially placed on the penis backwards, do not turn it around; throw it away and start with a new one (because some preejaculate may be on the condom).
5. Squeeze the air out of tip of the condom.
6. Unroll the condom down the penis.
7. Smooth out the air bubbles.
8. With the condom on, insert the penis for intercourse.
9. After ejaculation, hold onto the condom at the base of the penis while withdrawing the penis.
10. Withdraw the penis while it is still erect.
11. Remove the condom from the penis.
12. Tie the condom to prevent spills or leaks.
13. Dispose of the condom safely.

Objectives

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

- Explain the principles and practises of universal precautions to prevent transmission of HIV and other STIs in health care and home care settings during pregnancy and post-partum.
- Demonstrate at least one universal precaution in detail.

Essential Ideas to Convey

- Universal precautions are simple infection control measures that reduce the risk of transmission of bloodborne 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.
- Universal precautions involve washing hands and wearing gloves, eye protection or face shields, and gowns, when appropriate; safely handling and disposing of needles; safely handling sharp instruments; correctly processing instruments used in clinical procedures; safely disposing of contaminated waste materials; handling, transporting, and processing used or soiled linen correctly; and preventing injuries with needles and other sharp instruments.
- Universal precautions in the home and community are the same as those followed in the health care setting. It is also important that health care staff teach family members and other lay health practitioners about these precautions.
- Many women deliver at home and rely on midwives or traditional birth attendants to assist them. Clean home delivery kits are now available for safer home births.

Time

1 hour, 30 minutes

Materials

- Participant Handout: Overview of Universal Precautions (pages 109–112)
- Flipchart paper
- Markers
- Masking tape
- Supplies for demonstrating universal precautions

Advance Preparation

1. Prepare a flipchart with the definition of universal precautions from Participant Handout: Overview of Universal Precautions
2. On flipchart paper, write the following list:
 - Washing hands
 - Wearing gloves
 - Using eye protection
 - Wearing protective clothing
 - Processing instruments
 - Handling needles and other sharp instruments
 - Practising environmental cleanliness and disposing of wastes
 - Handling and processing linen

Training Steps

1. Introduce this session by asking the group to define universal precautions. Summarise the various definitions offered by the group by presenting the definition from the Participant Handout: An Overview of Universal Precautions:

“*Universal precautions* are simple infection control measures that reduce the risk of transmission of bloodborne 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. 2003. *Universal precautions, including injection safety*. Geneva. Retrieved at: <http://www.who.int/hiv/topics/precautions/universal/en/> on October 3, 2003)
2. Tell the participants that they will be reviewing essential universal precautions during pregnancy, labour and delivery, and postpartum by focusing on specific issues or areas within the health care setting and in home care.
3. Explain that home care can include health care workers’ going to clients’ homes, family members providing care to their loved ones, or traditional health care providers, such as traditional birth attendants, working in the home.
4. Divide the participants into four small groups. Assign groups 1 and 2 universal precautions in the health care setting, designating group 1 to address the first four items on the list in the Participant Handout and group 2 the remaining items. Assign groups 3 and 4 universal precautions in the community and home care setting, designating group 3 the first four items on the list and group 4 the remaining items.
5. Instruct the groups to brainstorm all of the universal precaution issues that need to be taken into consideration related to the items on the list for the setting they were assigned. For each item on the list they are assigned, each group should answer the following questions:
 - What are the proper universal precautions?

- How do they protect against HIV infection?
- What are the challenges to implementing universal precautions consistently and correctly and how can we overcome them?

If infection control supplies are readily available, have them on hand, and ask each group to properly demonstrate at least one of the universal precautions from their list during their report back. Try to ensure that each group demonstrates a different universal precaution.

6. Instruct each group that they have 30 minutes for their discussion and that they should select a person to record responses and report back to the large group. Ask them to also select other people from the group who will demonstrate the ideal universal precautions as their group member reports back.
7. Reassemble the large group and have each small group present their report. Allow 10 minutes for each group to report back.
8. Guide the discussion by validating correct content, correcting inaccurate content, and expanding where content is missing.
9. Display the prepared flipchart and questions and review with the group the list of categories of universal precautions for both health care settings and home-based care (below).
 - Washing hands
 - Wearing gloves
 - Using eye protection
 - Wearing protective clothing
 - Processing instruments
 - Handling needles and other sharp instruments
 - Practising environmental cleanliness and disposing of wastes
 - Handling and processing linen
10. Lead a discussion covering the following key discussion points:
 - * What are the challenges to implementing proper infection control practices in a resource-constrained setting?
 - * What other precautions can health care providers take during labour and delivery?
11. Provide the participants with a summary of the essential ideas to convey.

Safer Delivery Practises

15

Objectives

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

- Explain the clinical practises during labour and delivery that decrease the risk of HIV infection from an HIV-positive mother to an infant
- Describe at least three ways to safely manage labour and delivery in HIV-positive women and women of unknown HIV status

Essential Ideas to Convey

- Adherence to standard practises for childbirth and to procedures that reduce foetal contact with maternal blood and secretions can reduce the risk of mother-to-child transmission (MTCT) in facility-based and home-based births.
- Consistent and correct application of universal precautions, regardless of the client's known or perceived HIV status, will protect clients and health care providers from HIV and other bloodborne infections (see Session 14: Universal Precautions).
- Prolonged labour increases the foetus's exposure to maternal blood and infected secretions, and therefore should be avoided, as it may increase the risk of MTCT.
- MTCT risk may increase with prolonged membrane rupture or artificial rupture of the membranes.
- Invasive procedures such as foetal monitoring, use of episiotomies, or the use of forceps or vacuum extractors may increase the risk of MTCT by exposing the foetus to maternal blood and secretions.
- Blood transfusions should be avoided, but if one is required, ensure that the blood supply has been screened for HIV and, if possible, other infectious agents.
- Caesarean section is associated with a reduced risk of MTCT when performed before the onset of labour or membrane rupture (WHO. 2004. PMTCT—Generic training curriculum: Participant guide. Draft. Geneva). In resource-constrained settings, elective caesarean section may not be feasible or safe and may increase the risk of complications.

Time

30 minutes

Materials

- Participant Handout: Overview of Safer Delivery Practises (page 113)

Training Steps

1. Tell the participants that you will provide them with some basic information about safer delivery practises, and that this will be followed by a large-group discussion.
2. Give the participants a short presentation on safer delivery practises to reduce the risk of MTCT. Cover the points in the Participant Handout: Overview of Safer Delivery Practises (page 113).
3. Lead a large-group discussion covering the following key discussion points:
 - * What clinical practises during labour and delivery decrease the risk of MTCT?
 - * What key prevention strategies for reducing MTCT during labour and delivery can you implement in your setting?
4. Provide the participants with a summary of the essential ideas to convey.

Providing Male-Friendly Services

16

Objectives

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

- Explain the importance of male involvement in reducing women’s vulnerability to infection with HIV
- Describe at least three potential barriers to accessing services that men might encounter, and ways of overcoming these barriers

Essential Ideas to Convey

- The perspective of male clients can easily be forgotten and needs to be a central consideration when providing HIV and STI services for pregnant and postpartum women.
- Enlisting men to prevent HIV infection is an important part of the response to change the course of the epidemic. Involving men in HIV prevention is about more than just preventing HIV or about increasing men’s access to HIV services. It also entails raising men’s awareness about gender inequities.
- It is important to encourage men’s involvement in family planning and reproductive health, so men adopt safer sex practices and prevent unintended pregnancies.
- The facility’s physical appearance and/or client flow can communicate subtle messages to men about the way services are delivered.
- Current maternal health services can benefit from staff’s looking at their facility’s systems and procedures with “fresh” eyes, or from the perspective of the male client.

Time

1 hour, 30 minutes

Materials

Participant Handout: Facility Walk-through Checklist (pages 114–115)

Training Steps

1. Referring the participants to the Participant Handout: Facility Walk-through Checklist, lead them on a walk through the facility and provide the following instructions:
 - Ask each to look around as if he or she were a male client coming to the facility for the first time.

- Using the checklist as a guide, ask him or her to assess how the facility would appear to such a client, by observing the following:
 - Physical environment (e.g., colours, pictures, furniture)
 - Appearance of cleanliness, efficiency, and professionalism
 - Client education materials and condoms on display
 - Specific items that address the needs of men
 - Reading materials or items for male clients to pass the time while waiting for an appointment
 - Any indicators of attitudes that might be considered hostile towards male clients or insensitive to their needs
 - Signage pertaining to male-friendly services available at the site and the cost of these services
 - Ask the participants to point out examples of low-cost changes that could easily be made (e.g., posters) and more expensive changes that might not be feasible to change in some settings (e.g., furniture).
2. Allow 30 to 45 minutes for the walk-through, and reconvene the group in the main meeting area.
 3. Facilitate a large-group discussion for the participants to share their observations, using the following key discussion points:
 - * What did you observe under each of the items discussed at the beginning of the exercise?
 - * What actions can you identify to address any of the problems that you have identified?
 - * What actions can you take if you have limited resources for implementing male-friendly services?
 - * How does providing male-friendly services reduce pregnant and postpartum women's vulnerability to HIV?
 4. Provide the participants with a summary of the essential ideas to convey.

Considerations for the Facilitator/Training Options

If all of the participants are female, try to arrange to have two to six men join them during the walk-through. These individuals may include other staff members, advisory board members, or spouses or adult children of the participants.

You may conduct the walk-through with all of the participants in one large group or, if you can, you may break the participants into small groups of 5 to 10 people. If using small groups, vary the composition, if possible, by mixing men and women, individuals of various ages, and frontline and clinical staff.

When visiting different service areas at the facility, it is important that the participants do not judge the work of their colleagues. This is an assessment and not an evaluation of services. It is important to remind participants that they are looking at systems and processes and not at individuals during the walk-through.

Applying the Key Prevention Messages

17

Objectives

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

- Explain at least three ways to incorporate the key messages, introduced in Session 3, into their day-to-day work
- Describe at least three benefits of integrating HIV and AIDS prevention interventions into maternal health services

Essential Ideas to Convey

- Providing clear and accurate information about HIV and AIDS to women, to their male partners, and within communities is a critical component of HIV prevention among pregnant and postpartum women.
- It is important to keep in mind that information alone is insufficient to change behaviour or to change the social context that places women at risk of HIV infection.
- Ideally, HIV and STI information should be integrated with comprehensive sexual and reproductive health counselling as part of an overall maternal health care approach. Women also need to be empowered to reduce their vulnerability to HIV infection and to increase their access to treatment and care.
- Key prevention messages provide the foundation for HIV or STI interventions during pregnancy and the postpartum period. These messages reinforce each another and can be adapted to different settings, as needed. This will depend on, among other things, local resources, epidemiological patterns for HIV and other STIs, and the local cultural, social, and political environment.
- To adapt these key messages to each woman's individual needs, taking into consideration the cultural dimensions, providers should acknowledge her belief system and way of life, adapt information to her learning and communication style and her language, consider a woman's specific interests and concerns regarding life and survival (for herself, her family, and her community), and promote broader acceptance of medical and preventive actions, such as HIV counselling and testing, peer education, and community mobilization.
- There are many benefits to integrating HIV and STI interventions with maternal health services, including building on established relationships with sexually active women, providing HIV and STI services anonymously, and building the skills and capacity of staff in new areas of service provision.

Time

1 hour

Materials

- Participant Handout: Key HIV/STI Prevention Messages for Pregnant and Postpartum Women (pages 88–90) (from Session 3)
- Flipchart paper
- Markers
- Masking tape

Advance Preparation

Display the key messages that were developed by each group in Session 3.

Training Steps

1. Provide an overview of the key prevention messages introduced in Session 3 and compare them with the key messages the participants developed during that session. Be sure to point out the strengths in their key messages, including conciseness, relevance to local content, engaging graphics, etc.
2. Divide the participants into four groups and provide the following instructions:
 - Tell the group they will have 15 to 20 minutes to think of all of the ways to incorporate the key messages into their day-to-day work and how the messages can be adapted for their cultural context.
 - Explain that each group will report back to the larger group and that they should identify a recorder and a presenter.
3. Bring the participants back into the larger group and facilitate their report back.
4. After they complete their report back, facilitate a large-group discussion by using the following discussion points:
 - * How can these key messages be incorporated in HIV and STI prevention efforts for pregnant and postpartum women?
 - * How can these messages be incorporated so they do not cost extra money or a lot of money?
 - * How can the messages be adapted for your cultural context?
 - * What are the challenges or disadvantages of integrating HIV and STI prevention with maternal health care services?
 - * What are the benefits or advantages of integrating HIV prevention with maternal health services?
5. Provide the participants with a summary of the essential ideas to convey.

Objectives

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

- Administered the 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 closed the proceedings

Time

45 minutes

Materials

- Participant Evaluation Form, Appendix B
- Certificates of participation for each participant

Advance Preparation

1. Identify and invite guests for closing ceremony.
2. Make enough copies of Participant Evaluation Form.
3. Prepare a certificate of participation (as appropriate for each setting) for each participant.

Training Steps

1. Distribute the Participant Evaluation Form. Allow the participants 15 minutes to complete it and collect all copies.
2. Conduct a closing ceremony appropriate to the setting. Thank the participants and celebrate the completion of the training.



APPENDICES

Sample Three-Day Training Agenda

Appendix



| Day 1 |
|--|
| Morning |
| <p>Session 1: Climate Setting (45 minutes) Session 2: Values Clarification (1 hour) Break (15 min.) Session 3: Essential Knowledge about HIV/AIDS and Key Prevention Messages during Pregnancy and Postpartum (1 hour) Session 4: HIV and STI Risk Continuum for Pregnant and Postpartum Women (1 hour)</p> |
| Afternoon |
| <p>Session 5: Values and Sexual Behaviour (1 hour) Session 6: Sexuality and HIV Risk during Pregnancy (1 hour) Break (15 min.) Session 7: Pregnant and Postpartum Women’s Vulnerability to HIV and Other STIs (1 hour) Closing (15 min.)</p> |
| Day 2 |
| Morning |
| <p>Checking In: Participants’ insights from the previous day’s sessions (15 min.) Session 8: Voluntary Counselling and Testing for HIV (1 hour) Session 9: Prevention of Mother-to-Child Transmission of HIV (1 hour, 30 minutes) Break (15 min.) Session 10: Safer Infant Feeding Practises (1 hour)</p> |
| Afternoon |
| <p>Session 11: What Is Dual Protection and Why Talk about It with Pregnant and Postpartum Women? (1 hour, 30 minutes) Break (15 min) Session 12: Condom Negotiation (1 hour, 30 minutes) Closing (15 min.)</p> |
| Day 3 |
| Morning |
| <p>Checking In: Participants’ insights from the previous day’s sessions (15 min.) Session 13: Condom Use (Female and Male) (2 hours) Break (15 min.) Session 14: Universal Precautions (1 hour, 30 minutes)</p> |
| Afternoon |
| <p>Session 15: Safer Delivery Practises (30 minutes) Session 16: Providing Male-Friendly Services (1 hour, 30 minutes) Break (15 min.) Session 17: Applying the Key Prevention Messages (1 hour) Session 18: Closing Session (45 minutes)</p> |

Participant Evaluation Form

Appendix

B

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 (page 84), please circle the appropriate number to indicate the degree to which you feel that objective was:

- 5—totally achieved
- 4—mostly achieved
- 3—somewhat achieved
- 2—hardly achieved
- 1—not at all achieved

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

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
Very well
4
Mostly
3
Somewhat
2
Not very well
1
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. _____

Participant Handouts

Appendix

C

| Session | Handout Title |
|----------------|--|
| 3 | Key HIV/STI Prevention Messages for Pregnant and Postpartum Women |
| 4 | HIV/STI Risk Continuum—Additional Considerations for Pregnant and Postpartum Women |
| 8 | Voluntary Counselling and Testing for HIV |
| 9 | Overview of Prevention of Mother-to-Child Transmission of HIV |
| 10 | Overview of Safer Infant Feeding Practises |
| 11 | Introduction to Dual Protection |
| 12 | Responding to Excuses for Not Using Condoms |
| 13 | Reducing Errors in Condom Use |
| 13 | Female Condom Overview |
| 13 | Instructions for Using the Female Condom |
| 14 | Overview of Universal Precautions |
| 15 | Overview of Safer Delivery Practises |
| 16 | Facility Walk-through Checklist |

3 Participant Handout

Key HIV/STI Prevention Messages for Pregnant and Postpartum Women

Message No. 1:

As a pregnant/postpartum woman, you may be at increased risk for HIV and other sexually transmitted infections (STIs).

Some male partners of pregnant or postpartum women may be more likely to have other sexual partners in periods of potentially less-frequent sexual relations, such as during pregnancy and postpartum.

You may be at greater risk postpartum due to vaginal lesions and abrasions following labour and delivery.

Message No. 2:

Your child is at risk of acquiring HIV during pregnancy, labour, delivery, and breastfeeding if you are HIV-positive.

The best way to prevent your child from becoming HIV-positive is by staying HIV-negative yourself through safer sexual practises.

Without intervention, about one-third of infants born to HIV-positive mothers will become infected with HIV.

If you are HIV-positive, there are ways to reduce the risk of transmitting HIV to your children—through safer delivery practises, through counselling and support for infant feeding in the context of HIV, and through use of antiretroviral drugs.

Message No. 3

As a pregnant/postpartum woman, you can reduce your risk of acquiring HIV and other STIs by adopting safer sexual practises, including consistent and correct condom use.

Know how HIV and other STIs are transmitted and how to prevent becoming infected.

Marriage and stable relationships do not automatically protect you from HIV and other STIs, because your partner may have other partners.

Message No. 4

Communicating with your sexual partner is important for preventing HIV and other STIs.

Gain skills to improve communication with your sexual partners about:

- HIV risks during pregnancy and postpartum
- Safer sex practises, such as using condoms and reducing your number of sexual partners
- Benefits of getting tested for HIV

3 Participant Handout

Key HIV/STI Prevention Messages for Pregnant and Postpartum Women

Message No. 5:

When you use condoms consistently and correctly, you can prevent infection with HIV and other STIs and unintended pregnancies.

If you encounter resistance to condom use from your partner, seek relevant prevention counselling services to help you learn to negotiate condom use and become empowered to reduce your vulnerability to HIV.

Message No. 6:

Involving your partner in health care during pregnancy and the postpartum period can help you to discuss HIV/STI prevention and contraception.

Some men may be more receptive to attending health services when their partner is pregnant because they are interested in the health of their family.

Involving your partner in reproductive health, including family planning, can encourage use of safer sexual practises and prevent future unintended pregnancies.

Message No. 7:

Know your HIV status, and consider going for voluntary counselling and testing for HIV to protect your health and the health of your family.

Voluntary counselling and testing for HIV provides HIV prevention counselling to help you learn ways to practise safer sex that will help you and your partner reduce the risk of HIV.

If you test positive for HIV, prevention counselling can help you develop strategies to avoid transmitting HIV to others and can help you get the best treatment, care, and support available.

Message No. 8:

When you are HIV-negative or do not know your HIV status, exclusive breastfeeding for the first six months postpartum is recommended, with the introduction of appropriate complementary foods at about six months.

Exclusive breastfeeding for the first six months of life can help infants achieve optimal growth, development, and health.

For HIV-positive women, replacement feeding is recommended if it is acceptable, feasible, affordable, sustainable, and safe. Otherwise, breastfeeding is recommended for the first few months.

Know your HIV status and make informed decisions about the most appropriate infant feeding options.

3 Participant Handout

Key HIV/STI Prevention Messages for Pregnant and Postpartum Women

Message No. 9:

You have the right to access health services free from stigma and discrimination.

Health care services should be provided regardless of your HIV status, socioeconomic background, gender, age, marital status, occupation, or any other reasons.

Message No. 10:

Inequitable gender relations may result in a lack of power for women to protect themselves from HIV and other STIs.

You can become empowered to exercise your sexual and reproductive health rights, including getting tested for HIV, practising safer sex, and accessing quality health care.



Participant Handout

HIV/STI Risk Continuum—Additional Considerations for Pregnant and Postpartum Women

Biological factors that may increase the risk of HIV and STI transmission for pregnant and postpartum woman:

- A pregnant or postpartum woman with open sores, lesions, or abrasions on the vagina, mouth, or anus is at higher risk of infection with HIV or other STIs if she is exposed to these during unprotected sex.
- A postpartum woman whose genitals were cut during labour or delivery, or who has vaginal lesions following delivery, is at higher risk of infection with HIV or other STIs if she is exposed to these during unprotected sex.
- The tissue lining the rectum is very susceptible to microlesions and tears during anal intercourse, thus creating entry points for HIV and other STIs to enter the bloodstream if that intercourse is unprotected.
- Adolescent girls, whose vaginal tissue is not fully mature, are more likely to develop microlesions during intercourse and are thus at higher risk of becoming infected with HIV and other STIs when they are exposed to these during unprotected intercourse.
- A pregnant or postpartum woman with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if exposed to an STI during unprotected intercourse.
- A pregnant or postpartum woman with advanced HIV disease or AIDS has a higher viral load and thus is more likely to transmit the infection during unprotected sex than is an HIV-positive woman who has a lower viral load.
- An HIV-infected pregnant or postpartum woman who is healthy and well nourished, and who thus has a lower viral load, is less likely to transmit HIV to her infant during pregnancy, labour, or breastfeeding.
- An HIV-infected mother is more likely to transmit the virus to her infant while breastfeeding if she has cracked and bleeding nipples (e.g., mastitis, breast abscess, or nipple fissure).

Why is it important to understand the sociocultural and gender dimensions that influence pregnant and postpartum women's own perceptions of risk and their ability to bring about behaviour change?

- Perceptions about risk are very personal; each pregnant or postpartum woman will have a different attitude about risk in her life.
- Culturally prescribed periods of abstinence or decreased sexual activity between a couple during pregnancy and postpartum can lead to male “extramarital” relations. As a result, these practises increase a woman’s risk of infection once she resumes sexual relations with her partner after childbirth.
- Sexual desire or passion may overshadow thoughts of potential risk.
- Young pregnant or postpartum women are more likely to take risks than are older women, as young people often see themselves as invincible.



- Some pregnant or postpartum women may feel comfortable with engaging in lower risk activities (e.g., having oral sex), while others may not be willing to take any risks.
- Some pregnant or postpartum women may not worry about risk for HIV when they are faced with what they consider more pressing concerns, such as feeding their family, the threat of violence in their community, or exposure to other life-threatening illnesses.
- Some pregnant and postpartum women may recognise risk in their lives but may not be able to reduce the risk (e.g., may not be able to ask their male partners to use condoms).
- Some pregnant and postpartum women may be worried about their risk but are more afraid of the consequences of talking about their sexuality (e.g., fear of being perceived as immoral by their partner(s) or community).
- Greater awareness of our own beliefs and values may ensure that they do not hinder our ability to provide client-centred, quality services to all who need them.

Other factors that may influence a pregnant or postpartum woman's risk perception:

- Lack of knowledge about her partner's risk-taking behaviours (sexual and otherwise)
- Perceptions about the effectiveness of protective measures such as condoms
- A belief that being monogamous is sufficient
- Perceptions of invincibility (particularly among adolescents)
- Perceptions about being or not being in a known “risk group”
- Underestimation of risks related to personal behaviours (despite demonstrated concern about outside threats, such as violence or accidents)

8 Participant Handout

Voluntary Counselling and Testing for HIV

What is an HIV test?

- An HIV test is used to determine whether a person is infected with HIV, the virus that causes AIDS. An HIV test usually involves taking a sample of blood, oral fluid (fluid from the mouth), or urine from a person and then analyzing the sample in a laboratory. Tests look for antibodies to HIV, the HIV organism itself, or antigens (HIV viral proteins).
- The most common HIV tests are more than 99.5% accurate. However, when a person is infected with HIV, his or her body generally does not produce detectable levels of antibodies until about three months (and sometimes up to six months) after infection. (Ninety-six percent of infected individuals develop antibodies within 12 weeks.) During this period of time, called the window period, a person will not test positive for HIV, even if he or she is infected with the virus.
- Anyone who has an HIV test should only do so voluntarily. It is strongly recommended that clients be counselled both before and after taking the test.

What is pretest counselling?

- Pretest counselling provides an opportunity for counsellors and clients to talk about the HIV testing process, the meaning of positive and negative test results, the client's potential HIV risks, ways to reduce HIV risk, and the client's intended plan of action once he or she gets the test result.
- In addition, before the actual test, the counsellor should ensure that the client is getting tested voluntarily and has the information he or she needs to make an informed decision about proceeding with the test.

What is posttest counselling (if the test results are positive)?

- A positive HIV test indicates the presence of HIV antibodies or antigens and means that the person is infected with HIV. Testing positive does not mean that the person has AIDS. Many people who test positive stay healthy for several years, even without treatment.
- If a client tests positive, the counsellor should explain what a positive result means, address the client's emotional response, answer any questions, discuss implications of disclosure, discuss treatment and care options, discuss how the client can avoid transmitting HIV to others, and set up referrals for health care and social support services. A counsellor should also address family planning options, if desired by the client.
- Women who test positive and who are pregnant should be counselled on options available to prevent mother-to-child transmission (MTCT) of HIV. Such women should be referred to programmes specialising in the prevention of MTCT.



What is posttest counselling (if the test results are negative)?

- A negative HIV test result means that no HIV antibodies were present in the person's body at the time of the test. If a person tests negative and has not been exposed to HIV in the past six months, then most likely the individual is not infected with HIV.
- When disclosing a negative test result, the counsellor should explain what the test result means, discuss the window period, indicate whether the client should return for another test, answer any questions the client might have, address the client's emotional response, suggest strategies for remaining HIV-negative, and talk to the client about a personal risk-reduction plan.
- Pregnant and postpartum women with a negative HIV test result should be provided with information on how to stay negative. They should be encouraged and supported at subsequent visits to adopt and maintain risk-reduction strategies.
- Pregnant and postpartum women who tested negative for HIV should also be counselled on the risk of HIV transmission to an infant if they become infected during pregnancy or while breastfeeding.
- Pregnant and postpartum women who tested negative for HIV should also be counselled on sustained and exclusive breastfeeding for infant health.
- Follow-up with postpartum women who are HIV-negative is challenging; such women should be referred to reproductive health and family planning services that can also provide voluntary counselling and testing (VCT). Family planning may represent more of an incentive than HIV counselling for postpartum women to make follow-up visits.

What are some implications of VCT for pregnant and postpartum women?

- A positive HIV test result can lead to isolation and stigma because of misinformation, fear, and prejudice surrounding HIV in the community and society in general.
- In addition to receiving regular pretest and posttest counselling, HIV-positive pregnant woman should be given appropriate information so they can make informed decisions about continuation of their pregnancy and future fertility, about treatment options to prevent MTCT during labour and delivery, and about breastfeeding options.
- Sometimes, women do not receive antenatal care prior to labour. Most women in this situation will not know their HIV status. If rapid testing is available, a woman who is already in labour can learn her HIV status and, if HIV-positive, can receive late antiretroviral prophylaxis to prevent MTCT. In general, it can be difficult to offer adequate counselling, obtain informed consent for testing, or give the results of a positive HIV test to a woman who is in labour.



What are some advantages for pregnant and postpartum women of voluntary counselling and testing (VCT) for HIV?

- If a pregnant and/or postpartum woman takes an HIV test and the result is negative, she can be reassured that she did not have HIV three months before the test and can receive prevention counselling so she remains HIV-negative.
- Some pregnant and postpartum women believe that they will feel better if they know their HIV status, even if they are infected.
- If a pregnant or postpartum woman is infected with HIV, she can prevent infecting her partner and her other children (if she is still breastfeeding) in the future.
- If members of a couple have been practising abstinence during pregnancy and the postpartum period, they may want to be sure that neither has HIV before they resume sexual activities.
- Children born to women who have HIV stand a considerable risk of becoming infected during pregnancy, labour and delivery, and breastfeeding. Therefore, when a pregnant woman learns that she is HIV-positive, she can seek out appropriate treatment and breastfeeding options to prevent MTCT.
- Some pregnant and postpartum women may want to know their HIV status so that if they are infected with HIV, they can make lifestyle changes that will help preserve their health and ensure that they live longer or better lives.
- Male partners of pregnant and postpartum women may be more receptive to couple counselling and testing, given their heightened level of concern for their partner during pregnancy.
- A negative test result may provide relief from worry and may motivate continued commitment to remaining HIV-negative.
- In addition to regular pretest and posttest counselling, VCT ensures that HIV-positive women receive information on appropriate sexual and reproductive health counselling and services.

What are some disadvantages for pregnant and postpartum women of VCT?

- When an HIV test comes back positive, a pregnant or postpartum woman may not be able to handle knowing that she is infected with HIV. Before a pregnant or postpartum woman takes the test, she should think about how she will react to receiving such a result and about delaying the test until she is ready.
- Before providing an HIV test, providers should discuss the possibility of a positive result with the woman. She should be aware of the fact that being HIV-positive carries with it a lot of stigma. In addition, sometimes the children of HIV-infected parents are prevented from going to school.
- Cultural taboos in some countries prohibit women from having sex during pregnancy and postpartum. A woman's moral character and motivations are open to question, she may



be shamed in her community, and there may be potential for violence in the home if she decides to have an HIV test. Before a pregnant or postpartum woman takes the test, she should be aware of the ramifications of some cultural practises.

- HIV has consequences for the person who is tested, beyond that of the diagnosis. The result of VCT will also have implications for the infant, partner, and family of an HIV-positive pregnant woman. Being classified as HIV-positive can lead to isolation and stigma because of misinformation, fear, and prejudice surrounding HIV.
- Research has also shown that when women take an HIV test and their partners or husbands do not, a positive test may lead to the woman's being blamed for introducing the infection into the couple, which sometimes leads to violence or abandonment. Men should be encouraged to test along with their pregnant wife or partner, when feasible. When being tested together, couples will have the support of a counsellor to deal with challenging issues surrounding HIV status within a couple.

Why should male partners of pregnant and postpartum women be encouraged to participate in VCT services?

- Ideally, the pregnant or postpartum woman and her partner(s) should go through the entire sequence of pretest counselling, testing, and posttest counselling together, as a way of avoiding having blame placed on either member of the couple should one or both test HIV-positive.
- It is often the woman's partner's behaviour that puts a woman at risk of HIV infection. VCT can provide an excellent opportunity to raise important and personal issues about sexual and domestic relationships that may need to be resolved through further discussion with male partners or with the woman in couple counselling.

How does VCT help reduce stigma and discrimination?

- People should think through the possible disadvantages of VCT before they make a decision to be tested. Many people choose not to get tested or not to disclose their test results to avoid some of the problems outlined above. Unfortunately, because so many people do not get tested or keep their test results to themselves, a community may never know how common HIV is and how extensively the illness affects its members.
- When members of a community believe that HIV affects only a few individuals, they find it easier to stigmatise and discriminate against those living with HIV and to avoid taking personal responsibility for preventing HIV transmission and supporting and caring for those who are infected with and affected by HIV.
- Promoting VCT services in the general public helps demystify HIV/AIDS and provides an opportunity for individuals and the community to learn about the illness and create a supportive and enabling environment for people living with HIV/AIDS.

9 Participant Handout

Overview of Prevention of Mother-to-Child Transmission of HIV

Preventing HIV transmission in pregnant women and from mothers to their children—often referred to as prevention of mother-to-child transmission, or PMTCT—has become a crucial intervention in the global fight against HIV and AIDS. About 200 million women become pregnant each year and need effective maternal and child health care. Globally, 99% of these pregnant women are HIV-negative and need counselling, information, and services to remain so. HIV-positive pregnant women also need information, counselling, and services to avoid transmitting HIV to their infant and their partner, as well as to access treatment and care for themselves and their families.

HIV infection can be transmitted to the infant during pregnancy, at labour and delivery, and during the postpartum period, via breastfeeding. Estimated transmission risks during all of these periods are shown below:

| Estimated risk and timing of MTCT of HIV in the absence of interventions | |
|--|-------------------|
| Timing | Transmission Rate |
| During pregnancy | 5–10% |
| During labour and delivery | 10–20% |
| During breastfeeding | 5–20% |
| Overall, without breastfeeding | 15–30% |
| Overall, with breastfeeding to six months | 25–35% |
| Overall, with breastfeeding to 18 to 24 months | 30–45% |

Adapted from: 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.

About 2.5 million children were living with HIV as of 2003 (UNAIDS. 2003. *AIDS epidemic update*. Geneva). According to UNAIDS, the vast majority of these children were born to mothers who were infected with HIV.

Several antiretroviral regimens have proved effective in preventing HIV transmission from an infected woman to her newborn (see: WHO. 2004. *Scaling up antiretroviral therapy in resource-limited settings: Treatment guidelines for a public health approach, 2003 revision*. Geneva; WHO. 2004. *Antiretroviral drugs and the prevention of mother-to-child transmission of HIV infection in resource-limited settings: Recommendations for a public health approach*. Geneva).



Historically, there has been a tendency to view the “mother” in PMTCT as simply a vehicle for producing a healthy infant, with efforts directed mainly at providing antiretroviral prophylaxis to pregnant women so as to prevent transmission of HIV to the infant. The most effective approach to PMTCT, however, is to ensure that a woman does not become infected in the first place.

Preventing HIV infection in these women protects the women themselves, as well as protecting their children and partners.

The UN system has agreed upon a comprehensive approach to PMTCT consisting of the following four elements:

- Prevention of HIV, especially among young people and pregnant women
- Prevention of unintended pregnancies among HIV-infected women
- Prevention of HIV transmission from HIV-infected women to their infants
- Provision of treatment, care, and support to HIV-infected women and their families

As was stated earlier, while this guide focuses mainly on the first of the four elements—that is, prevention of HIV—it also covers a number of HIV interventions that comprise the other elements, including safer delivery practices, counselling on infant feeding, universal precautions, etc.

10 Participant Handout

Overview of Safer Infant Feeding Practises

Between 5% and 20% of all infants born to HIV-positive mothers become infected during breastfeeding.

Breastfeeding is associated with better nutrition and fewer infections. In resource-constrained settings, failure to breastfeed an infant during the first two months of life is associated with a six-fold increase in mortality from infectious diseases.

In many countries where HIV prevalence is high, uninfected women may think that they are infected with the virus. In the absence of breastfeeding promotion, such women may stop breastfeeding, even though breastfeeding remains one of the most effective strategies for improving their infant's health and chances of survival.

In some countries, cultural beliefs that breastfeeding is an inferior method of infant feeding pose barriers to women's exclusive breastfeeding.

United Nations (UN) guidelines state that “when replacement feeding is acceptable, feasible, affordable, sustainable, and safe [see below], avoidance of all breastfeeding by HIV-infected mothers is recommended.”

Definitions from UN Guidelines

These terms should be adapted in the light of local conditions and formative research. The following may serve as a starting point:

Acceptable: The mother perceives no barrier to replacement feeding. Barriers may be cultural or social, or may relate to fear of stigma or discrimination. According to this concept, the mother is under no social or cultural pressure not to use replacement feeding; she is supported by family and community in opting for replacement feeding, or she will be able to cope with pressure from family and friends to breastfeed; and she can deal with possible stigma attached to being seen with replacement food.

Feasible: The mother (or family) has adequate time, knowledge, skills, and other resources to prepare replacement food and feed the infant up to 12 times in 24 hours. According to this concept, the mother can understand and follow the instructions for preparing infant formula and, with support from the family, can prepare enough replacement feeds correctly every day and at night, despite disruptions to prepare family food or for other work.

Affordable: The mother and family, with community or health system support, if necessary, can pay the cost of purchasing/producing, preparing, and using replacement feeding, including all ingredients, fuel, clean water, soap, and equipment, without compromising the health and nutrition of the family. This concept also includes access to medical care, if necessary, for diarrhoea and the cost of such care.

(continued)

Definitions from UN Guidelines (*continued*)

Sustainable: Availability of a continuous and uninterrupted supply and dependable system of distribution for all ingredients and products needed for safe replacement feeding, for as long as the infant needs it, up to one year of age or longer. According to this concept, there is little risk that formula will ever be unavailable or inaccessible, and another person is available to feed the child in the mother's absence and can prepare and give replacement feeds.

Safe: Replacement foods are correctly and hygienically prepared and stored, and fed in nutritionally adequate quantities, with clean hands and using clean utensils, preferably by cup. This concept means that the mother or caregiver:

- Has access to a reliable supply of safe water (from a piped or protected well source)
- Prepares replacement feeds that are nutritionally sound and free of pathogens
- Is able to wash hands and utensils thoroughly with soap and to regularly boil the utensils to sterilise them
- Can boil water for at least 10 minutes for preparing each of the baby's feeds
- Can store unprepared feeds in clean, covered containers and protect them from rodents, insects, and other animals

Source: WHO, UNICEF, UNAIDS, and UNFPA. 2003. *HIV and infant feeding: A guide for health care managers and supervisors*. Geneva. p. 25.

Infant Feeding Guidelines

For HIV-negative mothers and mothers whose HIV status is unknown:

- Exclusive breastfeeding is recommended for the first six months of life, to ensure achievement of optimal growth, development, and health. Afterwards, infants should receive nutritionally adequate and safe complementary foods while breastfeeding continues for up to two years of age or beyond.
- The availability and use of VCT for women whose HIV status is unknown should be promoted.

For HIV-positive mothers who are considering their feeding options:

- Where mothers are using combinations of antiretrovirals for treatment, the infant feeding recommendations in this document still apply.
- When replacement feeding is acceptable, feasible, affordable, sustainable, and safe, HIV-positive mothers are recommended to avoid all breastfeeding.
- When replacement feeding does not meet the above criteria, exclusive breastfeeding is recommended for the first months of the infant's life and should then be discontinued as soon as similar conditions are met. (This would normally imply the same conditions as for replacement feeding from birth—that is, acceptable, feasible, affordable, sustainable, and safe.)

10 Participant Handout

Overview of Safer Infant Feeding Practises

- Counsel clients on infant feeding options, including:
 - **Mixed feeding:** Feeding both breast milk and other foods or liquids (Studies suggest that exclusive breastfeeding during the first few months of life may be associated with a lower risk of HIV transmission than is mixed feeding. Research is in progress to clarify this issue. Exclusive breastfeeding during the first 4-6 months of life carries greater benefits for the infant than does mixed feeding with respect to morbidity and mortality from infectious diseases other than HIV.)
 - **Commercial infant formula:** A specially formulated powdered milk that is made specifically for infants and sold in shops and stores or provided by programmes to prevent HIV transmission to infants
 - **Home-modified animal milk:** Fresh or processed animal milk that has been modified by the addition of water, sugar, and micronutrient supplements (Any water added should be boiled, regardless of its source.)
 - **Exclusive breastfeeding:** The practise of providing only breast milk and no water, other liquids, or food, except prescribed medicine, to the baby for the first months of life
 - **Wet-nursing:** The practise of having another woman breastfeed a baby—in this case, a woman who has tested as HIV-negative
 - **Expressing and heat-treating breast milk:** The practise of removing milk from the breasts manually or with a pump, then heating it to kill HIV
 - **Breast-milk banks:** Places where donor milk is pasteurised and made available for infants
 - **Early cessation:** Helping the mother with transitioning from breastfeeding to replacement feeding by cup, using commercial or home-prepared infant formula

Note: For a more detailed presentation of the benefits and challenges of the above infant feeding options, see: WHO. 2004. *HIV and infant feeding: Guidelines for decision-makers*. Geneva.

What is dual protection?

Dual protection can be defined as a strategy for preventing both transmission of HIV and other 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 unsafe sexual practises. 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 method (for example, using the pill with a primary partner but the pill plus condoms with secondary partners)
3. Avoidance of unsafe sexual practises 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?

- Condoms, when used correctly and consistently, are the only technology that has been proven to be highly effective at preventing both the sexual transmission of HIV and other STIs and pregnancy at the same time.

Why is it important to legitimate condoms as an effective method of family planning?

- In some cases, preventing pregnancy can be a greater motivator for condom use than is preventing transmission of HIV and other STIs.
- If family planning 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.
- In general, many family planning providers believe that condoms are not effective for pregnancy prevention but are effective for HIV and STI prevention. In part, this bias is based on the fact that some other family planning methods, such as sterilisation, 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 providers and clients alike.



- Data show that the probability of acquiring various STIs (including HIV) from a single act of unprotected sexual relations is much greater than is the probability of becoming pregnant. Therefore, if condoms are used consistently and correctly to prevent infection with HIV and other STIs, they may be just as or even more effective against pregnancy.
- Condoms and those who use them are stigmatised because they are currently associated with HIV and STI prevention and their 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 both pregnancy and disease transmission.

Why is dual-protection counselling so important in maternal health services?

- Many maternal health clients may be at risk of infection with HIV and other STIs as well as at risk of unintended pregnancy after delivery. Many women are at risk of HIV or other STIs mostly as a result of their partners' risky behaviours. Dual-protection counselling can help clients perceive their own risk of infection and unintended pregnancy and help them develop strategies to protect themselves after delivery.
- Meeting clients' needs for dual protection improves the quality of maternal health services by addressing clients' multiple concerns.
- Pregnancy prevention and HIV and STI prevention needs are inseparable and should be addressed together.

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 clients are knowledgeable about and aware of their risks for HIV or other STIs and unintended pregnancy while they are making family planning decisions.
- Clients cannot make a truly informed choice about a family planning method unless they are aware of their risks for HIV and other STIs and know how effective the various family planning 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 a maternal health setting?

- Working with clients on partner communication and condom negotiation skills
- Involving men in counselling and education and addressing their concerns about condoms
- Making condom use palatable to both partners
- Helping women consider the ramifications of their decisions (both positive and negative) and recognising the limitations that many women may experience in negotiating condom use (i.e., insisting on condom use may lead to violence, abandonment, etc.)
- Promoting the female condom as a viable method (where it is available)

12 Participant Handout

Responding to Excuses for Not Using Condoms

1. **“I can’t feel anything when I wear a condom.”**
Possible response: “I know there’s a little less sensation, but there’s not a *lot* less. Why don’t we put a drop of water-based lubricant inside the condom? That’ll make it feel more sensitive.” (*Note:* Lubricants should be water-based.)
2. **“I don’t need to use a condom. I haven’t had sex in three months, so I know I don’t have any diseases.”**
Possible response: “That’s good to know. As far as I know, I’m disease-free, too. But I’d still like to use a condom because either one of us could have an infection and not know it.”
3. **“If I have to stop and put it on, I won’t be in the mood anymore.”**
Possible response: “I can help you put it on. That way, you’ll continue to be in the mood, and we’ll both be protected.”
4. **“Condoms are messy, and they smell funny.”**
Possible response: “It’s really not that bad. And sex can be a little messy sometimes. But this way, we’ll be able to enjoy it and both be protected from HIV and other STIs and pregnancy.”
5. **“Let’s not use condoms just this once.”**
Possible response: “No. Once is all it takes to get pregnant or get an infection.”
6. **“I don’t have a condom with me.”**
Possible response: “That’s okay. I do.”
7. **“You never asked me to use a condom before. Are you unfaithful?”**
Possible response: “No. I just think we made a mistake by never using condoms before. One of us could have an infection and not know it. It’s best to be safe.”
8. **“If you really loved me, you wouldn’t make me wear one.”**
Possible response: “If you really loved *me*, you’d want to protect yourself—and me—from infections and pregnancy so we can be together and healthy for a long time.”
9. **“Why are you asking me to wear a condom? Do you think I’m dirty or something?”**
Possible response: “It’s not about being dirty or clean. It’s about avoiding the risk of infection and pregnancy.”
10. **“Condoms don’t fit me.”**
Possible response: “Condoms can stretch a lot—in fact, they can stretch to fit over a person’s head! So we should be able to find one that fits you.”
11. **“Why should we use condoms? They just break.”**
Possible response: “Actually, they told me that condoms are tested before they’re sent out—so while they have been known to break, it happens rarely, especially if you know how to use one correctly, and I do.”
12. **“What happens if it comes off? It can get lost inside you, and you’ll get sick, or could even die. Do you want that?”**
Possible response: “It’s impossible for the condom to get lost inside me. If it came off, it’d be inside my vagina, and I could just reach in and pull it out.”

12 Participant Handout

Responding to Excuses for Not Using Condoms

13. **“If you don’t want to get pregnant, why don’t you just take the birth control pill?”**
Possible response: “Because the birth control pill only protects against pregnancy. The condom protects against both pregnancy and infections.” or “Because I discussed my options with a doctor and we decided that condoms are the best method for me to use to prevent pregnancy.”
14. **“My religion says that using condoms is wrong.”**
Possible response: “It might help to talk with one of your religious leaders to find out their views and make sure that you aren’t making any false assumptions.”
15. **“Well, I’m not going to use a condom, and that’s it. So let’s have sex.”**
Possible response: “No. I’m not willing to have sex without a condom.”
16. **“No one else uses them. Why should we be so different?”**
Possible response: “Because a lot of people who didn’t use them ended up with HIV.”
17. **“You’re a woman. How can you possibly ask me to use a condom? How can I respect you after this?”**
Possible response: “You should respect me even more because I am acting responsibly. I’m suggesting this because I care about you and respect myself enough to protect myself. That’s enough for me.”

Note: For other possible excuses and responses to them, you can refer to: UNAIDS Interagency Task Force on Condom Programming for Prevention of HIV/AIDS. 2004. *Myths, perceptions, and fears: Addressing condom use barriers*. Geneva: UNAIDS.

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Reducing Errors in Condom Use

Inconsistent and incorrect use of the condom, rather than poor condom quality, account for most failure to be protected from HIV/STI transmission or from unintended pregnancy. Most condom users rarely experience breakage, slippage, or improper insertion. Condom effectiveness depends heavily on the skill level and experience of the user, as well as on the ability to negotiate use.

Common errors in condom use that increase the risk of HIV and other sexually transmitted infections and/or unintended pregnancy include:

- **Failure to use the condom consistently.** Condoms must be used consistently.
- **Failure to use condoms throughout intercourse.** Some men put condoms on after starting intercourse or may remove condoms before ejaculating, practices that raise the risk of HIV/AIDS and other STIs or pregnancy. In one study, men acquired gonorrhea despite condom use because they failed to put the condom on before starting intercourse. For condoms to be effective, they must be used every time, “from start to finish.”
- **Use of improper lubricants with latex condoms.** Unlike water-based lubricants (e.g., K-Y Jelly), oil-based lubricants (e.g., petroleum jelly, baby oil, and hand lotions) reduce the integrity of latex condoms and facilitate breakage. Some people use oil-based products as condom lubricants, mistaking them for water-based lubricants because they readily wash off with water. Because vaginal medications (e.g., for yeast infections) often contain oil-based ingredients that can damage latex condoms, clients who are using or have been prescribed these medications should be advised to remain abstinent, use polyurethane condoms (if available), or use other contraceptives until the infection is cured. *Note:* Oil-based products may be safely used as lubricants with polyurethane condoms.
- **Incorrect placement of the condom on the penis.** Condoms may tear if clients are not careful when removing the condom from the package. Some men accidentally place the condom upside-down on the penis, then flip the condom over and use it for intercourse, a practice that may expose their partner to preejaculatory fluid or infectious penile secretions. Although pregnancy is unlikely to result from exposure to preejaculate, HIV has been detected in the preejaculatory fluid of infected men. Whether the amount of HIV in preejaculate is sufficient to cause infection has not been established. Incorrect placement can also cause air bubbles to be trapped inside the condom, which then cause breakage during intercourse. The air must be pinched out of the condom’s tip before it is put on.
- **Poor withdrawal technique.** Slippage during withdrawal, one of the most common reasons for condom failure, may be prevented if the condom’s rim is held against the base of the erect penis while withdrawing, soon after ejaculation. One study found only 71% of men held the rim of the male condom during withdrawal and that only 50% withdrew immediately after ejaculation.
- **Failure to check the expiration date and quality of condoms.** Condoms should not be used after their expiration date. (This is usually printed on the packaging.) Users should check that condoms are sealed and that there are no cracks or holes or any other damage.
- **Failure to store condoms properly.** Heat damages condoms; therefore, they should never be stored in hot places (for example, under direct sunlight).

13 Participant Handout

Female Condom Overview

Description of the female condom

- It is a strong, loose-fitting polyurethane sheath about 17 cm (6.5 inches) long, with a flexible ring at each end.
- Polyurethane is a soft, thin plastic that is stronger than latex, which is what is used to make most male condoms.
- Polyurethane conducts heat efficiently, so sexual activities can be more sensitive and pleasurable for both partners.
- Polyurethane is odorless, as is the lubrication that comes with the female condom.
- The inner ring is used to insert the female condom and helps keep the female condom in place. The inner ring slides into place behind the pubic bone.
- The outer ring is soft and remains outside the vagina during sexual intercourse. It covers the area around the opening to the vagina (the vulva). This can also provide more pleasure for the woman because the ring often comes into contact with the clitoris during intercourse.

Advantages of the female condom

- There are no serious side effects associated with the use of the female condom. Fewer than 10% of users report mild irritation.
- The female condom can be inserted up to eight hours before a sex act, so it does not interrupt sexual activity.
- The penis does not have to be erect when it is inserted into the female condom.
- The female condom does not need to be removed immediately after ejaculation.

Special considerations

- The female condom comes prelubricated with a nonspermicidal (spermicides kill sperm), silicone-based lubricant that is needed to ease insertion and movement during intercourse.
- Lubrication reduces noise during sexual intercourse (some users have reported some squeaking when using the female condom) and makes sex smoother.
- Additional lubricant, whether oil- or water-based, can be used.
- Male and female condoms should *not* be used together. Friction between the polyurethane and latex can result in failure of either condom. In addition, if an oil-based lubricant is used with the female condom, it will cause the latex in the male condom to deteriorate.
- The female condom is currently approved only for a single use. (*Source:* WHO. 2002. WHO information update: Considerations regarding reuse of the female condom, July 2002. Geneva. Retrieved from: www.who.int/reproductive-health/rtis/reuse_FC2.pdf on October 3, 2003.)

Source: WHO and UNAIDS. 2000. *The female condom: A guide for planning and programming*. Geneva.

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Instructions for Using the Female Condom

1. Check the expiration or manufacture date on the package.
2. Open the package carefully; it should be torn at the notch at the top right. Do not use scissors, a knife, or teeth to open the package.
3. Choose a comfortable position for insertion. This may be squatting, raising one leg, or sitting or lying down.
4. Look at the condom to make sure that it is lubricated.
5. While holding the sheath at the closed end, grasp the flexible inner ring and squeeze it with the thumb and second or middle finger so it becomes long and narrow.
6. With the other hand, separate the outer lips of the vagina.
7. Gently insert the inner ring into the vagina. Feel the inner ring go up and move into place.
8. Place the index finger on the inside of the condom and push the inner ring up as far as it will go. Be sure the sheath is not twisted. The outer ring should remain on the outside of the vagina.
9. The female condom is now in place and ready for use with a partner.
10. When you are ready, gently guide your partner's penis into the sheath's opening with your hand to make sure that it enters properly. Be sure that the penis is not entering on the side, between the sheath and the vaginal wall. Use enough lubricant so that the condom stays in place during sex. If the condom is pulled out or pushed in, there is not enough lubricant. Add more either to the inside of the condom or to the outside of the penis.
11. To remove the condom, twist the outer ring and gently pull the condom out. Try to do this before standing up, to avoid spilling any semen.
12. Wrap the condom in its package or in a tissue and throw it in the garbage.

Source: WHO and UNAIDS. 2000. *The female condom: A guide for planning and programming*. Geneva.

Universal Precautions in Health Care Settings

Universal precautions are simple infection control measures that reduce the risk of transmission of bloodborne 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. 2003. *Universal precautions, including injection safety*. Geneva. Retrieved at: <http://www.who.int/hiv/topics/precautions/universal/en/>, October 3, 2003.)

Washing hands

Wash your hands with soap and running water after coming in contact with blood, body fluid, secretions, excretions, and contaminated items, whether you have worn gloves or not. Wash your hands immediately after removing gloves, between client contacts, to avoid transferring organisms among clients and to or from the environment.

Wearing gloves

Wear gloves when you come into contact with blood, body fluid, secretions, excretions, and contaminated items. Put on clean gloves just before touching mucous membranes and non-intact skin. Change into a new, clean pair of gloves between tasks and procedures on the same client after contact with material that may contain a high concentration of microorganisms. Rinse your gloved hands in 0.5% chlorine solution before removing the gloves. Then remove the gloves *immediately before* touching noncontaminated items and surfaces. Any breaks in the skin, including rashes and chapped skin, provide points for organisms to enter the bloodstream, thereby potentially causing infection.

Note: Health care staff who have open lesions, cuts, and weeping dermatitis should avoid direct client contact and should not handle contaminated equipment. (See: Markle, W. H. 1999. Protection against HIV infection for medical trainees outside the United States, *Family Medicine* 31(7):495–500.)

Protecting your eyes

Wear eye protection (a face shield or mask) to protect the mucous membranes of the eyes, nose, and mouth during procedures (e.g., delivery or cutting of the umbilical cord) and client care activities that might produce splashes or sprays of blood, body fluids, secretions, and excretions.

Wearing protective clothing

Wear gowns (clean, nonsterile gown) to protect skin and to prevent soiling of clothing during procedures and client-care activities that might produce splashes or sprays of blood, body fluids, secretions, and excretions. If feasible, use a plastic or rubber barrier (e.g., an apron) to protect clothing if a great deal of soiling is anticipated. Remove a soiled gown *immediately*, place it in a designated container for decontamination, and wash your hands. (For details related to processing linen, see Modules 8, 9, 10, and 11 of EngenderHealth’s infection control

training curriculum [AVSC International. 1999. *Infection control curriculum: A training course for health care providers and other staff of hospitals and clinics*. New York.]

Processing instruments

Process used instruments consistent with infection control guidelines for decontamination, cleaning, high-level disinfection, and/or sterilisation. Make sure that a reusable instrument is not used on another client until it has been appropriately processed. (For details, see Modules 8, 9, 10, and 11 of EngenderHealth's infection control training curriculum [AVSC International. 1999. *Infection control curriculum: A training course for health care providers and other staff of hospitals and clinics*. New York.]

Handling needles and other sharp instruments

Handle needles and other sharp instruments with care; to avoid injury and the risk of infection, do not bend, break, or recap needles after use (or use the one-hand capping technique—see AVSC International. 1999. *Infection control curriculum: A training course for health care providers and other staff of hospitals and clinics*. New York, Module 6, page 223). Make sure that single-use items such as disposable needles, syringes, and sharp instruments are disposed of in a puncture-proof container. If you are injured by a contaminated needle or sharp instrument, wash the area immediately with soap and water and follow your facility's postexposure prophylaxis guidelines, if they exist.

Maintaining a clean environment and disposing of waste

Maintain environmental cleanliness and waste-disposal practises according to infection control guidelines for liquid, solid waste, and sharps. Make sure that liquid waste is placed in a container with enough disinfecting solution to effectively kill microorganisms.

Make sure that all solid waste (bloody dressings, swabs, tissues, gauze, and cloths soiled with body fluids) are placed in designated bags or containers (e.g., coloured red, red-tagged, or red-marked), collected, and taken for incineration. Immediately clean up surface spills of blood, body fluid, secretions, and excretions with a disinfectant solution such as 0.5% chlorine solution, and then clean the area with detergent and water. (For details, see AVSC International. 1999. *Infection control curriculum: A training course for health care providers and other staff of hospitals and clinics*. New York, Module 12, page 423.)

Handling and processing linen

Maintain the safety of linen by using gloves when collecting linen soiled by blood, body fluids, secretions, and excretions and placing the linen in a designated bag or container (e.g., coloured red, red-tagged, or red-marked). If using a plastic bag, place linen in one bag and then place that bag inside another plastic bag (i.e., double-bag it). Transport soiled linen in a way that avoids puncturing the bag or losing soiled items on the way to the laundry. Launder soiled linen using detergent and germicide, according to infection control guidelines. (For details, see AVSC International. 1999. *Infection control curriculum: A training course for health care providers and other staff of hospitals and clinics*. New York, Module 8, page 275.)

Using Universal Precautions When Providing Care in the Community or the Home

As in the health care setting, universal precautions can help prevent infection when care is being given in the community or the home. Community-based and home-based care may include childbirth, postnatal follow-up of mother and infant, care of individuals with an infectious disease such as HIV infection, and any medical care provided by lay health professionals, whether in the home or in the community.

Universal precautions in community-based and home-based care are the same as those followed in the health care setting. Health care staff providing home-based care should follow the universal precautions that they would in the facility. It is essential that health care staff instruct family members, lay health professionals, and other caretakers in infection control practises. Clients should also be informed of infection control practises, so they do not misinterpret the behaviour of their caretakers as rejection or scorn. If the family members or caretakers can read, a short instruction sheet can be prepared for their reference. Any information shared with the family and/or caretakers should include the following, as a minimum:

- **Hand washing**—Wash hands with soap and running water immediately:
 - After you take off gloves, or if the glove gets torn
 - If you get blood or body fluids on your hand (or, if you get blood or body fluids on any other body area, wash that area)
 - Before and after touching the infected person
- **Gloves**—If feasible, wear latex gloves when:
 - You touch the infected person’s mucous membrane (e.g., mouth or genitals), broken skin, or body fluid (blood, stool, urine, drainage from wounds, saliva, or vomit)
 - You handle any items or surfaces soiled with blood or body fluids
 - You clean up blood or body fluids around the area where you are caring for the client

Put on a pair of new gloves each time you perform a procedure or task. **If gloves are not available or affordable, consider putting plastic bags over your hands (bags that do not have holes, such as those that you might get from a market).**
- **Protective clothing (masks, eye or face shields, gown or apron)**—Wear protective clothing during any task that might expose you to blood or body fluids. If large plastic garbage bags are available, cut a hole in the middle of the sealed end and on either side so that you can put the bag over your head and put your arms through. Wear the bag if you expect to be exposed to splashes or to be made wet with contaminated fluids.
- **Washing soiled linen and clothing**—Linen and clothing that have been soiled with blood must be washed separately from other items, using a detergent and a bleach solution. Ask your health care worker how many parts of bleach to water you should use for laundering soiled clothing.
- **Disposal of contaminated waste**
 - When throwing away items soiled with blood or body fluids, place them in a plastic bag and put the bag inside a second plastic bag (i.e., double-bag them). If possible, mark the

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Overview of Universal Precautions

bag with a coloured tie or marker (e.g., red) and place it in the area designated by the local health facility for waste disposal.

- Find out from your health facility or health care worker where to dispose of infected body fluids and waste.
- If burial is the only means available, dig a hole 50 metres from any water source, downhill from a well and not close to areas set aside for planting. Dig the hole at least 1 to 2 metres wide and 2 to 5 metres deep. If possible, fence the area to keep out children and animals.
- **Keeping surfaces safe**—Keep furniture, walls, and floor safe by cleaning them daily with a solution of bleach and water. Ask the health care staff in your area what proportion of bleach to water is used in your area. Clean up spills of body fluids immediately with the bleach solution before washing the area with soap or detergent and water. Remember to wear heavy-duty gloves when cleaning up spills and cleaning surfaces.
- **Needle precautions**
 - If health care staff will be giving injections in the home, remember not to recap or bend the needles.
 - Throw needles and syringes away in a puncture-resistant container that is not overly full.
 - If you experience a needlestick injury, immediately:
 - Flush the injured area with running water
 - Wash your hands with soap and water
 - Where there is bleeding, allow the site to bleed briefly
 - Inform your supervisor after caring for the wound

Note: In the absence of water, an antiseptic solution can be used to flush the area. Remember, however, that antiseptic solutions have not been proven to be any more effective than soap and water.

- If a family member will be giving injections, teach the person(s) not to recap or bend needles and to throw the needles away in a puncture-resistant container (e.g., a tin can or container with a lid) that is not overly full. Tell the family member(s) that when the container is three-quarters full, they should bring it to the facility's waste disposal site for safe destruction. Inform the family members that if they are accidentally injured by a used needle, they should wash the wound immediately with soap and water, allow the wound to bleed, cover it, and come to the facility for assessment and management.
- **Increasing awareness of potential risks**—Remind clients and family members that there can be a risk of HIV transmission associated with practises performed by traditional healers, traditional birth attendants, and circumcisionists, when exposure to blood through unsafe injections and shared cutting instruments are involved.

Note: This section is based on: McKesson HBOC Clinical Reference Systems. 2001. Universal precautions against infectious diseases. Retrieved at: www.realage.com/Connect/Healthadvisor/Adulthealth/crs/unipre.htm on October 31, 2003.

Safer Delivery Practises in Facility-Based and Home-Based Births

Adherence to standard practises for childbirth and to procedures that reduce foetal contact with maternal blood and secretions can reduce the risk of mother-to-child transmission (MTCT) of HIV in facility-based and home-based births.

Apply universal precautions in all situations

Consistent and correct application of universal precautions, regardless of the client's known or perceived HIV status, will protect clients and health care providers from HIV and other bloodborne infections (see Session 14: Universal Precautions, page 67).

Avoid prolonged labour

Prolonged labour increases the foetus's exposure to maternal blood and infected secretions, and therefore should be avoided, as it may increase the risk of MTCT.

Avoid prolonged membrane rupture and routine artificial rupture of the membranes

MTCT risk may increase with prolonged membrane rupture or artificial rupture of the membranes. Delay routine rupture of membranes until the cervix is dilated 7 cm or greater.

Avoid unnecessary trauma during childbirth

Invasive procedures such as foetal monitoring, use of episiotomies, or the use of forceps or vacuum extractors may increase the risk of MTCT by exposing the foetus to maternal blood and secretions.

Safe transfusion practises

Minimise the use of blood transfusion; when it is necessary, use only blood that has been screened for HIV and, if possible, other infectious agents.

Elective caesarean section for childbirth

Caesarean section is associated with a reduced risk of MTCT when performed before the onset of labour or membrane rupture. Decision making about vaginal childbirth or elective caesarean section should consider the availability of specific resources, the safety of the blood supply, and the risk of complications. In some settings, elective caesarean section may not be feasible or safe and may increase the risk of complications.

Adapted from: WHO. 2004. PMTCT—Generic training curriculum: Participant guide. Draft. Geneva.

16 Participant Handout

Facility Walk-through Checklist

As you walk through your facility, imagine that you are a man coming to the facility for services or information for the first time. Keeping the man's perspective in mind, assess how the facility would appear on the basis of the following criteria.

| Facility Walk-through Checklist | Yes | No |
|--|-----|----|
| Identity | | |
| 1. Does the name of the facility seem welcoming to men? | | |
| 2. As you approach the facility, is it obvious that it is a suitable place for a man to seek services? | | |
| 3. Does the gatekeeper know about all services that are available for men? | | |
| Services Provided | | |
| 4. Is there a sign or wall poster indicating that services are provided for men? | | |
| 5. Does the sign or poster list the hours, eligibility, and free or low-cost options for services? | | |
| 6. Does the sign or poster indicate the types of services offered for men? | | |
| 7. Are brochures or handouts containing information about services for men readily available? | | |
| 8. Does the receptionist know about all services available for men? | | |
| Reception/Waiting Area | | |
| 9. Is the environment in the reception/waiting area comfortable for a man (as opposed to seeming more intended for women or children)? | | |
| 10. Are magazines, newspapers, or other items that appeal to men readily available? | | |
| 11. Are brochures, pamphlets, posters, or other client-education materials that deal with men's health issues readily available? | | |
| 12. Is the area clean, neat, and efficient-looking? | | |
| 13. Do you see any other male clients in the area? | | |
| 14. Do you see any male staff members? | | |
| 15. Is a men's toilet available? | | |
| 16. Is it clear where a man would go to register for services? | | |
| 17. Do the staff appear to be polite and respectful towards men? | | |
| 18. If a man just wanted to get some condoms and did not want an examination, is it clear where he would get them? | | |
| 19. Is illustrated literature or a diagram of how to use a condom readily available? | | |
| Service Areas and Examination Rooms | | |
| 20. Is the environment comfortable for a man (as opposed to seeming more intended for women or children)? | | |
| 21. Are client-education materials and posters dealing with men's health issues readily available? | | |
| 22. Do you think a man could speak confidentially with a service provider or counsellor here, without being seen or overheard? | | |

Facility Walk-through Checklist

Additional Comments/Observations:
