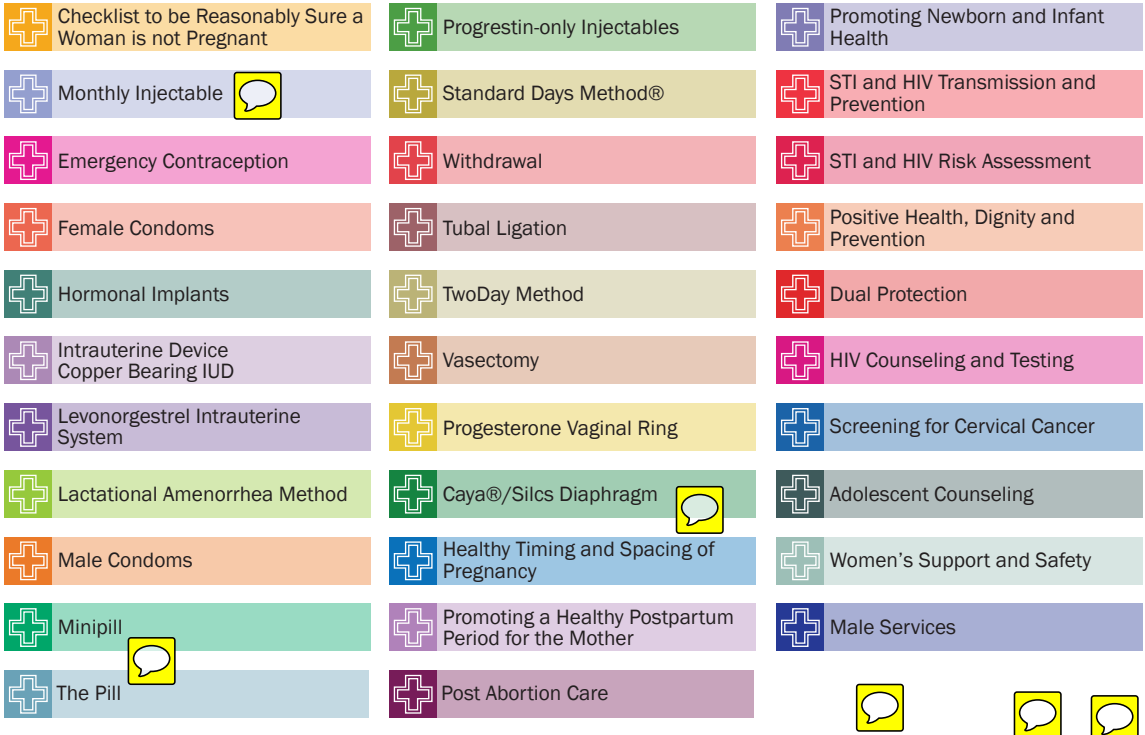
The Balanced Counseling Strategy Plus

A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings

COUNSELING CARDS

Third Edition, 2015

POPULATION COUNCIL
Ideas. Evidence. Impact.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Positive Health, Dignity and Prevention
Dual Protection
HIV Counseling and Testing
Screening for Cervical Cancer
Adolescent Counseling
Women's Support and Safety
Male Services

Effectiveness Ratings

METHODS ARE DEFINED FOR TYPICAL USE AS FOLLOWS:

HIGHLY EFFECTIVE

<5 pregnancies per 100 women in designated time period

EFFECTIVE

5-10 pregnancies per 100 women in designated time period

LESS EFFECTIVE

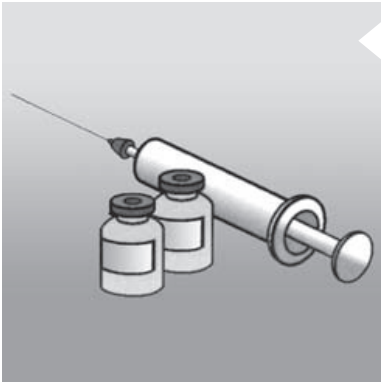
>10 pregnancies per 100 women in designated time period

Checklist to be Reasonably Sure a Woman is not Pregnant

Checklist to be Reasonably Sure a Woman is not Pregnant

The goal of FP provision is to provide the client with her preferred method on the same day as her visit. It is preferable to give a contraceptive method instead of having her leave and becoming pregnant. The risks associated with offering any contraceptive method to a woman who may be pregnant and not aware of it are low.

ASK THESE 6 QUESTIONS:	If "Yes" to **any** of these questions, **and** client is free of signs and symptoms of pregnancy,	If "No" to **all** of the questions:
1. Did you have a baby less than 6 months ago? If so, are you breastfeeding? Have you had no menstrual bleeding since giving birth?	*Once the client has answered yes to one of the questions, it is not necessary to continue asking the remaining questions 1. Pregnancy is unlikely 2. Continue to **Step 5**	1. Pregnancy cannot be ruled out. 2. Give client pregnancy test if available, or refer her to an antenatal clinic. 3. Provide her with a back-up method, such as condoms, to use until she has her menstrual bleeding. 4. Provide in advance her preferred method (where possible) to use on the 1st day of her menses OR request that she return at that point to receive her preferred method. 5. Go to **Step 13**
2. Have you abstained from unprotected [no method of FP] sex since your last menstrual bleeding or delivery?		
3. Have you given birth in the last 4 weeks?		
4. Did your last menstrual bleeding start within the past 7 days (or within 12 days if you plan to use a copper-bearing IUD)?		
5. Have you had a miscarriage or abortion in the past 7 days?		
6. Have you been using a reliable contraceptive method consistently and correctly?		



Monthly Injectable

Combined Injectable Contraceptives (CICs)

Monthly Injectable

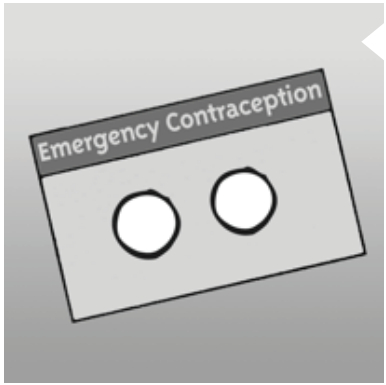
Combined Injectable Contraceptives (CICs)

EFFECTIVENESS

Typical use
Some missed or late injections – 6 pregnancies per 100 women

- Requires that the client get an injection every 4 weeks (30 days) to prevent pregnancy.
- More regular monthly bleeding than with DMPA or NET-EN injectables.
- Delayed return of fertility after woman stops method. It takes an average of about 1 month longer than with most other methods.
- Not advised if woman is within 21 days of giving birth, regardless of breastfeeding status.
- Not advised if woman is breastfeeding an infant less than 6 months old.
- Not advised if a woman has migraines and is 35 years or older.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- Not advised if woman has a history of breast cancer or if woman has major risk factors for venous cardiovascular disease, including older age, stroke, smoking, diabetes, hypertension or known dyslipidaemia.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

EFFECTIVE



Emergency Contraceptive Pills

ECPs

Emergency Contraceptive Pills

ECPs

TYPES

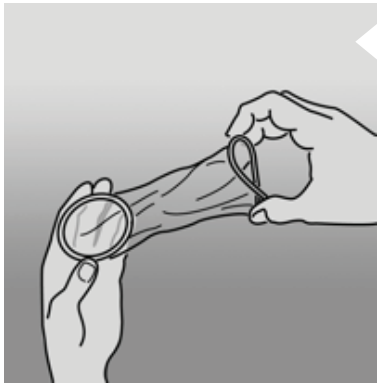
- Progestin only
- Combined progestin and estrogen
- Ulipristal acetate (UPA)

EFFECTIVENESS

Correct use
Most effective if taken within first 24 hours; can be taken within 5 days of having unprotected sex –
2- 12 pregnancies per 100 women after one instance of unprotected sex depending on the ECP

- One of the only methods that can help prevent pregnancy *after* a woman has had unprotected sex. Other effective emergency contraception includes Copper-bearing or LNG-containing IUDs.
- Not recommended for regular use, but there is no harm to the user if used repeatedly. However, a woman using ECPs repeatedly should receive additional family planning counseling in order to select the most appropriate continuous method.
- Breastfeeding not recommended for one week after using UPA.
- Must be used within 5 days (120 hours) of unprotected sex.
- Safe for women who cannot use regular hormonal contraceptive methods, including postpartum breastfeeding women.
- ECPs do not disrupt existing pregnancy.
- Safe for a woman living with HIV/AIDS, even if she takes any type of antiretroviral (ARV) medicines.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

HIGHLY EFFECTIVE - EFFECTIVE



Female Condoms

Female Condoms

TYPES

- Female Condom 2 / FC2
- Cupid

EFFECTIVENESS

Typical use
Not used consistently –
21 pregnancies per 100 women

- The female condom is a sheath made of transparent plastic film (polyurethane). FC2 has a flexible ring at both ends. Cupid has a medical grade sponge at one end. It is the same length as a male condom.
- Before having sex, place the female condom into the client's vagina up to eight hours before an anticipated sexual act. It fits loosely inside the vagina.
- The client must use a new condom for each act of sex.
- Protects against pregnancy and sexually transmitted infections (STIs), including HIV, if used consistently and correctly.
- Preserves feeling of sex for men and women.
- Requires partner's cooperation.

LESS EFFECTIVE

Hormonal Implants

Hormonal Implants

TYPES

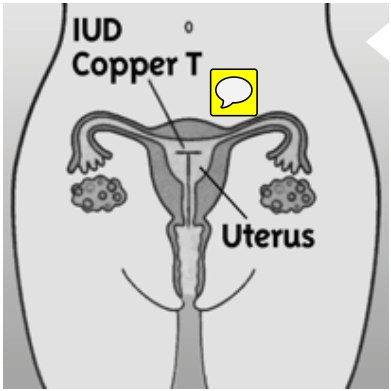
- Single rod (Implanon, Nexplanon/Implanon NXT)
- Double rod (Jadelle, Sino-plant II)

EFFECTIVENESS

First year of use
Less than 1 pregnancy per 100 women

HIGHLY EFFECTIVE

- Either 2 small rods or 1 small rod (about the size of a matchstick) put under the skin.
- Provides long-term protection from pregnancy. Length of protection depends on the implant:
  - Jadelle: 5 years.
  - Sino-plant II: 4 years
  - Implanon or Nexplanon: 3 years
- A trained provider must insert and remove implants.
- If a woman has unexplained vaginal bleeding, she should be further evaluated and treated prior to initiating this method
- Safe for women who are breastfeeding. Women may get implants after giving birth.
- Not advised if a woman has a history of breast cancer.
- Causes changes in monthly bleeding. May cause absence of bleeding or temporary heavy bleeding for a few months.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.



Intrauterine Device

Copper-bearing IUD

Intrauterine Device

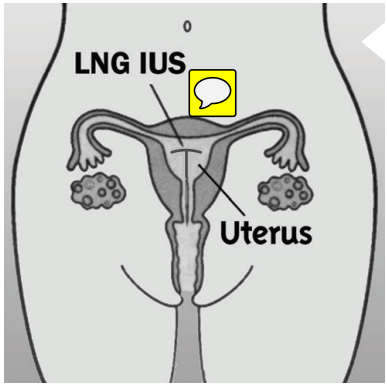
Copper-bearing IUD

EFFECTIVENESS

First year of use
Less than 1 pregnancy per 100 women

HIGHLY EFFECTIVE

- Provides long-term protection against pregnancy for 5 - 12 years.
- Is a small, flexible, plastic and copper device placed in the uterus. Most IUDs have 1 or 2 thin strings that hang from the cervix into the vagina.
- It is a safe and effective method for almost all women, including women in the postabortion or postpartum period.
- A trained provider must insert and remove the IUD.
- Can be inserted immediately after childbirth (within 48 hours) or after 4 weeks postpartum.
- Typically causes slightly longer and heavier bleeding and more cramps or pain during monthly bleeding.
- If a woman has unexplained vaginal bleeding, she should be further evaluated and treated prior to initiating this method.
- Safe for a woman living with HIV/AIDS who is clinically well (WHO Stage 1 or 2 of HIV clinical disease) on antiretroviral (ARV) medicines.
- Not advised for a woman with very high risk of having sexually transmitted infections (STIs), particularly chlamydia or gonorrhea. Evaluate the client for STI risk prior to initiating this method. (See STI and HIV Risk Assessment Card).
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.



Intrauterine Device/System

Levonorgestrel LNG IUD/IUS

Intrauterine Device/System

Levonorgestrel LNG IUD/IUS

EFFECTIVENESS

First year of use
Less than 1 pregnancy per 100 women

HIGHLY EFFECTIVE

- Provides long-term protection against pregnancy for up to 5 years.
- Is a small, flexible, plastic device placed in the uterus with an inner reservoir of levonorgestrel, a progestin hormone. The LNG IUS has 1 or 2 thin strings that hang from the cervix into the vagina.
- A trained provider must insert and remove the LNG IUS.
- Can be inserted immediately after childbirth (within 48 hours) or after 4 weeks postpartum.
- Typically causes lighter and shorter monthly periods of bleeding and may cause periods to stop all together.
- If a woman has unexplained vaginal bleeding, she should be further evaluated and treated prior to initiating this method.
- Not advised if a woman has a history of breast cancer.
- Safe for a woman living with HIV/AIDS who is clinically well (WHO Stage 1 or 2 of HIV clinical disease) on antiretroviral (ARV) medicines.
- Not advised for a woman with very high risk of having sexually transmitted infections (STIs), particularly chlamydia or gonorrhea. Evaluate the client for STI risk prior to initiating this method. (See STI and HIV Risk Assessment Card).
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

Lactational Amenorrhea Method

LAM

Lactational Amenorrhea Method

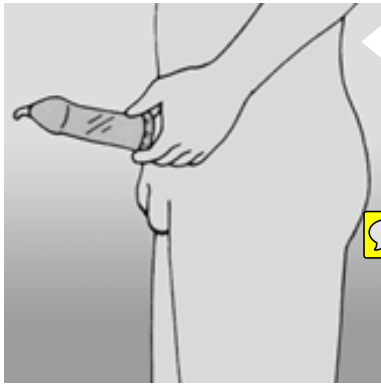
LAM

EFFECTIVENESS

Typical use
First 6 months after childbirth when all 3 criteria are met — 2 pregnancies per 100 women

HIGHLY EFFECTIVE

- LAM is for women who are exclusively breastfeeding their baby. All women who have infants six months or younger should be encouraged to exclusively breastfeed for the well-being of their baby.
- LAM requires 3 conditions. All 3 must be met:
  1) The client's monthly bleeding has not returned since giving birth
  2) The baby is exclusively breastfed, day and night
  3) The baby is less than 6 months old
- LAM is a temporary family planning method used after pregnancy. A woman using LAM should plan to visit her provider before she starts to use supplemental feeding to talk about switching to another modern method once the 3 conditions for LAM are no longer met. If the woman is willing, initiate the conversation now about what method she plans to use once LAM is no longer effective.
- Safe for a woman living with HIV/AIDS when she exclusively breastfeeds. There is a chance, however, that mothers with HIV may transmit HIV to their infants through breastfeeding if they are not on ARVs. Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.
- Dispensing ECP when counseling on LAM increases pregnancy protection and timely transition to another method. Counseling on ECP should suggest to clients to use it as a backup if they fail to meet one of the LAM criteria before they are able to obtain another method.



Male Condoms

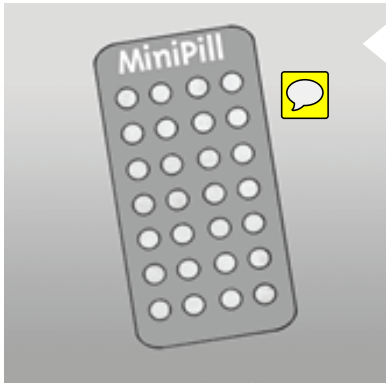
Male Condoms

EFFECTIVENESS

Typical use
Not used consistently — 18 pregnancies per 100 women

- Most condoms are made of thin latex rubber. Some condoms are coated with a lubricant and/or spermicide.
- If the client has had an allergic reaction to latex rubber, they should not use latex condoms. Use polyurethane condoms as a safe and effective alternative for people with a latex allergy.
- Before having sex, place the condom over the erect penis.
- The client must use a new condom for each act of sex.
- Protects against pregnancy and sexually transmitted infections (STIs), including HIV.
- Requires partner's cooperation to use consistently and correctly.

LESS EFFECTIVE



Minipill

Progestin-only Oral Contraceptives

Minipill

Progestin-only Oral Contraceptives

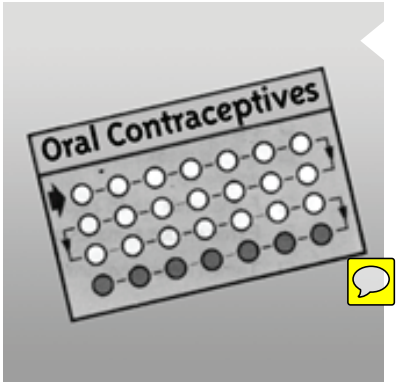
EFFECTIVENESS

Typical use in first year
Some missed pills —
3 to 10 pregnancies per 100 women

For breastfeeding women in first year
1 pregnancy per 100 women

- Requires that the client takes 1 pill every day.
- Safe for women who are breastfeeding. Women may begin the minipill after giving birth.
- May cause irregular monthly bleeding. For breastfeeding women, causes delayed return of monthly bleeding.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- Not advised if a woman takes medicine for seizures or takes rifampicin (for tuberculosis or other infections).
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

EFFECTIVE



The Pill

Combined Oral Contraceptives

The Pill

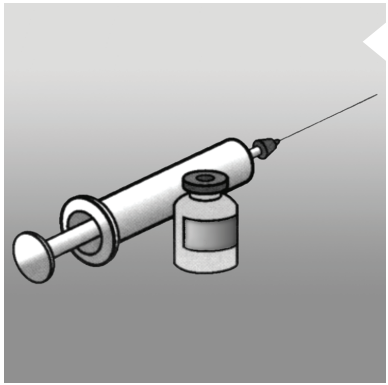
Combined Oral Contraceptives

EFFECTIVENESS

Typical use
Some missed pills –
9 pregnancies per 100 women

EFFECTIVE

- Requires that the client takes 1 pill every day.
- Not advised if breastfeeding an infant less than 6 months old.
- Not advised if woman is within 21 days of giving birth, regardless of breastfeeding status.
- May cause irregular bleeding during the first few months of use, after which users may experience lighter and more regular bleeding.
- May cause other side effects.
- Not advised if woman takes medicine for seizures or takes Rifampicin (for tuberculosis or other infections).
- Not advised if a woman has history of breast cancer.
- Not advised if a woman has migraines and is 35 years or older.
- Not advised if woman has major risk factors for venous cardiovascular disease, including older age, stroke, smoking, diabetes, hypertension or known dyslipidaemia.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- There are many different brands and regimens of combined oral contraceptives. Discuss available and most appropriate method with the client.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.



Progestin-only Injectables

DMPA or NET-EN

Progestin-only Injectables

DMPA or NET

TYPES

- Intramuscular DMPA 150mg or NET-EN
- Subcutaneous DMPA 104mg (Sayana Press)

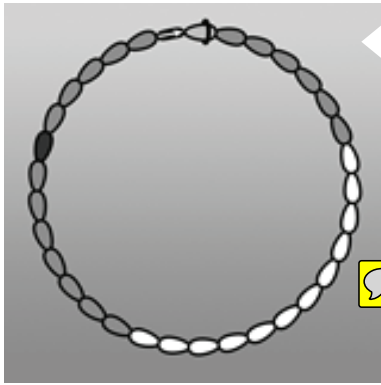
EFFECTIVENES

94%

Typical use in first year
Some missed or late injections –
6 pregnancies per 100 women

EFFECTIVE

- The client gets an injection every 2 months, depending on type of injection.
- Safe for women who are breastfeeding a baby. For a woman who is breastfeeding but not using LAM, injectables can be started after 6 weeks. Fertility can return as early as 3 weeks postpartum, so clients should use a backup method such as condoms until they begin injectables.
- May cause irregular or no menstrual bleeding.
- There is a delayed return to fertility after the client stops the method. It takes longer than with most other methods. Return to fertility is, on average, 1 month for NET-EN and 4 months for DMPA.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines. Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.
- If a woman has unexplained vaginal bleeding, she should be further evaluated and treated prior to initiating this method.
- Not advised if woman has a history of breast cancer or if woman has major risk factors for venous cardiovascular disease, including older age, stroke, smoking, diabetes, hypertension or known dyslipidaemia.
- NET-EN:
  - NET-EN is not advised if a woman takes medicine for seizures or takes Rifampicin (for tuberculosis or other infections).
  - If on NNRTIs (specifically Efavirenz or Nevirapine) or Ritonavir-boosted protease inhibitors as part of HAART, there may be lower effectiveness of NET-EN injectables. Emphasize dual protection if using NET-EN to reduce chance of pregnancy.



Standard Days Method®

SDM

Standard Days Method®

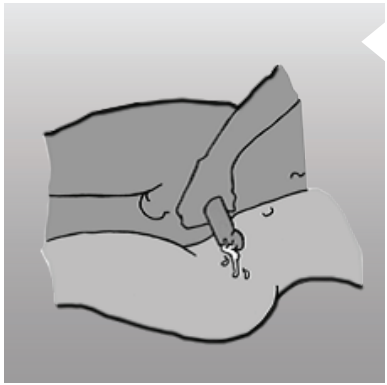
SDM

EFFECTIVENESS

Typical use in first year
12 pregnancies per 100 women

- Ideal for women whose menstrual cycles are usually between 26 and 32 days long. Women who have regular monthly bleeding fall within this range.
- The client keeps track of their menstrual cycle to know the days they can get pregnant (fertile days).
- The client uses a calendar or CycleBeads®, a string of color-coded beads, to track the days they can get pregnant and the days they are not likely to get pregnant.
- On the days the client can get pregnant, they must abstain from having unprotected sex. Or, they can use a condom or other barrier method.
- Postpartum or breastfeeding women must have 3 regular menstrual cycles before they can use SDM. An alternate method should be used in the interim.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.
- Requires partner's cooperation.

LESS EFFECTIVE



Withdrawal

Coitus Interruptus, “Pulling out”

Withdrawal

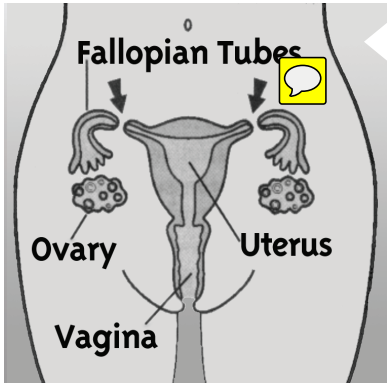
Coitus Interruptus / "Pulling Out"

EFFECTIVENESS

Typical use
22 pregnancies per 100 women

- The man withdraws his penis from his partner's vagina before ejaculation and he ejaculates outside of the vagina.
- Is one of the least effective methods, yet offers better protection than no method at all.
- Not suitable for men who cannot sense consistently when ejaculation is about to occur or ejaculate prematurely.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.
- Requires partner's cooperation.

LESS EFFECTIVE



Tubal Ligation

Female Sterilization

Tubal Ligation

Female Sterilization

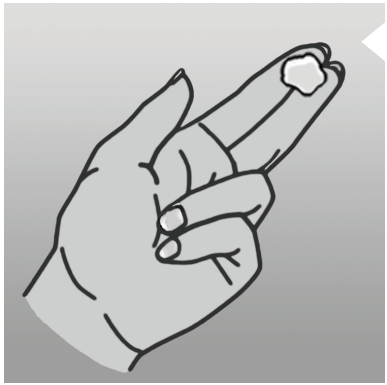
EFFECTIVENESS

In first year
Less than 1 pregnancy per 100 women

Over 10 years
2 pregnancies per 100 women

- Permanent method for women who do not want more children.
- Involves a surgical procedure. There are both benefits and certain risks involved in the procedure.
- Protects against pregnancy right away.
- Safe for a woman with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

HIGHLY EFFECTIVE



TwoDay Method®

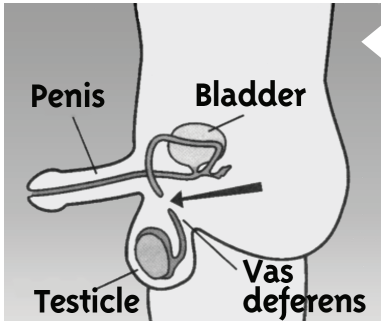
TwoDay Method®

EFFECTIVENESS

Typical use
14 pregnancies per 100 women

- Ideal for women who have healthy cervical secretions.
- Healthy secretions do not have a foul smell or cause itchiness or pain.
- The client has to monitor their cervical secretions each day. This helps the client know the days when they can get pregnant (fertile days).
- On days the client can get pregnant, they must abstain from unprotected sex or they can use a condom or other barrier method.
- Does not protect against sexually transmitted infections (STIs), including HIV.
- Requires partner's cooperation.

LESS EFFECTIVE



Vasectomy

Male Sterilization

Vasectomy

Male Sterilization

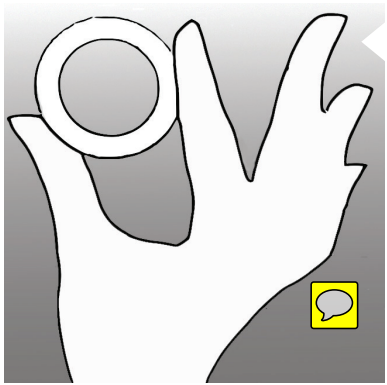
EFFECTIVENESS

In first year
Less than 1 pregnancy per 100 women whose partner has had a vasectomy

Over 3 years
4 pregnancies per 100 women whose partner has had a vasectomy

- Permanent, safe method for men who do not want more children.
- A safe, simple surgical procedure.
- Does not affect male sexual performance.
- Does not protect from pregnancy immediately. There is a 3-month delay before the method takes effect.
- The client must use condoms or another method for 3 months after the procedure.
- Safe for a man with HIV/AIDS, even if he takes antiretroviral ARV) medicines.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

HIGHLY EFFECTIVE



Progesterone Vaginal Ring

PVR

Progesterone Vaginal Ring

PVR

EFFECTIVENESS

Correct use
Consistent use every 3 months —
2 pregnancies per 100 women

HIGHLY EFFECTIVE

- ~~Used to space pregnancies.~~
- Smooth, soft, flexible, silicone ring containing natural progesterone.
- Easily inserted and removed from the vagina by the woman.
- Each ring is effective up to 3 months; method can be used successively up to one year (4 rings in 1 year).
- For use by women ≥4-6 weeks postpartum who breastfeed at least 4 times per day.
- Initiation of method should be inclusive of counseling on proper use (including insertion and removal).
- May cause irregular or no menstrual bleeding.
- As with other progesterone only methods, spotting or irregular bleeding can occur.
- There is no effect on breastmilk production; method supports continued breastfeeding/infant nutrition.
- Rapid return to fertility following discontinuation.
- Partner may be able to feel the ring.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

Caya®/SILCS Diaphragm

Caya®/SILCS Diaphragm

EFFECTIVENESS

Typical use
Not used consistently – 18 pregnancies per 100 women

LESS EFFECTIVE

- The diaphragm is a soft, flexible cup that a woman inserts in her vagina to cover her cervix. It blocks sperm from entering the cervix. The diaphragm is recommended for use with a contraceptive gel.
- The diaphragm is controlled by the woman, has no hormonal side effects, and is inserted ahead of time so it does not interfere with sex.
- The diaphragm should be used each time the client has sex. For greatest protection, insert the diaphragm before sex begins and wear the diaphragm for at least 6 hours after sex ends. Then remove the diaphragm, wash it with soap and water, rinse and let it dry. Store the diaphragm in its case until next time the client wants to use it. Never leave the diaphragm in the vagina for more than 24 hours without taking it out to wash it.
- The Caya diaphragm is made of silicone and is very strong. It is reusable for up to 2 years.
- The Caya diaphragm fits most women. When the Caya is correctly inserted, the client should not feel pain or discomfort. Practice inserting, checking that the client's cervix is covered, and removing the Caya to ensure the client is comfortable with this method.
- The diaphragm can be used by almost all women, and it is safe for breastfeeding women. Women should wait 6 weeks after childbirth or second trimester abortion before using a diaphragm so the cervix and uterus have returned to normal size.
- Does not protect against sexually transmitted infections (STIs), including HIV. Emphasize the need for dual protection with the client.

Healthy Timing and Spacing of Pregnancy

Healthy Timing and Spacing of Pregnancy

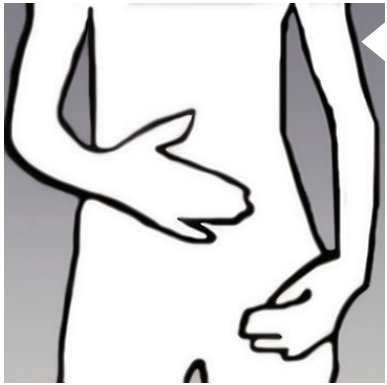
Advise on healthy timing and spacing of pregnancy.

- For women who want to have additional children after a live birth, advise:
  - For the health of the mother and baby, wait at least 2 years (24 months) before trying to become pregnant again.
  - Use of a family planning method of her choice allows a woman to plan for a healthy pregnancy and provides better health outcomes for her newborn baby and any other children she may have.
- For women who decide to have a child after a miscarriage or abortion, advise:
  - For the health of the mother and baby, wait at least 6 months before trying to become pregnant again.
  - Use of a family planning method of her choice allows a woman to plan for a healthy pregnancy.
- For adolescents, advise:
  - For the health of the mother and the baby, wait until 18 years of age before trying to become pregnant. For teen parents, counsel on waiting until 18 years of age for next pregnancy.
  - If sexually active, early adoption and initiation of a FP method of her choice allows a young woman to prevent unintended pregnancy and preserve her health.
- For women over 35 or with 5 or more term pregnancies, additional pregnancies carry higher risks for both the mother and the baby.

Promoting a Healthy Postpartum Period for the Mother

Promoting a Healthy Postpartum Period for the Mother

- Ensure that the mother has support for the first few days after birth; encourage rest and sleep.
- Recommend a nutritious diet for the mother that includes plenty of fluids and micronutrients (including Vitamin A and iron).
- Discuss normal postpartum bleeding and lochia. Counsel on maternal danger signs, such as heavy bleeding or vaginal discharge that has a foul smell and fever, severe headaches, or convulsions.
- Discuss the need for four postnatal care visits: at 24-48 hours, 3 to 7 days, 4 to 6 weeks, and 4 to 6 months.
- If a woman plans to start supplemental feeding before 6 months postpartum, discuss transition to a FP method prior to starting supplemental feeding.
- Advise on maintaining personal hygiene, including care of perineum and breasts.
- Counsel on return to sexual activity, which should be whenever the mother feels ready and usually after lochia stops. After that she can become pregnant again even before her menses returns. Pregnancy can occur even if she is still partially breast-feeding and is more likely with older infants.
- Encourage her to use FP. Most methods are safe for breastfeeding mothers. Consider providing emergency contraception with instructions to use if she stops exclusively breastfeeding or if she resumes menses and has sex before starting another family planning method.
- Counsel on postnatal depression, which may entail: crying easily; feeling tired, agitated, or irritable; lacking motivation; having difficulty sleeping; rejecting the baby.



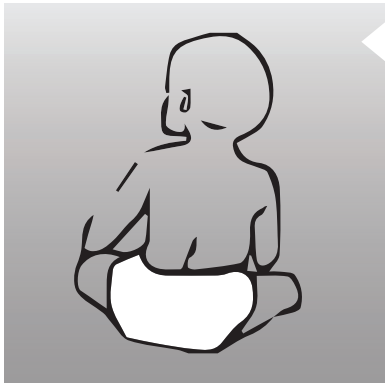
Post Abortion Care

PAC

Post Abortion Care

PAC

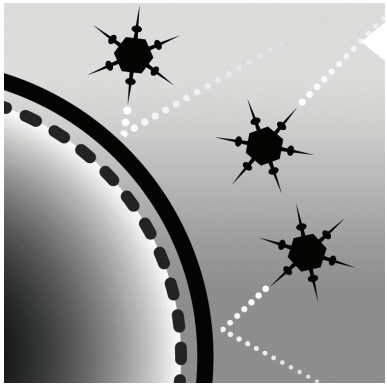
- Inform client on the quick return to fertility, within 2 weeks after the event, for a 1st trimester miscarriage.
- For better health of mother and child, couples should wait 6 months before trying to get pregnant.
- Counsel on return to sexual activity, which should be when the woman feels ready (unless the woman has a history of infection or trauma, then wait until condition is treated and resolved).
- Advise that she can become pregnant even before her menses returns. Encourage her to use FP.
- Most contraceptive methods can be used by a woman presenting for PAC - with the exception of tubal ligation and IUD if there is infection or trauma to the cervix or vagina.
- After any evacuation of the uterus, discuss and help the woman pick a contraceptive method of her choice. If it is not available or she is undecided, provide her with either condoms or emergency contraception, and offer to refer her to the nearest health center if she hasn't decided before being discharged.
- Inform the woman of the advantage of condoms as a dual-protection method.
- A woman who has been treated with misoprostol can be immediately offered any contraceptive method except an IUD. If the woman prefers an IUD, ask her to return following complete evacuation of the uterus and verification that she does not have any infections.
- Discuss normal post-abortion bleeding. Counsel on maternal danger signs, such as heavy bleeding or vaginal discharge that has a foul smell.
- Ensure that the woman has support for the first few days. Encourage rest and sleep.
- If the woman is a survivor of rape and sexual assault, refer her to other supportive care services.
- Recognize that accessing PAC can be emotionally traumatic and inform her what psychosocial services are available and offer for her to share her feelings about the process.



Promoting Newborn and Infant Health

Promoting Newborn and Infant ~~Health~~

- Discuss careful hand washing to prevent infection prior to handling the baby and after cleaning the baby's bottom or changing diapers.
- Put nothing on the baby's cord and do not get the cord area wet until it dries up and falls off, about 2 weeks after birth.
- Counsel the mother on newborn danger signs and when to seek care immediately. Danger signs include: difficulty feeding and/or breathing; feeling too hot or too cold; being irritable for an extended period of time.
- Discuss the importance of providing good ventilation and keeping the baby warm.
- Encourage exclusive breastfeeding for 6 months. Nothing else is necessary, not even water. Introduce complementary foods at 6 months and continue to breastfeed. Exclusive breastfeeding during the first 6 months and the absence of a period/menses during this time is the Lactational Amenorrhea Method (LAM) (see LAM card).
- For infants exposed to HIV:
  - Advise mother to give infant antiretroviral (ARV) medicines daily while breastfeeding and to continue for 1 week after cessation of breastfeeding (around 1 year), or for mother to continue ARV treatment per national protocols.
  - Recommend that HIV-exposed infants get tested for HIV at 6 weeks and start co-trimoxazole prophylaxis (CTX).
  - Link mother and infant to HIV clinic.
- Explain immunization schedule for infants using national or global guidelines, and include recommendation for Vitamin A at 6 months.
- Discuss the need to attend child-welfare clinic (including key activities such as growth monitoring).



STI/HIV Transmission & Prevention

STI/HIV Transmission & Prevention

Discuss the following about all sexually transmitted infections (STIs), including HIV:

- A person can become infected with STIs, including HIV, through unsafe or unprotected sexual activity.
- STIs are common.
- A person living with STIs (including HIV) may have no symptoms, may look healthy and may not be aware that s/he is infected.
- Common STI symptoms include vaginal discharge, discharge from the penis, sores in the genital area, burning on urination for men, lower abdominal pain for women.
- Some STIs can be treated. To avoid re-infection, both partners must be treated.
- Risk of infection can be reduced by using a condom, limiting the number of sex partners, and delaying sex.

Discuss the following facts specifically about HIV:

- HIV is a sexually transmitted infection. HIV is transmitted through an exchange of bodily fluids such as semen, blood, breast milk, and during delivery.
- Knowing the client's HIV status protects them, their partner, and their family. Clients can be offered testing today if it is available, or offered a referral to a testing facility
- Although HIV cannot be cured, early identification and treatment can allow a person to live a long productive life and prevent his/her partner from becoming infected.
- Male circumcision significantly reduces the risk of HIV infection in heterosexual couples.
- Maternal transmission of HIV to the child can be substantially reduced by identifying women living with HIV and providing treatment or prophylactic ARV medicines during pregnancy and breastfeeding, should the woman choose to breastfeed.

STI and HIV Risk Assessment

STI and HIV Risk Assessment

Discuss the following issues to assess the client's risk of STIs and HIV:

- Ask client about past and present condom use (including perception of partner's attitude) and ask whether s/he is aware that condoms protect against both STIs/HIV and pregnancy.
- Ask the client whether they know their HIV status and the HIV status of partner(s). If partner is positive, ask whether s/he is taking ARV medicines.
- Discuss risks associated with multiple or concurrent partners. This includes increased risk for sexually transmitted infections (STIs) and HIV.
- Ask whether the client has knowledge of their male partner's circumcision status. Explain that male circumcision reduces the transmission risk of STIs or HIV to the male's partner.
- Discuss with clients the types of sex or sexual activities and behaviors that can increase risk for getting an STI or HIV (for example, if partner or self has multiple sexual partners, oral sex, anal sex, dry sex, use of detergents or spermicides).
- Discuss whether the client has knowledge of partner's sexual history, including multiple or concurrent partners. If partner or self has history of multiple or concurrent partners, counsel client to attend couples' counseling or voluntary testing and counseling (VCT) to determine HIV status.
- Ask about client's home-life situation (for example, partner violence and social support). If they mention violence, refer to Women's Support and Safety card.
- Ask whether client has ever used PMTCT during pregnancy. Discuss benefits of PMTCT to prevent HIV transmission during pregnancy.

Positive Health, Dignity & Prevention

Positive Health, Dignity & Prevention

Provide support and counseling on issues relating to disclosure of HIV status. Be sure that client knows it is her/his decision to disclose her/his status and that the provider will not share status without consent.

Discuss the following with the client:

- People living with HIV need regular checkups to see if they need antiretroviral (ARV) medicine, to evaluate how they are doing on ARVs, and to rule out other infections or illnesses. Visits may be frequent when ARV medicine is started.
- A person on ARVs should do her/his best to take the medication as prescribed and should not share medication.
- Partners should get tested as well. The client can bring her/his partner in for counseling and to talk together.
- If currently taking medication for tuberculosis, s/he should follow up with the provider.
- If a woman with HIV wants to get pregnant:
  - The risk of passing HIV to her newborn may be greatly reduced by taking ARV medicine and having a safe delivery. It is important to receive care at an antenatal clinic and an HIV treatment center.
- If a woman is in a serodiscordant relationship (one partner has HIV and the other doesn't) and is trying to get pregnant:
  - The risk of transmitting HIV can be reduced by only engaging in unprotected sex (sex without condoms) during a woman's fertile period. The seropositive partner should continue ARVs to reduce the amount of virus in her/his body.
- Positive health results from taking care of oneself and being alert to health concerns that need attention, which may include physical and mental health issues as well as social support.

Dual Protection

Dual Protection

Discuss the following with the client:

- Dual protection is the use of condoms consistently and correctly in combination with another family planning method. This provides added protection against pregnancy in case of condom failure.
- Use a male or female condom correctly and consistently with every act of sex. This one method protects against STIs and pregnancy.
- Only engage in safer sexual intimacy that prevents semen and vaginal fluids from coming in contact with partner's genitals or other vulnerable areas, such as the mouth and anus.
- Delay or avoid sexual activity, especially with a partner whose STI/HIV status is not known.

HIV Counseling and Testing

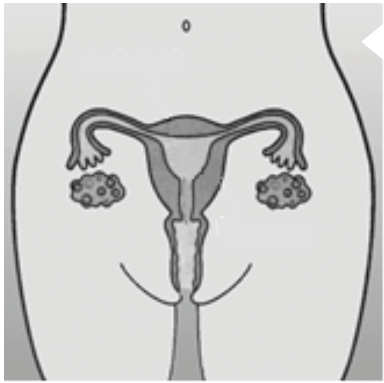
HCT

HIV Counseling and Testing

HCT

Discuss the following with the client:

- Knowing the client's HIV status can help them make decisions about protecting themselves and their sexual partner(s).
- Testing permits people living with HIV to seek treatment so that they can live a full life. The test involves taking a small sample of blood. The test is free and available at clinics, hospitals, and HIV counseling and testing sites.
- Test results are kept confidential.
- When a person is first infected with HIV, it can take 3 or more months for the test to detect the infection. This is called the "window period" and is the reason why repeat testing is important.
- A positive test result means the person is infected with HIV and can transmit the virus to others.
- A negative test result can mean the person is not infected or that s/he is in the "window period". Another test should be taken within 3 months. If the second test is still negative, the person is currently not living with HIV but can still become infected with HIV.
- HIV is a sexually transmitted infection (STI). It is important to ask their sexual partner(s) to be tested too.



Screening for Cervical Cancer

Screening for Cervical Cancer

If the client is 30-49 years of age or HIV positive at any age, ask if the client has ever been screened for cancer of the cervix.

- Cancer of the cervix is a common cancer of the reproductive tract. It is preventable, easily detectable, and curable in the early stages.
- Cervical cancer results from infection with a virus known as HPV.
  - Most infections clear up, but those that are persistent may lead to cervical cancer.
- Describe how cervical cancer presents:
  - Cancer of the cervix is painless and progresses slowly.
  - It occurs at the opening of the uterus.
  - When advanced, a woman may experience an abnormal/unusual smell or odor from her vagina, painful sexual intercourse, bleeding after sex and lower abdominal and back pain.
- Detection is through a quick, simple, and generally not painful test done by a trained provider (HPV test, VIA or Pap smear).
- Screening for cancer of the cervix should be done every 3-5 years (depending on national guidelines). Women living with HIV should be screened every 3 years. If the test is positive, then treatment is recommended. Early treatment involves freezing the sores (cryotherapy) and can be done as an outpatient procedure.
- Clients with advanced cancerous sore/s are referred for special treatment.

Adolescent Counseling

Adolescent Counseling

If a client is younger than 18 years, discuss adolescent health needs.

- Adolescence is a time of transition marked by physical, psychological and social milestones.
- Adolescents have unique reproductive health needs that can be addressed through health services, including counseling.
- Ask clients about resources in their communities:
  - Are there supportive and positive individuals that you can go to for advice or support? These can include partners, parents, teachers and community leaders.
- For married adolescents, discuss desired family size (refer to HTSP card).

- For unmarried adolescents, describe the importance of delaying marriage and pregnancy:
  - For the health of the mother and baby, wait until at least age 18 before trying to become pregnant.
  - Early marriage and pregnancy should be avoided in order to allow for girls' full mental and physical development.
  - To prevent unintended pregnancy, it is important for a young woman to consistently use a modern contraceptive method.
- Describe other health issues facing adolescent girls:
  - Adolescent girls who are sexually active are at risk for STIs, including HIV. Using a condom in addition to another family planning method can provide added STI and HIV prevention, (refer to STI/HIV Transmission & Prevention).
  - Girls have important nutritional needs to ensure their healthy development.
- Discuss available youth-focused services, including sports clubs, support clubs, young mothers clubs, faith groups or community-based groups. Refer the client to services as needed.

Women's Support and Safety

Women's Support and Safety

Take the time to assess the woman's risk for intimate partner violence and the potential risks that accompany FP use for the woman.

Begin by sharing some information on intimate partner violence with the client:

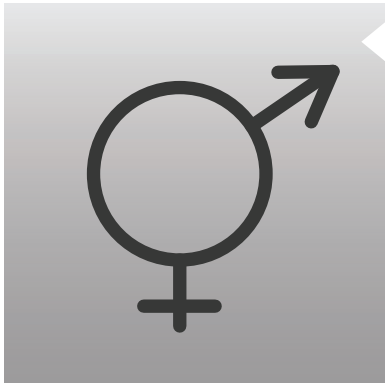
- We want to ensure that women and their families thrive in a safe and supportive environment. This includes ensuring that women feel that they and their children are safe at home. We share the following information with all of our clients and ask some confidential questions.
- 1 out of 3 women worldwide have experienced either intimate partner violence or non-partner sexual violence in their lifetime.
- Any intimate partner violence involves harm to a human that can evolve into other health risks, not only for the woman but for her child or children as well. This includes increased risk for: chronic diseases, depression, suicide, lowered immune system, low birth weight, child abuse and intergenerational violence.

Ask the following questions to screen for IPV:

- Are you currently in a relationship with a person who threatens, frightens, or insults you, or treats you badly?
- Is there anyone who forces you to participate in sexual activities that are unwanted or make you feel uncomfortable?

If the client mentions fear of or experience with intimate partner violence OR if the client exhibits clinical indications of intimate partner violence (including chronic or acute pain with unknown origin, frequent sexual or gynecological problems, or depression and anxiety), follow these steps:

- Be supportive and validate their experience.
- Assess whether the client is living in a situation of risk—if she is, develop a safety plan or refer to another resource that can provide immediate assistance.
- Assess whether the client is in crisis, e.g. if she is in extreme emotional distress—if she is, provide her with the necessary emotional support or immediately refer her to another resource that can provide immediate assistance.
- Counsel the client on available referral services in their community. These can include: women's centers, shelters or safe houses, psychological counseling, couples counseling programs, and legal and medical services. Provide client with support and referral to the service(s) of her choice.



Male Services and Support for their Partners

Male Services and Support for their Partners

Discuss men's responsibility in sexual and reproductive decision-making

- Men should be active in parenting and being fathers. Men can jointly decide with their partners:
  - The number of children they want to have.
  - When and how to use family planning methods.
  - Where to seek family planning services, maternity services and child health services.
- They are also partners in preventing and treating sexually transmitted infection (STIs), including HIV.

If the man is present during an FP and HIV services consultations

- Congratulate the man for his presence and tell him about the services available for men, and explain the benefits of family planning and birth spacing.
  - Family planning allows the client(s) to plan the number of children they want to have and when they want to have them. Waiting for 36 months between the births of their children improves their partner's health, all of their children's health, and the available resources they have to support their family.
- Describe services that are available to men, such as STI screening and treatment, HIV testing and counseling, hypertension screening, obesity counseling, and smoking counseling.
- If the clinic has any of the services mentioned above, offer the services or refer the man within the facilities. If these services are not available, inform the man where the services are available and offer a referral to these facility.

Balanced Counseling Strategy Plus

Third Edition

The Balanced Counseling Strategy Plus (BCS+) toolkit, developed and tested in Kenya and South Africa, provides the information and materials that health-care facility providers need so they can offer complete, high-quality family planning counseling to clients living in areas with high rates of HIV and STIs. The BCS+ was adapted from the Balanced Counseling Strategy (Léon 1999; Léon et al. 2003a, b, c; Léon et al. 2008). First and second editions of the Balanced Counseling Strategy and the Balanced Counseling Strategy Plus toolkits are products of Population Council's FRONTIERS program, supported by United States Agency for International Development (USAID), Cooperative Agreement HRN-A-00-98-00012-00.

This Third Edition of the BCS+ includes content updated according to the latest WHO Medical Eligibility Criteria (2015). It incorporates the most up to date evidence on clinical indications for the provision of family planning methods, including new methods, and includes four new counseling cards that address Adolescent Counseling, Male Services, Post Abortion Care, and Women's Support and Safety. These updated cards include instructions for providers, guiding them through supplemental counseling and services that family planning clients may need. Development of this Third Edition of the BCS+ counseling cards was funded by the Evidence Project and the Integra Project at the Population Council.

Note: These cards are part of a larger publication titled The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings.
The BCS+ toolkit is comprised of the following:

- Algorithm
- Counseling cards
- Method brochures
- User's Guide
- Trainer's Guide
- WHO Medical Eligibility Criteria Wheel

We would like to acknowledge the following individuals for contributing their time and technical expertise to this edition of the BCS+: Megan Christofield, Heather Clark, Mychelle Farmer, Kamlesh Giri, Joanne Gleason, Mark Hathaway, Anushka Kalyanpur, Maggie Kilbourne-Brook, Karen Kirk, Ricky Lu, Ruth Merkatz, Charity Ndwiga, Anne Pfitzer, Saumya Ramarao, Naomi Rijo, Elizabeth Rochette, Jill Schwartz, Leigh Stefanik, John Townsend, Chi-Chi Undie, Katie Unthank, Anneka Van Scoyoc, Charlotte Warren, Ellen Weiss, Kelsey Wright.

For the full Toolkit, please visit http://www.popcouncil.org/bcsplus