

## **The Balanced Counseling Strategy Plus:**

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

# **Counseling Cards**

**Second Edition, 2012**

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-  **Dual Protection**
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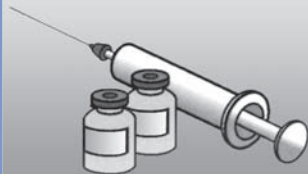


**Checklist to be  
reasonably sure a woman  
is not pregnant**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## Checklist to be reasonably sure a woman is not pregnant

Ask these 6 questions:	<p>If “Yes” to <b>any</b> of these questions, <b>and</b> client is free of signs and symptoms of pregnancy,</p> <ol style="list-style-type: none"> <li>1. Pregnancy is unlikely.</li> <li>2. Continue to <b>Step 5</b></li> </ol>	<p>If “No” to <b>all</b> of the questions,</p> <ol style="list-style-type: none"> <li>1. Pregnancy cannot be ruled out.</li> <li>2. Give client pregnancy test if available, or refer her to an antenatal clinic.</li> <li>3. Ask her to return when she has her menstrual bleeding.</li> <li>4. Provide her with a back-up method, such as condoms, to use until then.</li> <li>5. Go to <b>Step 13</b></li> </ol>
1. Did you have a baby less than 6 months ago? If so, are you fully breastfeeding? Have you had no menstrual bleeding since giving birth?		
2. Have you abstained from unprotected 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 an 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 or CICs**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Monthly Injectable**

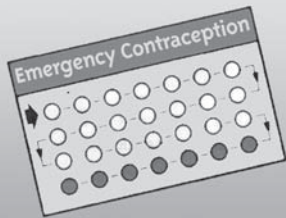
### **Combined Injectable Contraceptives or CICs**

#### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use:

- Correct use (no missed or late injections) —  
1 pregnancy per 100 women (1%)
- Typical use (some missed or late injections)  
— 3 pregnancies per 100 women (3%)

- Requires that you 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.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines. But not advised if on Ritonavir-boosted protease inhibitors as part of HAART.
- Does not protect against sexually transmitted infections (STIs), including HIV.



# **Emergency Contraception**

**Emergency Contraceptive  
Pills or ECPs**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Emergency Contraception**

### **Emergency Contraceptive Pills or ECPs**

#### **Effectiveness for pregnancy prevention for each act of unprotected sex:**

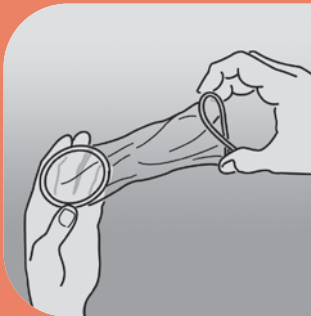
When taken within 5 days (120 hours) of  
having unprotected sex:

- With ECPs — only 1 or 2 pregnancies per 100 women (1 or 2%)
- Normally (no ECPs) — 8 pregnancies per 100 women (8%)

**1– 2**

- The only method that can help prevent pregnancy after a woman has had sex.
- Not recommended for regular use. A woman using ECPs repeatedly should receive additional family planning counseling in order to select the most appropriate continuous method.
- Must be used within 5 days (120 hours) of unprotected sex.
- Safe for women who cannot use regular hormonal contraceptive methods.
- ECPs do not disrupt existing pregnancy.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines. But not advised if on Ritonavir- boosted protease inhibitors as part of HAART.
- Does not protect against sexually transmitted infections (STIs), including HIV.





## **Female Condoms**

**Balanced Counseling Strategy Plus (2nd Ed.)**

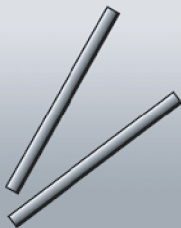
## Female Condoms

### Effectiveness for pregnancy prevention:

Pregnancy rate in first year of use is:

- Correct use (used with each act of sex) — 5 pregnancies per 100 women (5%)
- Typical use (not used consistently) — 21 pregnancies per 100 women (21%)

- The female condom is a sheath made of transparent latex with flexible rings at both ends. It is the same length as a male condom.
- Before having sex, place the female condom into your vagina up to eight hours before an anticipated sexual act. It fits loosely inside the vagina.
- You must use a new condom for each act of sex.
- Protects against pregnancy and sexually transmitted infections (STIs), including HIV.
- Preserves feeling of sex for men and women.
- Requires partner's cooperation.



## **Hormonal Implants**

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**Balanced Counseling Strategy Plus (2nd Ed.)**

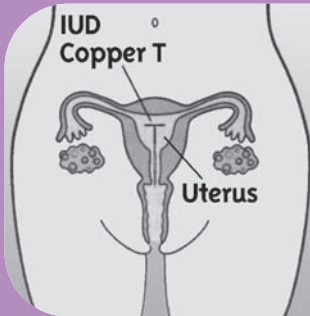
## **Hormonal Implants**

### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Less than 1 pregnancy per 100 women (1%)

- Are small rods or capsules (about the size of a matchstick) put under the skin.
- Provide long-term protection from pregnancy for 3 to 5 years. Length of protection depends on the implant.
- A trained provider must insert and remove implants.
- Safe for women who are breastfeeding. You may get implants 6 weeks after giving birth.
- Often cause changes in monthly bleeding.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines.
- Do not protect against sexually transmitted infections (STIs), including HIV.



# **Intrauterine Device**

**Copper-bearing IUD**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Intrauterine Device**

### **Copper-bearing IUD**

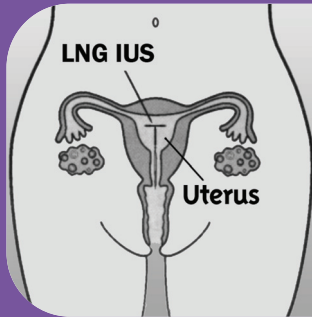
#### **Effectiveness for pregnancy prevention:**

Pregnancy rate is:

- In first year of use — less than 1 pregnancy per 100 women (1%)
- Over 10 years of use— 2 pregnancies per 100 women (2%)

**1 – 2**

- Provides long-term protection against pregnancy for up to 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.
- 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 longer and heavier bleeding and more cramps or pain during monthly bleeding.
- Safe for a woman living with HIV or AIDS who is clinically well on antiretroviral (ARV) medicines.
- Not advised for a woman at very high risk of having a sexually transmitted infection (STI).
- Does not protect against sexually transmitted infections (STIs), including HIV.



## **Levonorgestrel Intrauterine System**

**LNG IUS**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Levonorgestrel Intrauterine System**

**LNG IUS**

### **Effectiveness for pregnancy prevention:**

**Pregnancy rate is:**

- In first year of use — less than 1 pregnancy per 100 women (1%)
- Over 10 years of use— 5 pregnancies per 1000 women (0.5%)

**0.5 – 1**

- 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.
- Causes lighter and shorter monthly periods of bleeding and may cause periods to stop all together.
- Safe for a woman living with HIV or with AIDS who is clinically well taking antiretroviral (ARV) medicines.
- Not advised for a woman at very high risk of having a sexually transmitted infection (STI).
- Does not protect against sexually transmitted infections (STIs), including HIV.
- Can be inserted 4 - 6 weeks postpartum.





# **Lactational Amenorrhea Method**

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**LAM**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Lactational Amenorrhea Method**

### **LAM**

#### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first 6 months after childbirth is:

- When all 3 conditions are met — less than 1 pregnancy per 100 women (1%)
- As commonly used — 2 pregnancies per 100 women (2%)

**1 – 2**

- LAM is the use of fully breastfeeding after having a baby to delay the woman's return to fertility as a method of family planning.
- LAM requires 3 conditions. All 3 must be met:
  - 1) Your monthly bleeding has not returned since giving birth.
  - 2) The baby is fully breastfed, day and night.
  - 3) The baby is less than 6 months old.
- LAM is a temporary family planning method to use after pregnancy, when a woman can think about which method to use after LAM no longer protects her from pregnancy.
- Safe for a woman living with HIV/AIDS. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding.
- Does not protect against sexually transmitted infections (STIs), including HIV.



## **Male Condoms**

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**Balanced Counseling Strategy Plus (2nd Ed.)**

## Male Condoms

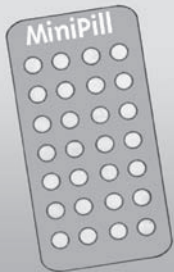
### Effectiveness for pregnancy prevention:

Pregnancy rate in first year of use is:

- Correct use (used with each act of sex) — 2 pregnancies per 100 women (2%)
- Typical use (not used consistently) — 15 pregnancies per 100 women (15%)

- Most condoms are made of thin latex rubber. Some condoms are coated with a lubricant and/or spermicide.
- If you have had an allergic reaction to latex rubber, you should not use latex condoms.
- Before having sex, place the condom over the erect penis.
- You must use a new condom for each act of sex.
- Protect against pregnancy and sexually transmitted infections (STIs), including HIV.
- Require partner's cooperation.

**2 – 15**



## **Minipill**

**Progestin-only  
Oral Contraceptives**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Minipill**

Progestin-only  
Oral Contraceptives

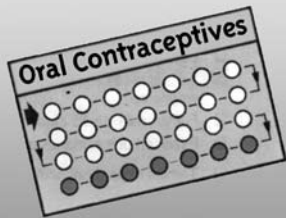
### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Correct use (no missed pills) — less than 1 pregnancy per 100 women (1%)
- Typical use (some missed pills) — 3 to 10 pregnancies per 100 women (3 to 10%)
- For breastfeeding women — 1 pregnancy per 100 women (1%)

**1 – 10**

- Requires that you take 1 pill every day.
- Safe for women who are breastfeeding. You may begin the mini pill 6 weeks 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. But not advised if on Ritonavir-boosted protease inhibitors as part of HAART.
- Does not protect against sexually transmitted infections (STIs), including HIV.



# The Pill

## Combined Oral Contraceptives

Balanced Counseling Strategy Plus (2nd Ed.)

## **The Pill**

**Combined Oral  
Contraceptives**

### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Correct use (no missed pills) — less than 1 pregnancy per 100 women (1%)
- Typical use (some missed pills) — 8 pregnancies per 100 women (8%)
- Requires that you take 1 pill every day.

**1 – 8**

- Not advised if breastfeeding an infant less than 6 months old.
- May cause irregular bleeding during the first few months of use.
- May also cause absence of periods or other side effects.
- Not advised if woman takes medicine for seizures or takes Rifampicin.
- Safe for a woman with HIV/AIDS, even if she takes antiretroviral (ARV) medicines. But not advised if on Ritonavir- boosted protease inhibitors as part of HAART.
- There are many different brands and regimens of combined oral contraceptives. Discuss available and most appropriate method with provider.
- Does not protect against sexually transmitted infections (STIs), including HIV.





## **Progestin-only Injectables**

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DMPA or NET-EN

Balanced Counseling Strategy Plus (2nd Ed.)

## **Progestin-only Injectables**

DMPA or NET-EN

### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Correct use (no missed or late injections) — 1 pregnancy per 100 women (1%)
- Typical use (some missed or late injections) — 3 pregnancies per 100 women (3%)

- You get an injection every 2 or 3 months, depending on type of injection.
- Safe for women who are breastfeeding a baby. You may begin the method 6 weeks after giving birth.
- May cause irregular or no menstrual bleeding.
- There is a delayed return to fertility after you stop the method. It takes longer than with most other methods.
- Not advised if woman takes medicine for seizures or takes Rifampicin.
- Safe for a woman living with HIV/AIDS, even if she takes antiretroviral (ARV) medicines. But not advised if on Ritonavir- boosted protease inhibitors as part of HAART.
- There is inconclusive evidence about possible increased risk of HIV acquisition among women using this method. Male or female condoms should always be used with this method to prevent HIV and other STIs.



## **Standard Days Method<sup>®</sup>**

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**SDM**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Standard Days Method®**

**SDM**

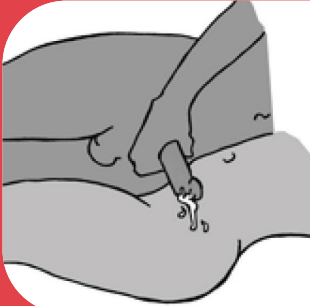
### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Correct use (no unprotected sex on fertile days) — 5 pregnancies per 100 women (5%)
- Typical use — 12 pregnancies per 100 women (12%)

**5 – 12**

- Ideal for women whose menstrual cycles are usually between 26 and 32 days long. Women who have regular monthly bleeding fall within this range.
- You keep track of your menstrual cycle to know the days you can get pregnant (fertile days).
- You use a calendar or CycleBeads®, a string of color-coded beads, to track the days you can get pregnant and the days you are not likely to get pregnant.
- On the days you can get pregnant, you must abstain from having unprotected sex. Or, you can use a condom or other barrier method.
- Postpartum or breastfeeding women must have 3 regular menstrual cycles before they can use SDM.
- Does not protect against sexually transmitted infections (STIs), including HIV.
- Requires partner's cooperation.



## **Withdrawal**

**Coitus Interruptus, "Pulling out"**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Withdrawal**

Coitus Interruptus, "Pulling out"

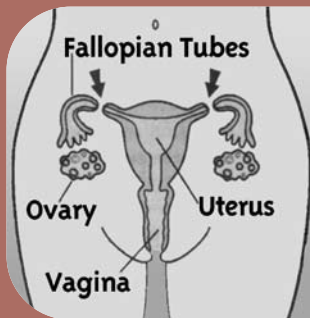
### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Correct use (no unprotected sex on fertile days) — 4 pregnancies per 100 women (4%)
- Typical use — 27 pregnancies per 100 women (27%)

**4 –27**

- 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.
- Requires partner's cooperation.



# **Tubal Ligation**

**Female Sterilization**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Tubal Ligation**

### **Female Sterilization**

#### **Effectiveness for pregnancy prevention:**

Pregnancy rate after the procedure is:

- In first year — less than 1 pregnancy per 100 women (1%)
- Over 10 years — 2 pregnancies per 100 women (2%)

- 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.





## **TwoDay Method<sup>®</sup>**

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**Balanced Counseling Strategy Plus (2nd Ed.)**

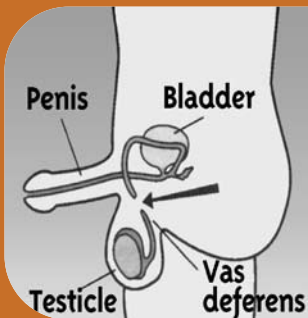
## **TwoDay Method<sup>®</sup>**

### **Effectiveness for pregnancy prevention:**

Pregnancy rate in first year of use is:

- Correct use (no unprotected sex on fertile days) — 4 pregnancies per 100 women (4%)
- Typical use — 14 pregnancies per 100 women (14%)
- Ideal for women who have healthy cervical secretions.
- Healthy secretions do not have a foul smell or cause itchiness or pain.
- You have to monitor your cervical secretions each day. This helps you know the days when you can get pregnant (fertile days).
- On days you can get pregnant, you must abstain from unprotected sex or you can use a condom or other barrier method.
- Does not protect against sexually transmitted infections (STIs), including HIV.
- Requires partner's cooperation.

**4 – 14**



# Vasectomy

Male Sterilization

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Vasectomy**

### **Male Sterilization**

#### **Effectiveness for pregnancy prevention:**

Pregnancy rate after the procedure is:

- Over first year — 1 to 3 pregnancies per 100 women whose partner has had a vasectomy (1 to 3%)
- Over first 3 years — 4 pregnancies per 100 women whose partner has had a vasectomy (4%)

- 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.
- You 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.



## **Healthy Timing and Spacing of Pregnancy**

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## **Healthy Timing and Spacing of Pregnancy**

Advise on healthy timing and spacing of pregnancy:

- For women who want to have more children after a live birth, advise:
  - For the health of the mother and baby, wait at least 2 years (24 months) but not more than 5 years 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 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 baby, wait until at least 18 years of age before trying to become pregnant.
  - If sexually active, use of a family planning method of her choice allows a young woman to prevent unintended pregnancy.



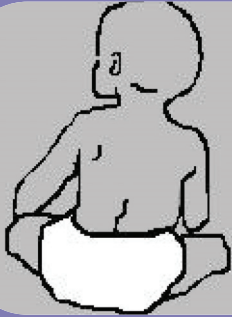
## **Promoting a Healthy Postpartum Period for the Mother**

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## **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 bleeding or vaginal discharge that has a foul smell.
- 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.
- 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. Advise that she can become pregnant again even before her menses returns, if she is not using contraceptives.
- Counsel on postnatal depression, which may entail: crying easily; feeling tired, agitated, or irritable; lacking motivation; having difficulty sleeping; rejecting the baby.





## **Promoting Newborn and Infant Health**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## Promoting Newborn and Infant Health

- Discuss careful hand washing to prevent infection prior to handling the baby and after changing diapers.
- 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 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.
- For infants exposed to HIV:
  - o 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.
  - o Recommend that HIV-exposed infants get tested for HIV at 6 weeks and start co-trimoxazole prophylaxis (CTX).
  - o 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 and HIV Transmission and Prevention**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **STI/HIV Transmission and 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 (adolescents).

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 your HIV status protects you, your partner, and your family.
- 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 reduces the risk of heterosexually acquired HIV infection in men by approximately 60% and should be one element of a comprehensive HIV-prevention package.
- 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.



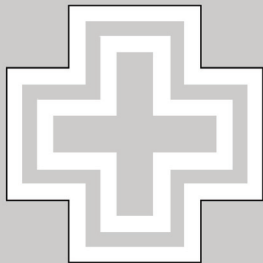
## **STI and HIV Risk Assessment**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **STI and HIV Risk Assessment**

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

- HIV status and HIV status of partner(s). If partner is positive, whether s/he is taking ARV medicines.
- Number of sexual partners, both current and in the past.
- Knowledge of partner's sexual practices and past partners.
- Knowledge of male partner's circumcision status.
- Past and present condom use (including perception of partner's attitude) and whether s/he is aware that condoms protect against both STIs/HIV and pregnancy.
- Current symptoms/treatment of STIs and history of previous sexually transmitted infections, symptoms and treatment for self and partner(s)
- Type of sex or sexual activities and behaviors (for example, mutual monogamy, whether partner has other sexual partners, oral sex, anal sex, dry sex, or use of detergents and/or spermicides).
- Home-life situation (for example, partner violence and social support).
- Use of PMTCT services during pregnancy, delivery, and breastfeeding.



## **Positive Health, Dignity and Prevention**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Positive Health, Dignity and 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 issues with the client:

- People living with HIV should always use a condom correctly and consistently with their sexual partners.
- If a woman with HIV wants to get pregnant, the risk of her passing HIV to her newborn may be greatly reduced by taking antiretroviral (ARV) medicines and having a safe delivery. It is important to receive care at an antenatal care clinic and an HIV treatment center.

- People living with HIV need regular health checkups to see if they need ARV medicine, to evaluate how they are doing on ARV medicines, and to rule out other infections or illnesses.
- If a person is taking ARV medicine, s/he should attend follow-up clinic visits as recommended by the provider. Visits may be frequent when ARV medicines are initiated.
- The person should do her/his best to adhere to the medication regimen prescribed and should not share medications.
- Partners should get tested as well. The person can bring her/his partner in for counseling, to talk together, if this will help.
- If currently taking medications for tuberculosis, s/he should follow up with provider.
- Positive health results from taking care of oneself and being alert to health concerns that warrant attention, which may include physical and mental health issues as well as social support.





## **Dual Protection**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## Dual protection

Discuss the following issues 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.



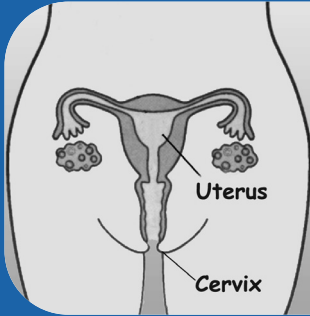
## **HIV Counseling and Testing (HCT)**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **HIV Counseling and Testing (HCT)**

Discuss the following with the client:

- Knowing your HIV status can help you make decisions about protecting yourself and your 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 your sexual partner(s) to be tested too.



## **Screening for Cervical Cancer**

**Balanced Counseling Strategy Plus (2nd Ed.)**

## **Screening for Cervical Cancer**

Discuss whether the client has ever been screened for cancer of the cervix

- Cancer of the cervix is one of the most common reproductive health malignancies. It is preventable, easily detectable, and curable in the early stages.
- Describe how cervical cancer presents:
  - o Cancer of cervix is painless and progresses slowly.
  - o It occurs at the opening of the uterus.
  - o In advance lesions the signs and symptoms include painful sexual intercourse, bleeding after sex and lower abdominal and back pain.
- Detection is through a simple pelvic examination by a trained service provider (VIA/VILI or Pap smear). It is a simple quick test and generally not painful.
- Screening for cancer of the cervix should be done every 3-5 years (depending on National guidelines) and if VIA/VILI is positive then once every year. Women living with HIV should be screened every 6-12 months.
- Early cervical lesions can be treated on outpatient basis through cryotherapy (freezing of the lesions).
- Clients with advanced cancerous lesion/s are referred for specialized treatment.



## **The Balanced Counseling Strategy Plus:**

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

# **Counseling Cards**

**Second Edition, 2012**

## Balanced Counseling Strategy Plus (2nd 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 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 and funding from the President's Emergency Plan for AIDS Relief (PEPFAR) through the USAID mission in Kenya and South Africa.

This second edition of the BCS+ includes content updated according to the latest WHO Medical Eligibility Criteria (2010) as well as additional instructions for providers, guiding them through supplemental counseling and services that family planning clients may need. Development of this second edition was funded by the Population Council and included input from the following: Katherine Williams, Saiqa Mullick, Wilson Liambila, Mantshi Menziwa, Charlotte Warren, Charity Ndwiga and Ian Askew.

**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 Balanced Counseling Strategy Plus Toolkit includes the following:

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

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