# Unit 20
# FAMILY PLANNING AND SEXUALLY TRANSMITTED INFECTIONS INCLUDING HIV

## Learning Objectives

By the end of this unit, learners will be able to:

- Define sexually transmitted infections (STIs)
- Outline groups at risk for STI and cervical cancer
- Explain common symptoms that suggest possible STIs
- List the benefits of offering family planning to clients with STIs/ human immunodeficiency virus (HIV)
- Explore the range of family planning choices for clients with HIV and related issues
- List contraceptive methods available to women and couples with HIV
- Explain the reasons for using the dual protection strategy
- Describe how the presence of HIV, AIDS and the use of antiretroviral (ARV) therapy affects method eligibility
- Explain the concerns, theoretical or otherwise, related to the use of hormonal contraception among women with HIV, including those who are taking ARV drugs.

## Teaching Resources in this Unit

### Learning Activities



### Unit Assessment

## Key Points

- **STIs are infectious diseases caused by bacteria and viruses spread through sexual contact.**
- **Family planning providers can play an important role in preventing the transmission of STIs, including HIV.**
- **Most family planning methods are appropriate for use by clients with STIs/HIV/AIDS.**
- **Condoms are the only family planning method proven to reduce the risk of STIs, including HIV.**
- **Dual protection, a strategy for protecting users against both unintended pregnancy and disease transmission, is particularly important for those at risk of STI/HIV.**
- **Clients with HIV, AIDS or who are on ARV therapy can initiate and continue use of most family planning methods.**

# 20.1 Defining Sexually Transmitted Infections

STIs, including infection with the HIV, are infectious diseases affecting men and women caused by bacteria and viruses spread through sexual contact.

### Groups at risk for STIs

- Adolescents
- Individuals with multiple partners
- Individuals whose partners have multiple partners
- Individuals involved in unprotected sex
- Mobile workers
- Sex workers
- Migrant populations.

### Sexual behaviours that can increase exposure to STIs include

- Sex with a partner who has STI symptoms
- Sex with a partner who has recently been diagnosed with or treated for an STI
- Sex with more than one partner—the more partners, the more risk
- Sex with a partner who has sex with others and does not always use condoms
- Where many people in the community are infected with STIs, sex without a condom may be risky with almost any new partner.

## 20.2 STI Detection

Early identification of STIs is not always possible; however, it is important both to avoid passing on the infection to others and to avoid more serious long-term health consequences. To help detect STIs early, a provider can:

- Ask whether the client or the client's partner has genital sores or unusual discharge
- Look for signs of STIs when doing a pelvic or genital examination for another reason
- Know how to advise a client who may have an STI
- Promptly diagnose and treat if the client has STI signs or symptoms, or else refer for appropriate care
- Advise clients to notice genital sores, warts, or unusual discharge on themselves or on their sexual partners.

### Table 20.1: Common Signs and Symptoms of STIs

| Symptoms | Suggested STI |
|---|---|
| Discharge from the penis—pus, clear or yellow-green drip | Commonly: Chlamydia, gonorrhoea<br>Sometimes: Trichomoniasis |
| Abnormal vaginal bleeding or bleeding after sex | Chlamydia, gonorrhoea, pelvic inflammatory disease |
| Burning or pain during urination | Chlamydia, gonorrhoea, herpes |
| Lower abdominal pain or pain during sex | Chlamydia, gonorrhoea, pelvic inflammatory disease |
| Swollen and/or painful testicles | Chlamydia, gonorrhoea |
| Itching or tingling in the genital area | Commonly: Trichomoniasis<br>Sometimes: Herpes |
| Blisters or sores on the genitals, anus, surrounding areas, or mouth | Herpes, syphilis, Chancroid |
| Warts on the genitals, anus, or surrounding areas | Human papillomavirus |
| Unusual vaginal discharge—changes from normal vaginal discharge in colour, consistency, amount, and/or odour | Most commonly: Bacterial vaginosis, candidiasis (not STIs)<br>Commonly: Trichomoniasis<br>Sometimes: Chlamydia, gonorrhoea |

(WHO/RHR and CCP/Knowledge for Health Project 2008)

### Cervical cancer

Cervical cancer is caused by certain types of human papillomavirus (HPV). HPV is a common STI that usually clears up on its own without treatment but sometimes persists.

**Persons at risk for cervical cancer include persons who:**

- Had first sex before age of 18
- Have many sexual partners now or over the years
- Have a sexual partner who has or has had many other sexual partners
- Had many births (the more births, the greater the risk)
- Smoke cigarettes
- Have a weak immune system (includes women with HIV/AIDS)
- Burn wood indoors (as for cooking)
- Have had other sexually transmitted infections
- Have used combined oral contraceptives (COCs) for more than 5 years.
- (WHO/RHR and CCP/Knowledge for Health Project 2008)

### HIV/AIDS

HIV is the **human immunodeficiency virus** that causes **acquired immunodeficiency syndrome (AIDS)**, a disease in which the body's immune system breaks down and is unable to fight off certain infections, known as opportunistic infections, and other illnesses that take advantage of a weakened immune system. One of the ways HIV is transmitted is through the exchange of bodily fluids (blood, semen, and vaginal secretions) during sexual contact.

## 20.3 Integrating Family Planning and STI/HIV Services

For a long time STIs/HIV and cervical cancer were not comprehensively addressed in family planning clinics. However, family planning providers can assist their clients to prevent the acquisition of STIs, HIV, and cervical cancer; prevent the transmission of STI/HIV; and decrease the likelihood of HIV infection in children. Likewise, providing integrated reproductive health services—that include family planning counseling and access to contraception—to women and couples with HIV can improve their lives and those of their families.

### Benefits of providing family planning services for women and couples with HIV

- Improves health and well-being of families and communities (spacing/limiting births)
- Prevents unintended pregnancies, thus reducing the number of:

  Women with pregnancy complications due to HIV
  Infants born HIV-positive
  Orphans.

### The role of a family planning service provider in offering STI/HIV services

- Thoroughly screen family planning clients for STIs and cervical cancer.
- Provide information on the following:

  Mode of transmission of STIs
  STIs/HIV testing and counseling
  Dual protection (see next page)
  Prevention of mother-to-child transmission (PMTCT) for HIV-positive women.
- Conduct STI/HIV and reproductive health risk assessment.
- Offer counselling on HIV testing.

- Counsel clients appropriately regarding the following risky traditional and cultural beliefs and practices:

  Multiple sexual partners, including polygamy
  Wife/husband inheritance
  Initiation rituals/practice of hiring a man for sex and conception (fisi)
  Sexual cleansing rituals (kusasa fumbi)
  Death rituals (kupita kufa)
  Insertion of herbs into the vagina for dry sex
  Prolonged postpartum abstinence which predisposes a man to promiscuity
  Traditional treatment of vulva/vaginal warts and hemorrhoids (e.g. by cutting)
  Traditional healer practices such as sexual intercourse with the healer as a cure for infertility.

- Provide STIs/HIV and related services

  Education
  Behaviour change communication
  Counselling
  Testing
  Treatment of opportunistic infections and other associated conditions
  Social support
  Nutritional counselling
  Home-based care
  ARV therapy
  Palliative care

- Treat patients syndromically following the flowcharts in the **Malawi STI Management Guidelines**.
- Help clients to choose suitable contraceptive methods according to the World Health Organization's (WHO) medical eligibility criteria (MEC).

## 20.4 Family Planning Choices for Clients with HIV

Women with HIV and their partners often need to make a variety of reproductive health decisions about pregnancy, childbearing, and contraceptive practice. They should be free to make these reproductive choices for themselves, just as other women and couples do. However, being HIV-positive may make women more vulnerable to societal, religious, or family pressures than women without HIV. Counsellors must take special care to ensure that women with HIV do not feel coerced or pressured into making certain reproductive choices.

Many sexually active women with HIV might not want to bear children and therefore desire contraception, for the same reasons as those of women who are not HIV-positive. In addition, an HIV-positive woman might have additional reasons, such as:

- Concern that pregnancy will further compromise her health (Note that pregnancy does not alter disease progression in women with HIV)
- Fear of transmitting HIV to children she might conceive
- Fear of leaving orphans
- Fear that others will be unwilling to care for the family during illness due to AIDS-related stigma and discrimination.

Contraceptive options for women with HIV are similar to those of women without HIV and include barrier methods, hormonal methods, the IUCD, female and male sterilisation, the lactational amenorrhoea method (LAM), and fertility awareness-based methods (FAM).

Condoms are the only method proven to reduce the risk of all STIs, including HIV. Condoms are most effective in preventing STIs that are transmitted through bodily fluids, such as HIV, gonorrhoea, and chlamydia. They are less effective against STIs that are transmitted through skin-to-skin contact, such as genital herpes and warts.

## 20.5 Dual Protection

Dual protection is a strategy that protects clients from *both* unintended pregnancy *and* STI/HIV infection/re-infection. Possible strategies include:

- Use condoms alone (male or female) consistently and correctly, with emergency contraception for pregnancy prevention should a condom accident occur
- Use male or female condoms plus another contraceptive method for added protection against pregnancy (*dual method* use)
- Maintain a *closed sexual relationship* (no other sexual partners) between uninfected partners combined with a contraceptive method
- Engage in other satisfying but safe forms of intimacy (actions that avoid contact with a partner's semen or vaginal secretions)
- Avoid unprotected penetrative sex (abstinence) and delay sexual debut.

For clients with HIV, use of a dual method is encouraged to reduce HIV transmission. Dual method use may not be easy to achieve. Providers need to help these clients understand the benefits of dual method use by considering the following:

- The limitations of a single-method approach
- Their individual risk of pregnancy and the implications of an unintended pregnancy
- Whether their partners have HIV or another STI
- The negative consequences of acquiring or transmitting HIV, especially as resistant strains of the virus emerge.

It is also important for providers to teach skills for negotiating condom use and the correct use of condoms. (See Unit 17: Barrier Methods.)

(WHO/RHR and CCP/Knowledge for Health Project 2008)

## 20.6 Family Planning Considerations for Clients with STIs, HIV, AIDS or on Antiretroviral Therapy

Clients with STIs, HIV, AIDS, or on ARV therapy can start and continue to use most contraceptive methods safely. However there are a few limitations:

### Table 20.2: Special Considerations for Clients with STIs, HIV, AIDS or on Antiretroviral Therapy

| Method | Has STIs | Has HIV or AIDS | On Antiretroviral (ARV) Therapy |
|---|---|---|---|
| **Intrauterine contraceptive device** | Do not insert an IUCD into a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, | A woman with HIV can have an IUCD inserted.<br>A woman with AIDS should not have an IUCD inserted unless she is clinically well on ARV therapy. | Do not insert an IUCD if client is not clinically well. |

| Method | Has STIs | Has HIV or AIDS | On Antiretroviral (ARV) Therapy |
|---|---|---|---|
| | purulent cervicitis, or pelvic inflammatory disease (PID). A current IUCD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUCD during and after treatment. | A woman who develops AIDS while using an IUCD can safely continue using the IUCD. | |
| **Female sterilisation** | If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilisation until the condition is treated and cured. | Women who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo female sterilisation. Special arrangements are needed to perform female sterilisation on a woman with AIDS. Delay the procedure if she is currently ill with AIDS-related illness. | |
| **Vasectomy** | If client has scrotal skin infection, active STI, swollen, tender tip of penis, sperm ducts, or testicles, delay sterilisation until the condition is treated and cured. | Men who are infected with HIV, have AIDS, or are on ARV therapy can safely undergo vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS. Delay the procedure if he is currently ill with AIDS-related illness. | |
| **Hormonal methods** (combined oral contracep-tives, progestin-only pills, progestin-only injectables, implants) | Can safely use any hormonal method. | Can safely use any hormonal method, unless she is on ARV therapy that includes a ritonavir-boosted protease inhibitor. (See column to right. →)<br>Except if she is taking antituberculosis antibiotics, **rifampicin** or **rifabutin**. Co-infection with tuberculosis is common among patients with HIV, and these antibiotics speed up the metabolism of contraceptive hormones, reducing the effectiveness of oral contraceptives. | If her ARV therapy includes a **ritonavir**-boosted protease inhibitor, she generally should not use COCs or POPs (MEC category 3). This type of ARV may make these methods less effective. She can use progestin-only injectables (MEC Category 1) or implants (MEC Category 2). Women whose ARV therapy does not include a ritonavir-boosted protease inhibitor can use any hormonal method. |
| **LAM** | Can safely use LAM. | Can safely use LAM although there is a risk (≈16%) of HIV transmission to the infant through breast milk. However, exclusive breastfeeding is still recommended unless | Can safely use LAM. ARV therapy during the first weeks of breastfeeding may reduce the risk of HIV transmission. |

| Method | Has STIs | Has HIV or AIDS | On Antiretroviral (ARV) Therapy |
|---|---|---|---|
| | | replacement feeding is acceptable, feasible, affordable, sustainable and safe. | |
| **FAM** | Can safely use FAM | Can safely use FAM | Can safely use FAM |

(WHO/RHR and CCP/Knowledge for Health Project 2008)

## Contraceptive methods for clients living with HIV

### IUCD

Current evidence suggests that IUCDs do not increase HIV transmission. The following situations are classified as WHO MEC Category 2 (can generally use):

- An IUCD can be provided to a woman with HIV if she has no symptoms of AIDS.
- A woman who developed AIDS while using an IUCD can continue to use the device.
- A woman with AIDS who is clinically well on ARV therapy—meaning that the symptoms of AIDS are controlled by the ARVs—can both initiate and continue IUCD use.
- IUCD initiation is generally not recommended in women who already have AIDS (MEC Category 3) because of the theoretical risk that advanced immunosuppression could increase the risk of IUCD-related complications.

### Sterilisation

For women and couples with HIV who have decided to have no more children, female or male sterilisation may be a good option.

- There are no medical reasons to deny sterilisation to clients with HIV.
- The procedure may be delayed in event of acute HIV-related infection.
- Encourage condom use to prevent STI/HIV transmission.

### Hormonal methods

- Do not protect against STI/HIV— dual methods should be promoted.
- They may increase the risk of acquiring cervical STI infections, which theoretically could increase risk of HIV transmission to a partner.
- Some antiretroviral drugs can affect blood levels of contraceptive hormones, so theoretically:

  Reduced concentrations could reduce the effectiveness of hormonal contraceptives.
  Increased concentrations could increase hormone-related side effects.
- Some hormonal contraceptives may affect the efficacy of some ARV drugs.

Most of the existing research examines the interaction between ARV drugs and combined oral contraceptives. Further research is needed about:

- Possible effects of hormonal contraception on HIV-positive women's infectivity
- Possible relationships between hormonal contraception and HIV disease progression.

It is important to balance concerns, which are primarily theoretical, against the real risk of unintended pregnancy and its impact on maternal and infant morbidity and mortality.

### Injectables and implants

These can be used without restriction (MEC Category 1) by women with HIV, who may or may not have AIDS, and women on any type of ARV regimen.

### Emergency contraceptive pills

- ECPs are safe and should be available to all women, including women with HIV or AIDS, or those on ARV therapy.
- Currently, no data are available on the extent and outcomes of interaction between emergency contraceptive regimens and ARV therapy.

### Lactational amenorrhea method

- It does not protect against STI/HIV—dual method should be promoted.
- Advise that infants can become infected (risk of acquisition through breast milk is about 16%).
- Exclusive breastfeeding during first six months reduces risk of acquisition by infant (compared to mixed feeding or partial breastfeeding), a recommendation which is also in line with the requirements of LAM.

### Fertility awareness methods (FAM)

Women who are HIV-positive who may or may not have AIDS and those on ARV therapy can use FAM without restriction; however:

- Women who want to use the Standard Days Method should have regular menstrual cycles.
- FAM provide no protection from STI and HIV transmission; thus, users should be encouraged to use condoms even on days when risk of pregnancy is low.
- Couples with HIV who do not want to have children may consider other, less client-dependent methods of contraception.

# Family Planning and STI/HIV Case Studies

## Case Study 1

Miss Lamba is a single woman, 25 years old, HIV-positive, with a six-week old baby. She is devoted to making sure her baby stays healthy. She decided not to breastfeed and is using formula. She is feeling well and enjoying being a first-time mother—spending many hours caring for her new infant. She wishes to use a family planning method to properly space her next pregnancy—she hopes to stay healthy and have at least 1 more child. She sometimes used condoms before. She does not live with the baby's father, but she still sees him; she is also sure that he is seeing other women.

What family planning methods should she consider?

## Case Study 2

Esther is a 29-year-old mother. She works in a bar and sometimes has sex for money so she can feed her two children. She has come to the health centre to get medicine for a sore in her vagina. She does not use condoms because some men have threatened not to pay for sex if she insists on using a condom. She does not use contraception because her periods are not regular and she thinks she cannot get pregnant. She definitely does not want another child.

What contraceptive methods would be the most appropriate for her?

## Case Study 3

Lillian is a 32–year-old widow and mother of 5 children. Her youngest child is 2 years old. Lillian has come to the family planning clinic because she has recently started having sexual relations with an older man, but she has no plans to remarry. She does not wish to have more children. She has suffered from gonorrhea in the past.

What forms of family planning should she consider?

# Answers to Family Planning and STI/HIV Case Studies

## Case Study 1

What family planning methods should she consider?

**Male or female condoms (dual protection or dual method use) recommended.**

In addition:

- **Long-term methods—implants, IUCD**
- **COCs**
- **DMPA**
- **FAM (after menses returns and periods are regular)**

## Case Study 2

What contraceptive methods would be the most appropriate for her?

**Female condoms (for dual protection or dual method use)**

In addition:

- **Long-term and permanent methods—implants, female sterilisation**
- **COCs**
- **DMPA**

## Case Study 3

What forms of family planning should she consider?

- **Long-term and permanent methods—implants, IUCD, female sterilisation (if no current STI)**
- **Male or female condoms (dual protection or dual method use)**
- **DMPA**
- **COCs**
- **FAM**

# Family Planning and STI/HIV Role plays

The following are role-play scenarios for family planning counselling with women and couples who are HIV-positive. Refer to the Counselling Unit for counselling steps and guidelines and to the Effective Teaching Appendix for how to conduct and observe role plays.

## Role Play 1

**Client**: You are a 20-year-old single student. You have been sexually active since you were 17, and you have been treated for chlamydia once. You have recently started a relationship with a man who has told you that he is HIV-positive. You have been using a condom during sex, but you want to make sure that you don't get pregnant.

**Provider**: Explain dual protection to your client and explore her contraceptive options.

## Role Play 2

**Client**: You are a 35-year-old man who has come to the clinic because your testicles are swollen, and you have noticed a discharge from your penis. You are not married, but are having occasional sexual relations with two women. The provider has just diagnosed and treated you for gonorrhoea and now wants to talk to you about family planning.

**Provider**: You have just diagnosed and prescribed a treatment to your client for gonorrhoea. Now turn the discussion to family planning and dual protection.

## Role Play 3

**Client**: You are a 22-year-old, HIV-positive teacher who is 8 months pregnant. Your husband, who works at a bank, is also HIV-positive and knows your status, and the two of you communicate well about HIV. Your husband's family does not know that you are HIV-positive. You are confused and nervous about passing HIV to your baby and about how you should feed the baby with the least risk of HIV transmission. You are also nervous about the family and neighbours finding out that you are HIV-positive because of your job as a school teacher. You both would like to have more children, but you understand the benefits of child spacing and would like to wait a few years.

**Provider**: Counsel this client about feeding her baby and family planning, and keep in mind the additional pressures HIV-positive women face when making family planning decisions.

## Role Play 4

**Client**: You are a 30-year-old woman with HIV who has just started ARV therapy (not a ritonavir-boosted protease inhibitor). You have been using COCs for 3 years, and you are very happy with them. When you were prescribed your ARV, the nurse told you that it would be safest to stop using the COCs and told you to see the family planning clinic. You don't want to change your contraceptive method, but you have come to the family planning clinic to find out more.

**Provider**: Answer the client's questions about ARVs and COCs and explore other options if the client is so inclined.

**Note to observer**: Make sure that the provider uses simple language to explain why the client should or should not change their contraceptive method.

# Family Planning and STI/HIV Quiz Questions

**Questions 1–11**. Indicate whether the following statements about infection prevention are **true** or **false by writing a "T" for true or an "F" for false in the space provided before each statement.**

1. All STIs are infectious diseases caused by viruses that are spread by sexual contact.
2. As a group, adolescents are at risk for STIs.
3. Early identification of STIs is important to avoid passing the infection to others and to avoid more serious long-term health consequences.
4. Women with HIV should not have children, so family planning counsellors should make sure that they use contraception.
5. Contraceptive options for women with HIV are similar to those of women without HIV and include barrier methods, hormonal methods, the IUCD, female sterilisation, LAM and FAM.
6. Male and female condoms are the only contraceptive methods proven to reduce the risk of STIs, including HIV.
7. A man with an active STI can undergo vasectomy.
8. Current evidence suggests that IUCDs do not increase HIV transmission.
9. In dual method use, people use condoms to prevent HIV or STI transmission plus an additional family planning method for increased pregnancy prevention.
10. Emergency contraceptive pills should NOT be used by women on ARV therapy.
11. The risk of an infant acquiring HIV through breast milk is about 80%.
12. One example of dual method use entails using the condom as the primary method for both STI and pregnancy prevention, with the use of emergency contraception as a backup if the condom is not used, breaks, or slips.

**Questions 13–16:** Circle the letter next to each answer that correctly responds to the statements or questions below. Note that one, two, or even all answers may be correct and, if so, should be circled.

13. All clients seeking family planning services have the right to:
    a. Access information and services, free from any barriers
    b. Choose from a variety of modern contraceptive methods
    c. Be supported to make an informed, voluntary choice of contraceptive method
    d. Receive the contraceptive method of their choice, even though they may not be medically eligible
    e. Have a knowledgeable provider who will choose the contraceptive method that he or she considers to be the best choice for the client
14. Which of the following statements accurately describes the role that family planning service providers can play in caring for clients with STIs/HIV?
    a. Provide information on the mode of transmission of STIs
    b. Counsel clients about risky traditional and cultural beliefs and practices
    c. Educate clients about harmful effects of pregnancy on HIV disease progression

d. Treat patients syndromically for STIs/HIV following the Malawi STI Management guidelines
e. Help ensure that clients with HIV do not have children

15. Which of the following statements concerning the use of hormonal contraceptives by women who take ARV drugs are true?
    a. Research has proven that combined oral contraceptives do not affect the efficacy of ARV drugs.
    b. Some ARV drugs reduce the blood levels of contraceptive hormones; lower blood levels could reduce the effectiveness of hormonal contraceptives.
    c. Some ARV drugs increase the blood levels of contraceptive hormones; higher blood levels could increase the side effects of hormonal contraceptives.
    d. Women who take ritonavir as part of their ARV therapy should not use any method of hormonal contraception.

16. Which of the following statements accurately summarizes the WHO MEC recommendations?
    a. There are no restrictions on the use of male or female condoms by clients with HIV/AIDS.
    b. With the exception of ritonavir-boosted protease inhibitors, women on ARV drugs can use (MEC Category 1) or generally can use (MEC Category 2) COCs.
    c. Injectables and implants are usually not recommended for women who are taking ARV therapy.
    d. An IUCD can generally be inserted in a woman with HIV if she has no symptoms of AIDS.
    e. A woman who develops AIDS while using an IUCD should have the IUCD removed.
    f. There are no medical reasons to deny sterilisation to clients with HIV as long as they are not experiencing any acute AIDS-related illness, in which case the procedure should be delayed.
    g. Women with HIV should never use the LAM because of the risk of transmitting the infection to the infant through breast milk.
    h. Women with HIV and AIDS can use FAM without restrictions.

# Family Planning and STI/HIV Quiz Questions Answer Key

**F** 1. All STIs are infectious diseases caused by viruses that are spread by sexual contact. ***STIs are caused by viruses and bacteria.***

**T** 2. As a group, adolescents are at risk for STIs.

**T** 3. Early identification of STIs is important to avoid passing the infection to others and to avoid more serious long-term health consequences.

F 4. Women with HIV should not have children, so family planning counsellors should make sure that they use contraception. Women with HIV should be free to make these reproductive choices for themselves, just as other women and couples do. Counsellors must take special care to ensure that women with HIV do not feel coerced or pressured into making certain reproductive choices.

**T** 5. Contraceptive options for women with HIV are similar to those of women without HIV and include barrier methods, hormonal methods, the IUCD, female sterilisation, LAM and FAM.

**T** 6. Male and female condoms are the only contraceptive methods proven to reduce the risk of STIs, including HIV.

F 7. A man with an active STI can undergo vasectomy. Sterilization should be delayed until the STI is treated and cured.

**T** 8. Current evidence suggests that IUCDs do not increase HIV transmission.

**T** 9. In dual method use, people use condoms to prevent HIV or STI transmission plus an additional family planning method for increased pregnancy prevention.

**F** 10. Emergency contraceptive pills should NOT be used by women on ARV therapy. ***ECPs are safe and should be available to all women.***

**F** 11. The risk of an infant acquiring HIV through breast milk is about 80%. ***The risk is about 16%.***

**T** 12. One example of dual method use entails using the condom as the primary method for both STI and pregnancy prevention, with the use of emergency contraception as a backup if the condom is not used, breaks, or slips.

13. All clients seeking family planning services have the right to:

    a. **Access information and services, free from any barriers**
    **b. Choose from a variety of modern contraceptive methods**
    **c. Be supported to make an informed, voluntary choice of contraceptive method**

14. Which of the following statements accurately describe the roles that family planning service providers can play in caring for clients with STIs/HIV?

    **a. Provide information on the mode of transmission of STIs**
    **b. Counsel clients about risky traditional and cultural beliefs and practices**
    **d. Treat patients syndromically for STIs/HIV following the Malawi STI Management guidelines**

15. Which of the following statements concerning the use of hormonal contraceptives by women who take ARV drugs are true:

    **b. Some ARV drugs reduce the blood levels of contraceptive hormones; lower blood levels could reduce the effectiveness of hormonal contraceptives.**
    **c. Some ARV drugs increase the blood levels of contraceptive hormones; higher blood levels could increase the side effects of hormonal contraceptives.**

16. Which of the following statements accurately summarizes the WHO MEC recommendations:

    **a. There are no restrictions on the use of male or female condoms by clients with HIV/AIDS.**
    **b. With the exception of ritonavir-boosted protease inhibitors, women on ARV drugs can generally use COCs.**
    **d. An IUCD can generally be inserted in a woman with HIV if she has no symptoms of AIDS.**
    **f. There are no medical reasons to deny sterilisation to clients with HIV as long as they are not experiencing any acute AIDS-related illness, in which case the procedure should be delayed.**
    **h. Women with HIV and AIDS can use FAM without restrictions.**

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