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The *Guidelines* is for individuals and organisations working in the area of sexual and reproductive health and HIV/AIDS. While the most up-to-date materials were used to prepare the *Guidelines*, users should be aware that information changes rapidly. Therefore, we urge users to consult a broad range of information and/or contact us at (613) 241-4474 for more details. Users relying on this information do so entirely at their own risk. Planned Parenthood Federation of Canada does not accept any responsibility for damage that may result from the use or misuse of this information.

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Ce document est disponible en français.

As changes in the field of Sexual Reproductive Health and HIV/AIDS occur regularly, this document may contain dated information. Please check the PPFC site (www.ppfc.ca) for addenda to this publication.

Sexual and Reproductive Health Counselling Guidelines

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Table of Contents

Introduction

About PPFC

The Planned Parenthood Federation of Canada is a pro-choice, volunteer organization dedicated to promoting sexual and reproductive health and rights in Canada and in developing countries.

What is the purpose of these guidelines?

In the past when service providers spoke to clients about sexuality it was within the context of reproduction and contraception. Sexual and reproductive health support services were, and still are, often an informal part of a health provider's practice. The appearance of HIV and recent increases in sexually transmitted infections (STI) in Canada have brought sexual and reproductive health to the forefront of discussion on sexuality, forcing service providers to discuss prevention and informed decision making practices with clients in order to increase client sexual and reproductive health. While a lot of informal work has been done in this area, currently, this is the only document that covers the integration of STI/HIV into sexual and reproductive health in a unified manner, written by Canadian authorities in the field.

Issues of pregnancy, contraception and STI/HIV are often separated when discussing client sexual and reproductive health. This separation results in clients receiving only fragmented messages on the combined prevention of pregnancy, STI and HIV. HIV is an STI and should be discussed in this context, but counsellors need to recognize and acknowledge that HIV/AIDS has its own set of unique and complex issues. In order to assist service providers in the field, this document provides a cohesive set of guidelines and information based on sexual and reproductive health literature and the experience of key informants working in the field. The document provides information, techniques and suggestions in a guideline format for service providers who wish to incorporate STI/HIV prevention into the support services they provide for clients.

This document will be useful to service providers including educators, counsellors, social workers, therapists, or any individual or organization working in the field of family planning, sexual and reproductive health, and/or crisis intervention. The document may be used as a tool to improve support skills, train staff or provide additional information in areas of interest to the service provider. The document should not be considered a set of rigid rules but a flexible guide to help meet the needs of the service provider's community.

While this document provides information and suggestions for the content of sexual and reproductive health counselling sessions which are intended to assist the reader in preparing to counsel, the document is not intended to provide actual procedures for counselling. It is assumed that individuals using this document already possess a minimum of basic counselling skills as well as a minimum understanding of the importance of healthy sexuality as an integral part of overall mental and physical well-being. While the information in this document provides basic instructions and facts on STI/HIV and can serve as a starting point for learning more about integrating STI/HIV prevention into sexual and reproductive health counselling, individuals with

no prior experience in the field of human sexuality may wish to consult the references cited throughout the document for additional information.

Readers are strongly encouraged to review the Information, Motivation, Behavioural Skills (IMB) model presented in Health Canada's *Canadian Guidelines for Sexual Health Education*. (See Appendix J for the link to the on-line version of this document.) The section on *Empirical Evidence Supporting the IMB Model* will provide the reader with information that may be helpful for effective sexual reproductive health counselling practice.

Who put this document together?

These SRH Counselling Guidelines are the result of collaboration between organizations that believe in the need to integrate HIV, STI and pregnancy prevention when discussing issues of sexual and reproductive health. With support from Health Canada, individuals working in the area of sexual and reproductive health including public health nurses, crisis counsellors, therapists, doctors, and community educators created this document. The counselling guidelines and information presented in this document are based on current literature, interviews with key informants in the field, and the expertise of a national advisory committee comprised of sexual and reproductive health care service providers.

Who can use the guidelines?

The sexual and reproductive health counselling guidelines outlined in this document can be used by service providers, social workers, therapists or any individual or organization that works (or intends to work) in the field of family planning, sexual and reproductive health, and/or crisis intervention. The document provides information for service providers already working in the field of sexual and reproductive health and for those who are just beginning. Therefore, the guidelines provide both basic information and more advanced techniques for integrating STI/HIV prevention into daily practice.

How do I use the guidelines?

This document provides general information, guidelines, resources, and client fact sheets on sexual and reproductive health within a Canadian context. There are five sections to the document including:

- Sexuality;
- Safer Sex, Contraception and STI/HIV;
- Pre and Post STI and HIV Test Counselling;
- Pregnancy Options; and
- Abuse and Violence.

Each section contains three different parts:

1. Guiding principles/objectives
    - A quick reference to establish whether the section will cover the area the service provider is interested in exploring.

2. Background information
    - Provides a context for the counselling guidelines on the topics explored.

3. Counselling guidelines
    - Practical techniques and tips for integrating STI/HIV prevention into sexual and reproductive health counselling and/or services.

In appendices A to J you will find additional information on particular sections. In appendices K to P and sheets 1 to 27 you will find client fact sheets that correspond to each section of the document. Service providers can either copy these sheets for clients, or use them as a resource for developing sheets specific to the community or communities they work with.

Healthy Living

Sexual health is a part of an individual's overall health and therefore should be addressed routinely when addressing a client's health. By doing so, the service provider is contributing to the client's overall well-being. Health Canada defines healthy sexuality "…as a positive, dynamic and enriching part of being human".[1]

This document attempts to promote healthy living in the area of sexuality by being client-centred, using the harm reduction approach and by being sex positive and non-judgmental (see glossary on page 12 for more details on these terms).

Making referrals

Service providers should know their boundaries, strengths and weaknesses for providing support. Often clients may require services that are not offered, that the service provider does not feel comfortable or is not legally able to provide (e.g., only doctors or nurses can administer medical treatments or provide advice on medical treatments). Therefore, service providers should establish a network of individuals, agencies and/or organizations that specialize in sexual and reproductive health care to refer clients to as needed.

Referrals will depend on the types of services provided by the agency/organization and the service provider's knowledge of sexual and reproductive health. The referral network should include:

- contraceptive and safer sex education;
- STI/HIV prevention, testing, treatment, and support;
- assistance for clients who have experienced sexual abuse, violence or coercion;
- education for the prevention of sexual abuse, violence and coercion;
- sexual dysfunctions/concerns;
- pre-conception planning;
- prenatal care; and
- lesbian, gay, bisexual, transgender, transsexual, two-spirited, queer, questioning issues.

[1] www.hc-sc.gc.ca/english/lifestyles/sexuality.html

Consider the following when making referrals:

- What are the client's preferences? Have they had previous experiences with various agencies/organizations/personnel? Are there any barriers to services and how can you make it easier for them?
- Explain what the client should expect from the referral.
- Enquire into whether the client followed up on the referral. Find out why or why not and try to help them out. Have the client call for self-referral with your guidance (if appropriate). Go with them if needed.
- Give your client a written list of facilities, including telephone numbers, addresses, hours of operations and services provided. Routinely contact your referral agencies to ensure they are still offering services.
- Write down all referrals. Find out if the client was satisfied with the services.
- Use the Service Provider Resource Referral Sheet Template in Appendix B to create a list of resources in your area that can be posted in the office for quick reference.

Pre-evaluation of Current STI/HIV Integration Strategy

This document provides information on how service providers can integrate STI/HIV into sexual and reproductive health support services. The first step in integrating STI/HIV prevention into sexual and reproductive health support services is identifying the need for a more encompassing approach to sexual and reproductive health. A checklist has been included in Appendix A to help service providers recognize areas of limitation within their own services/organizations. While not all areas will be relevant to all service providers/organization, the checklist provides a first step in identifying possible areas of improvement. Organizations may wish to begin by asking themselves if they ready as an agency to integrate STI/HIV? This will include weighing the risks and benefits to the organization. For example, how does the integration affect the mandate of the organization, the client base and/or funding? If the organization being evaluated is not doing well integrating STI/HIV, it may wish to refer to the organizations listed in Appendix J for more information on STI/HIV in the context of sexual and reproductive health.

Glossary

Abstinence: For some people abstinence can mean refraining from all sexual activities, while for others it may mean engaging in sexual activities that are non-penetrative (such as oral sex). When discussing abstinence with a client ensure that you are using a similar definition.

Abuse and/or Violence:

Gender based violence (GBV): Any act of violence that is based in gender and is likely to result in physical, sexual, or psychological harm or suffering.

Physical abuse*:* Involves physical assault. It includes hitting, punching, kicking, pulling hair and throwing things at someone. It could also include forcing a partner to inject drugs, controlling the frequency and manner of drug use. Physical abuse can result in permanent injury, disability, and death. In most cases, the perpetrator will use it to frighten the victim so that they can control them.

Sexual abuse: Involves a person forcing another to have sexual intercourse or other activities against their will; inflicts pain during sex or does not allow the partner to use contraception or protection against pregnancy or STI/HIV. This can result in emotional and physical trauma, illness and death.

Sexual harassment: Includes making unwanted sexual comments, touches or propositions.

Verbal Abuse: Includes speaking to another in a way that degrades, humiliates, frightens, demoralizes or dehumanizes. It can include, but is not limited to: rage, insults, put-downs and conversational monopolization.

Psychological abuse: Includes threats of suicide, violence or taking the children away, destruction of property or precious things or making a person perform degrading or dangerous acts.

Economic abuse: Includes keeping a partner short of money for basic needs, stopping him/her from getting a job or forcing him/her to do sex work; controlling the money and spending it on his/her own desires to the detriment of the partner and/or his/her children; destruction of property and undermining a partner's attempts to improve education.

Economic exploitation: Includes manipulating or bartering with someone to have sex they don't want with the offer of material rewards, jobs or basic needs.

AIDS (Acquired Immune Deficiency Syndrome): AIDS is caused by the Human Immunodeficiency Virus. AIDS cannot be caught, rather it develops from the HIV infection. AIDS can be diagnosed with a positive HIV test and also with a clinical illness, or indicator

disease.[2] The HIV infection kills off the "T-helper" (CD4) cells that direct the immune system on how to fight off diseases and infections. When the T-helper cells are killed off, the body no longer knows how to fight off infections or diseases. This can lead to indicator diseases or clinical illnesses. While there are many types of indicator diseases or clinical illnesses, the most common include: Mycobacterium avium complex (MAC or MAI), Toxoplasmosis (Toxo), Tuberculosis (TB), PCP lung infection (pneumocystis carinii pneumonia), KS skin cancer (Kaposi's sarcoma), CMV eye infection (cytomegalovirus), Invasive Cervical Cancer, or a fungal infection in the throat or vagina (candida).

Client centered: Client centered support services starts with the client, at their point in the process of harm reduction. Client centered services work on the principles of acceptance, empowerment and move clients toward better health and responsibility. The goal is to improve quality of life by working with the client's abilities and obstacles.

LGBTQ: Is an abbreviation used for "Lesbian, gay, bisexual, transgender, transsexual, two-spirited, queer, questioning".

> Lesbian: Women who are attracted (mentally, physically, and/or emotionally) to other women.
> Gay: Men who are attracted (mentally, physically, and/or emotionally) to other men.
> Bisexual: People who are attracted (mentally, physically, and/or emotionally) to both men and women.
> Transgender[3]: An umbrella term used to refer to individuals who dress and/or live in a gender different than the one they are supposed to adopt.
> Transsexuals: "Have a gender identity that is not congruent with their body. They typically experience discomfort with the disparity between their physical bodies and their sense of self, and seek to modify their body through hormones and/or surgical procedures in order to bring their body closer to their gender identity. Most transsexuals want to be perceived as the gender that is congruent with their identity, regardless of what physical changes they have pursued."[4]
> Two-spirited: Traditionally, the two-spirited person was one who had received a gift from the Creator, that gift being the privilege to house both male and female spirits in their bodies. The concept of two-spirited relates to today's designation of gays, lesbians, bisexual and transgender persons of Native origins. Being given the gift of two-spirits meant that this individual had the ability to see the world from two perspectives at the same time.
> Queer: This term has become a reclaimed word in the LGBTQ community. ***The counsellor should not use this word, rather it is a word the client may use to describe themselves or their community.***

[2] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/haest-tesvs/a_e.html
[3] "The language used to describe members of [these] communities is continually changing, as people become better able to articulate the similarities and differences in their identities and experiences. There are many ways in which trans people describe their sense of self, and it is difficult to define terms precisely. [These descriptions are offered] as ways of understanding some of the ways in which people describe themselves, not as a way of labelling anyone." From: http://www.transgender.org/transcend/guide/sec116.htm
[4] http://www.transgender.org/transcend/guide/sec116.htm

Questioning: People who are not yet clear on their sexual orientation.

Harm reduction[5]: The term harm reduction refers to various pragmatic strategies and approaches for reducing the physical and social harms associated with risk-taking behaviours. Risk-taking behaviours include any practice that puts the individual at risk for STI/HIV and/or pregnancy. Harm reduction seeks to prevent the harms caused by these behaviours rather than attempting to eliminate that behaviour altogether. Harm reduction acts on the recognition that sexual risk-taking behaviour has persisted despite all efforts to prevent it and will continue to do so. Harm reduction focuses on strategies to increase a client's safer sex practices while acknowledging they may not always be able to practice safer sex. It is about providing the best possible option for the client given their current situation.

Healthy relationships[6]: In healthy relationships people communicate with one in other in ways that help to work through disagreements, which can lead to successful negotiation of safer sex practices. Healthy relationships raise self-esteem, improve mental and emotional health, and help clients live fuller lives, all of which can reduce risky sexual behaviour

High-risk sexual activity[7]: These sexual activities involve an exchange of the body fluids semen, pre-ejaculate fluid, vaginal fluid, blood, menstrual blood, or breast milk, and have scientifically and repeatedly been associated with HIV infection and/or STI. High-risk sexual activities include unprotected vaginal and anal intercourse and the sharing of sex toys.

HIV (Human Immunodeficiency Virus): Is the virus that causes AIDS. HIV attacks the immune system, resulting in vulnerabilities to opportunistic infections and progressive illnesses. HIV can be treated with drugs to delay the development of AIDS. (See AIDS definition)

Informed consent: Informed consent involves the process of providing the client with all the information (both positive and negative) around what they are about to participate in so that they can make an uninfluenced, and informed decision. With regards to STI/HIV testing, informed consent involves having the client explicitly state that they would like to take the test and that they are doing so voluntarily and not because of pressure to do so. Furthermore, the client understands the implications of the test, and also the issues around confidentiality and anonymity for their testing. We suggest following the ethical procedures and guidelines for providing informed consent specific to your profession and/or organizational policies/procedures. If no ethical guidelines exist, work with others in your setting to create a set of standardized procedures. As part of the informed consent process, inform clients of the cost of the test and the different testing options available in your area. Explain how the test is done and how they will receive the results.

Intersex: "People have physical bodies outside the relatively narrow chromosomal, genital, hormonal, or other physiological ranges associated with medical definitions of 'male' and 'female'. People may be born intersex, or may become intersex as a result of an accident or

[5] www.ihrproject.org
[6] www.advocatesforyouth.org/youth/health/relationships/index.htm
[7] HIV Transmission Guidelines For Assessing Risk, by the Canadian AIDS Society (CAS)

medical intervention (e.g., gender transition). Intersex people may identify as trans because they have experienced transphobia, because they feel intersexuality falls within the umbrella "trans", or because they are, in addition to being intersex, crossdressers, bi-gendered, etc. Other intersex people do not identify as trans." [8]

Low-risk sexual activities[9]: Certain sexual behaviours that involve an exchange of the body fluids semen, pre-ejaculate fluid, vaginal fluid, blood, menstrual blood, or breast milk have a potential for STI/HIV transmission. These sexual activities include: performing oral sex on a man or woman without a barrier, penile-vaginal and penile-anal intercourse with a barrier.

Microbicides: A range of topically applied products that prevent STI/HIV. They can include gels, creams, suppositories, films, sponge or ring that releases the microbicide over time. Microbicides are not yet commercially available, although a number of products are currently undergoing clinical trials.

Negligible-risk sexual activity[10]: Some sexual behaviours present a potential risk for STI/HIV transmission, however the amounts, conditions and/or methods of the exchange of the body fluids semen, pre-ejaculate fluid, vaginal fluid, blood, menstrual blood, or breast milk are such that the risk of STI/HIV transmission is greatly reduced. These activities include receiving or performing oral sex on women and men with a barrier, rimming (anilingus) with or without a barrier, and digital-vaginal or digital-anal intercourse with or without a barrier.

No-risk sexual activity: Not all sexual behaviours put individuals at risk for STI/HIV transmission or pregnancy. Sexual activities that do not include semen, pre-ejaculate fluid, vaginal fluids, menstrual blood, breast milk, or blood going from one person into another are safe. These can include: massage, hugging, solo masturbation, body to body rubbing (excluding the genitals), sex talk, sexy dancing, sharing sexual fantasies, body kissing, showering together and using sex toys without sharing them.

Pre-ejaculate/Pre-cum: A small quantity of lubricating fluid that comes out of the man's penis before he ejaculates. This fluid may contain sperm and/or microbes.

Re-infection: HIV re-infection occurs when an individual that is HIV-positive is infected with another strain of the HIV virus. Because the HIV virus is always changing and mutating, an individual can be infected more than once with different strains of the virus. Being infected with a second strain of HIV can threaten the client's health.

Safer sex: Safer sex includes sexual activities with no risk or a low risk of STI/HIV and pregnancy. That is, safer sex includes activities that are theoretically safe and are not known to have been a route for infection. These behaviours are safer when there are no bodily fluids such as semen, vaginal fluid or blood being transferred from one person to another. Safer sex behaviours include: mutual masturbation when there are no cuts on hands or genitals and people

[8] http://www.transgender.org/transcend/guide/sec116.htm
[9] HIV Transmission Guidelines for Assessing Risk, by CAS
[10] HIV Transmission Guidelines for Assessing Risk, by CAS

don't touch their own genitals afterwards; open mouth kissing if both partners have no bleeding gums or cuts in the mouth; vaginal intercourse with a condom; and anal intercourse with a condom and water-based lubricant. It is important to note that there are STI, such as herpes and HPV that may be transmitted even with proper condom use.

Safer sex practices also refer to behaviours that lower the risk of pregnancy during vaginal intercourse. When discussing safer sex practices to prevent pregnancy, service providers should also discuss how these practices affect an individual's risk for STI/HIV infection. While there are many methods for preventing pregnancy, only condoms are effective in reducing both pregnancy and STI/HIV infection.

Sero-conversion: The time at which a person's antibody status changes from negative to positive. For the HIV infection this can take up to 14 weeks. During this time an HIV antibody test may show a false negative, that is, the individual shows no antibodies because they have yet to develop a sufficient amount to appear in an antibody test.

Sero-discordant: Occurs when individuals do not have the same HIV antibody status. Also known as "magnetic" it occurs when one partner is HIV-positive and one is HIV-negative.

Sex-positive services: Providing sex-positive services means putting an emphasis on the positive aspects of sexuality when discussing health promotion. This includes being non-judgmental, using inclusive language, making individuals aware of all of their choices, regarding sexuality as a human right, and using a comprehensive definition of sexuality in your practice.

STI vs. STD: STI refers to a sexually transmitted infection and STD refers to a sexually transmitted disease. The term "infection" is used over the term "disease" because it more accurately describes conditions that affect the genital tract and may not show symptoms. Infection is also more desirable because it carries less of a social stigma than disease.

Unsafe sex: Unsafe sexual activity includes any unprotected sexual activity that carries a risk for STI/HIV infection or unintended pregnancy. High-risk activities include vaginal and anal intercourse without a condom; any type of bodily fluid contact, including menstrual blood, semen, pre-ejaculate fluid, or vaginal fluid entering breaks in the skin; sharing sex toys and any type of sex that damages the delicate tissues in the vagina, head of the penis or rectum. For some clients, unsafe sexual practices can also put them at risk for pregnancy when semen is allowed to come into contact with the vagina or vaginal fluid surrounding the external female genitalia. Furthermore, the use of Nonoxynol 9 has been implicated in the increased risk of HIV transmission.

The risk of HIV infection increases when an untreated STI is present and the untreated STI can be transmitted through oral sex. Mouth to genital contact has been shown to be a possible route for transmission of HIV. Cases where this has happened are rare and receiving oral sex appears to be a safer sexual activity than performing oral sex. The risk of transmission increases when the person giving the oral sex has bleeding gums, mouth ulcers or open sores in the mouth or throat. The presence of menstrual blood increases the risk of infection. Barriers such as dental

dams and condoms used during oral sex can reduce the risk of STI/HIV transmission (see Fact Sheets 3 & 7 for more details).

Section One: Sexuality

Service Providers will work with clients to:

- assist clients, whatever their HIV status, in feeling confident and comfortable talking about their sexuality, sexual activities, intimacy and relationships;
- assist clients in expressing their feelings, needs and concerns about sexuality with partners and to negotiate safer sex;
- recognize how gender roles and stereotypes influence sexual relationships;
- recognize the needs and concerns of lesbian, gay, bisexual, transgender, two-spirited, queer or questioning clients and to help them express their sexual and reproductive health concerns; and
- understand that everyone has the right to pursue sexual well-being in their own way, but only if the happiness and health of others is not at risk.

Introduction

It is important when service providers provide sexual and reproductive health support services that sexuality is integrated into the discussion. A client's sexuality is integral to questions of contraception and STI/HIV prevention. Service providers should be aware that sexuality is a fundamental part of the life of every man, woman and child. For each individual their sexuality will involve physical, psychological, social, emotional, cultural and ethical dimensions. These dimensions will form the individual's sexual identity, roles, relationships, perceptions, expectations and biological functioning.

Service providers should be aware of all of these facets or factors when helping clients make decisions about safer sex practices. The decision to practice healthy sexual behaviours is both an intellectual and emotional process. Most important, service providers need to recognize that it is the client's responsibility to make their ***own*** choices and the service provider's role is to ***assist*** them in this process by providing information and support.

Checking Your Sexual Attitudes

How one chooses to express his/her sexuality depends on social, ethical, economic, spiritual, cultural and moral beliefs. In fact, sexuality is far more than sexual behaviours or sexual intercourse. Sexuality is comprised of biology, social roles, personality, gender roles, sexual identity, relationships and thoughts and feelings. Additionally, how one expresses or feels about their sexuality may change across his/her lifespan. Service providers must be aware of all of these different aspects of an individual's sexuality and how they may affect a client's sexuality and how the client chooses to express their sexuality.

Due to the sensitive and complex nature of sexuality, service providers giving sexual and reproductive health support services require open and accepting attitudes. They must be able to show respect for clients in order to allow them to talk openly about their sexual needs and fears.

Integrating the following attitudes and practices into support services can help create a safe environment for individuals to explore their sexual concerns:

- An awareness of one's own feelings and values surrounding sexuality. Service providers must be careful not to judge clients based on personal beliefs or impose their own values on the client. Be as impartial and objective as possible while remaining honest.
- Treat clients as people and not just medical conditions. Respect their approach to 'scientific' or 'traditional' health practices.
- Realize that gender biases and inequalities may affect males and females differently.
- Reassure clients that all information they provide is confidential and discuss any limitations to confidentiality.
- Be aware of your limits and know when to refer to a more knowledgeable service provider. This is especially important when discussing medical conditions or treatments. ***Medical advice should only be given by certified doctors or nurses.***
- Be aware that it might have taken a lot of courage for clients to speak to you about their sexuality.

Relationships

Clients may have many types of relationships with many people over their lifetime, and each relationship will be unique. Every client has the right to enjoy these various relationships. Be aware of the relationships in which clients are involved, including friends, family, significant others, partners, acquaintances, and how these relationships may affect their well-being.

Service providers should work to create an environment where clients feel safe to explore all aspects of their relationships. Lesbian, gay, bisexual, transgender, two-spirited, queer or questioning clients may be hesitant to discuss their relationship if they feel that the atmosphere is predominantly heterosexual. Therefore, do not make assumptions about the nature of a client's relationship. Allow the client to reveal details of their relationship rather than working on assumptions. Refer to a client's "partner" rather than a "spouse", "girlfriend" or "boyfriend". This provides the client with an opening to discuss their sexual behaviour without limits imposed by the service provider.

Clients are involved in a variety of relationships (e.g., casual dating, abusive, multiple partners, same-sex, opposite-sex, married, or common-law) each type of relationship may require different types of information in order to promote sexual health within the relationship. Therefore, it is important for service providers to be aware of how different client relationships will require different approaches to sexual and reproductive health. By providing an open and non-judgmental environment for exploring relationships, service providers can work with clients to help them understand how their relationships may affect their sexual and reproductive health. Service providers can then work with clients to create healthy interpersonal relationships. Healthy relationships increase self-esteem, improve mental and emotional health, and help clients live fuller lives, all of which can reduce risky sexual behaviour.

Same-Sex Marriages

The question of same-sex marriage is presently under debate in Canada. The debate focuses on whether the opposite-sex requirement for marriage is constitutional. Currently same-sex

marriages are being performed in Ontario and British Columbia. (Please see Appendix I for more information.)

The legal status of same-sex marriage may affect how some people feel in their relationships. People who are not legally entitled to rights that others are entitled to can experience the negative feelings that accompany stigma and discrimination. This can affect how one feels and behaves in a relationship and is a key factor in their sexual health.

Social Issues Affecting Sexual Health

Service providers should be aware that while STI/HIV are medical conditions, they are closely tied to social issues. There are a variety of stereotypes, stigmas and general misinformation attached to STI/HIV that create barriers to sexual and reproductive health. Service providers should be aware that these barriers might inhibit client disclosure. For instance, individuals in small communities may be hesitant to have an STI/HIV test for fear of their status being revealed to the rest of the community. Service providers must be active in creating a safe environment for clients to explore their health concerns.

Listed below is information on different social groups and the challenges they face when seeking out support services. While reading through this information consider how service providers may have treated clients from these groups in the past and how it may have impacted on the client. Be aware of the challenges that may exist for all members of the community and acquire knowledge on the different issues that may be affecting their access to support services.

Gender: Gender-role expectations affect sexuality and can create barriers to sexual and reproductive health. Be aware that different cultures may also reflect different ideas about gender-role expectations. Equality between men and women, or lack of it, affects expressions of one's sexuality. Gender role stereotypes can portray males as the "experts", inhibiting flexibility in social roles and discouraging men from seeking information and support on sexual and reproductive health.

Additionally, the inequity that exists between men and women also exists in sexual relationships. Many women hold less power than men, creating power imbalances in sexual relationships and thus putting both men and women at risk for STI/HIV. This lack of power may also affect a woman's ability to delay sexual activity, to insist on protection during sexual contact and to have pleasure in sexual relationships. Women engaging in unprotected sexual intercourse are also more likely to contract STI/HIV because of physical vulnerabilities. For example, the vagina provides a large mucosal surface for transmission; microlesions that can occur during intercourse can result in points of entry for the virus/bacteria; there is more virus in sperm than in vaginal secretions and coerced sex increases risk of microlesions[11]. Even without lesions, women are at increased risk as the body responds to infection by increasing the number of disease-fighting cells in cervical secretions. These cells are also the target of HIV, and their increased presence

[11] WHO Information, Fact Sheet No 242, June 2000

means increased risk. The cervix is also made up of a single layer of fragile cells that can be easily damaged, creating a possible site for STI/HIV transmission[12].

There are many social and economic inequities that may keep women of all ages from being able to protect themselves during sexual activity. These factors may contribute to the rise in STI/HIV infections in women. Some of these inequities include:

- Existing strategies for safer sex and STI/HIV prevention emphasize monogamy and male condoms, which require the woman to get her male partner's cooperation on protection. While women can influence a man's sexual behaviour they cannot control it, putting them at risk.
- Violence, coercion and economic dependency in relationships can make it hard for women to negotiate condom use or leave a relationship that puts them at risk.
- Woman and girls are often discouraged from learning about their bodies and about sexuality in general. This can leave women out of the sexual and reproductive health decision-making process.
- Gender-based social norms can lead to men seeking multiple partners, while women bear the burden of shame and stigma associated with STI/HIV.
- Increasing economic inequality and eroding social support networks have driven many women into commercial sex work to support their families.

Sexual Diversity: Lesbian, gay, bisexual, transgender, two-spirited, queer, and questioning (LGBTQ) clients may have difficulties disclosing to service providers about sexuality, and providers may not consistently ask about same-sex experiences. These two obstacles often make it difficult for LGBTQ clients to gain access to the full range of sexual and reproductive health information they need. Therefore, service providers need to consistently recognize the needs of LGBTQ clients in order to provide comprehensive support services.

Service providers can make positive steps in promoting the sexual and reproductive health of LGBTQ clients by closely examining their practices, offices, policies and staff training and by promoting a more positive and accepting environment in their office/agencies/organizations. While LGBTQ individuals have some of the same basic health care concerns as other populations, they also have different experiences that result from barriers related to sexual orientation and sexual behaviour. Additionally, some individuals may engage in same-sex sexual activities without identifying as a homosexual. ***Service providers should not make assumptions about the nature of a client's sexual activities and should give the client opportunities to discuss the possibility of same-sex activities***. By remaining open and non-judgemental, service providers allow clients from diverse sexual orientations to explore their sexual and reproductive health concerns.

Sex Workers: Clients who identify themselves as commercial sex workers are at an increased risk for STI/HIV. Be aware that sex workers may have difficulty negotiating safer sex practices if they are offered more money for sexual activities without protection. Understand that the stigma and lack of appropriate services also increase the risk for marginalized groups.

[12] www.global-campaign.org/barriers.htm

Injection Drug Users: Clients who use injection drugs are at an increased risk for STI/HIV. Individuals using drugs may also experience difficulties in negotiating safer sex because of impairment. In addition to impaired judgement, injection drug users are also at higher risk for contracting blood borne pathogens such as HIV and HCV because of someone else's blood being injected directly into the blood stream through the sharing of needles. Be aware that drugs and alcohol influence risk-taking behaviours in all individuals, and that stigma and lack of appropriate services also increase the risk for marginalized groups.

Youth: Adolescents go through a time of rapid growth and change; don't assume that they have all of the education they need about these changes. The younger population may think that they will not be affected by STI/HIV, as they may not have seen someone their age affected by STI/HIV. During this time they need to learn to deal with their sexual feelings and make decisions about the various types of sexual activities in which they are comfortable. They must also learn how to avoid unintended pregnancies and STI/HIV. Unfortunately, youth may have trouble accessing information and services on sexual and reproductive health, often because of societal norms that pressure them to be silent or make fun of their sexuality. Youth will have varying definitions of what "sex" is to them and these definitions will be determined by mood, society and/or culture. Asking youth how they define sex and/or sexual behaviour will assist in understanding the youth's needs and concerns.

The silencing of adolescent sexuality may lead to unplanned/unsafe sexual activity and the risk of pregnancy or STI/HIV. The pressure to engage in sexual activity in order to maintain an intimate relationship also increases the risk factor for youth. Youth may also be experimenting with drugs and alcohol, influencing risk-taking behaviours.

Sexual Rights

All individuals are sexual beings, whatever their STI/HIV status, sexual orientation, age, gender or socio-economic status.

Service providers should be capable of working with clients to ensure they are able to express their sexuality in a manner that is both enjoyable and safe. It is essential that service providers be aware that sexual pleasure may not be limited to intercourse and that clients will vary in what they view as sexual. How clients view sexuality may be determined by mood, society and/or culture.

While everyone has the right to pursue sexual behaviour in his/her own way, forced sex is unacceptable and punishable by law in Canada. The pursuit of a client's sexual fulfillment should not put the health and/or happiness of others at risk. Provide clients engaging in unsafe sex practices with information and education in order to explore the risks of their behaviour. Service providers and clients should be aware of their duty to disclose STI/HIV status based on the recent legal decision (Cuerrier), see Appendices G and I for more information.

General Guidelines for Integrating Sexual and Reproductive Health Counselling

When providing support to individuals about sexuality and/or STI/HIV it is important to be sensitive to the needs of the client. A service provider should know that clients might be unable to talk about sexuality issues for fear of rejection, lack of safety, and/or due to embarrassment. Service providers can build a positive relationship with their clients by being open and non-judgmental, allowing clients to overcome their concerns of discussing sexuality.

Starting a Conversation on Sexuality with Clients[13]

There are many different models that can be applied to counselling on contraception and/or STI/HIV. One model helpful for discussing contraception is the **GATHER** model:

Greet your clients
Ask your clients why they have come and about their situations
Tell your clients how you can help them
Help your clients to make their own decisions
Explain how to use the methods they have chosen
Return visits are arranged to see how they are getting on.

This model is flexible and allows you to work your own style of counselling into a discussion on STI/HIV and/or contraception/safer sex practices. When starting a discussion on sexuality give the client time to settle into the session before asking specific questions about sexuality issues. Start by asking questions like:

"What brings you here today?"
"Where would you like to begin?"

Information should be asked in a simple, non-judgmental manner using clear language. Try to do one-to-one education during the conversation, as it can be an important part of the client's health and well - being. You should mention to the client that they are not obligated to answer any questions they do not feel comfortable discussing. Once you and the client both feel comfortable, you can ask more specific questions like:

"Can you tell me more about your concerns?"
"What is it that worries you?"
"What do you think might have put you at risk for STI/HIV infection or pregnancy?"
"What activities do you like to do together sexually that concern you?"
"Do you feel that this relationship puts you at risk of unplanned pregnancy or STI/HIV infection? If yes, why do you think that?"
"Do you use any methods to prevent pregnancy or STI/HIV infection?"

Follow the client's pace and allow them to guide the session. Allow for pauses so the client has time to think or respond. When you have covered one topic you may wish to continue the session by asking:

"Is there anything else on your mind?"
"What else is happening?"

See Appendix C for intake questions sensitive to sexual diversity, which may be used as a tool for having conversations on sexuality with clients.

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[13] Adapted from IPPF's, *Programme guidance on Counselling for STI/HIV prevention in sexual and reproductive health setting*

Providing a Safe Environment for Discussing Sexuality

Service providers are important because they can provide a safe environment and often a first point of contact to explore issues that clients may not be able to discuss with friends, family or partners. Be sensitive to the needs of the clients in order to help them assess and reduce their risk of unplanned pregnancy or STI/HIV. Service providers may consider the following as ways of providing a safe environment for discussing sexuality:

- Do not assume to know why the client has come in for an appointment; ask open questions to allow the client to tell his/her own story.
- Do not assume that older adults take fewer risks than adolescents; adults frequently exhibit risk-taking sexual behaviours.
- Do not assume that the client has come to discuss only one issue; give them a chance to discuss additional concerns. If you don't have the time, refer them to someone else they can talk to, and follow up on the referral, or schedule a follow-up appointment with the client yourself.
- Do not assume that the presenting issue is the most important; give the client a chance to discuss the problem in detail.
- Always make sure that the client knows that the support being provided is part of a collaborative process but that the final decision belongs to them.
- Work with the client to prioritize the issues or problems when there is more than one.
- Ask the client about their expectations of the session and what they hope to achieve.
- Summarize and reflect on points discussed during the session.
- When planning ways to work on the client's concerns, always make sure that the pros and cons are considered, as well as the client's knowledge, skills and self-esteem, and the client's methods of coping.
- Provide the full services needed, including referrals and counselling.
- Be understanding and supportive, making it easy for the client to open up and talk.
- Give details and facts in clear language, at the client's pace.
- Back it up by giving a pamphlet or video for later consultation.
- Be confident and respect privacy.
- Speak with respect.
- Do not exert pressure for abstinence, but do explain the benefits of abstinence, especially with younger teens.
- Be comfortable with sexuality and in talking about sex.
- Accept the views and choices of the young person.
- Be 'youth positive' and 'queer positive'. This means being accepting, supportive, non-judgmental and respectful of a client and their sexuality regardless of age or sexual orientation.
- Encourage clients to make their own plan for reducing their risk of unplanned pregnancy and STI/HIV.
- Key areas that should be covered with the client are:
    - sexual experience, and frequency;
    - total number of and sex of partner(s);
    - range of sexual behaviours (e.g., risk taking);

- relationships; past experiences of abuse; and
- drugs and alcohol and their influence on risk-taking behaviours.

See page 23 for more information on starting a discussion on sexuality with clients or Appendix C for a list of questions that may be posed to clients that are sensitive to sexual diversity.

Working with Gender

- Discuss with clients how gender inequity in their sexual life challenges them. Help clients to understand these inequities if they were not already aware of them.
- Assist clients to know their rights and to help them practice assertiveness and negotiation skills. Have a copy of the International Planned Parenthood Federation Client Charter On Sexual and Reproductive Rights up in your office and refer to it as needed. (To request a charter you may contact the International Planned Parenthood Federation at www.ippf.org.)
- Offer clients information on both male and female sexuality.

Working with Youth

Like all clients, adolescents require understanding combined with factual information that will assist them in choosing abstinence, delaying sexual involvement or using condoms or contraceptives responsibly. According to the Youth Committee of IPPF (1996)[14], youth would like service providers to:

- state that the session is confidential;
- provide the information and services they need;
- accept who they are;
- use language they understand;
- ask and respect their options;
- allow them to make their own decisions;
- make them feel welcome;
- be non-judgmental; and
- provide services at the time they need them and within the time they have available.

In order to create a supportive environment for youth, service providers should also include the following[15]:

- Place signs, brochures or other education material in the office that shows that the office is supportive and positive of LGBTQ youth.
- Ask youth to clarify terms to ensure there is no miscommunication.
- Use gender-neutral terms such as “partners” or “significant other” and be aware of other discriminatory or heterocentric language. Apply terms such as “he” or “she” only if you are aware of the gender of a client’s partner.
- Provide both sexuality and life-skills education.

[14] IPPF Youth Committee, 1996
[15] Adapted from The Canadian Consensus Conference on Contraception, SOGC, Volume 20, Number 5, 1998

- Find ways to make condoms accessible. Try to have some condoms on your desk and/or in the reception area. Provide both male and female condoms if possible.

Working with Sexual Diversity

In order to create a more open environment for LGBTQ clients, service providers may want to consider the following:

- Placing signs, brochures or other education material in the office that shows that the office is supportive and positive of LGBTQ clients.
- Encourage openness in the session and be aware of barriers that clients may be experiencing.
- Ask clients to clarify terms to ensure there is no miscommunication.
- Use gender-neutral terms such as "partners" or "significant other" and be aware of other discriminatory or heterocentric language. Apply terms such as "he" or "she" only if you are aware of the gender of a client's partner.
- Reflect the client's use of language when discussing identity, partner(s), and relationships. It is vital to follow the client's lead by focusing on how they describe their own life.
- Be aware that abuse and/or violence can occur in relationships no matter what the sexual orientation.
- Be aware that LGBTQ clients are at risk for harassment and abuse and/or violence in the community.
- Do not assume that because someone does not use or identify with the labels "gay", "lesbian", "bisexual", "transgender", "two-spirited", "queer" or "questioning" that they are heterosexual. Clients, both youth and adults, may not identify with these terms.
- Respect transgender clients by using the pronouns they identify with, or by using their preferred name. When in doubt, ask or do not use pronouns at all.
- Develop an intake form or sexual history questions that are sensitive to LGBTQ clients (see Appendix C for an example of intake questions sensitive to sexual diversity).
- Determine the degree that clients are 'out' to family members, colleagues or friends to determine the support network they have in place, work with the client to create one if necessary. You may want to pose the following questions to clients to assess their readiness to come out:
    - "What are some of the positive changes that you think may result from coming out? What are the challenges?"
    - "How do you think others may react to you? Who do you think will be supportive? Who may not be?"
    - "Is expressing your individuality important to you? Is your sexual orientation an important part of this expression?"
    - "How affected are you by how others think about you? How will you deal with positive reactions? If any negative reactions arise how will you address them?"
    - "Do you have any concerns for your safety if you come out? How can you address these concerns?"
    - "How do you plan to come out?"

Section Two: Preventing STI/HIV and Pregnancy

Service Providers will work with clients to:

- always talk about contraception, safer sex and STI/HIV in combination where appropriate (not all relationships will need to talk about contraception);
- find ways to negotiate and enjoy safer sex, regardless of STI/HIV status;
- find a method or a combination of methods of contraception that provide them with adequate protection against pregnancy or STI/ HIV; and
- assess their risks of STI/HIV infection in the past, present and in the future (you can make a harm reduction plan).

Introduction

Service providers can promote safer sex practices when discussing issues related to sexual and reproductive health. When discussing methods of contraception with clients, service providers may take the opportunity to explore the STI/HIV-related risks for each method of contraception and not just the ways in which to reduce the chances of pregnancy. By integrating STI/HIV prevention in all areas of sexual and reproductive health, the service provider presents the client with the information needed to make informed decisions about future sexual behaviour.

Some service providers will be seeing clients on an on-going basis, while others will see clients only once. The amount of client contact a service provider has with the client will define the type of services and support they provide when seeing a client in a crisis or emergency situation. When a service provider has access to a client over many appointments they will be able to review important information at the client's pace, ensuring not to overwhelm them with questions or information. However, when a service provider has only one opportunity to see a client the support services will be direct. Service providers will have to be focused on retrieving information about the client and their relationships and then concentrate on what the client should do next.

Chain of Infection[16]

There are many different types of STI, including HIV, and many ways to contract them. Trying to explain all of the information about all types of infection and all forms of prevention can sometimes overload a client and lead to the overall harm reduction message being lost.

The "chain of infection" is a model that can be used to help clients understand the infection process and includes links, each representing a necessary aspect of the chain of infection (see Appendix D for a diagram). In order for transmission to occur, each link in the chain must be present and occur in order. An awareness of this model also provides the client with knowledge of methods of self-protection.

The links are:

1. **Infectious agent:** A microbial organism with the ability to cause disease. Infectious agents are bacteria, virus, fungi, and parasites. For example: HIV virus or other sexually transmitted infections.

2. **Reservoir:** A place within which micro-organisms can thrive and reproduce. For example: humans and animals.

3. **Portal of exit:** A place of exit providing a way for a micro-organism to leave the reservoir. The micro-organism may leave the reservoir through the penis in semen or vagina in vaginal discharge. For example: ejaculation.

4. **Mode of transmission:** Method of transfer by which the organism moves or is carried from one place to another. During unprotected sex, sperm can enter the vagina. For example: unprotected sexual contact or sharing needles.

5. **Portal of entry:** An opening allowing the micro-organism to enter the host. Portals include body orifices, mucus membranes, or breaks in the skin. For example: mouth or vagina.

6. **Susceptible host:** A person who cannot resist a micro-organism invading the body, multiplying, and resulting in infection. The host is susceptible to the disease, lacking immunity or physical resistance to overcome the invasion by the pathogenic micro-organism. For example: low immune system response.

[16] Adapted from Planned Parenthood Ottawa, Options Support Training Manual

HIV Transmission Equation[17] (See corresponding client fact sheet in Appendix E)

HIV can only be transmitted in very specific ways. Three things are needed for the virus to get from one body to another:

1. Certain body fluids of someone with HIV

(blood, menstrual blood, semen, pre-ejaculate fluid, vaginal fluid, or breast milk)

+

2. An entry point into someone else's blood stream

(vagina, anus, penis, open sores or injection sites)

+

3. An activity that brings the body fluid and the entry point together

(unprotected sex, sharing any type of needle or sex toy)

=

Risk of HIV Transmission

If any one of these three things is missing, HIV cannot be transmitted.

Overview of STI/HIV (See client fact sheets 17-27 for more details on individual STI/HIV.)

HIV (Human Immunodeficiency Virus) and AIDS (Acquired Immune Deficiency Syndrome): HIV is found in blood, semen, pre-ejaculate (pre-cum), vaginal fluids and breast milk and is the virus that causes AIDS. Currently, there is no cure for HIV infection. Treatment with Highly Active Anti-Retroviral Therapy (HAART) can slow the progression of the disease and reduce the risk of mother to child transmission.

AIDS is caused by the Human Immunodeficiency Virus. AIDS is not caught, rather it develops from the HIV infection. AIDS is diagnosed when a person is HIV-positive and diagnosed with a

[17] Adapted from AIDS Vancouver's Training Manual

clinical illness, or indicator disease.[18] The HIV infection kills off the T-4/CD4 cells (a type of white blood cell) that direct the immune system on how to fight off diseases and infections. When the T-4/CD4 cells are killed off, the body no longer knows how to fight off infections or diseases. This can lead to opportunistic infections. While there are many types of opportunistic infections, the most common include: Mycobacterium avium complex (MAC or MAI), Toxoplasmosis (Toxo), Tuberculosis (TB), PCP lung infection (pneumocystis carinii pneumonia), KS skin cancer (Kaposi's sarcoma), CMV eye infection (cytomegalovirus), or Invasive Cervical Cancer.

HIV may be indicated by a weight loss of greater than 10% of body weight; fever or diarrhoea for more than a month; persistent severe fatigue; cough for more than a month, itchy skin rashes, cold sores, shingles, thrush in the mouth and throat and swollen glands at 2 or more sites for more than 3 months. Symptoms may be different for each individual, and HIV may also be present with no symptoms at all. While these symptoms may indicate the presence of an HIV infection, an HIV test is needed to diagnose HIV infection. An individual that has recently been exposed to HIV may not test positive for HIV because they are in the "window period" (see pages 42 & 60 for more details). The HIV test tests for HIV antibodies and it usually takes 14 weeks for the HIV antibodies to develop and show up in testing. Clients that have been recently exposed to HIV are encouraged to wait 14 weeks prior to being tested. Encourage clients to engage in safer sex practices during this time.

Hepatitis C (HCV) and HIV Co-infection

Hepatitis is a disease characterized by an inflammation of the liver. While there is currently no vaccine or cure for hepatitis C, it is sometimes treatable. Rates of co-infection for HIV and Hepatitis C are rising. When Hepatitis C occurs with HIV the combined infection is more severe than the infection with either virus alone. When both infections co-occur most often one infection is dominant while the other is dormant. Occasionally both diseases may be active. See Sheet 20 for more information on HCV.

Piercing, Tattooing, Needles, and HIV and HCV

HIV and HCV can be transmitted through the use of unclean needles. Unclean needles used in such behaviours as injecting drugs, tattooing, piercing and skin popping can lead to the transmission of HIV and HCV from one individual to another. For more information on how needles can pass on HIV and HCV and how you can protect yourself, see the client fact sheet in Appendix M.

Sexually Transmitted Infections (STI)

STI (sexually transmitted infections, more commonly known as sexually transmitted diseases) are caused by viruses, bacteria, protozoa, or fungi. These infections can be transmitted through vaginal, oral or anal intercourse. STI include: gonorrhoea, chlamydia, syphilis, chancroid, genital infestations (e.g., crabs, scabies), human papilloma virus (HPV), herpes, Hepatitis B, trichomoniasus (trich), and Hepatitis C. STI are often indicated by: sores on the genitals, anus or lips (both painful and painless); unusual discharge from the penis or vagina, which may smell

[18] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/haest-tesvs/a_e.html

bad; burning pain on urination; itching, burning, or soreness in the genitals; lower abdominal pain; pain when having sex; unusual bleeding (not menstrual bleeding); and chills and fever. Inform clients that it is possible to have an STI without exhibiting any symptoms. Some STI, for example herpes and HPV (human papilloma virus), can be transmitted by kissing and body touching.

STI should be considered serious because they can lead to pelvic inflammatory disease, ectopic pregnancy, infertility, damage to unborn and new born children, illness and death. Additionally, individuals with an STI are at an increased risk for HIV infection because of the presence of active lesions, open cuts or sores on the genitals or anus that increase the risk of blood, semen or vaginal fluids entering the body. Some STI can remain in the body without symptoms and can be transmitted to a partner or unborn child (e.g., syphilis, hepatitis, herpes and chlamydia). It is important to discuss the client's sexual history and encourage them to go for a check-up and treatment even when STI symptoms are not present but unprotected sexual activity has occurred.

Safer Sex for HIV-positive Couples

When working with a couple that are both HIV-positive, it is important to explain why, as a couple, they need to practice safer sex:

- It protects them from other STI.
- It prevents them from contracting other strains of the virus, including those that may be drug resistant (when a virus mutates and becomes resistant to one or more medications).

Condom Negotiation

Prior to discussing condom negotiation, it is important to understand some of the barriers the client may be facing. Condom negotiation is a discussion between sex partners in order to reach a mutual agreement on condom use. Acquiring the skills to negotiate condom use is important to safer sex practices. In the counselling guidelines section (page 38) practical techniques and tips are provided for discussing condom negotiation with clients.

When discussing this topic with clients, consider the client's:

- level of education;
- comprehension level;
- motivation to use condoms;
- ability to obtain condoms;
- cultural and familial beliefs and practices; and
- type of relations.

The counsellor also needs to explore with the client the consequences of becoming pregnant or having an STI/HIV.

Be aware of how these different factors will affect the client's ability to negotiate condom use and work with them to overcome any barriers they may be experiencing.

Contraceptives

(See client fact sheets 1-16 for more detailed information on contraceptives.)
Contraceptives should be discussed with clients when STI/HIV and/or pregnancy are of concern. If a client is looking for information to reduce the risk of pregnancy, the risks of STI/HIV may be discussed with the client. Support and education should be provided to all clients to assist them in their attempts to prevent conception. Although condoms may be the only form of contraception that reduce the risk of STI/HIV, all forms of birth control should be discussed with the client looking for information on preventing pregnancy. The advantages and disadvantages should also be explained for each method. Abstinence can eliminate the risk of pregnancy and/or STI/HIV and remains an option for clients. Providing the client with a variety of contraception options will assist in their decision making process and their ability to reduce future risks of pregnancy and/or STI/HIV. Please see the client fact sheets 1-16 for more information at the end of this document. Sexual and reproductive health service providers should become familiar with the agencies in their community that provide contraceptives.

Contraception Methods That Protect Against STI/HIV and Unplanned Pregnancy
Condoms (both male and female) protect against STI/HIV because the virus/bacteria that cause STI/HIV cannot get through the condoms. Additionally, condoms prevent sperm from entering the vagina so that it cannot join with the egg, preventing pregnancy. In order to be effective, condoms must be used correctly (please see Appendix L and Fact Sheets 3 & 7). Effectiveness against pregnancy can be increased when a condom is combined with a spermicide. Male and female condoms are currently the only method for protecting against STI/HIV transmission (other than abstinence from sexual activity). Some clients may be allergic to latex condoms, so polyurethane condoms may be suggested as an alternative. Condoms with the Nonoxynol-9 spermicide may irritate the lining of the vagina or anus and may actually cause microscopic tears, allowing STI/HIV to enter.[19]

Non-Contraceptive Protection Against STI/HIV
Microbicides, which when applied topically, reduce the risk of STI/HIV transmission, are currently under development. Please see Appendix I for more information on microbicides.

Dental Dam: A dental dam is a thin layer of latex that may be used to make cunnilingus (licking the vulva) safer. Dental dams can be placed over the genitals of a partner to reduce the risk of exchanging bodily fluids. Dental dams can be bought in squares or made by cutting a condom (see Appendix L - page 95).

Contraception Methods That *Do Not* Protect Against STI/HIV, but That *Do* Protect Against Unplanned Pregnancy
Barrier methods such as natural membrane condoms, cervical caps and diaphragms can be used to prevent pregnancy and their efficacy increases with the use of a spermicide. It is also possible that barrier methods such as the diaphragm and to a lesser degree the contraceptive sponge, may

[19] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/hiv-vih/nonoxynol_e.html

reduce the risk of vaginal transmission of HIV/STI because these methods protect the cervix during intercourse.

While these methods do not prevent STI/HIV, they may be an option for a woman to reduce her risk of pregnancy if she is unable to negotiate condom use with her partner.

Some forms of contraception require that you see a physician. These include Intra Uterine Devices (IUD) and sterilization. IUDs are generally not recommended for clients who are at high risk for STI. Special consideration should be given when a client is HIV-positive and considering an IUD as it may increase the possibility of Pelvic Inflammatory Disease (PID). Additionally, AIDS is considered a contraindication for the IUD for the same reason. Sterilization in women is a procedure called tubal litigation, and in men the procedure is called a vasectomy. Individuals that choose sterilization will not be able to have children.

Hormonal methods, such as the birth control pill and Depo Provera®, must also be prescribed by a doctor. The brand of birth control pill (different brands may use different formulations) recommended by health care providers depends on the client's past medical history and any side effects the client may experience.

Natural family planning (NFP) may also be used as a form of contraception. This method involves charting the position of the cervix, the menstrual cycle for 6 months, basal body temperature and the qualities of vaginal mucous over the menstrual cycle to determine ovulation. By determining when a woman is ovulating she can avoid intercourse when she is most fertile.

The withdrawal method involves the removal of the penis from the vagina prior to male ejaculation. This method is often unreliable because it is not always possible for a man to control the time of ejaculation and sperm, bacteria and viruses are present in pre-ejaculate liquid that is released prior to ejaculation. The effectiveness of withdrawal as a birth control method can be increased if combined with an alternative method of contraception (e.g., condom).

Spermicides such as contraceptive foam, sponges, Vaginal Contraceptive Film, etc. protect against pregnancy by killing sperm. However, keep in mind that spermicides that contain Nonoxynol-9 may irritate the lining of the vagina or anus and may actually cause microscopic tears, allowing STI/HIV to enter.

Nonoxynol-9

Nonoxyol-9 (N-9) is the active spermicidal ingredient in many over-the counter birth control products in North America. N-9 works by disrupting the sperm's outer membrane, reducing the chances of pregnancy. It can be found in contraceptive jellies, creams, suppositories, foam and vaginal contraceptive films. While it was once thought that N-9 could provide some protection from STIs, this claim has not been supported by the research. According to the Global Campaign For Microbicides, N-9 does not prevent HIV or other sexually transmitted infections and should only be used as a contraceptive. N-9 may also increase the risk of STI/HIV

transmission because the frequent use of N-9 can induce lesions and ulcerations to genital mucosa, thereby increasing the risk of STI/HIV transmission[20].

In regards to the use of nonoxynol-9, Planned Parenthood Federation of Canada states that sexual and reproductive health will be optimized when health care providers and health educators:

- inform clients that nonoxynol-9 is a spermicide, not a microbicide, and as such, it should only be used for contraceptive purposes;
- inform clients that frequent use of nonoxynol-9 (for example, multiple daily acts of intercourse) can irritate the vaginal or anal lining and increase the risk of transmission of HIV, chlamydia and gonorrhoea;
- encourage clients to evaluate the risks and benefits of using nonoxynol-9 as a contraceptive method;
- stop distributing condoms and lubricants with nonoxynol-9;
- inform clients that using a condom with nonoxynol-9 or a lubricant with nonoxynol-9 for anal intercourse irritates the rectum and increases the risk of transmission of HIV; and
- inform clients that using a male or female lubricated condom ***without*** nonoxynol-9 for vaginal or anal intercourse is the most effective prevention against sexually transmitted infections, including HIV.

Emergencies

Seeing clients when they are in crisis can be one of the most difficult support services situations for both service providers and clients. However, when faced with a client in crisis, service providers have an opportunity to assist the client in making choices that will affect the client's current and future health. Therefore, service providers should create a plan for dealing with crisis situations. This may include:

- crisis protocol;
- having the numbers of referral agencies; and
- being aware of the different consequences that must be addressed when clients are in crisis.

Emergency situations for service providers may include clients with:

- unplanned pregnancies;
- unprotected sexual activities;
- STI/HIV infection; and
- experiences of sexual abuse and/or violence.

All clients will react differently to these situations and the service provider should pay close attention the coping abilities of the client when dispensing information or referrals. Remember that although you may be tempted to provide the client with as much information as possible, on how they can maintain their sexual and reproductive health during and after the emergency, too much information may be counterproductive. For example, while clients may be at risk for STI/HIV because of unprotected sexual intercourse that occurred during sexual abuse and/or violence, they may not be able to cope with the thought of an STI/HIV while dealing with the experience of the abuse and/or violence. Be sensitive to the needs of the clients and work within

[20] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/epiu-aepi/hiv-vih/nonoxynol_e.html

their limits. Client fact sheets provided in the Appendices (Sheets 17 to 27) of this document may be given to clients so that they can read the information when they are ready.

Emergency Contraception

Clients should be informed of the two main methods of emergency contraception (Emergency Contraception Pill (ECP) and Intra Uterine Device (IUD)), how they are used, and their availability in the community. The ECP reference handout on Fact Sheet 6 can also be provided to the client for future reference.

Explain to clients that emergency contraception can prevent them from becoming pregnant after an act of unprotected sexual intercourse. Inform the client that emergency contraception can help them if they had sex in the last 1 to 7 days but that ECP is most effective during the first 72 hours and the earlier it is taken the better. Inform clients that they may wish to use ECP when:

- they had unprotected sex;
- the condom broke;
- the diaphragm slipped;
- they were late for their birth control shot (Depo-Provera®); and/or
- they missed two or more birth control pills in a row.

ECP (sometimes called the "morning-after pill")

- ECP can prevent a pregnancy if they are taken within 3 days or within 72 hours of unprotected sex. Some research suggests that they may work up to 5 days after unprotected sex, but the pills are more effective if they are taken earlier. [21]
- If the client is already pregnant, ECP will NOT work. ECP will not cause a miscarriage or an abortion. According to the scientific information currently available, taking ECP while pregnant will not result in an abnormal pregnancy.
- ECP sometimes causes side effects such as nausea, vomiting, headaches, breast tenderness, dizziness and cramping. These side effects generally don't last more than 24 hours.
- Clients may be able to reduce their nausea and vomiting by taking the pills with food or at bedtime and by taking Gravol® an hour before each dose. If the client does vomit within one hour of taking ECP, she should call her health care provider and get another dose.
- There is a type of ECP that is made with a single hormone, the progestin "levonorgestrel," rather than the usual combination of oestrogen and progestin. This is also known as Plan B®. These single hormone pills are effective and tend to cause less nausea and vomiting.
- It is important to remember that, like any birth control pill, ECP does not protect you from STI/HIV. Latex or polyurethane condoms offer the best protection against STI/HIV. If you have any reason to believe that you might have contracted an STI, please talk to your health care provider.

[21] http://www.ppfc.ca/issues/emergency.htm

- When a client takes ECP, her period may come a little early or a little late. If she has not started her period within three weeks of taking the pills, she should be advised to see her health care provider.

Emergency IUD

- An emergency IUD can be inserted up to 7 days after an act of unprotected sex.
- Pain or cramping may occur for the first 24 to 48 hours after its insertion.
- If the IUD is kept for regular contraception, vaginal discharge may occur during the first few weeks.
- It is important to remember that IUDs do not protect you from STI/HIV. Latex and polyurethane condoms offer the best protection against STI/HIV. If you have any reason to believe that you might have contracted an STI, please talk to your health care provider.
- If a client has not started her period within three weeks of having the emergency IUD implanted, she should be advised to see her health care provider.
- This type of ECP is difficult to get access to in Canada as fewer and fewer physicians are trained to insert IUDs and the emergency insertion of an IUD is time sensitive.

Women and STI/HIV

Service providers can work with women to reduce their risks of STI/HIV. Women need education, economic opportunity and social support in order to reduce their risk of contracting an STI/HIV. This may include information on gender relationships so that they are able to protect their health and rights within opposite-sex partnerships. Encouraging the client to develop self-esteem will increase their self-confidence and help them take charge of their health. Additionally, women need STI/HIV prevention methods that they can control, such as female condoms.

Women's bodies are biologically more vulnerable to STI/HIV.
Consider the following:

- During and after unprotected intercourse, mucous membranes in the vagina are exposed to infectious fluids for a prolonged period.
- Younger women are at even greater risk, since the cervix is physiologically less mature and therefore more vulnerable to infection.
- Women who do get an STI may not know it, since these diseases are often asymptomatic in women. This can mean that women go without diagnosis and treatment for a long time, which has serious long-term consequences for their health. Untreated STI can cause infertility, pelvic inflammatory disease (PID), ectopic (tubal) pregnancy, infant mortality, and cervical cancer.
- Having an STI makes women more vulnerable to HIV. Some STI cause lesions, making it easier for HIV to enter the body.

Not only are women more biologically vulnerable to STI/HIV, but HIV symptoms may also differ for women. While women may experience many of the same symptoms as men, women may also exhibit menstrual problems, vaginal infections and diseases of the cervix—especially

invasive cervical cancer. Additionally, there are unique concerns for HIV-positive women in terms of the side effects of treatment and concerns about pregnancy and childbirth.

Counselling Guidelines for Providing Safer Sex Support

Service providers can help clients reduce their risk of pregnancy or STI/HIV infection by starting a discussion on safer sex practices, helping clients assess the risk level of their sexual activities, and by helping clients create a plan for negotiating safer sex practices.

Providing safer sex support is a ***three-step process*** that can help to reduce the risk of pregnancy or STI/HIV.

Step One: Starting the Conversation (See page 23 for more information on starting a conversation on sexuality.)

Ask the client whether or not they have concerns about pregnancy or STI/HIV. Explain that this question is a routine aspect of providing comprehensive service to clients. If clients are unwilling or unable to talk about it at the time, always leave the discussion open for future visits.

Use discussions on contraception options as an opener to a discussion on STI/HIV risks. Explain to the client how contraceptive methods do not always protect against STI/HIV infection. Use this time to explore a client's risks and options.

Provide clients who don't want to discuss STI/HIV infection or pregnancy with written information on potential risk and how to reduce risks.

Encourage clients to discuss signs of STI/HIV or pregnancy. Ask the client whether they are experiencing any problems with their genitals. Refer the client to a doctor if appropriate. If working in a clinical setting, arrange for a visual screening of the symptoms, but explain that not all STI/HIV infections show symptoms and that often a test is needed to confirm the presence of pregnancy or STI/HIV infection.

Step Two: Weighing the Risks of Risky Behaviours With Clients

Do not assume that a client knows all of the types of risky sexual behaviours. Share your knowledge on conception and STI/HIV transmission and help clients to reflect on their past activities and whether or not they have been put at risk for pregnancy or STI/HIV infection. Include sexual activities, drug- and alcohol-related behaviours, needle usage, piercings and tattooing, along with their medical history (e.g., blood transfusions). The Intake Questions Sensitive to Sexual Diversity in Appendix C may be used to assist in this process.

Be open and accepting. Provide a safe environment for clients to discuss all of their sexual activities and partners. This can include putting pride flags in the office or placing posters in the office that display sexual diversity. Provide reading material in the waiting room that could help to open up a conversation on sexuality. Do not make assumptions about the client's sexual activities nor the activities of their partners.

Discuss the level of risk associated with each of the behaviours the client discusses.

Address the client's concerns about the sexual activities they have discussed. Make sure that all of their concerns are covered.

When the client has finished discussing their concerns, identify any additional risk factors that may have been missed.

Summarize the issues that were discussed. Assess how the client feels about their risks for pregnancy or STI/HIV infection.

Step Three: Negotiating Safer Sex Practices
Understand that the best options for safer sex practices will be different for each individual and that these options can change over time. Use what has already been learned about the client when discussing options for reducing risky behaviour. Let the client choose their option and let them know their preferences can change at any time.

Go over the sexual activities discussed with the client and explore how they may continue to enjoy these activities or others while reducing their risk of pregnancy or STI/HIV.

Discuss each activity, including the pros and cons of the activity, and how they are related to pregnancy or STI/HIV. This may mean discussing prevention, enhancing relationships, intimacy and pleasure, partner's preferences, other consequences, practicalities and feelings.

Help clients to come to their own decisions about which options work best for them. Give them the time and information they need to explore their alternatives.

Once a client has chosen their method for safer sex practices discuss how the option may reduce their risk for pregnancy or STI/HIV.

Discuss ways that clients can negotiate consistent condom use.

Condom Negotiation

Helping clients negotiate condom use is important for all clients. Condoms are the only form of contraception that offers protection against STI/HIV.

Discuss the use of both male and female condoms. Discussing female condoms with clients is important, as it is currently the only female-controlled option for preventing HIV/STI transmission and it is an effective contraceptive. Female condoms are an option when talking to women who may not want to use condoms, or whose partners do not want to use them. They are also an alternative for people who are allergic to latex. Let the clients know where they can get them, and tell your clients where they can get them for free or at a reduced cost. ***Always let clients know that male and female condoms cannot be used together.***

Ask whether or not the client has had experience with using a condom. If they have, ask whether their experiences have been positive or negative. If they have, explore how condom use has affected their sexual life. Address any concerns and suggest ways the client can overcome their concerns about condom use.

If the client does not have experience with a condom or has expressed concerns with past condom use, demonstrate how to put on a condom and ask the client to do the same using a penis model. Provide additional information on condom use, as it is needed.

Explain to clients that condom negotiation begins in a private, comfortable setting without time limits. Negotiation should be avoided in awkward situations (e.g., after an argument or during sexual activity).

Clients should tell their partners that they want to discuss something that is important and give them time to prepare for the discussion.

Encourage clients to be assertive and confident without hurting their partner's feelings. Clients should be sure of the facts and be committed to change. They should say clearly what they would like and not be afraid of losing or offending their partner.

Clients should be encouraged to let their partners contribute to the conversation and give them time to speak and think. This will help to see how the partner is feeling about the issue and help the client to relax.

Encourage the client to listen to their partner and to not assume they know how they will react, think or feel.

The client should be encouraged to have a positive attitude, to stay calm, when trying to reach an agreement with their partner. Begging and threatening should be discouraged.

If condoms are unavailable for clients, or if they don't feel able to use them, support clients in finding new ways of expressing their sexuality that lower their risk for pregnancy or STI/HIV.

Clients often express worries about condoms. Listed below are some common comments and myths about condom use and suggestions for dealing with these issues. You may also provide clients with the condom fact sheets 3 & 7 and Appendix L for more information on condom use.

Myth: Condoms cause a reduction in pleasure.
Fact: Condoms can be made more comfortable by using water-based lubricant inside and outside the condom. Individuals may also increase sexual pleasure by increasing the time they spend caressing, kissing and romancing. Condoms can prevent premature ejaculation.

Myth: Pain during sex.
Fact: If used with enough lubrication, condoms should never cause pain during intercourse. Painful sex often results from dryness. Clients can try increasing foreplay or using a water-based

lubricant. If this doesn't help, the person experiencing the pain should be tested for an infection or an allergy to latex.

Myth: Condoms sometimes slip off.
Fact: When condoms are used properly they will not fall off. Discuss proper condom use with the client. Make sure that they are using the appropriate size of condom for them. Ensure that you share your knowledge of emergency contraception with them if they are going to continue using condoms.

Myth: Condoms have small enough holes to let STI/HIV through.
Fact: Latex and polyurethane condoms are an effective barrier against most STI, including HIV.

Myth: Condoms are only for singles or people with multiple sex partners.
Fact: Many monogamous couples use condoms to prevent pregnancy or STI/HIV transmission.

Myth: Condoms are costly or unavailable or buying condoms is embarrassing.
Fact: Many sexual health offices and AIDS Service Organizations(ASO), youth agencies/organizations provide condoms free of charge. You can even buy them from a vending machine to avoid any embarrassment.

Myth: Condoms don't fit my partner or me.
Fact: Condoms vary in size, shape, and tightness, so men can select a condom that is most comfortable for them. Female condoms come as a one size fits all product.

Section Three: Pre and Post Testing for STI/HIV

Service Providers will work with clients to:

- make an informed decision about whether or not to take an STI test or HIV antibody test and consider the effects if the client is pregnant;
- explore clients' knowledge of STI and HIV/AIDS and provide them with the correct information;
- assess clients' exposure risk to STI/HIV infection through past and present behaviour and encourage them to reduce their risk behaviours through a harm reduction strategy;
- explain the process of testing;
- to help clients prepare themselves for the result, understand the result, and come to terms with it;
- prepare for the social, legal and ethical issues arising after the test;
- express their feelings about the results;
- decide what to do about disclosure to sexual partners and others in the immediate future;
- reduce the client's risk of STI/HIV infection and infecting others;
- make a plan of action for the immediate future;
- provide referral services and help clients access the medical, psychological and practical support they need; and
- assist those who have been identified with STI/HIV in creating strategies for receiving treatment and following treatment recommendations.

Introduction

The management of STI/HIV and their treatment relies on a client's ability to gain access to an STI/HIV test. (See Appendix F for information on how to find out about HIV testing procedures in your province.) A client's access to an STI/HIV test will be partly determined by the support the client receives from the service provider when they express concerns about their sexual or reproductive health and by the service provider's awareness of behaviours that may place the client at risk for STI/HIV.

Additionally, how a client approaches STI/HIV treatment or management will depend on the pre- and post-testing support services provided to them. Therefore, service providers should be able to give clients the following services, either firsthand or through referrals, when a client's sexual and reproductive health is the focus:

- history taking;
- evaluation of behaviour risk;
- counselling (pre and post); and
- follow-up.

Physicians and nurse practitioners can also provide clients with the following services:

- physical evaluation;
- STI/HIV tests;
- confirmation of tests;
- diagnosis; and
- treatment.

STI/HIV Testing

There are a variety of tests available for STI/HIV. Although several tests can be done from one tube of blood, there is no one test that will cover all STI/HIV. This is because some tests require blood and others require urine, swabs or specimens. Service providers should be aware what tests are offered at the agencies in their communities.

HIV Antibody Testing: Taking an HIV antibody test is a difficult decision with serious consequences. Help the client to weigh the advantages and disadvantages of taking the test. Give the client time to weigh the options of taking the test. Understand that clients may choose not to take the test or they may never come back for the results; respect this decision, as it is part of the informed-choice process. If the client may be pregnant, encourage her to confirm the pregnancy as this may bring a whole new perspective to her taking the HIV antibody test. Appreciate that different social forces will work on each individual and this will affect their decision. Work with the client to put a social support system in place to help them cope with the results of their test. This will include discussing the possible social stigmas related to taking an HIV test and the consequences of a positive or negative result. No matter what the client decides, encourage them to work with you to create a harm-reduction plan and to visit you again for further support services.

An HIV test does not test for the presence of the HIV virus itself, rather it detects the presence of HIV antibodies in blood or saliva. Clients should wait for 14 weeks (the window period) after being exposed to a risk prior to being testing. Waiting for 14 weeks allows the body time to produce HIV antibodies (in an attempt to fight the infection).

Negative Results: If the test is negative for an individual that has waited 14 weeks this means that no antibodies are present. Let clients know that one negative test does not make them immune and that they are still at risk if they participate in unsafe sexual activities.

Positive Results: A positive test means that HIV antibodies have been detected in the blood. It does not mean that the person has AIDS or is going to die soon. Inform clients that healthy HIV-positive individuals can live for many years. Be aware of how the client reacts and that the reaction will depend on their history, personality, social support, coping mechanisms and the quality of pre-test support services.

Uncertain or Indeterminate Results: Uncertain results mean that the test did not clearly show the presence or absence of antibodies. The client may be in the sero-conversion phase and therefore

require another test. Indeterminate results may also be caused by how the client's blood reacts to the antibody test.

HIV Test Disclosure: There are three types of testing disclosure for HIV antibody testing in Canada. Availability of the various types of tests may vary from province to province and from region to region. The three types of test are: anonymous (which may not be available in all provinces), non-nominal and nominal. (See Appendix F for a reference on how to find out about HIV testing in your province.)

Anonymous HIV Testing: Anonymous testing involves no names and the client is not asked to give their health card or ID. When doing an anonymous test, the person ordering the HIV test does not know the identity of the person being tested for HIV. The HIV test is carried out using a code. The person ordering the HIV test and laboratory carrying out the testing on the blood sample do not know to whom the code belongs. Only the person being tested for HIV knows the unique, non-identifying code. Although the client's name will not be reported, since the test is anonymous, the results of a positive test may be reported to public health.

Non-nominal/Non-identifying HIV Testing: The HIV test is ordered using a code or the initials of a person being tested. The results may be reported to public health. The person's name and test outcome is recorded in a chart, and kept in the office/clinic where the person went to have the test performed.

Nominal/Name-based HIV Testing: The person ordering the test knows the identity of the person being tested for HIV. The HIV test is ordered using the name of the person being tested. The results may be reported to public health. The person's name and test outcome is recorded in a chart, and kept in the office/clinic where the person went to have the test performed. This is the type of test you would typically get at your doctor's office.

Testing for STI

Chlamydia and Gonorrhoea: can be done on cervical samples in females and on a sample from inside the tip of the penis or from a urine sample from males. Most males prefer to provide a urine sample.

Yeast Infections, Bacterial Infections, and Trichomona: Gram Stain and/or a "Wet Prep" is used for samples from inside the vagina to detect these infections. For men, yeast infections may be diagnosed visually; bacterial infections and trichomonas may also be found in men's urethral specimens.

Herpes: testing can be done in two ways. If there is an active lesion, a culture is done. If there is no active lesion, testing for herpes can be done with a blood test[22].

Syphilis (RPR): is detected through a blood test. Infection can take up to 90 days to show positive after infection.

[22] Blood tests for herpes are not available in all provinces. Please check the availability in your province or region.

The Human Papilloma Virus (HPV or Genital Wart Virus): is most often detected on a pap smear on females or by visual exam in females or males.

Ethical Considerations

Clients may feel pressured into taking a STI or HIV antibody test because of the influence of partners, family, religious bodies, work place or visa departments. Putting pressure on any individual to take a test is a violation of human rights and should be considered unethical. Work with clients to help them understand their rights about testing and explore their alternatives. Make sure that all clients understand informed consent procedures and that they have provided informed consent prior to testing.

Gender

Understand that women are more often at risk for abuse and/or violence as a result of STI/HIV infection and disclosure of the infection to their partner. Because of gender inequities it may be difficult for women to inform men of their pregnancy and/or STI/HIV infection, and men may not wish to inform partners of their infection. This can have consequences, such as infection of their partner or delays in treatment. Discuss barriers to disclosure or treatment with all of your clients regardless of their sexual orientation. Lesbian, gay, bisexual, transgender, two-spirited, queer, and questioning clients may have different and complex barriers, which the counsellor needs to acknowledge and assist the client with. See Appendices G & I for more information on the client's duty to disclose their HIV status.

HIV Counselling Guidelines for Providing Pre- and Post-test Counselling

Service providers can:

- assess their client's risk for HIV infection;
- discuss the advantages and disadvantages of taking the test; and
- provide support services for post testing for both positive and negative results.

Always consider that while your client may be coming to you because of their concerns over HIV, they may also be at risk for other STI. Discuss STI/HIV infection together and how testing positive for one may put them at risk for the other. Listed below are some suggestions for providing support services at all three of these stages.

Pre-test Counselling

Risk assessment: For more information on how to start a conversation on sexuality with a client see page 23 or the Intake Questions Sensitive to Sexual Diversity in Appendix C. These two tools may be used to help assess a client's risk for STI/HIV.

Address the client's concerns about HIV infection and assure them that the results of their test will be confidential. Explain the different levels of confidentiality and anonymity available in the client's region. This is especially important when providing support services in smaller or

remote areas where individuals may feel that their HIV status may be revealed to the rest of the community.

Explain to the client that taking the test is completely voluntary and the service provider's job is to assist them in making the best decision about testing. Explore the client's knowledge about the test and explain how the test works. Let them know that even if they don't take the test, services will still be provided to them.

Explore the reason why the client is seeking testing.

Communicate to the client information on HIV and ways of transmission and prevention.

Explore past and present sexual activities as well as other things (e.g., blood transfusion, Injection Drug Use (IDU), or piercing and tattooing) that may put the individual at risk. Refer to Appendix C for an Intake Questions Sensitive to Sexual Diversity that can help assess past behaviours.

Once the risk assessment has been completed, the main points should be summarized. Ask the client how they feel about their risk. The service provider can also share their own assessment of the client's risk. While it is possible to assess some of the risk, based on client reports, it may not be possible to assess risk reliably because the client may not know about their partner's behaviour or they may edit what they tell the service provider.

Explore a harm-reduction plan.

The Advantages of Having an HIV Test

- Taking the test may motivate people to reduce their risky behaviours and their chances of infecting others.
- Knowledge of HIV status can lead to treatment and may reduce the risk of transmission to others.
- It can help the client join a support group for individuals living with HIV.
- It assists couples in making informed decisions about childbearing.
- It helps parents take action to reduce the risk of mother-to-child transmission and complications due to infection.
- It enables clients to take positive action and stop them from wondering or worrying about their status.

The Disadvantages of Having an HIV Test

- There is the possibility of false positive (extremely rare) or false negative results. A false positive can lead to undue stress and worry. A false negative may cause a person to participate in risky behaviour that leads to the infection of someone else.
- Clients will all react differently to a positive result. Emotional reactions may include relief, becoming depressed, etc.

- Clients with positive test results risk the loss of their relationship, children, home or job. Women are especially vulnerable and face isolation, abuse and stigmatization. All of this can result in severe long-term effects on the well-being of the individual and their family.
- Negative results may lead to an increase in risky sexual behaviour.
- Clients with positive results may feel anxious or unhappy if they lack the power to completely address the test results.

Post-test Counselling

Whenever possible, the same service provider that gives the pre-test support services to a client should provide the post-test support services. This will facilitate the service provider-client partnership. Additionally, the service provider will be familiar with the client's history and the client may be more trusting. Be aware that if the client did not receive adequate pre-test support services that the service provider may need to spend additional time to explain things to the client after the test and help them make plans for their future. Listed below you will find techniques to assist with both positive and negative test results.

Positive Test Results

A client who receives a positive test result may be in shock, which can lead to crisis. Crisis is characterized by feelings of fear, anger, guilt or shame and sometimes disruptions in personal and interpersonal functioning. It is the job of the service provider to assist the client with emotional support, information and to assist them with plans for the future in order to overcome the crisis. The following process can be used in the post-testing support services:

- Ask how the client is feeling since their decision to have the test. Congratulate them on returning or waiting to hear their test results.
- Ask the client if they have any questions or if they would like to discuss anything prior to informing them of their results.
- Once the client is ready, give them their results in a neutral voice and wait for the client's response before proceeding.
- Begin to provide psychological support for the client. This includes identifying and exploring the client's feelings. Ask questions that encourage the client to discuss how they are feeling and their concerns. Inform the client that their initial feelings of shock are natural and that they are likely to change over time.
- Explore the different factors that may influence the client's reactions. Discuss how prepared they were for a positive result, their medical problems, their emotional and social support network, their personality and psychological condition. Explore the level of stigma or discrimination they may face in their community and discuss how their cultural or spiritual background may assist in the coping process.
- Review the different questions you discussed in the pre-testing session.
- Explore how the client has dealt with other difficult situations in the past and how that may help them now. This will include exploring the client's ability to cope and their ways of coping.
- Inform your client of the different social support programs in your area. This will include counselling organizations, church groups and local sources of support. Discuss how family, friends, partners, their church or clubs may provide different sources of support.

- Assess the client's medical, preventative and psychological support services and how their needs are met by these existing services.
- Take all suicidal thoughts or ideas seriously. Work to provide support for the individual immediately. Use the Service Provider Resource Referral Template (Appendix B) to assist the client in receiving immediate counselling. If necessary, call for ambulance assistance. Refer to the ethical codes or guidelines of your organization or professional body for more information on addressing suicidal ideations.
- Help the client make plans for the future. This will include reminding them of the plans they made in the pre-test session. Talk through the plan with them.
- Help the client establish a plan for continuing medical, social and psychological support. This may include setting up future appointments with the client or referring them to an appropriate agency.
- Discuss any signs or symptoms of the infection. Explain the consequences of having an HIV infection and how it can be treated.
- Explore any recent behaviour that may have put others at risk or that may have put them at risk for an additional STI.
- Make sure the client understands the consequences of the infection for both themselves and their sexual partners. Discuss what it means to be in a sero-discordant relationship (see glossary on page 16 for details).
- Offer an opportunity to repeat the test.
- Work with the client to create a harm-reduction plan. Harm-reduction plans assist in helping clients make decisions about how they will approach sexual activities or drug use in the future. Developing a harm-reduction plan should be done for clients as a way of reducing risk of STI/HIV re-infection for themselves and infection for the people with whom they are intimately involved.

Harm-reduction plans should involve the following:

- A review of safe, unsafe and safer-sexual practices with the client (for a review see glossary on page 15 and 16). Some clients may not be concerned about safer-sex practices in the post-test session. Encourage a discussion on the topic in order to help the client lower their risk of infecting others or re-infecting themselves.
- A discussion regarding the responsibility of the client to discuss their HIV status with their partner and past partners. (See Appendices G & I for information on the Cuerrier decision and duty to disclose.) Discussing their status with their partner can often make it easier for both partners to lower their risk of infection, re-infection or transmitting STI/HIV. The discussion may also encourage the partner to have an STI or HIV antibody test. If a client has a positive HIV test result and they are unsure of their partner's status or suspect that the partner infected them, the client needs to find a way to protect their partner and themselves. Recent research has indicated that re-infection (see page15 for more details) between partners can speed up the progression of the infection.
- A discussion on how the client's partner may respond to the test results. You may have to work with the client over time to help them reveal their status to their partner.
- A discussion on the immediate action(s) the client can take to minimize the risk of re-infection or transmission to others, the barriers to these immediate actions and how the service provider can help the client to carry out the actions.

- An exploration of how clients can change their behaviour or stay with behaviours that minimize the risk of HIV transmission.
- Review the harm-reduction plans discussed in the pre-test session.
- Review how HIV is not transmitted to reduce fears/anxiety.
- Discuss the process of disclosing their HIV status with others. This is not an event, but a process that has consequences for the client. Do not rush the client into disclosing. Instead, work with them to discuss the benefits and risks of disclosures. Discuss with the client whether or not they feel safe to discuss this issue with their partner. Explore possible responses.

Duty to Disclose[23]:

In the landmark Cuerrier case, the Supreme Court of Canada (September 1998) ruled that without disclosure of HIV status there couldn't be true consent. The consent is not restricted only to sexual intercourse. Rather it must be consent to have intercourse with a partner who is HIV positive. However the judgement of the Court is not clear exactly when, or under what circumstances, the duty to disclose HIV-positive status exists. The Court said that there is only a duty to disclose if failing to disclose would expose the sexual partner to ***a significant risk of serious bodily harm***. HIV infection, and perhaps other STI as well, could pose ***a risk of serious bodily harm***. This rather ambiguous ruling by the Supreme Court of Canada is open to the courts' interpretation of what significant risk means with regards to ***protected*** sexual intercourse, as well as low risk, and negligible risk activities. The Court's decision also may have implications for HIV-positive mothers who breast-feed.

People getting tested for HIV need to understand that criminal charges might be laid if they know their status and put someone else at ***significant risk*** of being infected with HIV or another STI that causes ***serious bodily harm***. Counsellors faced with a client who refuses to disclose need to make appropriate use of options available under public health law. Please contact your local AIDS service organization to learn more about the legal issues surrounding STI/HIV transmission.

What If an HIV-positive Person Will Not Inform Their Partner(s)?

As noted above, in Canada, an HIV-positive person is legally obligated to disclose their HIV status to their sexual partners. Please see Appendices G & I for more information on the duty to disclose. Service providers will also have to review how their organization or governing body deals with duty to disclose HIV status. In some cases, public health associations have a legal obligation to disclose HIV statistics. Service providers may also wish to inform clients that disclosure has its risks and benefits.

Disclosure can help to:

- aid people in accepting their status and reducing the stress of coping with a secret;
- provide access to medical services, care and support;

[23] Adapted from the series of info sheets on Criminal Law and HIV/AIDS (March 1999) by the Canadian HIV/AIDS Legal Network

- protect the client and others. Openness can help women negotiate for protected sex and make decisions about mother-to-child transmission;
- reduce the risk of transmission of the infection to others. Explain that even if they are showing no signs of infection that they can still pass it on to others;
- reduce stigmatization through normalizing HIV status; and
- aid the client in planning for the future and taking responsibility for their partners and family members.

Disclosure can also:
- result in negative consequences because of the negative stigma attached to HIV and AIDS;
- create problems in relationships. This can include partners, family, friends, community members, employers, or work colleagues;
- lead to experiences of rejection and being judged. This may include abuse, violence, rejection and abandonment. This is especially important for women/men who are at risk of violence when they disclose to their partner; and
- lead to pressure to become a role model and assist in STI/AIDS work.

Once you have discussed the risks and benefits of disclosure with the client, you can assist them in the steps toward disclosure. This can include:
- not putting pressure on the client and allowing them to work through their decision. You can also assist in protecting the client from pressure to disclose;
- helping clients to realize that it is easier to tell one or two trusted people first;
- making a plan for how they will tell others. This includes whom they will tell, where they will tell them and what they will say;
- working through possible reactions of others and how they will respond. Let them know that they may face shock or hostile reactions. These types of reactions are common and may or may not turn to acceptance with time;
- role-playing how they will tell different people to create confidence in the client;
- working to make the client feel strong enough to actively deal with the reactions of others; and
- discussing ways of informing past partners of positive status. Service providers may discuss ways they could become involved in partner notification or refer the client to other organizations that could assist in this process.

Most important is to assist the client in living a positive and productive life. This will include:
- explaining how the client can live with HIV infection and discuss how others have managed to live positively and productively;
- discussing how looking after their health and psychological needs, along with the needs of others, will help them live a positive life;
- discussing how staying active, healthy eating, getting rest, cutting down on smoking and drinking, reducing stress, seeking spiritual support, seeking medical treatment for infections promptly and exploring the possibility of having anti-retroviral treatment (ARV) can all assist in living positively;
- preparing the client for the future. This can make them feel in control and more positive;

- finding ways to help the client not feel guilty about their HIV status;
- having a list of organizations in the community that can support emotionally (AIDS Service Organization (ASO) and Planned Parenthoods), physically (clinics, Community Health Centres, etc.) and socially (HIV-friendly clubs and sports teams, etc.). Assist clients in making the phone call to set up appointments. This can be done by making the call while they are in the office or by letting them go to another room to make the call and then letting the client come back and talk about it. This way the service provider can make sure the client reached someone and had a positive exchange; and
- providing the client with a list of organizations in the community that can support them if they want to make further contacts at a later date.

Negative Test Results

- Ask how the client is feeling since their decision to have the test. Congratulate them on returning or waiting to hear their test results.
- Ask the clients if they have any questions or if they would like to discuss anything prior to informing them of their results.
- Once the client is ready, give them their results in a neutral voice and wait for the client's response before proceeding.
- Be prepared for a variety of reactions from the client. Do not assume that all individuals will be relieved or feel happy with a negative test result.
- Help the client to understand that a negative test only means that antibodies were not detected and there is a possibility that they may be infected but that they are not yet showing antibodies for HIV if they were tested within the window period.
- Give the client the opportunity to repeat the test to be sure of the results if they wish.
- Assess the client's medical and sexual history in the last three months to determine if they have been put at risk. If they have, suggest that they repeat the text three months after their last potentially risky behaviour.
- Work with the client to create a harm-reduction plan. This can include:
    - discussing skills and a plan to protect the client in the future. This should be discussed even if the client states that they are no longer having sex. Having a plan will help reduce risk of STI/HIV infection if they do decide to engage in sexual activities in the future;
    - discussing how they intend to tell their partner and how they will talk about safer sex or testing with their partner; and
    - working with the client to stay HIV-negative (if the HIV status of the client's partner is unknown).

Unclear Test Results

- Ask how the client is feeling since their decision to have the test. Congratulate them on returning or waiting to hear their test results.
- Ask the clients if they have any questions or if they would like to discuss anything prior to informing them of their results.
- Once the client is ready, give them their results in a neutral voice and wait for the client's response before proceeding.

- Explain that uncertain results mean that the test did not clearly show the presence or absence of antibodies. The client may be in the sero-conversion phase and therefore will require another test. An uncertain (indeterminate) test may also be a result of how the client's blood reacted to the antibody test.
- Understand that the client may be frustrated with this result.
- Discuss the client's sexual and medical history and determine when they were last at risk for STI/HIV infection.
- Encourage the client to have another test in three months or longer.
- Explain to the client that is important to take precautions for reducing risk and engage in safer-sex practices until the test is repeated.

Section Four: Pregnancy Options

Service Providers will work with clients to:

- inform them of the option of an STI/HIV test prior to conception or during pregnancy;
- provide information on all pregnancy options so they are able to address the needs of clients making a decision regarding an unplanned pregnancy;
- understand what actions they can help clients take to prevent the transmission of STI/HIV in pregnancy, childbirth or breast-feeding; and
- minimize the risk of STI/HIV infection during conception and pregnancy (regardless of HIV status).

Introduction

A client seeking to explore pregnancy options is often just coming to terms with the pregnancy and needs assistance in weighing all of the options available. Service providers can work with clients to help them realize the variety of support options available whatever the client's age, as well as their HIV/STI, marital, financial, or socio-economic status. While parenting is often thought of as the "natural" choice, it may not be the "right" decision for every client. Make sure the client knows that the decision always belongs to them.

Pregnancy options information and support services should be offered to all pregnant women who make a request. The support services should be scheduled to allow the client enough time to explore all of the options available. The amount of time allotted for an appointment may also depend on whether the client just found out that she is pregnant or if she is going in for support services at a later date. If the client requests it, others may be included in the support process (i.e., partner, parents, or other support person chosen by the client). The client must be permitted to consider all of her options and this must be done without pressure from the service provider. All questions the client poses should be answered in a direct, unbiased and non-judgmental manner. It should also be made clear to the client that only she can make the decision about her pregnancy.

Service providers who provide pregnancy options support services should have the following knowledge or skills:

- the options available to a woman in regards to pregnancy;
- facts regarding abortion, parenting and adoption;
- local referral providers and facilities for prenatal care, adoption and abortion; and
- knowledge of referrals for emergency situations (i.e., sexual violence or rape) and for other sexual and reproductive health services.

STI/HIV Testing and Conception/Pregnancy

STI/HIV testing should be available for all pregnant women, or women wishing to become pregnant. Ideally, STI/HIV testing should only take place with pregnant women if they have given specific informed consent. Ensure that appropriate STI/HIV pre-test support services and information are given prior to testing. Pregnant women should have the option to choose to test

or not to test, and should be able to make a free and independent decision. All HIV-positive pregnant women should be made aware of all available information on pregnancy and HIV and be allowed to make decisions about their bodies, their health and the pregnancy.

Service providers should also be aware of the informed consent procedures in their province with regards to HIV tests for pregnant women. Some provinces have an opt-out program, which means that an HIV antibody test will be given to a pregnant woman unless she requests otherwise. However, other provinces have an opt-in program where pregnant women are counselled and offered testing, but are not tested unless they provide express consent or "opt-in". As testing protocols may change over time, services providers need to keep current with the HIV testing protocols for pregnant women in their province. Inform your clients of the different programs in your province so they know their rights in regards to HIV testing (see Appendix F for more details on how to find information about HIV testing in your province). Clients should also be offered information on contraceptive and safer sex methods in order to prevent future unplanned pregnancies and STI/HIV, as a part of a long-term harm reduction strategy.

HIV-positive Women and Pregnancy

Wanting to have a baby is a normal and healthy desire for all women, regardless of HIV status. Women who are HIV-positive face unique issues, which may influence the choices they make when deciding to conceive a child. Often family, friends, co-workers and even health care providers unfairly judge or are not supportive of an HIV-positive woman, if she is keeping or planning a baby. The counsellor can help a woman evaluate her support networks. It is important that an HIV-positive woman receives judgement-free support from the counsellor if she is pregnant, or considering a planned pregnancy.

The following questions were drafted for HIV-positive women to stimulate discussion with their doctor, nurse, or other healthcare provider. [24] (Please see Appendix P for a client fact sheet containing these questions.)

1. Are all pregnant women tested for HIV?
2. I am HIV-positive. Can I have a baby?
3. What about stigma?
4. How can my child become infected? What is the risk that my child will be infected?
5. What impact will being pregnant have on my own health?
6. Will HIV affect my ability to get pregnant?
7. How can I get pregnant safely?
8. What can I do to ensure that my baby and I stay healthy?
9. What can I do to reduce the risk of transmission to my child?
10. What therapy should I start?
11. What is lactic acidosis?
12. When should I start therapy?
13. But I'm already on therapy!
14. What can I do if I don't want to take medication?

[24] From a checklist developed by the Canadian Treatment Action Council (CTAC) and presented during the National HIV/AIDS Skills Building Symposium in Calgary in 2003. Used with permission.

15. Does my child have to take treatment? Will my child experience side effects from the HIV medication?
16. What are my delivery options?
17. Can I breast feed?
18. Can I do anything else to reduce the risk of transmission?
19. What about opportunistic infections?
20. Can I receive vaccinations during pregnancy?
21. What about methadone and pregnancy?
22. What is the risk of HCV transmission? Can I receive treatment for HCV while pregnant?
23. How will I know if my baby is positive? What if my baby is positive?

HIV Transmission From Mother to Child (Vertical Transmission) and Methods of Prevention

The risk of HIV transmission from mother to child may be one factor a woman weighs when considering all of her pregnancy options. HIV-positive women should receive all of the information and support necessary for them to make an informed decision about pregnancy. It is important to provide accurate information on the risk of transmission and how it may be reduced if an HIV-positive woman decides to carry the baby to term. HIV can be transmitted from a pregnant woman to the foetus or newborn, before or during birth. HIV can cross the placenta during pregnancy or infect the newborn during the birth process. HIV can also be transmitted to an infant through breast-feeding.

Advances in HIV treatment have brought down the rate of mother-to-child HIV transmission significantly. If the mother takes appropriate medical precautions, the rate of transmission can be reduced from 25% to below 2%. In addition, studies have shown that being pregnant will not make HIV progress faster in the mother.

Treatment decisions can be complex and should be made in consultation with a physician who is knowledgeable about HIV and pregnancy whenever possible. The final decision to take treatments during pregnancy always rests in the woman's control.

The risk of mother to child transmission of hepatitis C is approximately 5%. However, the risk increases to approximately 17% with an HIV co-infection.[25] It is important for HIV-positive women to know that having a child is still an option for them and that drug therapy can substantially decrease the chances of transmission from mother to child. However, co-infected women should also be informed that medications for hepatitis C cannot be given to pregnant women. Ribavirin can cause severe birth defects and women should not use it for at least 6 months before they become pregnant or during pregnancy. Men using Ribavirin should not use it for 6 months prior to getting a woman pregnant. Currently, there is no known treatment to prevent perinatal transmission of Hepatitis C.

[25] http://www.liver.ca/english/docs/hepc_physicians_e.pdf

Additionally, sexual and reproductive health service providers should explain to the client that all babies born to HIV-positive mothers are born with their mother's HIV antibodies or markers. In order to test if a baby is HIV-positive, a series of blood tests are conducted. If the baby is still HIV-positive after 18 months, it is considered to have HIV. Currently, some places are now using polymerase chain reaction (PCR) testing in infants. PCR testing detects the presence of HIV in a person's genetic material. So, often babies are diagnosed in the first 6 weeks of life.

STI Transmission During Pregnancy

Service providers should inform clients of the risk of STI/HIV transmission during pregnancy and childbirth. By informing clients of the possibility of mother-to-child transmission and how it may happen, the client can make informed decisions on ways of reducing the risk to their baby. Let clients know that STI/HIV can be transmitted from a pregnant woman to the foetus or newborn, before or during birth. For example, some STI (like syphilis) cross the placenta and infect the foetus during its development. Other STI (like gonorrhoea, chlamydia, hepatitis B, and genital herpes) are transmitted from the mother to the infant as the infant passes through the birth canal during delivery. Bacterial STI (like chlamydia, gonorrhoea, syphilis, and bacterial vaginosis) can be treated and cured with antibiotics during pregnancy. Unfortunately, there is no cure for viral STI such as genital herpes, but antiviral medication for herpes may reduce symptoms in the pregnant woman. For women who have active genital herpes lesions at the time of delivery, a caesarean section may be performed to protect the newborn against infection. (See information above on HIV transmission.) Inform clients of ways of being tested for STI/HIV and how they may receive treatment (see page 42 for more information on STI/HIV testing).

Pregnancy Options Available for Women

Abortion

An abortion is a medical or surgical procedure that is performed to end a pregnancy. Medical abortions (using drugs to terminate a pregnancy) are performed only when a woman is less than 7 weeks pregnant. Surgical abortions are performed on women in the first or second trimester of pregnancy.

- First Trimester Abortion: 7 weeks to 12 weeks
- Second Trimester Abortion: Between 13 and 24 weeks
- Abortions past 20 weeks of pregnancy generally occur only if there are foetal abnormalities or there are risks to the woman's health if she were to carry the foetus to term.

In many Canadian provinces, abortions are performed up to 16 to 24 weeks of pregnancy. As this time frame varies from place to place, service providers need to familiarize themselves with what services are available in their region.

Although it is legal in Canada, abortion has political, moral, and emotional implications. Service providers should be aware of these different influences and how they may affect a woman's decision-making. For information on abortion services in Canada see Appendix H.

Surgical Abortion
The procedures will be slightly different in every clinic however, the procedure generally consists of:

- medical intake;
- support services/pre-procedure counselling;
- a drug (Ibuphrone) is administered to relax the cervix;
- the patient is given an ultrasound;
- the doctor performs an internal pelvic exam;
- the doctor administers a local anaesthetic to numb the cervix;
- tapered rods are inserted to open the cervix;
- a cannula, attached to a vacuum aspirator, is inserted into the cervical canal to gently remove the contents of the uterus; and
- a curette (a spoon-shaped instrument) is used to remove any remaining tissue from the uterine walls.

Recovery: After the procedure, the client may feel menstrual-type cramps for up to an hour, along with vaginal bleeding. The client's heart rate and blood pressure will be monitored and the amount of bleeding and discomfort should be checked to make sure it is within a normal range.

Complications: Abortion is a safe medical procedure when performed by a competent physician. Complications can arise depending on the woman's age, her pregnancy, and her health or due to medical factors (the skill of the doctor, the anaesthesia, and the method of abortion). Complication rates are lower for first trimester abortions and clients should be encouraged to see a doctor immediately if they feel there are any complications after the procedure. Some of the symptoms of complications are:

- a fever higher than 38 C or 101 F;
- severe and persistent cramping that cannot be relieved with Tylenol (some cramping is normal); and
- very heavy bleeding, (using one or more menstrual pads per hour for six hours).

Abortion and HIV: While women who are HIV-positive may have reason to be concerned about the possible transmission of HIV to their foetus, they should never be forced or coerced into having an abortion. They should receive the same support services and options discussed with other women. However, they should be provided with information on HIV transmission from mother to child and methods to prevent transmission. (See page 54 for more details.)

Medical Abortions[26] (Also known as pharmaceutical abortion):
Service providers need to check on the availability of medical abortions in their area, as access to them varies greatly in Canada. In order to have a medical abortion, women must be less than seven weeks pregnant, be available to return to see the doctor for a follow-up appointment, and be willing to have a surgical abortion if the medical abortion doesn't work (the drugs cause serious foetal damage).

[26] http://www.kensingtonclinic.com/procedures.htm

Medical Abortion Procedures usually follows these steps:

1. a blood test;
2. support services/pre-procedure counselling;
3. a physical assessment, including a transvaginal ultrasound;
4. a doctor will give the woman an injection of methotrexate. which stops the pregnancy by blocking folic acid, which causes the embryonic cells to stop growing;
5. a few days later, Misoprostol is inserted vaginally. Misoprostol causes uterine contractions, which expel the foetal tissue and end the pregnancy; and
6. a week later, the woman returns to the doctor for a follow-up visit. The doctor will do another ultrasound to make sure the abortion is complete.

What to Expect After the Procedure[27]: Women having a medical abortion may feel strong cramps, nausea, diarrhoea or abdominal pain. Women may take acetaminophen or ibuprofen to reduce symptoms. Women may pass large blood clots or tissue at the time of the procedure and have some bleeding for up to four weeks.

Complications: Medical abortions are generally safe. Clients that experience the following symptoms should contact their doctor:

- soaking more than 2 maxi pads an hour or passing large clots, more than 2 hours in a row;
- bleeding heavily for more than 12 hours in a row;
- running a temperature of 38 degrees C for more than 4 hours;
- feeling nauseated or throwing-up for more than 4 hours;
- pain, even after taking painkillers; and
- an allergic reaction to the medicine.

Adoption

Adoption occurs when the legal custody of a child is transferred from the birth parent(s) to the adoptive parent(s). Adoptions can be public, which is coordinated through provincial governmental departments, or through non-governmental organizations like the Children's Aid Society, that are responsible for the welfare of children (i.e., they do legal work, home studies, counselling, paperwork, etc.). Private adoption is done through a registered Licensee (who connects adoptive parents with birth parents).

While provincial laws and practices will determine how an adoption is negotiated and the form that the adoption takes, adoptions are either open or closed. Service providers should become aware of the laws and regulations in their own jurisdictions when providing clients with information on pregnancy options and adoption.

Open Adoption: birth parents and adoptive parents can decide level of "openness". For example, potential adoptive families can provide a letter, photos, and relevant background information, including lifestyle, religion, parenting style, home, etc. to the birth parent(s). The nature and the

[27] http://www.plannedparenthood.org/ABORTION/medicalabortion.html

frequency of contact between birth parent(s) and the child vary greatly. "Openness" may include phone calls, visits, letters, etc. depending on the agreement between the two families.

Closed Adoption: With a closed adoption there is no contact between the birth parent(s) and the child. The child may seek out their birth parent(s) and have access to information on them once they reach the legal age of 18.

Same-Sex Adoption: As adoption is under provincial jurisdiction, there is no national policy or legislation on same-sex adoption. Same-sex couples wishing to adopt will face different regulations and procedures depending on the province in which they reside. For more information on same-sex adoption as an emerging issue in sexual and reproductive health in Canada, please see Appendix I.

Parenting

At times people feel pressured to have children. In North America, parenting or having children is related to a social norm. It is expected amongst most cultural groups in North America that you will grow up, get married and have children at some point. This is not the reality for all clients. Information on community support services can help clients to overcome these barriers.

Service providers should be aware that making the decision to be a parent is not a simple one and will involve different factors for each client. Although some may think that parenting is easy, the ways in which children are raised and views regarding parenting are always changing. It is important to work with a client to explore their options for parenting and how different factors in the individual's life will affect their ability to parent. These factors may include future goals, finances, mental health, support systems available to that client, and finishing school.

Counselling Guidelines for Providing Options Support

Women who are HIV-positive will have added concerns and face different issues than women who are HIV-negative. Therefore, this section has been split into two for ease of reading.

Options Support Services for Women (HIV-negative)[28]

The following areas can be considered the main framework for providing options support services. The time spent on each area will depend on the time and resources available to the service provider. The different areas do not have to be addressed in any specific order and the questions used to guide the session do not have to be the same as the ones written below. Service providers should work within their own abilities and comfort level to develop a method for covering these areas.

Pregnancy

- "When did you find out you were pregnant?"
- "How far along do you think you are?"
- "When was your last normal period?"
- "How did you feel when you found out?"

[28] Adapted from the Planned Parenthood of Ottawa, Options Training Manual

Support

- "Have you been able to discuss this with anyone else? A partner, friend, parent, relative?"
- "Is he/she supportive of you?"
- "Is the father involved with this pregnancy (if he is not at the session)? Will he have a role to play in your decision?"
- "Do you have anyone else that you can speak to that will support you in your decision and afterwards?"

Practical Issues

- "What types of challenges do you face (financial, emotional, physical) right now in making this decision and considering your options?"
- "Of all the practical issues of parenting, adoption and abortion, which will the most difficult for you to cope with? The least difficult?"

Dealing With Options

- "Why would you choose to parent? Why wouldn't you choose to parent?"
- "Why would you choose adoption? Why wouldn't you choose adoption?"
- "Why would you choose abortion? Why wouldn't you choose abortion?"

Summary

- "If you decide on _____ (abortion, adoption, or parenting) what worries you the most about it and how do you plan to cope with it?"
- "What are the next steps for you?" " Do you have someone/or need someone to help you with those next steps?"

Discussing STI/HIV during Pregnancy Options Counselling

Clients should be assessed for their risk of STI/HIV, as the act of sexual intercourse that lead to the pregnancy may have also put the client at risk for STI/HIV. For some clients, the pregnancy may have been unplanned—leading them to feel overwhelmed. You may discuss STI/HIV, but do not overwhelm the client. Let all clients know that STI/HIV testing should only take place if they give specific informed consent. Consider discussing the following with the client:

- The nature of the relationship that lead to the unplanned pregnancy (e.g., was this a long-term partner, monogamous relationship?).
- The risk of STI/HIV related to this relationship.
- The risk of STI/HIV related to the act of intercourse (e.g., was lubricant used, was the sex rough or non-consensual, was nonoxynol-9/spermicide used?).
- Any signs or symptoms of STI/HIV?
- Going for an STI/HIV test (see page 44 for pre-test counselling guidelines).
- Risks of STI/HIV to the client and the pregnancy.
- Ways of reducing the risk of pregnancy or STI/HIV in the future.
- Ways of avoiding contracting an STI/HIV during the pregnancy (see page 55).

Reducing STI/HIV Risk During Pregnancy and Conception

The most effective way of reducing the number of people infected with an STI/HIV during conception and pregnancy is through the prevention of STI/HIV in men and women of childbearing age. Sexual and reproductive health service providers should work to prevent STI/HIV prior to a client's decision to parent, in order to reduce the risk of STI/HIV during the pregnancy. For clients who are pregnant, the type of support provided to reduce the risk of STI/HIV is similar to other clients. You may want to discuss the following ways of reducing the risk of STI/HIV during conception:

- Clients may wish to be tested prior to starting their attempts to conceive, so both partners should be encouraged to be tested. Explain the window period for HIV (HIV antibodies may not show up in the blood for up to 14 weeks after the last unprotected contact) and the possible need to be tested more than once.
- If STI/HIV are present, treatment options should be discussed and offered to the clients prior to attempts to conceive.
- Suggest that clients use a water-based lubricant in order to reduce the risk of broken skin and a possible site for transmission of infection.

Options and STI/HIV Testing

Make no assumption about who needs an STI/HIV test and who does not. Regardless of service provider's perceptions of client risk, if the client asks for a test it should be done. While the pregnancy may be at the forefront of concerns at the time, the health of the woman should still be primary. Attend to the client's health by informing them of their risks for STI/HIV. Service providers should encourage the client to consent to a test. When you are discussing an STI/HIV test with a client in terms of pregnancy it is beneficial to:

- Explain that the test-taking procedure is voluntary and can only be done with the woman's consent.
- Identify testing options available in the region and which are anonymous and which are confidential. Explain the difference between the two types of testing and how this may affect the client. See Appendix F for information on how to find out about testing by province.
- If she has a partner, discuss the possibility of having her partner participate in the process.
- Arrange a return appointment and explain the need for a follow-up visit to obtain the results.
- If the client chooses not to be tested, honour this choice.
- Discuss harm reduction and explore ways of reducing risky sexual behaviour.
- Discuss the following advantages and disadvantages of test taking with the woman.

The advantages of test taking are:

- The woman knows and understands her STI/HIV status and can be helped to cope with her status.
- She can become empowered to make informed choices about all of her options.
- She can receive access to appropriate health care for herself and the child.
- She can find support to decrease chances of STI/HIV transmission.
- She can gain access to ongoing support.

The disadvantages of test taking are:

- emotional distress;
- stigma;
- possible abuse or abandonment by partner (See Section 5 for more details on violence and/or abuse.);
- possible breaches of confidentiality; and
- frustration, if no treatment or support is available.

Reducing Mother to Child Transmission of STI/HIV

The health of the mother is of primary importance in reducing the risk of STI/HIV to the child. Advise them to discuss this further with their doctor.

When discussing mother to child transmission, doctors or nurses may do the following with clients, while other service providers may wish to discuss these options and encourage clients to discuss them with their physician:

- STI/HIV screening with pregnant women, always with their consent, and follow-up with treatment.
- Provide accessible voluntary support services and testing for both partners.
- Promote safer sex practices during pregnancy.
- Provide treatment, including providing informed consent, detailed explanations, monitoring and follow-up.
- Tell women with active herpes lesions in the nipple that they should not breast-feed. Once the lesions have healed she may resume breast-feeding.
- Let the client know that if she is receiving any form of treatment she should inform her physician that she is breast-feeding.
- Provide safer sex information after delivery to help reduce the risk of STI/HIV and an unplanned pregnancy.

Options Support Services for HIV-positive Women

HIV-positive women require the same basic options support that HIV-negative women do. However, because HIV-positive women have additional concerns, in addition to the options support services provided in the previous section for HIV-negative women, counsellors working with HIV-positive women should review the following with their clients:

- **STI Testing for HIV-positive Women**
  Because women who are HIV-positive are more vulnerable to other STI, STI testing should be discussed with your client. While the pregnancy may be at the forefront of concerns at the time, the health of the woman should still be primary. Attend to the client's health by informing them of their risks for STI. Service providers should encourage testing but only with the client's consent. When you are discussing an STI test with a client in terms of pregnancy it is beneficial to:
    - explain that the test taking procedure is voluntary and can only be done with the woman's consent;
    - arrange a return appointment and explain the need for a follow-up visit to obtain the results;
    - if the client chooses not to be tested, honour this choice;
    - discuss harm reduction and explore ways of reducing risky sexual behaviour; and
    - discuss the following advantages and disadvantages of test taking with the woman.

      <u>Advantages:</u>
      - She can receive access to appropriate health care for herself and the child.
      - She can find support to decrease chances of STI transmission.
      - She can gain access to ongoing support.

      <u>Disadvantages:</u>
      - Emotional distress.
      - Frustration if no treatment or support is available.

- **Reducing the Risk of Mother to Child Transmission in HIV-positive Women**
  Women who are HIV-positive can reduce the risk of transmission to their child. The health of the mother is of primary importance in reducing the risk of STI/HIV to the child, so the discussion of treatment options with her doctor should be encouraged. Provide the woman with a copy of the fact sheet in Appendix P (also see page 60 earlier in this chapter), review it with her, and add any questions she may have.

  When discussing mother-to-child transmission doctors or nurses may do the following with clients, while other service providers may wish to discuss these options and encourage clients to discuss them with their physician:
    - STI screening with pregnant women, always with their consent, and follow-up with treatment;
    - provide accessible voluntary support services and testing for both partners;
    - promote safer sex practices during pregnancy;

- provide treatment. This includes providing informed consent, detailed explanations, monitoring and follow-up;
- avoid invasive obstetrical procedures (e.g., amniocentesis);
- consider delivery options;
- discuss alternatives to breast-feeding: Mothers who are HIV-positive should not breast-feed their infants because HIV is present in breast milk. Assist clients in finding infant formula. Free formula for HIV-positive women is available in some places. Find out if such assistance is available for your clients;
- provide safer sex information after delivery to help reduce the risk of other STI and an unplanned pregnancy; and
- be sure to follow up with resources available to her in the community.

Section Five: Abuse and Violence

Service Providers will work with clients to:

- understand the dynamics of a client's sexual relationship in order to help them negotiate safer sex and minimize the risk of abuse;
- provide clients with information regarding the potential risks of sexual violence and/or abuse on their sexual and reproductive health;
- offer support and referrals to the client when appropriate; and
- build on the client's skills and ability to take action.

Introduction

Abuse and/or violence can take place anywhere at any time and can exist on a spectrum from a single act of violence to ongoing experiences of abuse and/or violence. The following section explores the influence that abusive and/or violent experiences may have on a client when seeking sexual and reproductive health support services. Both sexual and non-sexual forms of abuse and/or violence may affect a client's sexual and reproductive health.

Abuse and violence are about power. Despite increased awareness of this issue, service providers continue to overlook many of the signs of abuse and/or violence displayed by clients. Given that serious injuries and death may result from acts of abuse and/or violence, it is essential that service providers become more adept at identifying clients who have experienced sexual or physical abuse and/or violence.

Abuse and/or violence may occur in all types of relationships, including: dating, gay and lesbian, marital and common-law. Traditionally, abuse and violence have been thought of as occurring only in heterosexual relationships. ***Abuse and/or violence in gay and lesbian relationships is a reality that should not be downplayed or disregarded because of misconceptions or stereotypes.*** Service providers can look for signs of abuse and/or violence (see page 67) in any relationship. Making assumptions about the presence or absence of abuse based on the sexual orientation of the client may leave them without the support or information they need.

Individuals from immigrant or multicultural backgrounds may also face increased barriers when seeking support for abuse and/or violence. Language barriers and cultural differences may act as obstacles for clients trying to leave an abusive/violent situation. Making bilingual/bicultural support providers available can assist clients in overcoming these obstacles and gaining personal empowerment. While providing bilingual/bicultural service providers to clients is an ideal, it is not always possible. Creating a strong multicultural referral network can assist service providers in supporting clients from a variety of backgrounds.

This section centres mostly on individuals who are sexually active, with a focus on adult populations rather than on children or adolescents. Youth and adolescents pose a series of additional concerns for the sexual and reproductive health counsellor. For information on what to do about suspected cases of child or adolescent abuse and/or violence, please refer to your

local governmental department responsible for the welfare of children (e.g., Children's Aid Society).

Sexual Abuse and/or Violence and Power

While sexual abuse, violence and rape often include sexual activities, sexual violence is not about sex; it is about power. Traditionally, it is women and youth who have less power.

There is a disturbing connection between violence, abuse and HIV. Some people are forced into having sex with their partners in spite of fears about pregnancy and/or STI/HIV. Often, partners who do not disclose their STI/HIV status infect their partners with STI/HIV. Not disclosing one's STI/HIV status to a sexual partner can result in a person being found guilty of a crime under Canadian law (See Appendices G & I for more information on the Cuerrier case). Partners sometimes fear rejection and abuse and/or violence if they discuss ways to protect themselves from STI/HIV and pregnancy and sometimes partners refuse to use condoms at all. Often, clients are blamed for bringing STI/HIV into a relationship if they disclose their STI/HIV status. This can bring about scorn, rejection, and abuse and/or violence.

It is often difficult for women/men to leave abusive relationships for many reasons. These can include economic dependency, low self-esteem/self-confidence, fear, having nowhere to go, fear of losing the children or breaking up the family, an unwillingness to admit that the relationship is not working and a loss of their status as a spouse. Do not judge—provide support and help the client build a network of support in case they do decide to leave.

Sex trade workers may be abused or raped by their clients and/or pimps. This form of sexual violence is often ignored, as it is unlikely to be reported.

The Impact of Abuse and/or Violence on Sexual and Reproductive Health

The following are possible consequences of sexual abuse and/or violence that should be considered when a client has come to you after an experience:

- Forced vaginal or anal sex easily tears the lining of the vagina or anus and this makes it easier for HIV or STI to be transmitted to the body.
- Pregnant women who are abused are more likely to have miscarriages or premature births.
- Men who are abused may suffer from a variety of physical symptoms.
- Women who are abused may suffer from gynaecological symptoms such as chronic pelvic pain.

Drugs and/or Alcohol and Acquaintance Sexual Assault[29]

A large number of sexual assaults involve alcohol; often either the victim and/or the attacker are drinking. This does not mean that alcohol causes sexual assault, but rather that there is a relationship between sexual assault and alcohol. Alcohol is like any other drug; it may change behaviour. When people drink, they are less self-conscious and are more likely to make choices they would not normally make. These choices may put the person in vulnerable positions. For example, a woman or a man may choose to go to a secluded bedroom with a man or she/he may accept a drive home from someone she/he just met. Although women and men ***should be*** safe in these situations, statistics show that they have potential to be dangerous.

Drug-induced sexual assaults are hard to define: survivors remember very little. It is estimated that it doesn't happen very often, but precautions should still be taken. Most of the recent press around date-rape drugs focused primarily on Rohypnol® ("Roofies") and GHB (liquid ecstasy). Although it is important to provide clients with information about these specific drugs, it is also vital to inform them that medications like Valium®, and even alcohol can also be used as a date-rape drug. The effects of Rohypnol (a pill) or GHB (a white powder or liquid) are usually felt about 20-30 minutes after they are taken. The drugs stay in the system up to 24 hours. Consequently, it is important to have a urine sample done as soon as possible if a person wants to report the assault.

The law states that an intoxicated person ***cannot*** agree to have sex; she/he cannot consent because she/he is incapable of making a rational choice. Also, an attacker cannot use alcohol as a defence against a charge of sexual assault. Being drunk or under the influence of drugs does not excuse a man or a woman who forced someone to have sex. Remember that the victim is never responsible for date or acquaintance rape. For example, when a woman or a man refuses, a partner must choose how to handle the refusal. The partner is guilty of assault if he/she uses direct or indirect threats, verbal coercion, or physical force for sexual activity.

Counselling Guidelines for Providing Abuse and/or Violence Support

Not all clients may disclose their experiences of abuse or wish to discuss them. It is the responsibility of the service provider to help clients talk about the abuse. Consider the following when attempting to discuss experiences of abuse with your client:

- Be aware that any client may be in a relationship where they are experiencing abuse or have experienced an incident of abuse. The client's experiences of abuse and the service provider's awareness of them may affect the support provided.

- One of the most common times for a woman to be physically abused by her partner is when she is pregnant.

[29] Adapted from the Fredericton Sexual Assault Crisis Centre tool kit: *The Empowerment Project – a train the trainer tool kit for delivering self-protection and assertiveness workshops to women and girls.*

Look out for symptoms of abuse and screen clients for physical or sexual abuse. Provide support services for these clients or refer them to available services. Signs of possible abuse include:

- bruises;
- cuts;
- fractures or bites;
- unexpected miscarriage or premature birth;
- unexplained delay in seeking help for injuries;
- stress-related illnesses;
- anxiety-related illnesses;
- marital, family and sexual problems;
- depression;
- suicidal thoughts;
- alcohol or drug problems;
- low self-esteem;
- taking responsibility for the abuser's actions; and
- feeling guilty and denying terror and anger.

Additionally, service providers can create an environment for clients to disclose their experiences and seek out support by being[30]:

- Aware: This will include recognizing that abuse and/or violence against clients exist and becoming aware of practices that will help them identify clients that have experienced abuse.
- Approachable: While service providers can be key people for clients to disclose their situation to, few women/men disclose spontaneously. It is the responsibility of the service providers to create an environment where the client feels comfortable to disclose. Service providers can place educational material and phone numbers for sexual or physical abuse and/or violence support in the waiting rooms, examination rooms or in the washroom for clients to read.
- Able to identify problems: It is the service provider's responsibility to create and maintain an atmosphere where suspicion regarding past, present or potential experience of abuse and/or violence can be explored.
- Able to provide support and/or medical care: If you are unable to provide this support/care make a referral and assist the client in following up on the referral.

Assessment and Screening for Experiences of Abuse and/or Violence

The examination should not be a physical or emotional continuation of the assault. If a client discloses that they have experienced sexual abuse and/or violence, the most important thing to do is to listen to them and believe them. Service providers should also explain that physical, sexual and psychological abuses are not acceptable behaviours in ***any*** situation, and that no one deserves it. Great care should be taken to explain to the client that in no way is the client to blame. If a service provider is concerned that the client may be experiencing or has experienced

[30] Adapted from the SOGC Clinical Practical Guidelines, Policy Statement on Violence Against Women, No.46, March 1996

abuse the following questions[31] may be posed to the client. Adapt these questions to best fit the needs of the client:

- In general, how would you describe your relationship?
    - A lot of tension?
    - Some tension?
    - No tension?
- Do you and your partner work out arguments with:
    - Great difficulty?
    - Some difficulty?
    - No difficulty?
- Do arguments ever result in hitting, kicking or pushing?
    - Often?
    - Sometimes?
    - Never?
- Do you ever feel frightened by what your partner says or does?
    - Often?
    - Sometimes?
    - Never?
- Has your partner ever abused you physically?
    - Often?
    - Sometimes?
    - Never?
- Has your partner ever abused you emotionally?
    - Often?
    - Sometimes?
    - Never?

If sexual violence is disclosed as a result of these questions, please refer to the section below for more information.

What to Do if Abuse and/or Violence are Disclosed

Be concerned for the client's safety and discuss safety plans. This will include considering the problem, the full range of options, the risks and benefits of each option and how the risks can be reduced. Provide ideas, resources and information but always encourage the client to take responsibility for their well-being and safety. If the service provider is the only source of support for the client, make referrals when appropriate. In addition, the service provider can:

- **Believe the client's story.** Listen actively, ask questions, empathize and avoid making judgments or giving advice.
- **Build on the client's strengths.** Complement them on what they have achieved so far, their coping strategies and survival skills.
- **Validate the client's feelings.** Clients experiencing abuse often have mixed feelings about the abuser–for example, love, anger, hope, fear, sadness and guilt. Give the client

[31] Adapted from http://www.sexualityandu.ca/eng/health/DV/screening.cfm

time and support to let out all feelings. Let them know that their feelings are normal and reasonable.

- **Avoid blaming the client for the situation.** Reinforce that the abuse is not their fault – it is the responsibility and problem of the perpetrator. ***Resist the temptation to criticize his personality, talk instead about his behaviour.***
- **Take the client's fears seriously.** Listen and empathize with the client's fears and worries. Do not judge how serious the problem is. Discuss options to overcome these fears and worries.
- **Offer help.** Offer specific and appropriate forms of help and information. Do not make false promises and end up not being able to meet the client's needs.
- **Provide practical help for the client**. This can include networking and referring the client to the appropriate local services and groups.
- **Work with the client to reduce the risk of pregnancy.** Help your client find ways to talk to their partner about contraception. Alternatively, help your client to use contraception without her partner's knowledge ***if this is the only solution***. Discuss risks and potential difficulties. Finally, discuss the use of emergency contraception if the client has had unprotected sexual intercourse in the last 7 days (See page 35 or Sheet 6 for more information on emergency contraception). Offer a pregnancy test and discuss pregnancy options.
- **Work with the client to reduce the risk of STI/HIV.** Explore ways to talk with their partner and the possibility of using a condom (male or female) (please see Appendix L for more information on condom negotiation). Discuss having tests for STI/HIV and taking antibiotics, or anti-retroviral drugs. Call your local AIDS organization, or the provincial AIDS information line to obtain information on PEP (Post-exposure prophylaxis). Availability of PEP varies from province to province and region to region.
- **Discuss which trusted people might support the client to cope with the situation and make a plan for disclosure.** Discuss going to a lawyer and/or the police to take legal action.
- **Discuss options to prevent or end an abusive situation** and help the client to decide on the best course of action.
- **Be aware of the ethical codes and/or policies of agencies** in regards to disclosure of past, present or possible abuse and/or violence against the client, others or minors. ***If child abuse (either physical or sexual) is disclosed, health professionals have a legal obligation to notify child protection authorities.***
- **Discuss the client's options.** This can include leaving the partner and situation and living with a supportive person or in a support shelter. Provide the client with names of shelters and contact information. Help them make the call if necessary.
- **Discuss the possibility of obtaining more support** from a community leader, mediator, friend, or relative to change the partner's behaviours. Explore the possibility of individual, couple or small-group counselling.

Exit Plan

When working with clients living with abuse and/or violence, service providers may want to assist the client in generating an exit plan. These plans can be designed for clients who fear for their own safety and/or the safety of their children. An exit plan consists of:

- Having a change of clothing packed for the client and their children. This should include necessary medications and extra house and car keys. These can be placed in a suitcase and stored with a friend or neighbour.
- Cash, chequebook, and a savings account book may also be kept with clothing.
- Identification papers, birth certificates, social insurance cards, driver's license, and financial records such as mortgage papers, rent receipts and automobile title should be taken if available.
- Items of special interest to each child (e.g., teddy bear).
- A plan detailing exactly where to go, regardless of time of day, should be made. This may be a friend's or a relative's home or a shelter.

Remember that the client's intentions should be established and information supplied to them regarding their possible avenues of action. Most importantly, the client should not be coerced on the basis of what the service provider feels is "best for them", rather it should be based on what the client feels is the best decision for them under the circumstances. Explore community and family support systems with the client and make them aware of the resources available to them. Do not just give the client a list of names and numbers, work with them to ensure that that have connected with the resources they require.

Working With a Crisis or Emergency

As mentioned, some abuse and/or violence will be experienced on an on-going basis while other experiences will occur once, however, both will produce emergency situations for the client. In the case of on-going abuse and/or violence, the service provider may have already been aware of the abuse and/or violence and may wish to help the client with an exit plan or continue to support the client by providing support services or medical services. If the emergency situation is the result of an isolated experience of violence, the service provider should work with the client to address their concerns and provide support. Each emergency situation will create a unique set of issues for the service provider. What is important is that the service provider manages the emergency situation with a holistic approach, addressing the client's physical, emotional, mental and legal concerns. This may include:

- providing immediate medical attention or referring the client to someone who can;
- assessing the client's ability to cope with the situation and providing support services or referring them to an agency that can provide mental and emotional support;
- discussing the client's risk of STI/HIV or pregnancy. If sexual abuse, sexual assault, and/or violence with intercourse have occurred make the client aware of the emergency contraceptive pill, the possible need for STI/HIV testing (now or following the window period for infection) and the possibility of HIV prophylaxis (PEP) (see below for more information);
- making clear documentation of the injuries presented by the client so that future legal action can be explored if the client wishes; and
- supporting the client's decision to pursue or not to pursue legal action.

Post-Exposure Prophylaxis (PEP) and Sexual Assault [32]

A client who has recently been sexually assaulted may have to make the decision to take a post-exposure prophylaxis (PEP) to reduce the risk of HIV infection. If PEP is going to be administered, it should to be initiated within 36 to 72 hours after the assault, the earlier the better. If it is determined that PEP is appropriate for the client's situation, and the client decides to take the drug(s), they will be offered a starter kit or prescription (depending upon the region), and arrangements will be made for follow-up medical care and support services. People taking PEP are usually seen by a physician on a weekly or biweekly basis throughout the treatment period. Be aware of the PEP procedures in your area—including places where it is offered, costs involved, and the evaluation process (use the referral sheet in Appendix B)

Emergency Contraception

Please see page 35 for information about emergency contraception. Also see the client fact Sheet 6 on the topic.

[32] http://www.hc-sc.gc.ca/hppb/hiv_aids/you/sex_violence/prophylaxis.html#08

Appendix A

Pre-evaluation of Current STI/HIV Integration Strategy[33]

Read through the checklist and mark the areas where you are providing or not providing comprehensive services, then refer to the corresponding sections in this manual to assist with the incorporation process.

STI/HIV strategy

- Have you/your organization developed an STI/HIV prevention strategy?
- Have you/your organization disseminated it to key managers and service providers?
- Is the strategy currently being implemented?

Protocol/Norms/Guidelines

- Is staff given STI/HIV norms/guidelines for support services?
- Is staff given STI/HIV norms/guidelines for testing?
- Is staff given STI/HIV norms/guidelines for treatment/care?
- Are clients routinely asked questions that enable them to determine their risk of STI/HIV infection?
- Are clients routinely asked whether they are at risk for gender-based violence (GBV)?
- Have the service providers been trained/prepared to follow the norms/guidelines?
- Have the service providers been sensitized to provide support services on STI/HIV prevention to all clients regardless of perceived risk?
- Are clients routinely asked about their sexual practices, preference or orientation?
- Are providers trained in addressing gender based violence (GBV) risks associated with partner notification?
- Have service providers been trained in pre- and post-test support services?
- Are returning clients assessed for risk?
- Are women who return with repeat STI/HIV screened for GBV?

Sensitization and Training

- Has the staff been informed about the STI/HIV initiative?
- Has all of the relevant staff participated in STI/HIV sensitization activities?
- Did the sensitization training include gender dimensions of STI/HIV (i.e., gender power differentials, condom negotiation skills)?
- Did the sensitization training include the topic of discrimination and reduction of stigma?
- Has all the relevant staff received appropriate training in STI/HIV prevention and sensitization?
- Is there a mechanism to identify the need for additional training to new staff members soon after they are hired?

[33] Adapted from "Have you integrated STI/HIV prevention into your sexual and reproductive health services?" International Planned Parenthood Federation

- Is there a mechanism to identify the need for additional training concerning specific issues related to STI/HIV?
- Is there a mechanism for sharing educational information on STI/HIV (e.g., bulletins, memos, etc.) among staff?

Services

- Does your organization do follow-up or management for STI/HIV?
- Does your organization do STI/HIV testing?
- Does your organization do pre-test support services?
- Does your organization do post-test support services (for both positive AND negative results)?
- Does your organization provide STI/HIV prevention support services?
- Does your organization provide male condoms?
- Does your organization provide female condoms?
- Does your organization promote dual protection (pregnancy or STI/HIV) with all clients interested in family planning methods?
- Does your organization include condom negotiation skills in support sessions on STI/HIV prevention?
- Does your organization offer post-exposure prophylaxis and/or emergency contraception to women who have been assaulted and fear exposure to STI/HIV or pregnancy?

Documenting Information

- Is there a system for documenting whether a client has been tested for STI/HIV in accordance with the norms/guidelines?
- Is there a confidential system for documenting the results of an STI/HIV test?
- Is there a system for documenting whether a client has been treated for STI/HIV in the past?
- Is there a system for tracking patients who have been treated for STI/HIV?
- Is there a system in place to explore the issues related to partner notification in the event of a positive STI/HIV test (e.g., risk for violence, inter-couple confidentiality and risk of discrimination)?
- Is there a system for analyzing data on STI/HIV-related services (i.e., number of clients screened, with positive STI/HIV diagnosis, treated, referred)?
- Is there a system for exploring why some clients may have recurrent STI?
- Are clients who test positive referred to other organizations for related services?
- Are general sexual and reproductive services provided to clients who are STI/HIV-positive?

Directory of Organization

- Does your association have a directory of organizations that provide STI/HIV-related services?
- When was the directory last updated?
- Has it been distributed to all service providers in the organization?

Appendix B

Service Provider Resource Referral Template[34]

Listed below are various types of agencies that service providers may wish to refer clients to when they are unable to provide the services needed by the client. As a service provider, you may want to assist your client to make an appointment and note the day and time it is scheduled for. This would allow you to follow up with your client the next time you see them.

For each type of agency, you may wish to have one or more referrals and, depending on the mandate of your organization, you may wish to add other types of referral agencies. Create a resource template that meets your own needs and make it available to all the staff in your office, posting it close to the phone will make for easy access.

Abortion Referrals: a local or regional resource that performs first- and second- trimester induced abortions.
Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Drug and Alcohol Referrals: a local resource for clients who have concerns with drug or alcohol problems.
Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Sexual Health Referrals: A local service provider who has training in sexuality issues.
Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Sexual Diversity Issues: A local resource for clients with questions relating to LGBTQ issues.
Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

[34] Adapted from http://www.sexualityandu.ca/eng/includes/health/pdf/ResourceMapforSexualHealth.pdf

Sexual Assault Referrals:

Acute: a local resource (e.g., regional hospital-based sexual assault crisis team) for acute care of sexually assaulted clients.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Non-acute: a local resource for clients who have a history of sexual assault.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Social Services for Youth: a local resource for information and support for youth.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Partner Abuse and/or Violence Referrals:

Acute: a local resource, which can provide support and resources and referrals for clients who are currently in a crisis situation due to partner abuse.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Non acute: a local resource, which can provide support about options available to clients who are in an abusive relationship or one they think might be abusive.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

STI/HIV Referrals:

STI Clinic: a local clinic for confidential STI/HIV testing and treatment.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

HIV/AIDS Counselling and Testing: A site for anonymous or confidential HIV testing and counselling.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

HIV/AIDS Care: A local site for continuing specialized care for HIV positive clients.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Needle Exchange/Distribution Services: A local facility to obtain free, clean needles.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Unplanned Pregnancy Referrals: a local agency for providing non-judgmental support and information on all three pregnancy options.

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Legal Referrals:

Organization Name:_____
Contact Name:_____ Phone Number:_____
Hours:_____
Address:_____
Website:_____

Appendix C

Intake questions sensitive to sexual diversity[35]

Listed below are several questions that may be used during the initial interview. Some of these questions will be appropriate for your services while others may not. Adopt the questions to meet your personal needs, needs of the client and the needs of your organization/agency. Respecting where the client is with regards to their sexuality is of utmost importance.

Legal name:

Preferred name (if different):

Gender:

- Male
- Female
- Transgender
  - Male to female
  - Female to male
  - Other
- Other: _____

Are your current sexual partners men? women? or both?

In the past, have your sexual partners been men? women? or both?

What is your current relationship status?

- Single
- Opposite Sex Marriage
- Same sex marriage/common law
- Partnered
- Involved with multiple partners
- Separated from spouse/partner
- Divorced/permanently separated from spouse/partner
- Other:_____

[35] Adapted from the GLMA guidelines for creating a safe clinical environment for lesbian, gay, bisexual, transgender, and intersex (LGBTI) patients.

What is your living situation?

- Live alone
- Live with spouse or partner
- Live with roommate(s)
- Live with parents or other family members
- Other: _____

Are there any children in your home?

- No children in home
- My own children live with me/us
- My spouse or partner's children live with me/us
- Shared custody with ex-spouse/partner

How do you describe your sexual identity?

- Straight/heterosexual
- Lesbian
- Gay
- Bisexual
- Queer
- Other: _____
- Not sure
- Don't know

Do you have any concerns related to your gender identity?

What safer-sex methods or contraceptive methods do you use, if any?

Do you need any information about safer-sex techniques?

If yes, with:

- Men
- Women
- Both

Are you currently experiencing any sexual concerns?

Do you want to start a family?

Are there any questions you have, or information you would like, with respect to starting a family?

Have you or your partner experienced an unplanned pregnancy?

Do you currently use or have you used hormones?
(e.g., oestrogen, testosterone, etc)

Do you need any information on hormone therapy?

Have you ever been tested for HIV?

- ☐ Yes, most recent test: _____
- ☐ No

If yes, what was your result_____. When_____.

Have you ever been diagnosed with, or treated for, a sexually transmitted infection (STI)?
Yes, I have been tested and/or treated for:

- ☐ Herpes
- ☐ Syphilis
- ☐ Gonorrhoea
- ☐ Chlamydia
- ☐ HPV/human papilloma virus (causes genital warts & abnormal PAP smears)
- ☐ HIV/AIDS
- ☐ Other_____

Would you like more information on STI/HIV?

Would you like more information on how to reduce your risk of getting an STI/HIV?

Have you had any sexual experiences lately that you think may have put you at risk for STI/HIV?

Have you ever used any substances (e.g., alcohol, marijuana, injection drugs) to make you feel good?
If yes, which _____ _____ _____
and when was the last time _____ _____ _____?

Have you come into contact with needles as a result of tattooing, piercing, injection drugs or blood transfusion?
If yes, which _____ _____ _____
and when _____?

Have you ever been diagnosed with, or treated for, hepatitis A, B, and/or C?
If yes, which and when?

Have you ever been vaccinated against hepatitis A or B?
Vaccinated against hepatitis A
Vaccinated against hepatitis B

Below is a list of risk factors for hepatitis A, B, and C. Do any of these apply to you?

- ☐ Yes
- ☐ No
- ☐ Not sure

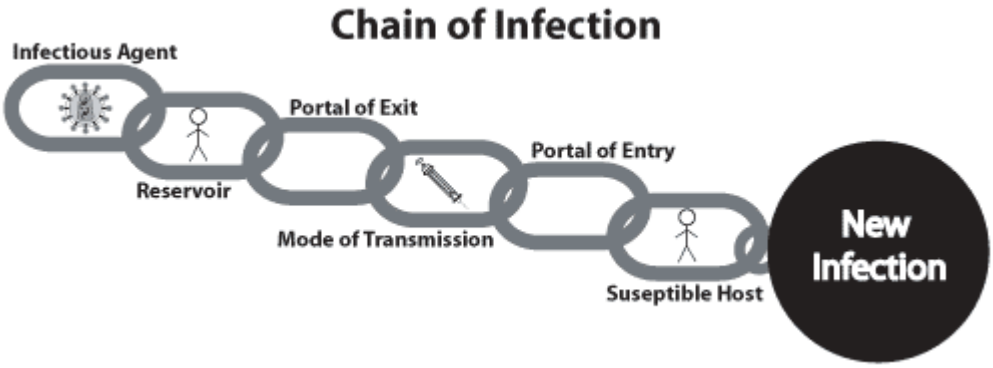
Hepatitis Risk Factors

Have you:

- ☐ participated in sexual activity that shares blood or fluid;
- ☐ had multiple sex partners;
- ☐ had oral-fecal contact;
- ☐ had sexual activity during a menstrual period;
- ☐ traveled to regions where Hepatitis is common;
- ☐ ever had a tattoo, or a piercing;
- ☐ used injecting or non-injecting drugs;
- ☐ ever been diagnosed with or treated for STI/HIV; and or
- ☐ come into close contact with someone who has Hepatitis A, B or C?

Appendix D

Chain of Infection Diagram



Infectious Agent: A microbial organism with the ability to cause disease. Infectious agents are bacteria, virus, fungi, and parasites. For example: HIV virus or other sexually transmitted infections.

Reservoir: A place within which micro-organisms can thrive and reproduce. For example: humans and animals.

Portal of Exit: A place of exit providing a way for a micro-organism to leave the reservoir. The micro-organism may leave the reservoir through the penis in semen, or vagina in vaginal discharge. For example: ejaculation.

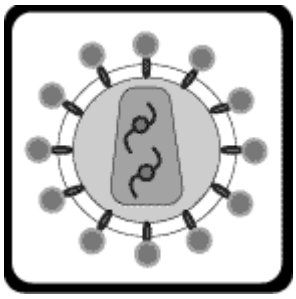
Mode of Transmission: Method of transfer by which the organism moves or is carried from one place to another. During unprotected sex sperm can enter the vagina. For example: unprotected sexual contact or sharing needles.

Portal of Entry: An opening allowing the micro-organism to enter the host. Portals include body orifices, mucus membranes, or breaks in the skin. For example: mouth or vagina.

Susceptible Host: A person who cannot resist a micro-organism invading the body, multiplying, and resulting in infection. The host is susceptible to the disease, lacking immunity or physical resistance to overcome the invasion by the pathogenic micro-organism. For example: low immune system response.

Infection: The last stage in the Chain of Infection. The microbial organism is now able to thrive in the host.

Appendix E



HIV/AIDS[36]

What are HIV and AIDS? HIV stands for Human Immunodeficiency Virus. HIV can eventually lead to AIDS (Acquired Immune Deficiency Syndrome). HIV attacks the immune system and makes the person unable to fight off infections. AIDS is a collection of illnesses a person gets when their immune system becomes weak.

How is HIV transmitted? Three things are needed for the virus to get from one body to another:

1. Certain body fluids of someone with HIV

(blood, menstrual blood, semen, pre-cum, vaginal fluid, or breast milk)

+

2. An entry point into someone else's blood stream

(vagina, anus, penis, open sores or injection sites)

+

3. An activity that brings the body fluid and the entry point together

(unprotected sex, sharing any type of need of sex toy)

=

Risk of HIV transmission

If any one of these three things is missing, HIV cannot be transmitted.

[36] http://www.fredericton.ppfc.ca/resourcekit/kitindex.htm Used with permission.

HIV/AIDS

What is risky and what is not?

High Risk:

- Vaginal or anal intercourse without a condom.
- Sharing any type of needle, including those used in tattooing, piercing, and steroids.
- Sharing sex toys.

Low Risk:

- Performing oral sex on a man or a woman without a barrier.
- Vaginal or anal intercourse with a condom.
- Using a needle or syringe that has been cleaned.

Negligible Risk:

- Performing oral sex with the use of a barrier.
- Receiving oral sex without the use of a barrier.
- Licking the anus (rimming).
- Digital-anal intercourse (fingering someone's anus).
- Wet kissing (with exchange of blood).

No Risk:

- Wet or dry kissing.
- Masturbation either solo or by a partner without semen or vaginal fluid as lubricant.
- Using unshared sex toys.
- Urinating, ejaculating or defecating onto unbroken skin.
- Massages, touch, body rubbing.
- Injection of substance or tattooing or piercing with a new needle.
- Mosquito bites, sharing a glass, talking on the phone, sitting on a toilet, kissing.

Appendix F

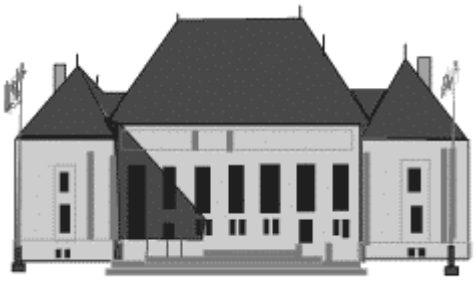
HIV Testing in Canada by Province

HIV testing and reporting procedures vary from province to province. Because decisions about health care services are determined provincially and locally, and subject to change over time, counsellors will need to inform themselves about the availability of HIV testing services in their province and community. For more information on the types of testing available in your province and for more information on HIV/AIDS please refer to the Health Canada Website listed below:

http://www.hc-sc.gc.ca/hppb/hiv_aids/you/sex_violence/testing.html#02

Appendix G [37]

Duty to Disclose*



In the landmark Cuerrier case, the Supreme Court of Canada (September 1998) ruled "Without disclosure of HIV status there cannot be true consent. The consent cannot simply be to have sexual intercourse. Rather it must be consent to have intercourse with a partner who is HIV-positive". However, the judgement of the Court is not clear exactly when, or under what circumstances, the duty to disclose HIV-positive status exists. The Court said that there is only a duty to disclose if failing to disclose would expose the sexual partner to a "significant risk of serious bodily harm". HIV infection, and perhaps other STI as well, could pose a risk of serious bodily harm. This rather ambiguous ruling by the Supreme Court of Canada is open to the courts' interpretation of what "significant risk" means with regards to *protected* sexual intercourse, as well as low-risk, and negligible-risk activities. The Court's decision also may have implications for HIV-positive mothers who breast-feed.

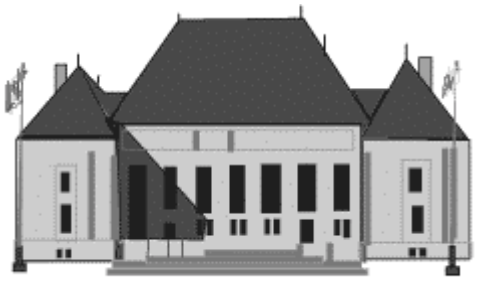
People getting tested for HIV need to understand that criminal charges may be laid if they know their status and put someone else at "significant risk " of being infected with HIV or another STI that causes "serious bodily harm". Counsellors faced with a client who refuses to disclose need to make appropriate use of options available under public health law. Please contact your local AIDS service organization to learn more about the legal issues surrounding STI/HIV transmission.

* Please also see Appendix I: Emerging Issues.

[37] Adapted from the series of info sheets on Criminal Law and HIV/AIDS (March 1999) by the Canadian HIV/AIDS Legal Network.

Appendix H

Abortion in Canada*



Since the Supreme Court of Canada struck down the abortion section of the Criminal Code in 1988, Canada has had no legal restrictions placed on abortion services. Abortion is a medical procedure, and in Canada, women legally have the right to choose whether or not they continue with a pregnancy. However, legal matters not withstanding, a recent access survey conducted by the Canadian Abortion Rights Action League (CARAL) has confirmed that many women in Canada do not have adequate access to abortion services.

A summary of the report can be found at: http://www.caral.ca/uploads/shortcaral-e.pdf. The full report can be found at: http://www.caral.ca/uploads/caralreporti.pdf.

Because decisions about health care services are determined provincially and locally, and subject to change over time, counsellors will need to inform themselves about the availability of abortion services in their province and communities.

*Note: Planned Parenthood offices in Canada to ***not*** provide abortion services, but do provide abortion referrals and information.

Appendix I

Emerging Issues in Sexual and Reproductive Health

Anal Pap Smears: More research is needed to determine if the anal pap smear should become a routine part of medical examinations for gay men. A study in Seattle Washington in 2002 indicated that 32% of gay men tested positive for Human Papilloma Virus (HPV), or genital warts, which could lead to anal cancer, as HPV in women can lead to cervical cancer.[38]

Same-sex Marriage: At the time of publication, (early 2004) the future of same-sex marriage in Canada was very uncertain. The new Prime Minister appointed a new Minister of Justice. This new Justice Minister decided to review the entire issue. At the present time, the Federal government's position on the matter is not clear.

Same-sex Adoption: Since adoption falls under the jurisdiction of provincial governments, the rules vary from province to province. For example, in New Brunswick, currently a same-sex couple can go through the process of a home study together, but only one person in the couple will become the legal adoptive parent of the child. The current legislation in NB states that only married couples can adopt together. Since NB does not recognize same-sex marriages, only one person can adopt a child. If one person in a same-sex couple has a biological child, the non-birth parent cannot adopt that child unless the birth parent gives up parental rights. Conversely, in British Columbia, (where same-sex marriages are recognized and performed) same-sex couples are able to jointly adopt a child. Therefore, counsellors will need to inform themselves about the laws governing same-sex adoption in their province.

Microbicides[39]: The word microbicides refers to a range of different products that share one common characteristic: the ability to prevent the sexual transmission of HIV and other sexually transmitted diseases (STDs) when applied topically. A microbicide could be produced in many forms, including gels, creams, suppositories, films, or in a sponge or ring that releases the active ingredient over time.

Although microbicides are not yet available, scientists are currently testing many substances to see whether they help protect against HIV and/or other STDs, but no safe and effective microbicide is currently available to the public. However, scientists are seriously pursuing almost 60 product leads, including at least eleven that have proven safe and effective in animals and are now being tested on people. If one of these leads proves successful and investment is sufficient, a microbicide could be available in five to seven years.

The Canadian AIDS Society (CAS) will be publishing a resource document in 2004 dealing with microbicides. The document is called: *Microbicides in Canada: Legal, Ethical and Human*

[38] http://www.ppfc.ca/issues/April2002.htm
[39] Adapted from http://www.global-campaign.org/

Rights Issues. Please contact CAS directly to obtain more information on this resource or to order a copy for yourself.

Cuerrier Decision[40]: (Also see Appendix G for information about the duty to disclose.) In the Cuerrier decision of September 1998, the Supreme Court of Canada ruled that where sexual activity posses a "significant risk of serious bodily harm," there is a duty on the HIV-positive person to disclose their status. Where this duty exists, not disclosing may constitute "fraud" that renders a sexual partner's consent to that activity legally invalid, thereby making the otherwise consensual sex an 'assault' under Canadian criminal law.

There are a number of resources available that provide detailed information on the Cuerrier decision and its implications for clients and counsellors. Contact the Canadian HIV/AIDS Legal Network (http://www.aidslaw.ca/) and the Canadian AIDS Society (http://www.cdnaids.ca/) for more information about resources that they have produced.

HIV and Hepatitis C Virus (HCV) Co-infection[41]: People infected with both HIV and Hepatitis C (HCV) are considered to be co-infected. Co-infected individuals are much more likely to have their HCV progress faster, and co-infected mothers are more likely to transmit HCV to their infants during the birthing process. Since there is no specific combined treatment for co-infection, each illness needs to be treated separately.

Because HCV is primarily spread through shared needle use, counsellors may need to examine their own attitudes about injection drug use and drug users. Co-infected individuals may face complex and difficult issues. For further information, counsellors are encouraged to contact any of the following sources for more information: local needle exchanges, Hepatitis C Society, the local chapter of the Canadian Liver Foundation, local HCV projects, and local and provincial AIDS service organizations.

[40] Adapted from *After Cuerrier: Canadian Criminal Law and the Non-Disclosure of HIV-Positive Status* by the Canadian HIV/AIDS Legal Network (1999).

[41] Adapted from the *Is there a connection between HIV and hepatitis C?* Fact sheet by he Canadian HIV/AIDS Information Centre, and the *Integrating Hepatitis C information Into Your Agency* fact sheet from the Ontario AIDS Network.

Specific Populations may have specific needs. There are many organizations in Canada that specialize in working with specific target populations, and have developed extensive tools for this work. The following listings can be used as a starting point for information gathering on the following specific populations.

- **Prisoners/Prison Issues:**
  Prisoners with HIV/AIDS Support Action Network (PASAN)
  http://www.pasan.org/

- **Aboriginal Issues:**
  Canadian Aboriginal AIDS Network
  http://www.caan.ca

- **Ethnic Communities:**
  Canadian AIDS Society's website for Ethnocultural Programs
  http://www.cdnaids.ca/

Appendix J

Web-based Resources for Further Information

AIDS Resources

Canadian AIDS Society
http://www.cdnaids.ca/

Prisoners with HIV/AIDS Support Action Network (PASAN)
http://www.pasan.org/

Canadian Aboriginal AIDS Network
http://www.caan.ca/

Canadian HIV/AIDS Legal Network
http://www.aidslaw.ca/

Planned Parenthood Federation of Canada Women & Youth HIV Site
http://www.ppfc.ca/HIV/index.html

Positive Women's Network
www.pwn.bc.ca

Voices of Positive Women
http://www.vopw.org

Women & AIDS Virtual Education
www.pwn-wave.ca

Planned Parenthoods

Planned Parenthood Federation of Canada
http://www.ppfc.ca/

Planned Parenthood Federation of America
http://www.plannedparenthood.org/

International Planned Parenthood Federation
http://www.ippf.org/index.asp

Sexual Reproductive Health

Society of Obstetricians and Gynaecologists of Canada Sexuality Website
http://www.sexualityandu.ca/

Canadian STD Guidelines
http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts98/

Canadian Guidelines for Sexual Health Education
http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/cgshe-ldnemss/

Sexuality Information Education Council of Canada
http://www.sieccan.org/

IMB Counselling Model
http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/cgshe-ldnemss/cgshe_9e.htm

Global Campaign for Microbicides
http://www.global-campaign.org/index.htm

Society of Obstetricians and Gynaecologists of Canada
http://www.sogc.org/index.html

Emergency Contraception Princeton
http://ec.princeton.edu/

Health Information

Canadian Health Network
http://www.canadian-health-network.ca/

Health Canada
http://www.hc-sc.gc.ca/

Canadian Public Health Association
http://www.cpha.ca/

Motherisk
http://www.motherisk.org/

Canadian Women's Health Network
http://www.cwhn.ca/

Youth Sites

Planned Parenthood Federation of America Teen Site
http://www.teenwire.com/

Planned Parenthood of Toronto Youth Site
http://www.spiderbytes.ca/

Scarlet Teen (Youth Site)
http://www.scarleteen.com/

Go Ask Alice (Teen site)
http://www.goaskalice.com/

Pregnancy

Morgantaler Clinics
http://www.morgentaler.ca/

Childbirth By Choice
http://www.cbctrust.com/

Childbirth By Choice Trust Medical Procedure
http://www.cbctrust.com/medproc.html

Canadian Abortion Rights Action League
http://www.caral.ca/

GLBTQ

Gay & Lesbian Medical Association
http://www.glma.org/

TRANSCEND - Transgender Support & Education Society
http://www.transgender.org/transcend/index.htm

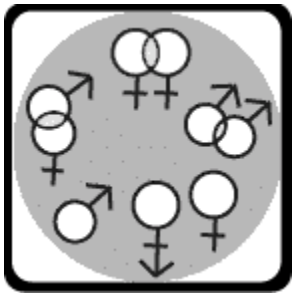
Trans Alliance Society
http://www.transalliancesociety.org/

PFLAG
http://www.pflag.ca/index.htm

EGALE (Equality for Gay and Lesbians Everywhere
http://www.egale.ca/

CLIENT FACT SHEET

Appendix K



Sexuality

Information on How to Talk to Your Service Provider About Sexuality[42]

- Many people find it helps to bring an article with them to start talking about what is worrying them. You can start by saying, "I was reading this and wondered what you thought."

- Try to be positive, you can start by saying, "I was hoping that you might be able to help me with this problem I have."

- Your health care provider may be a bit uncomfortable about discussing sexuality with you. Don't take it personally or feel that they are judging you if your health care provider becomes uncomfortable.

- Don't take "No" for an answer. Some health care providers don't know how to help and they may try to play down your concerns. If your health care provider doesn't help you with your sexual concerns, ask to see someone else who can help. Don't give up!

- Look in your local yellow pages or check with your local hospital or sexual health centre for doctors or counsellors you can talk to.

[42] Adapted from www.newshe.com

Suggestions for Those "Coming Out" [43]:

- You don't know how someone will react until you come out to that person. You can take steps to make the coming-out process as smooth as possible. The following tips may help:

- You can start by letting others know that you don't judge people based on race, sex, religion, sexual orientation, or anything else.

- If you have a partner, start referring to them by name or as a "close friend" whom you care deeply about.

- Consider having your family and/or friends meet your partner and get to know them before you come out.

- When you're ready to come out, set up a time and place to talk with the person you want to come out to. The best time to come out is when you are feeling good about yourself.

- Get ready for a whole range of different reactions from good to bad. If possible, try to have a friend or family member ready to be there for you after you have come out.

[43] Adapted from http://www.sexualityandu.ca/eng/adults/SGO/comingout.cfm

CLIENT FACT SHEET

Appendix L

Safer Sex, Contraception and STI/HIV

Condom negotiation[44]
The best time to bring up the subject of condoms is before, not during, sex. This could be when you and your partner are talking about having sex, or thirty minutes before sex. It may be easier to have "the condom talk" as soon as you both know you're headed toward having sex. That way you can go into things knowing you've agreed to use condoms.

There are several ways to start talking about condoms without sounding like a traffic cop. Humour often helps to lighten the discussion. For instance:

"Let's get the condom talk over with now, so we can enjoy ourselves later."

"There's something I've been meaning to ask you...if and when the time comes, would you rather I put on your condom or do you prefer to roll your own?"

"And now for a really romantic question. Your condom or mine?"

Most partners will not only understand that you want to use a condom but share your concerns about avoiding STI/HIV or unwanted pregnancy. But there's always a chance your partner will grumble. He might say:

"Sex with a condom does nothing for me."
You can say: "Let's see if we can do something about that."

"I'm a little confused here—it's not like I've been sleeping around or anything."
You can say: "Even so, you or I may be carrying STIs without knowing it. I'm concerned about protecting both of us."

"This discussion is so predictable. I was hoping you'd be more spontaneous about the whole thing."
You can say: "Sorry about the yawn factor, but sex without condoms is not an option for me right now."

If the discussion turns into an argument or a battle, suggest a nonsexual activity. You can bring up the subject again some other time, or wait until you find a partner who's more willing to use a condom or discuss condom use with you.

Sometimes you simply don't have enough warning to bring up condom use ahead of time, or you may feel that talking about it wouldn't help. If this happens, you can bring out a condom and say something like, "Here, let's use this if we're going to have sex." If said firmly but gently, saying this can keep you and your partner safer from unplanned pregnancy or STI/HIV.

[44] Adapted from http://www.sexualityandu.ca/eng/adults/CN/raising.cfm

Putting on a condom (male)
Male condoms usually come rolled up in a sealed packet, and most are pre-lubricated on the outside (the preferred choice). If the condom is brittle, stiff, sticky, or past its expiry date, throw it out and use another one. Make sure that when you feel the condom in its package it feels like there is air in the package. Air in the package means that the condom has not been damaged.

- Begin putting on the condom when your penis is hard.
- Put a drop or two of lubricant or saliva inside the tip of the condom (optional).
- If you're not circumcised, pull back your foreskin.
- Place the rolled up condom over the tip of your penis, leaving a half-inch space for semen.
- Pinch the air out of the tip of the condom.
- Unroll the condom all the way to the base of the penis.
- Make sure there is no air trapped between the condom and the penis.
- If you're not using a pre-lubricated condom, lubricate the outside of the condom with a water-based lubricant.

When you've finished having sex (vaginal, anal or oral), hold the condom against the base of your penis while you pull out, and roll it off your penis gently and tie it in a knot to prevent leakage.

You cannot use a male and female condom at the same time.

If you are using a condom for protection against diseases, make sure you use only latex or polyurethane condoms. Novelty condoms do not protect you against STI/HIV or pregnancy.

Putting in a condom (female)
Female condoms can be put in up to 8 hours before having sex. You can put it in either standing with a foot on a chair, or sitting or lying with your legs apart.

- With one hand, squeeze the ring at the closed end of the condom.
- With the other hand, spread your outer vaginal lips.
- Insert the condom into the vaginal canal.
- Push the inner ring of the condom past your pubic bone and over your cervix.

The outer ring of the female condom hangs about an inch outside the body, and will need to be held in place during sex (when the penis is in the vagina). After intercourse, twist the outer ring so that all fluids stay inside the condom, and then gently pull it out.

You cannot use a male and female condom at the same time.

Making a Dental Dam out of a Condom

A dental dam (the kind the dentist uses when putting fillings in your teeth) is a good barrier if you are going to perform oral sex on a woman because it protects both you and your partner from STI/HIV. You can easily make your own dental dam using a condom. Use a condom that isn't lubricated with spermicide, or use a flavoured condom, since you'll be putting your mouth on it.

They're simple to make. First unroll the condom, then:

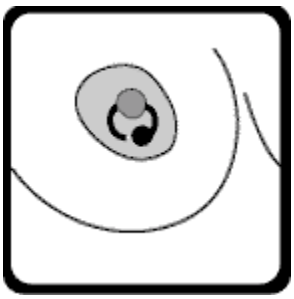
- cut off the tip;
- cut off the base; and
- cut down one side.

CLIENT FACT SHEET

Appendix M

Fact Sheet on Needle Use and HIV[45]

What kind of needles can pass on HIV? Any needle that is not clean could pass on HIV, which is the virus that leads to AIDS. This includes needles used for injecting drugs (including steroids), tattooing, piercing and skin-popping.



How do I know that the place where I get my piercing or tattoo is safe? Does it have a business licence? Do they have an autoclave machine for sterilizing their reusable equipment? Do they have a sharps container to store their dirty needles? Do they use disposable razors for shaving the area before tattooing? Do they use individually wrapped, disposable needles? Do they pour new ink into new, disposable containers for each customer? Do they use latex gloves? Do they give you after-care instructions to help prevent infections? ***The answers to all these questions should be YES.***

How do I clean a needle? Rinse the needle and syringe 3 times with bleach. Leave the bleach in the needle and syringe for 30 seconds each time. Rinse the needle and syringe 3 times with water. Get rid of the bleach and water after you're done. If you share needles, syringes, filters or cookers, clean them between uses. ***Always throw out the water! Do not share the water!*** Make sure that you clean the needle and kit with water when you're done. Make sure you don't shoot the bleach.

Remember, the best protection when using needles is to use your own clean needle!

Where do I get clean needles? Phone your local AIDS organization. They can tell you if there is a needle exchange in your area. In some places, you can get needles at pharmacies. Ask your local AIDS organization about that.

Should I shoot up in different veins? Yes. When you stick a needle in your vein, it leaves a hole in the skin and in the vein. You can keep your veins in good shape if you let the spot heal before you hit on it again.

How long does it take to heal? At least 2 days. Longer is better.

[45] http://www.fredericton.ppfc.ca/resourcekit/kitindex.htm Used with permission.

What happens if I don't let it heal? The risk of spreading HIV increases when you or your partner has an STI. Your veins could collapse and you will lose your vein totally. You might get an infection. Your veins might leak and then you've wasted your shot. You could get abscesses. You might push a blood clot into your bloodstream. This clot could get stuck somewhere in your body like your brain, heart, or lungs. This is really dangerous.

How can I shoot up more safely? Make sure you use a clean needle. Use a new needle anytime you can. A sharp point saves your veins. Don't share needles, syringes, cookers, bleach or water. If you have to share supplies, make sure you clean them first (***Remember, this is not 100% safe***)**.** Rotate the spot where you shoot up. Clean the spot with soap and water before shooting up. If you inject yourself, practice injecting in your other arm with your other hand. This gives you more spots to choose from. Plan ahead. Try to find a place to shoot up where there is lots of light.

Everyone is entitled to take care of themselves, whether they use drugs or not. Learning to take care of yourself takes time and thought.

Learn to inject safely.

CLIENT FACT SHEET

Appendix N

HIV Antibody Testing

What is an HIV test? The Human Immunodeficiency Virus (HIV) antibody test is a blood test that tells if you have been infected with HIV. HIV is the virus that causes Acquired Immunodeficiency Syndrome (AIDS). The HIV antibody test does not tell you whether you have developed AIDS.

Should you get tested for HIV? This is a hard choice to make. If you or your partner(s) have had unprotected vaginal sex (penis into vagina) or unprotected anal sex (penis into anus) or if you have shared needles or have had a blood transfusion before 1985, you may want to get tested for HIV. Talk to a doctor, nurse or counsellor to help you decide if you should take an HIV test. If you are pregnant, you might want to be tested because there are drugs that can be given to HIV-positive pregnant women that may protect the baby.

How do you get tested for HIV? You can get a blood test. Testing can be done three different ways: anonymous, non-nominal and nominal.

Anonymous HIV testing: For anonymous testing the person doing the HIV test does not know the name of the person being tested for HIV. The HIV test is done using a code. The person (doctor or nurse) ordering the HIV test and laboratory carrying out the testing on the blood sample do not know to whom the code belongs. Only the person being tested for HIV knows the code. The results may be reported to public health.

Non-nominal/non-identifying HIV testing: The HIV test is ordered using a code or the initials of a person being tested. The code on the test can be linked back to the person having the test. The results may be reported to public health.

Nominal/name-based HIV testing: The person ordering the test (doctor or nurse) knows the name of the person being tested for HIV. The HIV test is ordered using the name of the person being tested. The results may be reported to public health. This is the type of testing typically done in the doctor's office.

Test Results
An HIV test does not test for the HIV virus itself, but rather the presence of HIV antibodies in blood (the body produces antibodies to try and fight off the infection). You should wait at least 14 weeks (the window period) after being exposed to a risk prior to being tested. Waiting for 14 weeks allows the body time to produce HIV antibodies to fight the HIV infection.

Window Period: This is the time between being exposed to HIV and having your body produce enough antibodies to be detected by a test. This takes about 14 weeks. During this time an HIV antibody test may show a false-negative, that is the individual shows no antibodies because they have yet to develop enough to show up in an antibody test.

Negative Results: If the test is negative and you have waited 14 weeks this means that no antibodies are present. One negative test does not make you immune and you are still at risk if you have unsafe sexual activities.

Positive Results: A positive test means that HIV antibodies have been detected in the blood. It does not mean that you have AIDS or are going to die soon. Healthy individuals can live for many years. If you have HIV-related illnesses you may have AIDS but you can be helped with care and treatment.

Uncertain Results: Uncertain results mean that the test did not clearly show the presence or absence of antibodies. You may be in the sero-conversion phase and antibodies haven't shown up enough yet to show up on a test, therefore you need another test.

Negative or positive, it's important to play it safe!

You can reduce your risk of getting HIV and other sexually transmitted infections by practising safer sex and never sharing needles and syringes. Make talking about health a part of your sexual relationship. Talk about sexually transmitted infections and protection with your partner(s) before you have sex. Using latex condoms can reduce your risk of getting HIV and other sexually transmitted infections (STI's).

CLIENT FACT SHEET

Appendix O

Pregnancy Options[46]

If you are pregnant, you have three basic choices:

- continue the pregnancy and choose to parent;
- continue the pregnancy and choose to give the baby up for adoption; or
- end the pregnancy by having an abortion.

There may be things you need to find out before you can make a decision. If so, you can get more facts about each of your choices from places like the ones listed below. Either call with your questions, or ask them to send you information.

Adoption agencies and abortion clinics in your area are listed in the yellow pages of your telephone book. (If an agency tells you that abortion is unsafe or immoral, that is a clue that they are not interested in helping you make your own decision. Call your local department of public health, family planning clinic or Planned Parenthood office for non-judgmental assistance and accurate information about all three options.)

Children's Aid Societies and many physicians also have information about adoption, prenatal care, delivery, and parenting.

Note: If you are a teenager considering abortion, many places say you can make that decision on your own, but others require teens to involve a parent or guardian.

[46] www.cbctrust.com

If you have any questions, call:

- Planned Parenthood Federation of Canada (national toll-free hotline 1-866-373-PPFC),
- Your local public health department (under government listings in your phone book)

If you cannot decide, you may need to get more information about your choices or talk with someone you trust, ***not to decide for you***, but to help you decide what you think will be best for you. That person could be a:

- parent or other family member;
- teacher or religious counsellor;
- close friend or partner who cares about you; and/or
- counsellor in a social service or family planning agency such as Planned Parenthood.

CLIENT FACT SHEET

Appendix P

Pregnancy Issues Checklist for HIV-positive Women[47]

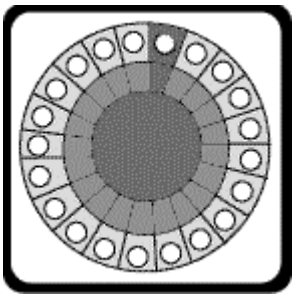
Here are some questions to stimulate discussion with your doctor, nurse or other healthcare provider. You may have others of your own. Asking questions is an important step in making an informed choice about your health.

- ☐ Are all pregnant women tested for HIV?
- ☐ I am HIV-positive. Can I have a baby?
- ☐ What about stigma?
- ☐ How can my child become infected?
- ☐ What is the risk that my child will be infected?
- ☐ What can I do to reduce the risk of transmission to my child?
- ☐ What impact will being pregnant have on my own health?
- ☐ What is lactic acidosis?
- ☐ What can I do to ensure that my baby and I stay healthy?
- ☐ How will I know if my baby is positive?
- ☐ What if my baby is positive?
- ☐ Will HIV affect my ability to get pregnant?
- ☐ How can I get pregnant safely?

[47] From a checklist developed by the Canadian Treatment Action Council (CTAC) and presented during the National HIV/AIDS Skills Building Symposium in Calgary in 2003. Used with permission.

- What therapy should I start?
- When should I start therapy?
- But, I'm already on therapy!
- What can I do if I don't want to take medication?
- Does my child have to take treatment?
- Will my child experience side effects from the HIV medication?
- What are my delivery options?
- Can I breast-feed?
- Can I do anything else to reduce the risk of transmission?
- What about opportunistic infections?
- Can I receive vaccinations during pregnancy?
- What about methadone and pregnancy?
- What is the risk of Hepatitis C Virus transmission?
- Can I receive treatment for HCV while pregnant?

Sheet 1



The Birth Control Pill

What it is: The birth control pill is a hormonal birth control method that you can get once you have a prescription from a doctor.

How it works: There are a number of things that the birth control pill does to prevent pregnancy: The birth control pill:

- will prevent the release of an egg from the ovaries each month;
- will cause the cervical mucus to thicken. This makes it more difficult for sperm to get through the cervix and into the uterus and;
- changes the lining of the uterus, causing it to get thinner. When the lining of the uterus is thinner, it is more difficult for a fertilized egg to attach itself to the uterus.

Effectiveness: "The pill is 99.9% effective, making it the most reliable contraception available."[48] In actual use however, it is more likely that 5% to 10% of women will get pregnant while on the pill. "***Actual effectiveness*** is a measure of how well a method works during actual use—that is, when it takes into account human error." [49] Illness, such as vomiting and diarrhoea can also influence the effectiveness of the pill. There are certain medications that will influence the effectiveness of the pill in preventing an unplanned pregnancy including: antibiotics, antacids, antihistamines, and anticonvulsants. ***If you experience any illness or take any medication that can influence the effectiveness of your birth control pill, it is important that you use another type of birth control while you are finishing that pack of pills***. If your physician prescribes you medication, remind them that you are on the pill, so they can inform you about how your birth control pill may be affected.

Using the birth control pill: If you decide to use the birth control pill, your physician can instruct you on how to use it and what type is best for you. They are available in packages of 21 or 28. When you get your package of birth control pills, make sure you read the accompanying directions and check the date of expiration before you begin using them. If you have a 21-day package of birth control pills, you take them for 21 days and then stop for 7 days. If you have a 28-day package of birth control pills, you take one every day. The first 21 pills that you take contain hormones; the last 7 do not. During the last 7 days, the probability that you will become pregnant is still low, even though you are not taking any hormones. One of the best things to do when taking the pill is to be consistent. It is very important that you take the pill at the same time

[48] http://www.sexualityandu.ca/eng/adults/CN/oral.cfm
[49] http://www.plannedparenthoodbc.org/facts/fs419.htm

each day (or within 2 hours of that time). When you first start taking the pill it does not prevent you from becoming pregnant. ***It takes about one month to reach peak effectiveness, so it is important that you use another kind of birth control during this first month.***

PROS:	**CONS**:
▪ reduces the probability that you will become pregnant; ▪ regulates your period. You may experience a lighter flow during your period; ▪ reduces acne; ▪ the hormones used (oestrogen and progesterone), both lower your possibility of developing ovarian cancer and cancer of the endometrium (lining of the uterus); ▪ does not require that you interrupt sex to use it; ▪ a woman is in control using this method.	▪ you must get a prescription from a physician; ▪ you have to remember to take it and at the same time every day; ▪ does not provide any protection against STI/HIV; ▪ it is expensive if you are buying it at a pharmacy, but some birth control clinics do have it at a reduced cost; ▪ it may not be safe for you to use. Talk to your doctor; ▪ "nausea, vomiting, breast tenderness, weight gain or loss, headaches or dizziness, and/or spotting are problems women may have the first one to three months.[50]

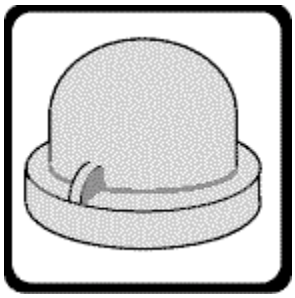
A small number of women have more serious side effects, including: heart attack, stroke, blood clots and/or liver tumours. As your age increases, so does your risk of having these side effects. You are at a higher risk for these side effects if you are a smoker or have high blood pressure.

Where to get the pill: In order to obtain the birth control pill, you must have a prescription from a physician. The birth control pill is available at pharmacies and most birth control clinics. If you do not have a doctor, or you are not comfortable using your family doctor, there may be a Sexual Health Clinic in your area that can help you get a prescription. You can make an appointment to see a doctor there and get a prescription for the birth control pill.

[50] http://www.plannedparenthoodbc.org/facts/fs401.htm#how

Sheet 2

The Cervical Cap



What it is: The **Cervical Cap** is a latex cup-shaped device, which is inserted into the vagina before engaging in sex.

How it works: The cervical cap has two basic functions: It keeps spermicide near the entrance of the uterus (cervix) and it acts as a barrier to keep sperm out of the uterus. The size of a cervical cap depends on the individual, thus a physician or nurse determines what size is right for you. They can also show you how to properly insert and remove a cervical cap.

Fitting over the cervix, a cervical cap suctions to the cervix, acting as a barrier to the entrance of the uterus.

A cervical cap should not make you feel uncomfortable when it has been inserted. If you choose to use this type of birth control, it is important that you also use some kind of spermicide to decrease the probability of becoming pregnant.

NOTE: Recent studies have shown that the ***spermicide nonoxynol-9*** (N-9) ***does not reduce the risk of sexually transmitted infections (STI/HIV).*** In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Further, lubricated condoms ***without*** N-9 are the best way for sexually active people to reduce the risk of transmitting STI/HIV.

Effectiveness: The effectiveness rate of the cervical cap ranges between 73 and 92%. The chances of becoming pregnant are greatly reduced when you ensure that you are using the proper methods when inserting and removing the cervical cap, as well as using it during all acts of vaginal sex. You can even further reduce your chances of becoming pregnant if you augment the cervical cap with an alternate form of birth control, like a condom.

Using the cervical cap: Read the directions that accompany it. Insert the cervical cap up to one hour prior to sexual intercourse. According to the manufacturer, "It can be kept in place for up to 2 days without additional applications of spermicide needed to maintain effectiveness."[51]

[51] http://www.cervcap.com/about.html

Ensure that prior to having sex, and after having sex, your cervical cap is in the right position. There are a number of things that can cause your cervical cap to become dislodged: sex, a deep cough, playing sports, or a bowel movement. It is important that you check to make sure it is in the right place. If you find that your cervical cap is not secure, visit your physician, you may need a new size. After you have sex, do not remove the cervical cap for eight hours. This gives the spermicide time to kill the sperm.

When menstruating you should not use a cervical cap. If you have given birth, had a miscarriage, or had an abortion, visit your physician to have your cervical cap checked. It is recommended that you have a Pap smear performed once you have been using the cervical cap for six months. You have to replace your cervical cap after six months of use.

PROS:	**CONS:**
▪ inexpensive; ▪ used only when you require it; ▪ most men are unaware that the cervical cap is in place; ▪ since you can put the cervical cap in an hour prior to having sex, it does not require any interruption during sex; ▪ the woman is in control using this method; ▪ it does not alter your body in any way.	▪ you may experience difficulty in insertion or removal of the cervical cap ▪ allergies to spermicides or latex would prevent you from choosing a cervical cap; ▪ while menstruating, you cannot use the cervical cap; ▪ you have to be fitted for a cervical cap by a physician or nursing professional; ▪ not all women can find a cervical cap in the right size; ▪ after each use you have to clean the cap ▪ using a cervical cap requires that you are comfortable touching your body; ▪ an abnormal PAP test may prevent you from choosing a cervical cap as a method of birth control; ▪ it may increase your chances of having Toxic Shock Syndrome.

Where to get the cervical cap: While it is not required that you have a prescription to purchase a cervical cap, it is necessary that you visit a physician or nursing professional to determine what size you require. Ask your physician where you can purchase a cervical cap in your area. Spermicides are readily available at your local pharmacy or sexual health centre.

Sheet 3

Condoms

What they are: A **condom** is a thin, tight-fitting covering that is put on a man's erect penis just before a sex act. Condoms serve two purposes: they help to prevent pregnancy and to protect against STI/HIV. Beware of novelty condoms—they will not offer the best possible protection. Only condoms made of latex or polyurethane protect you against both STI/HIV and pregnancy. There are a large variety of condoms. You can get different colours and flavours. Some are lubricated—others are not lubricated. Some are ribbed.

How they work: A condom is a barrier method of birth control that will prevent sperm from entering the uterus and possibly fertilizing an egg. You can use a latex or polyurethane condom during vaginal, anal, or oral sex, to give yourself some protection against STIs like gonorrhoea, chlamydia, Hepatitis B and HIV.

Effectiveness: In preventing pregnancy, using a condom is 88 to 98% effective. Used with a spermicide, "the combined effectiveness is 95% or greater."[52]

Using a condom: Using a condom properly is essential to reduce the possibility that you will become pregnant. You must use a condom every time you have sex and it is advisable to use a second method of birth control if you want to prevent pregnancy and STI/HIV. Read the directions that accompany your condoms or visit a physician, nurse, or birth control clinic for instructions on how to use them. Check the expiry date on your condom package before you open it. Condoms can rip. Check the package for damage before opening—place it between your thumb and finger and make sure there is some air inside the package. If the package is damaged, assume the condom is as well—do not use it. Do not expose condoms to excessive amounts of heat and light, as they can weaken. Store condoms in a place that is cool (at approximately room temperature) and dry. Avoid putting condoms in your wallet, pocket or glove compartment of you car for long periods of time.

[52] http://www.plannedparenthoodbc.org/facts/fs403.htm#effective

PROS:	**CONS:**
▪ condoms are cheap and easy to obtain; ▪ used only when needed; ▪ can guard against certain sexually transmitted infections, including HIV; ▪ it may help a man have a longer-lasting erection; ▪ there are a wide variety of condoms that you can use; ▪ you can (and should) combine condoms with other types of birth control to further reduce the possibility of becoming pregnant.	▪ a condom may rip or not stay in place during sex; ▪ you or your partner may have allergies to latex; ▪ putting on a condom may mean interrupting the sex act.

If you use condoms with N-9 spermicide, you should know that recent studies have shown that the ***spermicide nonoxynol-9 (N-9) does not reduce the risk of sexually transmitted infections (STIs).*** In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Further, lubricated condoms ***without*** N-9 are the best way for sexually active people to reduce the risk of transmitting STI/HIV.

Where to get condoms: Condoms are easy to find. You can buy them at drugstores, in washroom vending machines, or get them free from family planning clinics, Planned Parenthoods, and AIDS organisations.

Sheet 4

Depo Provera®

What it is: Depo Provera is a hormonal method of birth control, which is administered by injection. To avoid an unintended pregnancy you get an injection every 12 weeks.

How it works: Depo Provera works by preventing your ovaries from releasing an egg each month. It also changes the lining of the uterus—causing it to become thinner and it also thickens the mucus at the opening of the uterus (cervix).

Effectiveness: Providing that you get the shot every three months, the effectiveness rate of Depo Provera is approximately 99%.

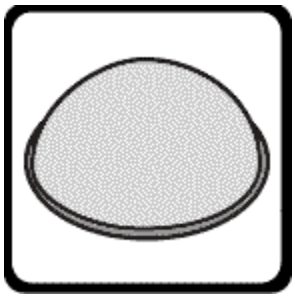
Using Depo Provera: You must have a prescription from a physician in order to get Depo Provera. You have to visit a doctor or nurse every 12 weeks so that they can administer the injection. The first injection you receive will be during your period. After you get the first shot you should use another form of birth control for two weeks.

PROS:	CONS:
▪ the probability that you will become pregnant is very low; ▪ only requires you to get a shot every 12 weeks; ▪ is not something you have to take every day or interrupt sex to use; ▪ may decrease the cramps you have prior to or during menstruation; ▪ may decrease the amount of bleeding you experience during menstruation or may stop it altogether; ▪ safe to use if you are breast-feeding; ▪ reduces your risk of developing some kinds of cancer; ▪ may be an option for those women who are not able to take the birth control pill; ▪ does not require that you have any supplies in your own home.	▪ some will experience irregular bleeding or they will cease having periods; ▪ you have to go visit a physician every 12 weeks; ▪ if you are late in getting an injection, this increases the likelihood that you will become pregnant; ▪ there are possible side effects, including: headaches, dizziness, bloating, tender breasts, mood changes and weight gain; ▪ offers no protection against STI/HIV; ▪ the "effects of Depo-Provera, including return to fertility, are not immediately reversible (may take 6-12 months)."[53]

Where to get Depo Provera: If you are interested in Depo Provera, visit a physician with whom you can discuss the suitability of this option.

[53] http://www.plannedparenthoodbc.org/facts/fs411.htm

Sheet 5



The Diaphragm

What is it: A diaphragm is a shallow and flexible latex cup that is inserted into the vagina prior to sex. You need to visit a physician so that they can tell you what size you require and teach you how to use it. You insert the diaphragm deep inside the vagina. It should not feel uncomfortable once it is in place. A diaphragm should be used with spermicide, which will decrease the possibility that you will become pregnant.

NOTE: Recent studies have shown that the ***spermicide nonoxynol-9*** (N-9) ***does not reduce the risk of sexually transmitted infections (STIs).*** In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Further, lubricated condoms **without** N-9 are the best way for sexually active people to reduce the risk of transmitting STI/HIV.

How it works: A diaphragm will keep spermicide near the opening of the uterus and act as a barricade to stop sperm from entering the uterus.

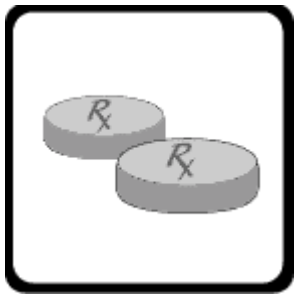
Effectiveness: The effectiveness rate of the diaphragm is approximately 85%. You decrease your chances of pregnancy when you use the diaphragm properly. This means that you must use it whenever having vaginal sex. You also decrease your chances of becoming pregnant by using spermicides or another method of birth control with the diaphragm.

Using a diaphragm: Read and comply with the accompanying directions. Insert the diaphragm up to 6 hours prior to vaginal intercourse. The diaphragm should be refilled with spermicide every time you have sex. Do not remove the diaphragm to refill it, use a spermicide applicator. A diaphragm must be kept in 6 to 8 hours after the last instance of sex to allow time for the sperm to be killed. There is a type of applicator that comes with it that you can use to help with insertion and removal of the diaphragm. You may need a different sized diaphragm if you have experienced the following: given birth, had a miscarriage, had an abortion, gained or lost ten or more pounds, had surgery in the pelvic region, or feel discomfort when your diaphragm is inserted. Your diaphragm needs to be replaced every 1 to 2 years.

PROS:	**CONS**:
▪ inexpensive; ▪ used only when you require it; ▪ does not alter your body in any way; ▪ both you and your partner should be unaware that the diaphragm is in place; ▪ since you can put the diaphragm in 6 hours prior to having sex, it does not require any interruption during sex ; ▪ women are in control using this method.	▪ some women experience difficulty in insertion or removal of a diaphragm; ▪ requires that you feel at ease touching your body; ▪ you or your partner may be allergic to spermicides or latex; ▪ you have to be fitted for a diaphragm by a physician or nurse; ▪ not all women can find the right size in a diaphragm; ▪ you have to take the time to clean and care for your diaphragm; ▪ before each act of sex, you have to add spermicide; ▪ using a diaphragm may increase your chances of having Toxic Shock Syndrome or of developing urinary tract infections.

Where to get a Diaphragm: To obtain a diaphragm you must visit a physician or nurse to find out what size is right for you, however, you do not require a prescription to get one. They are available over the counter, as are spermicides. You can buy both at most pharmacies or you can contact your local sexual heath centre to find out where to get one.

Sheet 6



The Emergency Contraceptive Pill (ECP)

What it is: The **emergency contraceptive pill** (ECP) was once called the Morning-After Pill. It is now classified as a method of emergency birth control. To obtain this particular method of birth control, a prescription from a medical doctor is required in most provinces (in some provinces it may be available over the counter at a pharmacy).

There are two types of emergency contraceptive pills. One type uses hormones that are the same type and dose as hormones used in some kinds of ordinary, combination birth control pills. These hormones are called estrogen and progestin. The other type of emergency contraceptive pill contains only the hormone called progestin. This type is specially packaged and labelled for use as the brand name Plan B. [54] It is more effective than the first type, and the risk of nausea and vomiting is also lower.

When you get the prescription you will receive 2 sets of 2 pills if you receive the combination pill, or 1 package of Plan B that contains 2 pills***. They should be taken as soon as possible after having sex that may cause you to get pregnant,*** because the sooner you take them, the more effective they are. They ***can be taken within 120 hours (5 days) of having sex*** that may cause you to become pregnant, "***although effectiveness is unknown beyond 72 hours***."[55]

How it works: When you take the ECP, it begins working by causing changes in the lining of the uterus. There are a number of things that can happen to prevent pregnancy:
"ECPs may inhibit or delay ovulation, inhibit tubal transport of the egg or sperm, interfere with fertilization, or alter the endometrium (the lining of the uterus), thereby inhibiting implantation of a fertilized egg."[56]

Effectiveness: Use of this pill cuts the chance of pregnancy by 75%[57]. You can increase the effectiveness by taking the pills as soon as possible—before a fertilized egg is implanted in your uterus. "ECPs when used perfectly, are not as effective as other methods of ongoing contraception when used perfectly."[58]

[54] http://ec.princeton.edu/info/ecp.html
[55] http://www.plannedparenthoodbc.org/facts/fs418.htm#type
[56] http://ec.princeton.edu/questions/ecwork.html
[57] http://ec.princeton.edu/info/ecp.html
[58] http://ec.princeton.edu/questions/eceffect.html

Taking ECP: The pills must be taken within 120 hours of having unprotected sex, which you suspect may lead to pregnancy. After you have taken the pills, you need to use another method of birth control if you are going to have vaginal intercourse. Most women should be able to take ECP, even if they cannot use the Birth Control Pill as their regular type of contraception.[59] When taking this prescription there is the potential that you will experience an upset stomach and vomiting. To avoid this, it is recommended that you take a Gravol™ pill 30 minutes prior to the final set of pills, as well as eating something and taking the pills with milk. Phone your doctor or a clinic if you vomit during the first hour after taking ECP. You may require another dose. It is also possible that you might experience some bleeding after using the ECP. This is not necessarily your period. Your period may be irregular, arriving early or later than usual. It is important to contact your physician or medical clinic if your period is two weeks late or unusual. A pregnancy test may be required.

PROS:	**CONS:**
▪ can be used if you had unplanned sex and did not use birth control; ▪ can be used if you suspect that your birth control method failed; ▪ it is safe for the majority of women to use.	▪ may cause nausea or vomiting; ▪ may cause bleeding between periods; ▪ may cause you to experience pain; ▪ may cause you to experience diarrhoea; ▪ increases your chances of an ectopic pregnancy (a pregnancy which occurs outside of the uterus); ▪ the severity of side effects differs from woman to woman. Ask your doctor about the risks and benefits of using ECP before taking it.

Where to get the ECP: The Emergency Contraceptive Pill is available from your doctor, local hospital, or birth control clinic.

[59] http://ec.princeton.edu/info/ecp.html

Sheet 7

The Female Condom

What it is: As the name implies, this condom was developed with women in mind, and is intended for their use. For many people, the female condom looks strange. Made of polyurethane (a soft plastic), it resembles a pouch. There are two rings, one on the inside and the other on the outside. The outer ring covers the area that is outside of the vagina, and the inner ring is to help insert the condom and keep it in place. **The female condom** not only prevents unplanned pregnancy—it also can protect you against STI/HIV.

How it works: The female condom works in much the same way as a male condom. It acts as a barrier preventing sperm from entering the uterus. This prevents a woman's egg from becoming fertilized. It can also prevent the transmission of viruses, which cause sexually transmitted infections.

Effectiveness: When used correctly, the female condom is approximately 95% effective. The effectiveness rate decreases when it is not used properly.

Using a female condom: The first time you use a female condom can be intimidating. Before you use a female condom as a form of birth control or protection from STI/HIV, practice putting it in and taking it out. The female condom can be inserted up to eight hours prior to sexual intercourse, although most women insert it 2 to 20 minutes prior to sex.

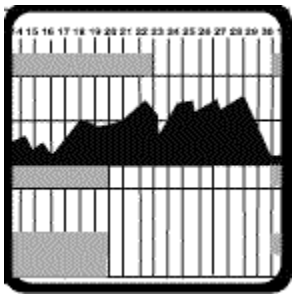
Read the instructions that come with the female condom. Learn how to hold the condom. Take the time to become comfortable with it. Female condoms can only be used once. When intercourse is over, hold the outer ring and twist it, then take it out. Do not throw it in a toilet—put it in a garbage can.

Do not use both a female condom and a male condom at the same time.

PROS:	CONS:
▪ allows women to have more control over the use of birth control as well as protection from STI; ▪ protects both the outside and the inside of the vagina; ▪ made from a soft plastic, so people who have latex allergies may be able to use this; ▪ can be inserted up to eight hours prior to sexual intercourse, so sex need not be interrupted; ▪ when used properly, it can be highly effective in preventing pregnancy; ▪ do not need a doctor's prescription; ▪ only use it when you need it.	▪ female condoms are costly, but you may be able to get them for free at a sexual health centre; ▪ some women may find the female condom difficult to insert; ▪ if they are inserted improperly they are not as effective; ▪ there is a possibility that they may rip or tear.

Where to get female condoms: You can purchase female condoms at a pharmacy or you might be able to get them for free at a sexual health centre.

Sheet 8



Fertility Awareness Methods

What they are: Fertility awareness methods (calendar charting, basal body temperature, and cervical mucus charting) are used to avoid pregnancy or to determine at what point during a woman's menstrual cycle she can most easily become pregnant. "To be effective as birth control, it also requires a willingness to abstain from intercourse or to use a barrier method of birth control during the fertile time, approximately one third of the month."[60]

How they work: Using these methods, you determine when a woman is most likely to become pregnant. During this time, either abstain from sex or use some other method of birth control (like a condom) to avoid pregnancy.

Effectiveness: The effectiveness rate of fertility awareness isn't very high. "The effectiveness depends on many factors including the regularity of the woman's menstrual cycle and the ability to use the methods accurately and consistently."[61] "Twenty percent of women become pregnant within the first year of using this method."[62] To reduce the chances of becoming pregnant, use a second method of birth control such as a condom.

Using fertility awareness methods: Fertility awareness methods are used to figure out when a woman's chances of becoming pregnant are higher. There are three different methods that can be used to determine this:

1. **Calendar Charting (**Rhythm method)**:** This method requires a woman to track when ovulation occurs. Since you are most likely to become pregnant when an egg is released during ovulation, you try to figure out when ovulation has occurred in the past. Using this method alone is not recommended if you are trying to avoid pregnancy. It is best to use calendar charting with some other type of birth control.
2. **Basal Body Temperature** (BBT): BBT is the temperature of the body after three hours of rest. Before ovulation, BBT will be lower and 12 hours after ovulation the temperature rises slightly until menstruation begins. Using this method, a woman keeps track of her body temperature to help determine when an egg has been released.
3. **Cervical Mucus Charting:** Using this method, a woman tracks changes in her cervical mucus. When a woman nears ovulation she will begin to notice mucus. Around the time

[60] http://www.fwhc.org/birth-control/fam.htm
[61] http://www.plannedparenthoodbc.org/facts/fs415.htm#effective
[62] http://www.sexualityandu.ca/eng/adults/CN/fertilityAwareness.cfm

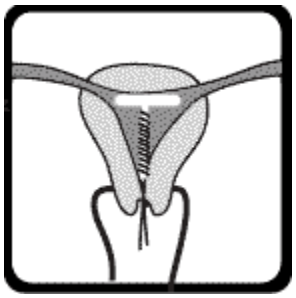
of ovulation is when the most dramatic changes in mucus may be observed. During these times, if a woman wants to avoid pregnancy she should abstain from sex or use some kind of birth control like a condom and spermicide.

If you use these methods, you lower your chances of becoming pregnant by using two or more together. Before you start using fertility awareness methods, visit a doctor or nurse to get instruction on how to use these methods properly.

PROS:	**CONS:**
▪ inexpensive; ▪ methods do not alter your body in any way; ▪ no side effects; ▪ you and your partner can become more educated about the times when a woman is more likely to become pregnant; ▪ a natural way to avoid pregnancy or to try to get pregnant.	▪ you need to be instructed on how to use these methods; ▪ learning how to use fertility awareness methods requires both time and effort ; ▪ if you use these methods to avoid pregnancy, there may be certain times every month that you will have to abstain from sex or use another method of birth control; ▪ if you are a woman who experiences irregular menstrual cycles, this method may not be effective ; ▪ offers no protection against STI/HIV; ▪ when a woman is under stress or ill, irregularities or changes may occur in her menstrual cycle, so calendar charting may not be effective; ▪ requires that a woman feel at ease with her own body.

Where to get info on fertility awareness methods: To learn more about fertility awareness methods, visit a doctor and check in your area for a natural family planning clinic.

Sheet 9



Intrauterine Contraceptive Device

What it is: An IUD, or IUCD, is a small device that looks like an anchor, or a T, which a doctor puts into a woman's uterus. They are about 3 cm long and generally are made of plastic and copper, although there are a number of different kinds. An IUCD is able to stay in the uterus for two years or more. Attached to the IUCD are strings that hang inside the vagina, they cannot be seen outside of the body. An IUCD can be used as an emergency form of birth control. If inserted up to 7 days after an act of unprotected sex, it may stop a pregnancy from occurring.

How it works: Exactly how an IUCD works is not really known. An IUCD may:

- cause the lining of the uterus to become somewhat inflamed, which will prevent an egg that has been fertilized from implanting itself;
- destroy sperm (due to changes the chemistry in the uterus caused by the copper);[63]
- hinder the movement of sperm and;
- cause an egg to move through the fallopian tube faster.

Effectiveness: The effectiveness rate of the IUCD is approximately 97 to 99%.

NOTE -There is a new IUD on the market, Mirena, which releases hormones directly into the uterus. "The Mirena IUD is 99% effective and has the added advantage of reducing the amount of menstrual bleeding after a few months."[64]

Using an IUCD: It is necessary to have a physician or a nurse put in an IUCD. First a pelvic exam will be carried out to determine the position of the woman's uterus. Next, a speculum will be inserted in the vagina to look at the cervix and then the cervix will be washed with an antiseptic. The IUCD will be inserted in the uterus with strings being cut beneath the cervix. This procedure can be uncomfortable and you may want to consider taking some kind of pain medication prior to having an IUCD put in place. You cannot remove an IUCD yourself; a physician or a nurse must take it out.

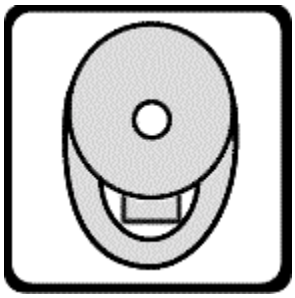
[63] http://www.sexualityandu.ca/eng/adults/CN/iud.cfm
[64] http://www.womenshealthmatters.ca/centres/sex/birthcontrol/mirena.html

PROS:	**CONS**:
▪ a very effective method of avoiding pregnancy; ▪ inexpensive; ▪ no need to interrupt sex to use it; ▪ female partner is in control; ▪ it can stay inside the uterus for extended periods of time; ▪ an IUCD can act as an emergency method of birth control; ▪ the Mirena IUD can reduce the amount of menstrual bleeding after the first 3 months.	▪ will not offer any protection against STI/HIV; ▪ a slight increase in your chances of developing pelvic inflammatory disease (PID) in the first three weeks;[65] ▪ can increase the chances of having an ectopic pregnancy, (a pregnancy that occurs outside of the uterus); ▪ a standard (non-hormonal) IUCD can cause a woman's menstrual cycle to change, resulting in a heavier flow and an increase in cramps; ▪ having an IUCD inserted is unpleasant and can be somewhat painful; ▪ there are some risks in having an IUCD inserted and removed that should be talked about with a physician.

Where to get an IUCD: If you are interested in having an IUCD inserted, contact a doctor or a sexual health centre in your area.

[65] http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=2&DR_ID=21

Sheet 10



Leas Contraceptive

What it is: Leas Contraceptive (aka Leas Shield) is made of silicone and looks like a round dome. It has a one-way valve on the bottom, allowing a tight fit upon insertion as well as allowing cervical secretion to get out (which can prevent infections and unpleasant odour). The front of Leas contraceptive contains a silicone ring allowing for easy removal. It works in much the same way as a cervical cap, acting as a barrier between the opening of the uterus (cervix) and sperm.

How it works: Leas Contraceptive is inserted into the vagina prior to engaging in sexual intercourse. Once inserted you should experience no discomfort. You must use spermicidal jelly with the shield in order to kill sperm and reduce the likelihood that you will become pregnant. Leas Shield serves two basic functions: It keeps spermicide near the entrance of the uterus (cervix) and it acts as a barrier between sperm and the uterus.

Effectiveness: According to the producers of Leas Contraceptive, when used as directed, the effectiveness rate is 95%. In actual use it is more likely that the effectiveness is 86 to 94%.[66] It is important to read and comply with the directions that come in the package. You can even further reduce your chances of becoming pregnant if you accompany Leas Contraceptive with an alternate form of birth control (like a condom) as well as using it every time you have sex.

Using Leas Shield: Read the directions that accompany it. Insert Leas Contraceptive prior to sexual intercourse. Ensure that prior to having sex and after having sex the shield is in the right position. After sex, do not remove the shield for eight hours to allow the spermicide time to kill the sperm. The maximum amount of time that Leas Contraceptive can be in the vagina is 48 hours. It is recommended that a PAP smear be performed once you have been using Leas Contraceptive as your method of birth control for six months. You have to replace the shield after six months of use.

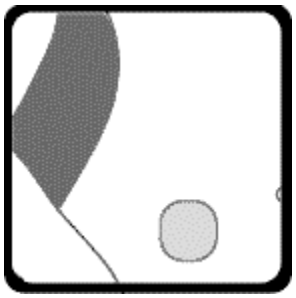
[66] http://www.plannedparenthoodbc.org/facts/fs410.htm

PROS:	CONS:
▪ one size fits all; you do not need to visit a physician; ▪ use only when you require it; ▪ your partner should be unaware that it is in place; ▪ you can put Leas Contraceptive in prior to having sex, so it does not require any interruption during sex; ▪ women are in control; ▪ it does not alter your body in any way; ▪ it is small and can easily fit in a purse.	▪ expensive; ▪ you may experience difficulty with insertion or removal; ▪ can't be used if you or your partner are allergic to spermicide; ▪ it must be cleaned after each use; ▪ requires that you feel at ease with your body; ▪ an abnormal PAP test may prevent you from choosing Leas Contraceptive.

NOTE: Recent studies have shown that the ***spermicide nonoxynol-9*** (N-9***) does not reduce the risk of sexually transmitted infections (STIs).*** In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Further, lubricated condoms ***without*** N-9 are still the best way for sexually active people to reduce the risk of transmitting STI/HIV.

Where to get Leas Contraceptive: It is not necessary that you have a prescription to obtain Leas Contraceptive. It can be purchased at your local pharmacy. When you buy Leas Contraceptive you will also find a tube of spermicide in the package, but you can also purchase spermicide jelly at your local pharmacy or obtain it for free at most sexual health centres.

Sheet 11



The Ortho Evra® Birth Control Patch

WHAT IT IS: the ORTHO EVRA birth control patch is a small transdermal patch that sticks to your skin and releases the same hormones that are found in the Birth Control Pill. There are four recommended places on your body that you can put the patch: the buttocks, abdomen, upper torso (front and back, excluding the breasts) or upper outer arm.

How it works: There are a number of ways that the birth control patch works:

- it will prevent the release of an egg from the ovaries each month;
- it will cause the cervical mucus to thicken. This makes it more difficult for sperm to get through the cervix and into the uterus and
- it changes the lining of the uterus, causing it to get thinner. When the lining of the uterus is thinner, it is more difficult for a fertilized egg to attach itself to the uterus.

Effectiveness: According to the manufacturer, ORTHO EVRA is 99 percent effective when used correctly.[67] The patch starts to work 24 hours after use, if you start on the first day of your period. If you start on the Sunday after your period starts, you will need to use another method of birth control (such as a condom and spermicide) for seven days.[68]

Using the patch: With the help of your doctor, decide what day you want to start wearing the patch, either the first day of your period, or the first Sunday after your period starts. You only need to change the patch once a week for 3 consecutive weeks. The fourth week you don't wear a patch.[69]

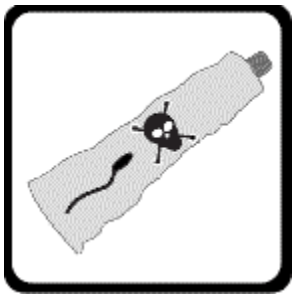
[67] http://www.orthoevra.com/for_prescribers/for_prescribers.html
[68] http://contraceptive-patch.orthoevra.com/faqs/faqs.html#q29
[69] http://contraceptive-patch.orthoevra.com/about_ortho_evra/wearing.html

PROS:	CONS:
▪ you need not interrupt sex to use it; ▪ you don't have to remember to use it at the same time each day like you would if you used the birth control pill; ▪ a woman is in control of this method; ▪ it is very effective in preventing pregnancy; ▪ at just an inch and three quarters square, it can be hidden under your clothing.	▪ you need to see a doctor to get a prescription; ▪ certain drugs may interact with the ORTHO EVRA birth control patch, to make them less effective in preventing pregnancy or cause an increase in breakthrough bleeding;[70] ▪ it has the same side effects as the birth control pill; ▪ it does not protect against STI/HIV.

Where to get the patch: In order to obtain the patch, you must have a prescription from a physician. The ORTHO EVRA patch is available at pharmacies and birth control clinics. If you do not have a doctor, or you are not comfortable using your family doctor, there may be a Sexual Health Clinic in your area that can help you get a prescription. You can make an appointment to see a doctor there and get a prescription for the patch.

[70] http://contraceptive-patch.orthoevra.com/faqs/faqs.html#q29

Sheet 12



Spermicides

What it is: Spermicides are chemicals (Nonoxynol-9) in the form of cream, jelly, film, foam or suppository that are inserted into the vagina before engaging in sex. Nonoxynol-9 kills sperm.

How it works: Nonoxynol-9, contained within spermicides, works by killing sperm. This will prevent an egg from becoming fertilized during sexual intercourse.

Effectiveness: "The failure rate of spermicides used alone is between 6% (perfect use) and 21% (typical use)."[71] Using spermicide correctly is the key to lowering the chances of becoming pregnant. You must use it every time you have sex and it is best to combine it with some other form of birth control (like a condom).

Using spermicides: Read the directions that come with the spermicide and check the expiry date before you use it. Insert more spermicide each time you have vaginal sex. Spermicides do not taste good. If you have oral sex prior to vaginal sex, insert the spermicide after oral sex. Spermicides should never be used for anal sex.

The spermicide should be left in 6 to 8 hours after sex. You can use a tampon to make sure the spermicide stays in place. During the 6 to 8 hours after sex (when you should leave the spermicide in), you can shower, but do not have a tub bath, douche or go swimming. Normal vaginal discharge will take care of the spermicide.

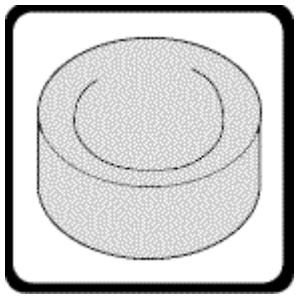
[71] http://www.sexualityandu.ca/eng/adults/CN/spermicide.cfm

PROS:	CONS:
▪ you do not need to visit a doctor or nurse; ▪ you utilise spermicides only when you require them; ▪ women are in control; ▪ they do not alter your body in any way; ▪ they can be used with other forms of birth control to decrease the possibility of becoming pregnant; ▪ they can also act as a vaginal lubricant during sex.	▪ if you do not use spermicides with another form of birth control, it may not be as effective in preventing an unintended pregnancy; ▪ you need to feel comfortable with your body so that you can insert it into your vagina; ▪ they do not taste good and can be messy; ▪ you or your partner may have a spermicide allergy which would prevent you from using this method of birth control.

NOTE: Recent studies have shown that the ***spermicide nonoxynol-9*** (N-9***) does not reduce the risk of sexually transmitted infections (STIs*).** In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Further, lubricated condoms ***without*** N-9 are the best way for sexually active people to reduce the risk of transmitting STI/HIV.

Where to get spermicides: You can purchase spermicides at a pharmacy, or get them at a sexual health centre.

Sheet 13



The Protectaid® Contraceptive Sponge

What it is: The Protectaid Contraceptive Sponge looks like what you might expect—a small portion of foam that is rounded and soft. For easy removal, the sponge has foam handles, which allow it to be grasped. Before having vaginal intercourse, it is inserted into the vagina to avoid pregnancy. A physician or nursing professional can instruct you on insertion and removal procedures. Known as a barrier method, the sponge covers the cervix, which is the entryway into the uterus. Contained within the sponge is "F-5 Gel an innovative product in that it contains three agents: Nonoxynol-9, Benzalkonium Chloride, and Sodium Cholate".[72] Since the F-5 gel kills sperm, it reduces the probability of you becoming pregnant.

How it works: There are four functions performed by the sponge:

- The sponge ensures that spermicides are near the cervix;
- The spermicides in the sponge work by destroying sperm;
- The sponge has absorption power just like a regular sponge, which means it soaks up sperm and contains it; and
- The sponge acts as a boundary, which covers the cervix, preventing sperm from entering.

Effectiveness: The effectiveness rate of the sponge ranges between 75 and 90%. Essential to reducing the likelihood that you will become pregnant, is using the sponge properly and during all instances of vaginal sex. You can further reduce the potential of pregnancy by using an additional method of birth control such as a condom.

Using a sponge: Read and comply with the accompanying directions. Insert the sponge prior to vaginal intercourse. The sponge can be inserted 6 hours prior to vaginal intercourse. The sponge allows you to engage in sex as often as you like during a period of 12 hours without requiring that it be changed. The sponge must be kept in 6 to 8 hours after the last instance of sex to allow time for the sperm to be killed. The sponge cannot be used during menstruation.

[72] http://www.babytech.com/protectaid.html

PROS:	CONS:
▪ you are not required to visit a medical professional to obtain the sponge; ▪ you utilise the sponge when you require it; ▪ you and your partner should be unaware that the sponge is in place; ▪ since you can put the sponge in 6 hours prior to having sex, it does not require any interruption during sex; ▪ women are in control using this method; ▪ it does not alter your body in any way.	▪ expensive; ▪ some women experience difficulty in insertion or removal of the sponge; ▪ you cannot use the sponge while menstruating; ▪ it requires that you feel at ease with touching your body; ▪ an abnormal PAP test may prevent you from choosing the sponge; ▪ it may increase your chances of having Toxic Shock Syndrome; ▪ allergies to spermicides would prevent you from choosing the sponge as a method of birth control.

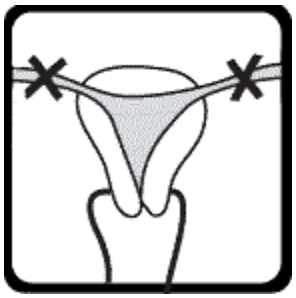
NOTE: Recent studies have shown that the ***spermicide nonoxynol-9*** (N-9) ***does not reduce the risk of sexually transmitted infections (STIs).*** In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Lubricated condoms ***without*** N-9 are still the best way for sexually active people to reduce the risk of transmitting STI/HIV.

The three agents in the "Protectaid Sponge are used in low concentrations, thereby minimizing the risk of cervico-vaginal irritation and irritation to the penis. Studies with Protectaid have shown an absence of significant colposcopic irritation after 6-12 hour use periods."[73]

Where to get the sponge: To obtain the Protectaid Sponge, you do not need to visit a physician. The sponge is available over the counter at most drug stores, over the Internet, or at a sexual health clinic.

[73] http://www.babytech.com/protectaid.html

Sheet 14

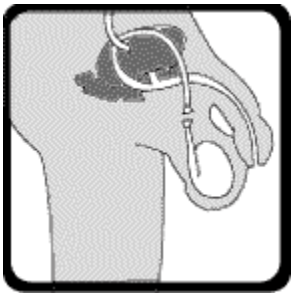


Sterilization

What it is: Sterilization is an operation that is performed by a doctor. When a woman is sterilized it is called a tubal litigation. This will prevent a woman from becoming pregnant.

When a man is sterilized it is called a vasectomy. This will prevent a man from getting a woman pregnant. If an individual is sterilized, they will not be able to have children.

How it works: When a woman is sterilized, the fallopian tubes are disconnected or tied. This prevents eggs from travelling out of the fallopian tubes and sperm from travelling into the fallopian tubes. This means that an egg cannot be fertilized.



When a man is sterilized the tube that carries sperm from the testicles is blocked or cut. A man can still ejaculate, but there will be no sperm in the ejaculate (cum). It is easier for a man to be sterilized than a woman because there are fewer risks and it can be done in a doctor's office with a local anaesthetic.

Effectiveness: The effectiveness rate of sterilization is approximately 99%. In women, "a 1 - 2.5% chance of failure may occur up to 10 years later, because sometimes the tubes try to "heal" themselves."[74]

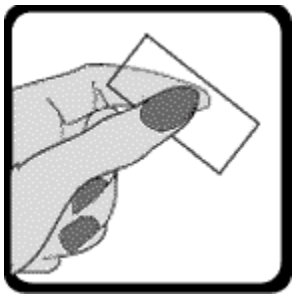
[74] http://www.sexualityandu.ca/eng/adults/CN/ligation.cfm

PROS:	CONS:
▪ it is effective; ▪ sterilization should be considered permanent; ▪ you do not have to interrupt sex; ▪ you do not need to use another method of birth control; ▪ for women, sterilization works immediately; ▪ men are able to have the procedure done in a doctor's office.	▪ sterilization is usually not reversible. For women, "reversal is costly, difficult, and not guaranteed."[75] Men can have an expensive operation to reverse the procedure, but only 30 to 50% will be successful; ▪ sterilization requires surgery; ▪ there are risks involved in surgery, more so with a tubal litigation; ▪ there is a possibility of infection; ▪ sterilization offers no protection against STI/HIV; ▪ vasectomies are not always effective immediately and may require waiting for the level of sperm to decrease.

Where to get more info: If you are interested in finding out more about sterilization, visit a doctor or contact a sexual health centre in your area.

[75] http://www.sexualityandu.ca/eng/adults/CN/ligation.cfm

Sheet 15



Vaginal Contraceptive Film

What it is: Vaginal Contraceptive Film (VFC) is a thin 2 by 2 inch film containing a spermicide called nonoxynol-9 that is inserted into the vagina prior to sexual intercourse. VFC dissolves fast and is a cleaner method than spermicide foams and gels.

How it works: VCF acts as a barricade between sperm and the opening to the uterus. The nonoxyl-9 kills sperm.

Using Vaginal Contraceptive Film: Read and comply with the accompanying directions. Insert the VCF at least 15 minutes prior to vaginal intercourse.

Effectiveness: The effectiveness rate of VCF is approximately 94%. You can decrease the possibility of becoming pregnant if you use VCF properly. Using VCF with another form of birth control like a condom will also lower the possibility of becoming pregnant. Every time you have vaginal sex you have to use VCF. Each film works for about 90 minutes.

PROS:	**CONS**:
▪ VCF can be inserted an hour before intercourse, so you need not interrupt sex to use it; ▪ neither you nor your partner should be aware that it is there; ▪ women are in control; ▪ does not alter your body in any way; ▪ you can use VCF in combination with other types of birth control to decrease the possibility of pregnancy; ▪ VCF is easy to transport and is discrete; ▪ used only when you require it and ▪ it is not necessary for you to visit a doctor to obtain VCF.	▪ VCF must be inserted for every instance of sex; ▪ using VCF requires you to feel at ease with touching your own body; ▪ you or your partner may have an allergy to spermicides, which would prevent you from choosing this method of birth control and ▪ VCF may cause vaginal irritation.

NOTE: Recent studies have shown that the ***spermicide nonoxynol-9*** *(N-9)* ***does not reduce the risk of sexually transmitted infections (STIs)***. In fact, N-9 may irritate the vagina, vulva, penis, and rectum, and ***thus may actually increase susceptibility to STIs, including HIV.*** Nonoxynol-9, however, is still safe and effective as contraception for women who are at low risk for STI/HIV and who do not have intercourse more than once a day. Further, lubricated condoms ***without*** N-9 are still the best way for sexually active people to reduce the risk of transmitting STI/HIV.

Using VCF: Read and comply with the directions accompanying VCF. Before you use it, check the expiry date on the package. You can put it in your vagina up to 15 minutes before having sex.

Where to get VCF: VCF is available at some pharmacies. Check with the sexual health centre in your area or talk to a physician about where to access it.

Sheet 16

The Withdrawal Method

What it is: Withdrawal is a method of birth control that requires a man to remove his penis from the vagina before ejaculation. This prevents semen (which contains sperm) from entering the uterus and causing pregnancy.

How it works: When engaging in vaginal sex, a man removes his penis from the vagina before ejaculating.

Effectiveness: "This method ***isn't very effective***, because there may be sperm in the pre-ejaculate (pre-cum), which can lead to pregnancy. It requires a lot of self-control and practice. Studies show a failure rate of 19% in typical users."[76] There are a number of factors that may cause this method to be ineffective: It is not always possible for a man to control the time of ejaculation. Withdrawal, as a method of birth control, is more effective if combined with an alternative method (such as a condom).

Using the withdrawal method: When engaging in vaginal sex, the man must pull his penis out of the woman's vagina when he senses he is going to ejaculate. He must then ejaculate away from the woman's vaginal area. If you suspect that semen has entered your vagina, you should put some spermicide in your vagina immediately to reduce the likelihood of becoming pregnant. ***Withdrawal is not a method that will act as protection against STI/HIV, which can be transmitted through pre-ejaculate.***

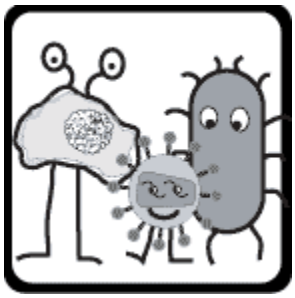
If you think that withdrawal has failed, you may be concerned that you have conceived. There are several options available to you. First, you can obtain the Emergency Contraceptive Pill (ECP). In order to get this you have to get a prescription from your physician (in some provinces it is available over the counter). It must be taken within 72 hours of having sex that has caused you to suspect that you may become pregnant. A second option available to you is to get your physician to insert an Intrauterine Device (IUD) within 7 days of having sex that has caused you to suspect you might get pregnant.

[76] http://www.sexualityandu.ca/eng/adults/CN/withdrawal.cfm

PROS:	CONS:
▪ can be used when no other birth control methods are available; ▪ no cost; ▪ does not require that you visit a doctor; ▪ is only used when you need it and ▪ does not alter your body in any way.	▪ does not offer any protection against contracting or transmitting STI/HIV; ▪ men are in control of this method—not women; ▪ there is the possibility that you may become pregnant; ▪ requires an abrupt interruption of sex and ▪ good negotiation skills are essential when using the withdrawal method to make sure that both you and your partner are willing to halt sex.

Where to get more info: If you are interested in finding out more about the withdrawal method of birth control, speak with a doctor, nurse, or someone at a sexual health centre.

Sheet 17



Chlamydia

What is chlamydia? Chlamydia is a sexually transmitted infection that is very common, especially among teenagers and young adults. It is caused by a bacteria and can cause serious health problems, so it must be treated. "It can spread silently in females and cause a painful, long-term condition called PID (pelvic inflammatory disease) and infertility (the inability to have children)."[77]

How do you get chlamydia? You can get chlamydia if you have oral sex, vaginal sex, or anal sex with a person who already has the infection. A pregnant woman can also pass it on to her baby while she is giving birth.

How can you tell if you have chlamydia? ***Many people who have chlamydia do not have any signs that tell them they have a sexually transmitted infection. You can pass on chlamydia without even knowing that you have it.***

Women might notice:

- strange discharge from the vagina;
- itchy vagina;
- a little bit of bleeding even when it is not time for your period;
- bleeding during or after you have had vaginal sex;
- pain in the lower abdomen and/or
- pain when you urinate.

Men might notice:

- needing to urinate a lot;
- a feeling of burning when you urinate;
- watery or milky discharge from the penis;
- burning or itching around the opening of the penis and/or
- pain in your testicles.

How do you get tested for chlamydia? "A quick and reliable urine test is available for chlamydia in most centres for both men and women."[78]

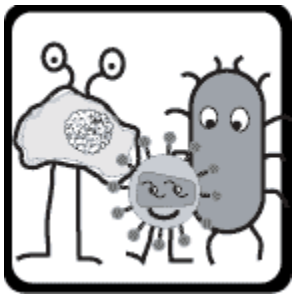
[77] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_g.html
[78] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_g.html

How is chlamydia treated? It can be cured with antibiotics. It is important to tell your sexual partner(s) that you have chlamydia. They also need to be treated. It is important to treat chlamydia because it can lead to serious health problems. ***Both men and women might become infertile if it is not treated.*** A woman could also have difficulties with pregnancy.

Do you need a follow-up test? Yes. You should have another test. Women should get this test done after they have finished their antibiotic treatment and have had one period. Men should get another test done a month after finishing the antibiotics.

How do you know when you can no longer pass on the infection? The only way to be sure that you are cured and can no longer pass on the infection is to do the follow-up test after you have taken the antibiotics. If the test is negative, you no longer have chlamydia and cannot pass it on to your partner(s). It is important to use condoms or a latex barrier with your sexual partner(s) to decrease the risk of getting a sexually transmitted infection, such as chlamydia.

Sheet 18



Gonorrhoea

What is gonorrhoea? Gonorrhoea is a sexually transmitted infection that is caused by bacteria. Gonorrhoea can cause serious health problems, so it must be treated. Gonorrhoea can infect the penis, rectum, throat, eyes, or cervix. "Gonorrhoea in women left untreated could lead to a painful, long-term condition called PID (pelvic inflammatory disease) and infertility."[79]

How do you get gonorrhoea? You get gonorrhoea if you have unprotected oral sex, vaginal sex, or anal sex with a person who already has the infection. A pregnant woman can also pass it to her baby while she is giving birth. It is important to use condoms or a latex barrier with sexual partners to decrease the risk of getting a sexually transmitted infection, including gonorrhoea.

How can you tell if you have gonorrhoea*? Some people who have gonorrhoea do not have any signs* that tell them they have a sexually transmitted infection. You can pass on gonorrhoea without even knowing that you have it.

Women might notice:

- strange discharge from the vagina;
- an itchy, red, or swollen vagina;
- pain when urinating;
- pain in the lower abdomen;
- pain during vaginal intercourse; and/or
- rectal discharge.

Men might notice:

- pain when urinating;
- discharge from the penis that is thick, white, and yellow;
- rectal discharge; and/or
- pain or swelling in the testicles.

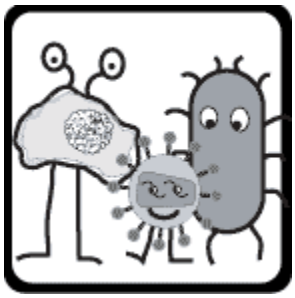
How do you get tested for gonorrhoea? "To test for gonorrhoea, a swab of the area is usually taken or a new urine test may be used at some centres."[80]

[79] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_h.html
[80] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_h.html

How is gonorrhoea treated? It can be cured with antibiotics. You should tell your sexual partner(s) that you have gonorrhoea. They need to get treated too. It is important to treat gonorrhoea because it can lead to serious health problems including infertility.

Do you need a follow-up test? Yes. You should have another test one week after finishing your antibiotics. Women should also get a second follow-up test after they've finished their antibiotics and had one period.

How do you know the infection is gone? After you have taken the medication, you should have another test to make sure the infection is gone. If the follow-up test is negative, you no longer have the infection, and you cannot pass it on.



Sheet 19

Hepatitis B

What is Hepatitis B? Hepatitis B is a virus that can cause a serious infection of the liver. "The majority of people who become infected with the hepatitis B virus recover completely and as a result of their infection develop lifelong immunity to the virus. However, around 10 percent of adults and 90 percent of infants who get infected with the hepatitis B virus, although completely symptom free, cannot get rid of the virus. They become carriers of the hepatitis B virus."[81]

How do you get Hepatitis B? You can get Hepatitis B through blood, semen, vaginal fluid, and saliva while having vaginal sex, oral sex, or anal sex with a person who has the infection. Hepatitis B can also be passed on by sharing personal items, like toothbrushes and razors, or by sharing needles or tattoo equipment. A pregnant woman can pass Hepatitis B on to her baby before it is born.

How do you tell if you have Hepatitis B? You might notice: You feel tired, have pain in your abdomen, or your urine or stool is a strange colour. Your skin is yellow. You are not very hungry, or you feel like throwing up. ***Almost half of the people who have Hepatitis B don't even know that they have it.***

How do you get tested for Hepatitis B? You can get a special blood test.

How is Hepatitis B prevented and treated? It is important to use condoms or a latex barrier with sexual partners to decrease the risk of getting Hepatitis B. You can also protect yourself against Hepatitis B with a vaccine. The course of vaccination consists of three or four doses given over a period of 2 to 12 months.[82] If you are at risk for getting Hepatitis B, you and your partner(s) should ask a doctor or a nurse for the vaccine.

"Alpha interferon is effective in decreasing viral activity in 35 to 40 percent of patients treated. However, this medication should not be

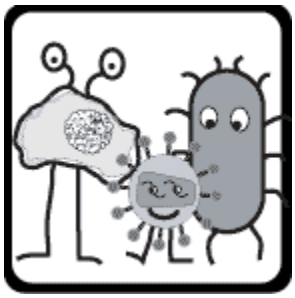
[81] http://www.liver.ca/english/liverdisease/hepatitis_b.html
[82] http://www.hc-sc.gc.ca/pphb-dgspsp/dird-dimr/vpd-mev/hepatitis-b_e.html

used during pregnancy. Current research is directed toward finding other effective antiviral treatments."[83] As part of your treatment, you need to follow the Canada Food Guide and you should stop drinking alcohol. A small number of people don't get better. They are called carriers and are able to give the virus to others. They may develop serious liver problems. "Fifteen to twenty five percent of people chronically infected with Hepatitis B die from liver disease."[84]

Do you need a follow-up test? Yes. If you have Hepatitis B, the doctor or nurse will give you another blood test to see if you are still able to pass the infection on to other people.

[83] http://www.liver.ca/english/liverdisease/hepatitis_b.html
[84] http://www.cdc.gov/ncidod/diseases/hepatitis/b/fact.htm

Sheet 20



Hepatitis C

What is Hepatitis C? Hepatitis C is one of several viruses that can cause an infection of the liver. It is different from Hepatitis A and Hepatitis B. The most common way a person can be infected by Hepatitis C is by sharing needles. It is also possible to spread hepatitis C through sexual contact, but it does not happen as easily as by sharing needles. Before a test became available for the blood supply, the infection was also spread by blood transfusions. Today, evidence suggests that the infection rarely spreads from an infected mother to her child during pregnancy.

How do you tell if you have Hepatitis C? Only 5 to 10% of people who have Hepatitis C develop symptoms like fever, loss of appetite and jaundice (yellowing of the skin). So***, many people do not know that they have been infected with the virus***. Unfortunately, 60-70% of people who have Hepatitis C develop an on-going infection of the liver and some of them develop liver failure and liver cancer many years later.

Is there a test for Hepatitis C? Yes. There is a blood test, which detects whether you have the antibody against Hepatitis C. The presence of the antibody suggests that you have been infected with Hepatitis C, but the test cannot tell you when this might have happened.

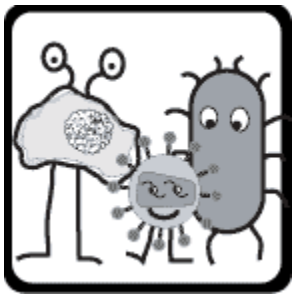
Is there a vaccine against Hepatitis C? No. There is no vaccine available at this time. Vaccination against Hepatitis A and Hepatitis B will ***not*** protect you against Hepatitis C.

How can I protect myself against Hepatitis C? Since the virus is mainly spread by infected needles, it is important not to share needles and related equipment with others. It is important to use condoms or a latex barrier with your sexual partners to decrease the risk of getting a sexually transmitted infection such as Hepatitis C.

Are there any treatments for Hepatitis C? Until very recently, there were no medicines that would cure Hepatitis C. However, "new medicines for the treatment of chronic Hepatitis C are being introduced in Canada. Recent studies with the newly approved pegylated combination therapy indicate that the overall cure rate is about 54%."[85]

[85] http://www.liver.ca/english/liverdisease/hepatitis_c.html

Sheet 21



Herpes (HSV)

What is herpes? Herpes is an infection that is caused by a virus. The virus is called herpes simplex virus (HSV). There are two types of HSV. They can both cause sores around the mouth called cold sores. They can also cause sores on the genitals, known as genital herpes.

How do you get herpes? You may get it by kissing someone who has a cold sore. You may get herpes in your genital area if you receive oral sex by someone who has cold sores. You may also get herpes around your eyes, mouth, and genitals by touching the sores. In most cases, people with herpes pass on the virus when they have sores on their mouth or genitals that are easy to see, but sometimes they can pass on the virus when there are no sores. Rarely, a pregnant woman may pass the virus to her baby when she is giving birth.

How can you tell if you have herpes? You will most likely feel itching or tingling on your skin. Then, you will get blisters full of water. You will get a painful sore when the blisters break. This sore forms a scab that will heal by itself. When you first get herpes, you may also feel like you have the flu. This may last several weeks.

Can herpes come back? Yes, once you have it, you have it for life. Most people have more than one outbreak, but it is milder after the first time and can occur as often as every 30 days.

How do you get tested for herpes? A doctor or nurse swabs or visually checks the sores. Usually, blood tests are not useful in checking for herpes.

How is herpes treated? It cannot be cured. Acyclovir™ is a prescription drug that may reduce the length of the herpes outbreak. This medication will also reduce the pain. A doctor can also prescribe another medication for the pain.

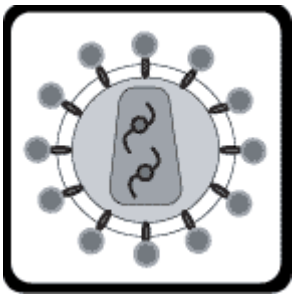
When you have a herpes outbreak:

- keep the area clean;
- wear cotton underwear and loose-fitting clothes; and
- after urinating, wash your genital area with cool water. If it hurts when you urinate, sit in a tub of warm water to urinate. You might feel better if you put wet tea bags on the sores.

How can you prevent passing on the virus?

Do not give oral sex when you have cold sores around the mouth. You should not have sex if you have an outbreak of genital herpes. It is important to use ***condoms or a latex barrier with sexual partners to decrease the risk*** of getting sexually transmitted infections including herpes.

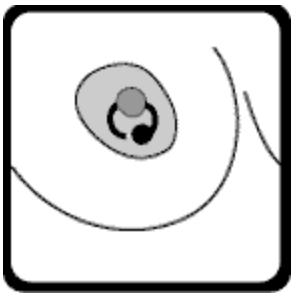
Sheet 22



HIV and AIDS

What are HIV and AIDS? HIV stands for Human Immunodeficiency Virus, which is the virus that causes Acquired Immune Deficiency Syndrome (AIDS). HIV attacks the cells of the immune system and weakens it. Without a strong immune system, the body is unable to fight off infections This eventually leads to AIDS.

What spreads HIV? HIV is passed from one person to another by the exchange of infected blood, semen, vaginal fluids, or breast milk.



You can only get HIV in a few ways.
These include: vaginal sex without a condom; anal sex without a condom; sharing needles, including those used in body piercing and tattooing; sharing sex toys; and possibly through oral sex without a barrier on either a man or a woman.

How do I protect myself?

If your partner agrees to it: Talk about condoms and STI/HIV before having sex. Use latex or polyurethane condoms and barriers when having sex; Use a water-based lubricant like KY Jelly; For oral sex on a man, use a condom that doesn't have spermicide on it; For oral sex on a woman or rimming (bum licking) use a dental dam, a condom cut into a square, or a piece of non-microwavable plastic wrap; Use a new latex or polyurethane condom for each person when sharing sex toys.

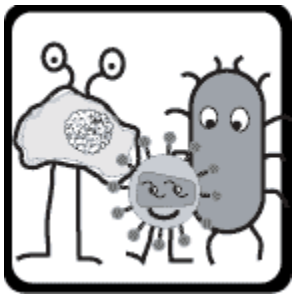
If your partner doesn't agree to condoms: (This does not protect you from HIV, but it might be better than using nothing at all.) Use something like a sponge, or cervical cap, that he can't detect, but could still protect you from pregnancy, and provides a barrier to your cervix. Use a water-based lubricant that might protect your vagina or anus from cuts and tears. If you are a man, try suggesting other forms of sex play that don't involve sharing of bodily fluids.

If you use alcohol or other drugs: Plan ahead before you get drunk or high, and never share needles.

Where can I get free supplies? You can get condoms and other safer sex supplies at AIDS organizations, Planned Parenthoods, or sexual health clinics. You can get needles from needle exchanges. Check with an AIDS organization to find out if there is a needle exchange near you. Phone your local or provincial AIDS organization for more information.

Where can I get more information or help? If you want to know more about HIV/AIDS or about testing: Call an AIDS organization, Planned Parenthood, or sexual health clinic near you. Also check this Internet site for useful information: http://www.ppfc.ca/HIV/index.html

Sheet 23



Human Papilloma Virus (HPV or Genital Warts)

What is HPV? There are many different types of Human Papilloma Virus. All HPV types are sexually transmitted, but not all cause genital warts—some HPV types can cause changes to a woman's cervix, which can lead to cervical cancer.

How do you get HPV? You can get HPV if you have oral sex, vaginal sex, or anal sex with a person who already has the virus.

How can you tell if you have HPV? ***Some people with HPV can pass the virus without even knowing they have it***—especially if they have the type that doesn't cause warts. If you find warts that look like small, hard spots, or like cauliflower on the penis, anus, scrotum, thighs, or inside or outside the vagina you may have HPV. Some warts are hard to see but a doctor or nurse can find them using a vinegar solution. "Very rarely, warts may appear on the lips or in the mouth after oral sex with an infected person."[86]

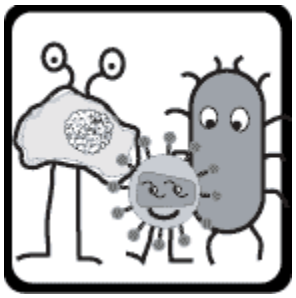
How do you get tested for HPV? There is no special test for HPV warts. A doctor or nurse can tell if you have genital warts by looking at them or by using a vinegar solution. A PAP test can be done to check your cervix. If you are sexually active, it is important to have a PAP test once a year. If you have HPV, you might need PAP tests more often.

How is HPV treated? "No treatment can guarantee that you will be cured of your HPV infection. However, treating your warts may lower your risk of passing them along to others."[87] If you want the warts taken off, there are many different ways a doctor or nurse can do this: They can put a liquid directly on the warts. Usually it has to be done many times before the warts go away. They can freeze the warts with dry ice. They can burn the warts. They can remove the warts surgically. "Over time, many people eventually clear HPV from their bodies, and don't get any more warts."[88] If your PAP test shows that HPV has caused changes to your cervix, you may be sent to a specialist for treatment.

[86] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_l.html
[87] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_l.html
[88] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_l.html

How can you prevent spreading the virus to your partner(s)? There is no guarantee you can be cured HPV, so you may always have the virus in your body. ***Even after you have been treated for warts, you could pass HPV on to the people you have sex with***. That's why it is so important to talk to your partner(s) before you start having vaginal or anal intercourse. It might be hard to talk about HPV, but it is important that both you and your partner(s) know the risks. It is important to use condoms or a latex barrier to decrease the risk of getting a sexually transmitted infection like HPV.

Sheet 24



Molluscum Contagiosum

What is molluscum contagiosum? Molluscum contagiosum is an infection caused by a virus. If you have it, you may have skin lesions that look like warts.

How do you get molluscum contagiosum? You may get molluscum contagiosum by touching someone who is infected, usually by having sex.

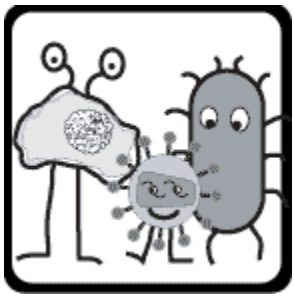
How can you tell if you have molluscum contagiosum? Molluscum contagiosum causes growths that may look waxy and pinkish-white. They are firm and have the shape of a dome with a dent in the centre. You can get them around your genitals, thighs, buttocks, and lower abdomen.

How do you get tested for molluscum contagiosum? There is no special test. A doctor or nurse can tell if you have molluscum contagiosum by looking at the growths.

How is molluscum contagiosum treated? The growths are not bad for your health and they don't have to be taken off. If you want the growths taken off, there are many different ways a doctor or nurse can do this: They can put a special liquid on the growths. Usually this has to be done many times before the growths go away. They can freeze the growths with dry ice, burn them off, or remove the growths surgically.

How do you prevent passing on molluscum contagiosum to your partner(s)? Mollusca contagiosum is not dangerous. If your partner avoids contact with the growths, they will be less likely to develop molluscum contagiosum themselves. It is important to use condoms or a latex barrier to decrease the risk of getting mollusca contagiosum.

Sheet 25



Pubic Lice and Scabies

What are pubic lice and scabies? "Symptoms of scabies and lice occur when tiny insects either bite you or burrow into your skin to lay their eggs."[89] They are usually found around the genitals in pubic hair or between the fingers, around the genitals, on the wrists, buttocks, or under the arms. Pubic lice are also known as "crabs".

How do you get pubic lice or scabies? You get pubic lice or scabies by touching someone who has them, or if you share a bed with someone who has the infection. Lice can live for up to two days away from the body. You can get them from infested sheets, towels, and wearing other people's clothing.

How can you tell if you have pubic lice or scabies? If you have pubic lice you may feel itching in the genital area. You may see tiny blood spots on your underwear. You may also see blue spots on the skin of your pubic area or thighs. You might see the pubic lice or eggs. If you have scabies, you might get a rash on any part of your body, but you will usually find them between fingers.

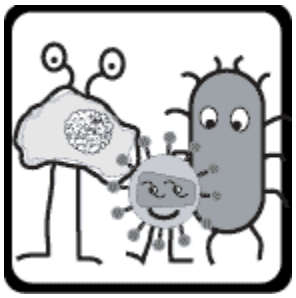
How do you get tested for pubic lice or scabies? You can usually tell if you have pubic lice by finding the adult lice or eggs on the hair. If it moves, it is pubic lice. However, scabies are harder to recognize. If you think you may have scabies, you should be checked by a doctor or nurse.

How are pubic lice and scabies treated? You can go to the drug store and they will give you special creams, lotions or shampoos to treat pubic lice and scabies. Infants, women who are pregnant, and women who are breast-feeding should ask for a special treatment. Your partner(s), friends, and family may also have lice or scabies, so they may have to be treated too. Dry clean and press with a very hot iron or machine wash in hot water any of your clothing that has been in contact with pubic lice or scabies. Wash all bed linens. If you cannot wash quilts and blankets try freezing them or storing them for two weeks in an airtight plastic bag. You might want to get a spray at the drugstore to clean everything that has been infested with lice or scabies.

Do you need a follow-up test? The treatment usually works if you follow the directions carefully. If you still feel that you have lice or scabies, talk to a doctor or nurse.

[89] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_j.html

Sheet 26



Syphilis

What is syphilis? Syphilis is an infection that is caused by a bacteria. It can cause serious health problems, so it must be treated. "Pregnant women with syphilis can give it to their unborn child, sometimes causing birth defects—even death."[90]

How do you get syphilis? You can get syphilis if you have oral sex, vaginal sex, or anal sex with a person who already has the infection.

How can you tell if you have syphilis? Syphilis can cause painless sores around the genitals and mouth, a skin rash, and flu-like symptoms. Symptoms may appear days to months after exposure.

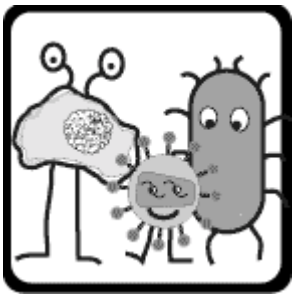
How do you get tested for syphilis? You can get a special blood test.

How is syphilis treated? You should be treated with antibiotics as soon as you find out that you have syphilis. You should tell your sexual partner(s) that you have syphilis. They need to get treated too.

Do you need a follow-up test? Yes. The doctor or nurse will do a blood test to make sure that the infection is gone.

How do you prevent passing the infection on to your partner(s)? Once you have had a negative follow-up test, you can no longer pass on the infection because you are cured. Until you have a negative follow-up test, you may be able to pass on the infection. ***It is important to use condoms or a latex barrier with your sexual partners to decrease the risk of spreading syphilis.***

[90] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_n.html



Sheet 27

Trichomonas (Trich)

What is trichomonas? Trichomonas is an infection caused by a microscopic parasite that can cause vaginitis in women. Trichomonas is sexually transmitted and must be treated. "Very rarely trichomonas can lead to pelvic inflammatory disease (PID)–a serious infection in women."[91]

How do you get trichomonas? You can get trichomonas if you have vaginal sex with a person who already has the infection. The parasite can live on wet objects for a few hours, so it can also be passed on through infected towels, washcloths, toilet seats, and saunas.

How can you tell if you have trichomonas? If you have trichomonas, you might notice:

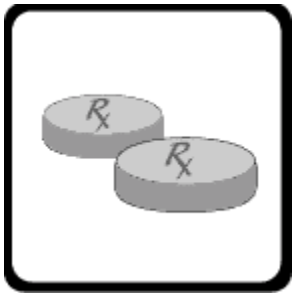
Women:

- discharge from your vagina that is green or yellow;
- vaginal odour;
- itching, red, or sore vagina;
- pain during vaginal intercourse; and/or
- painful or frequent urination.

Men:

- a small amount of discharge from your penis;
- irritation or redness around the opening of your penis;
- burning when you urinate; and/or
- you may not have any symptoms.

How do you get tested for trichomonas? A doctor or nurse will take a swab of the discharge or infected area.



How is trichomonas treated? "Trichomonas can be treated with pills, but both you and your partner (or partners) need to be treated to prevent you from getting the infection again."[92]

[91] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_i.html
[92] http://www.hc-sc.gc.ca/pphb-dgspsp/publicat/std-mts/sti_i.html

Do you need a follow-up test? You should get a follow-up test one week after treatment.

How do you know when you are cured, and can no longer pass on the infection? Once you and your partner(s) get the results of your follow-up tests, you can be sure that the infection is gone.

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Web-based Resources:

All web-based resources are cited as footnotes.