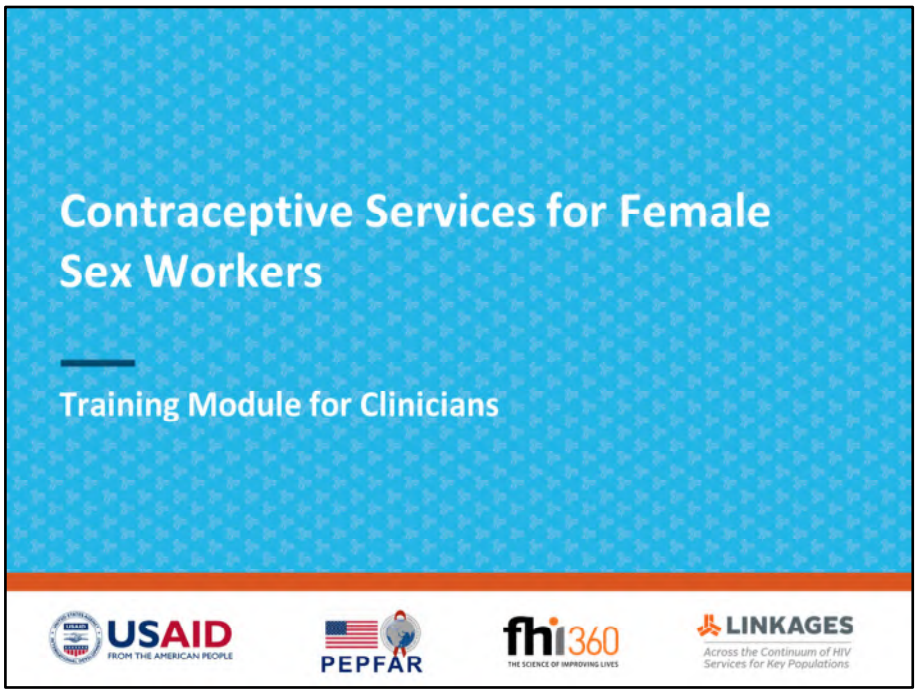
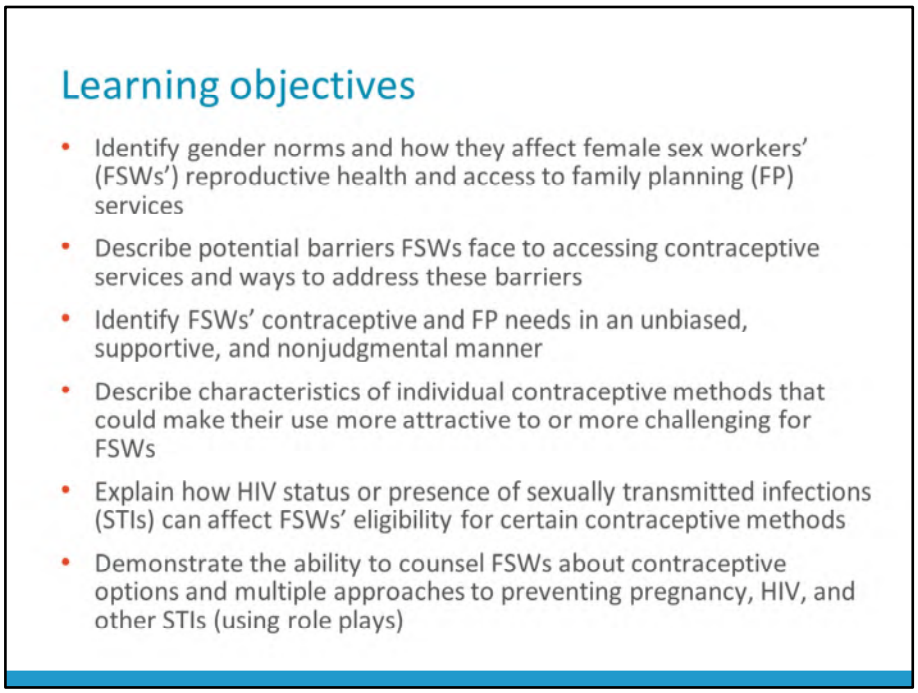
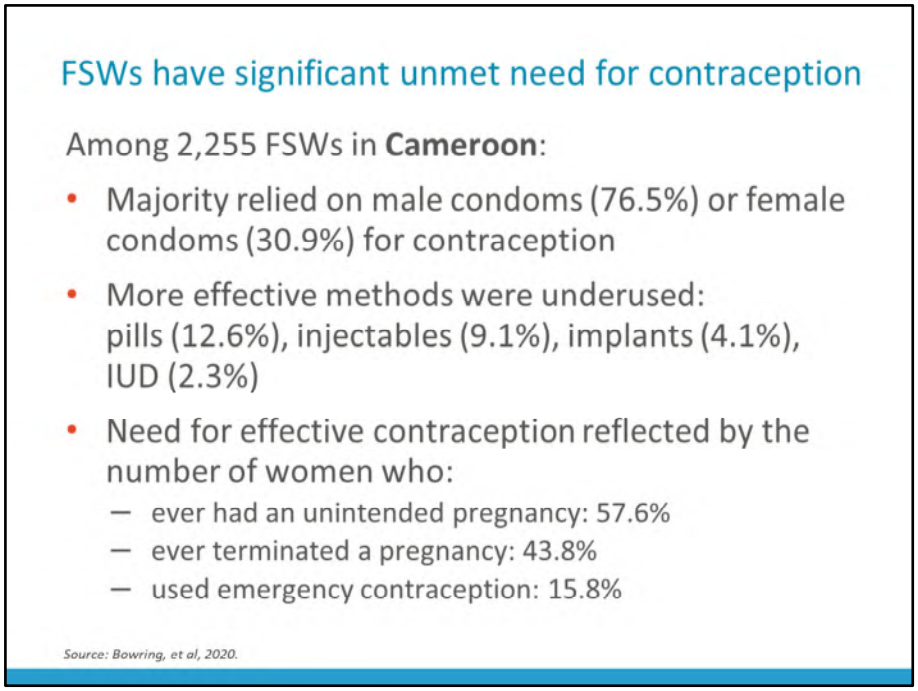


<*Refer to the* Contraceptive Services for Female Sex Workers: Training Module for Clinicians *for additional information about how to conduct the session.*>

Version: December 2020

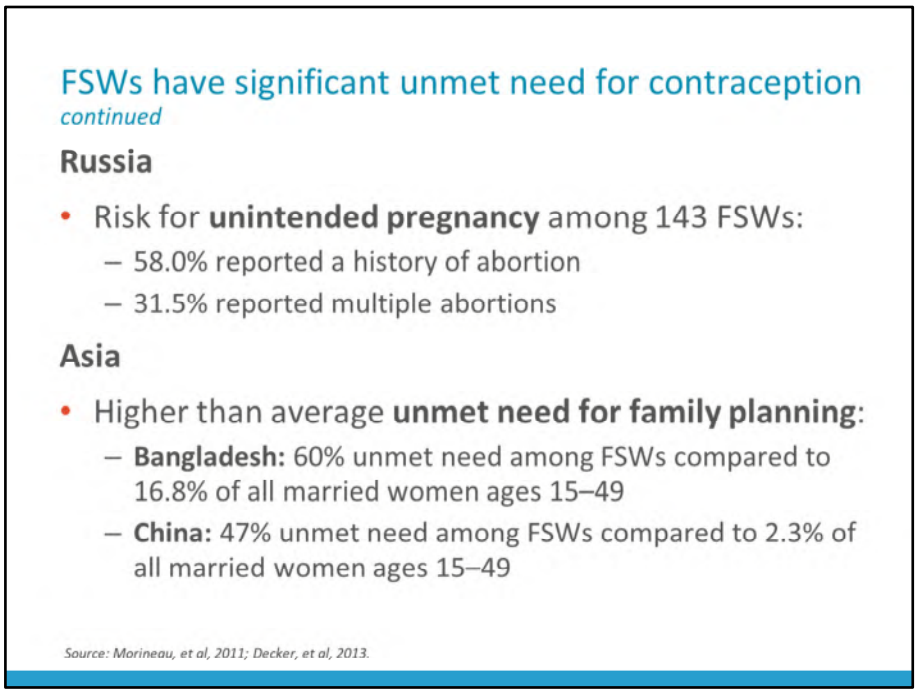


<After discussing the learning objectives, post the prepared flipchart of the objectives to refer to during the session.>



Speaker Notes:
This study from Cameroon found that the most common contraceptive methods among 2,255 FSWs were male and female condom, 76.5% and 30.9% respectively. More effective contraceptive methods, such as pills, condoms, implants, and the IUD were underutilized. Overall, the study confirmed that, based on the number of FSWs who had an unintended pregnancy, 57.6%; terminated a pregnancy, 43.8%; or used emergency contraception, 15.8%; FSWs in Cameroon have significant unmet need for effective contraception.

Source:
Bowring AL, Schwartz S, Lyons C, et al. Unmet need for family planning and experience of unintended pregnancy among female sex workers in urban Cameroon: results from a national cross-sectional study. Glob Health Sci Pract. 2020;8(1):82-99. https://www.ghspjournal.org/content/8/1/82.

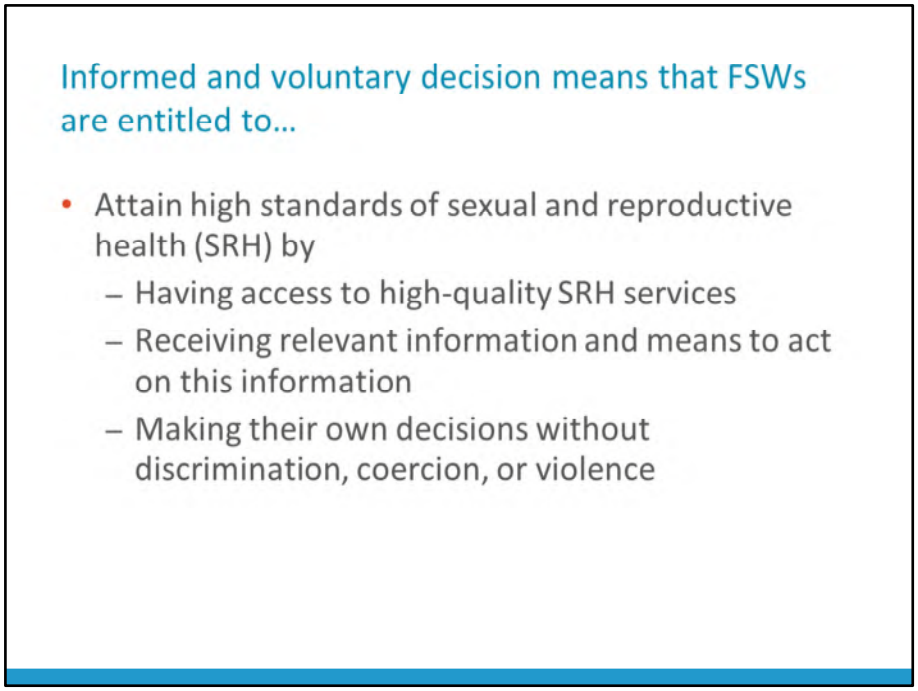


Speaker Notes:
Another study in Russia, also confirmed a substantial risk for unintended pregnancy among FSWs. In total, among 143 surveyed FSWs, 58.0% reported a history of abortion, with 31.5% indicating multiple abortions.

Some existing data suggest that FSWs in Asia have a higher than average unmet need for family planning compared to the general population. For example, 60% of FSWs surveyed in Bangladesh had an unmet need for family planning compared to 16.8% of all married women ages 15–49. In China, 47% of FSWs surveyed had an unmet need for family planning, while only 2.3% of all married women ages 15–49 reported an unmet need.

Sources:
Michele R. Decker, Eileen A. Yam, Andrea L. Wirtz, Stefan D. Baral, Alena Peryshkina, Vladmir Mogilnyi, and Chris Beyrer. Induced abortion, contraceptive use, and dual protection among female sex workers in Moscow, Russia. Int J Gynaecol Obstet. 2013 January; 120(1): 27–31.

Guy Morineau, Graham Neilsen, Sopheab Heng, Chansy Phimpachan, Dyah E. Mustikawati. Falling through the cracks: contraceptive needs of female sex workers in Cambodia and Laos. Contraception 84 (2011) 194–198.



Speaker Notes:
<Post prepared flipchart with the title, Informed and voluntary decision means that FSWs are entitled to…; *solicit responses from participants; record responses on the flipchart; show slide to reveal list/answers; use the speaker notes below to summarize.>*

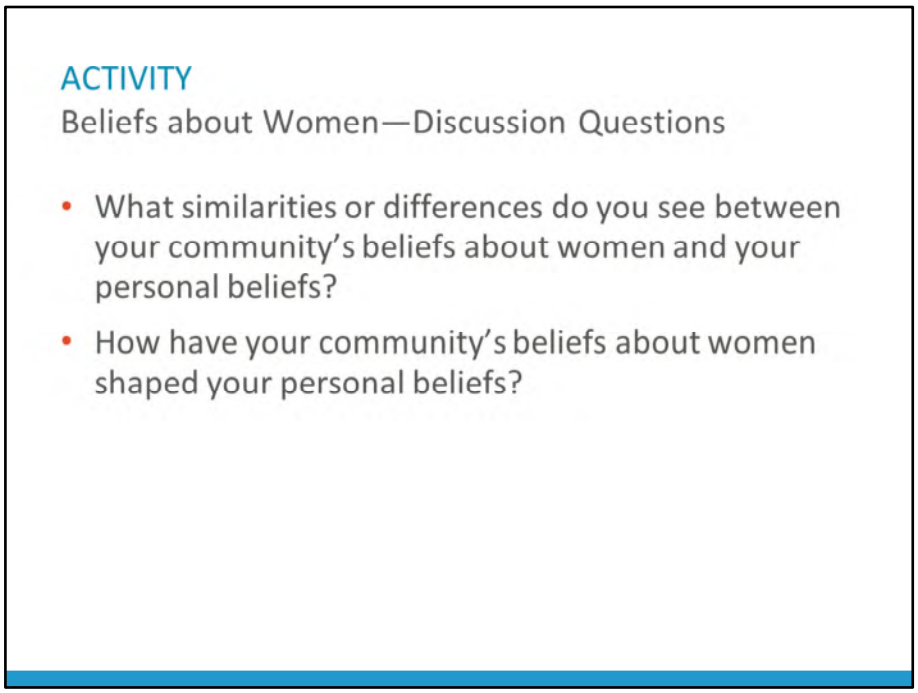
Like all women, FSWs should be able to attain high standards of sexual and reproductive health (SRH). To achieve that goal:

- FSWs should receive high quality SRH services, including STI/HIV testing, care, and treatment; contraception, pregnancy planning and infertility services, pre-natal, postpartum, and postabortion care.
- FSWs should receive information and support to help them make informed decisions about their sexual and reproductive health—appropriate to their life stage and desired fertility intentions. FSWs should be free to make their own decisions with no fear of discrimination, coercion, or violence.
- Services for FSWs should be free of stigma and discrimination and available, accessible, and acceptable to key populations based on the principle of the right to health. Being able to make an informed and voluntary decision about sexual and reproductive health, including contraception, is one of the human rights recognized by the international community and supported by many countries around the world. Well-informed clients who voluntarily choose a course of action, preventive approach, or treatment (when appropriate) that meets their needs best are more likely to be satisfied and to better adhere to their choice.

Sources:
Huezo C, Malhotra U. Choice and User-Continuation of Methods of Contraception: A Multicentre Study. London: International Planned Parenthood Federation, 1993.
Pariani S, Heer DM, Van Arsdol MD Jr. Does choice make a difference to contraceptive use? Evidence from east Java. Stud Fam Plann. 1991;22(6):384-90.
Brody DS. The patient's role in clinical decision-making. Ann Intern Med. 1980;93(5):718-22.
Joint United Nations Programme on HIV/AIDS (UNAIDS), Office of the United Nations High Commissioner for Human Rights (UNHCHR). International Guidelines on HIV/AIDS and Human Rights, Consolidated Version. Geneva, Switzerland: UNAIDS and UNHCHR, 2006.

Speaker Notes:
In this activity, we're going to consider the attitudes and beliefs about women that are common in your community.

<Distribute the handout, Appendix 3: Beliefs about Women. Ask participants to read each statement and add a checkmark in the column that best reflect beliefs that are widely held in their community. Ask them to please be honest; there is no need to write their name on the handout. Allow ~5 minutes.>

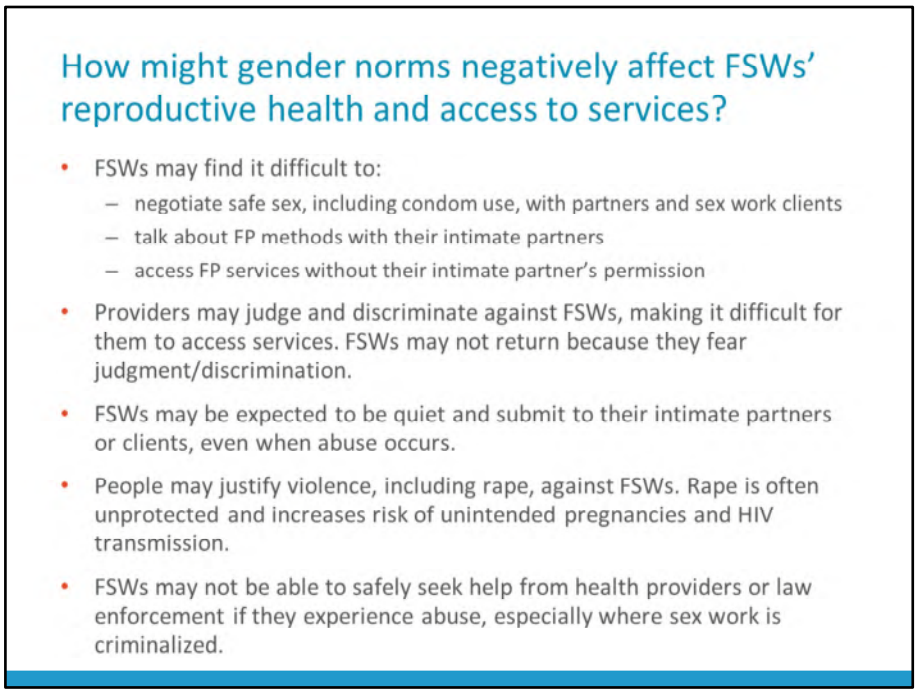


Speaker Notes:
<After participants have completed their handouts, debrief using the questions on the slide. After a few minutes of discussion, use the speaker notes to introduce gender norms.>

Beliefs about women that are widely held in our communities are examples of gender norms. Gender norms are expectations or rules assigned by our society and culture that tell us how to act, look, and feel as women and men. Gender norms change from culture to culture and over time.

We learn gender norms from an early age through interactions with our parents, teachers, and peers. Gender norms are reinforced throughout our lives and often shape our beliefs about women and men. Not everyone follows gender norms, but we know they are there.

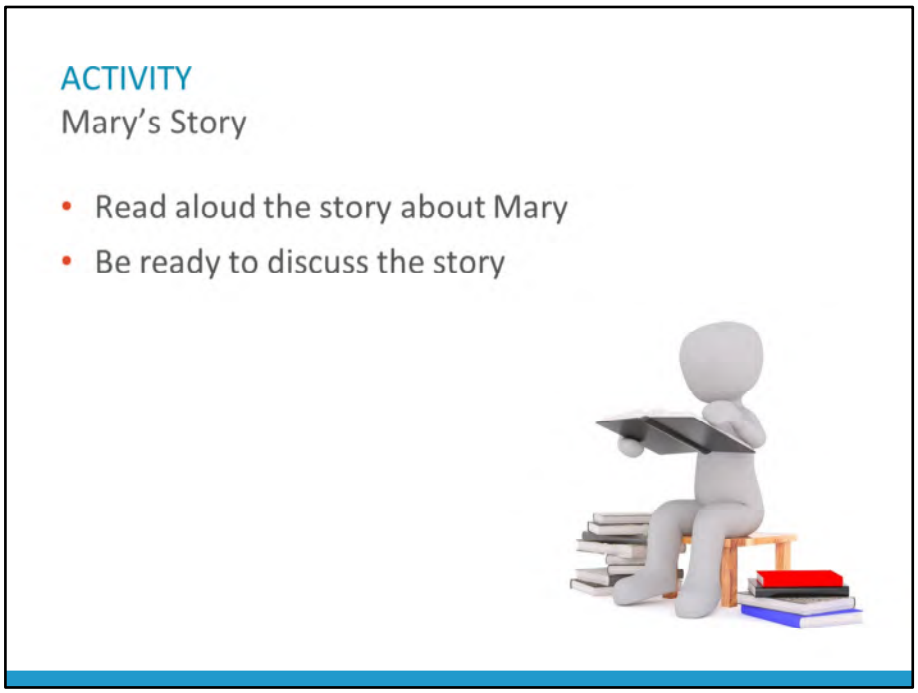
Some gender norms are fine and help us enjoy our identities as women and men. However, some are unhealthy or harmful.



Speaker Notes:
<Post prepared flipchart with the title: How might gender norms negatively affect FSW's reproductive health and access to services? Solicit responses from participants; record responses on the flipchart. Show slide to reveal answers; use the speaker notes below to describe the negative impact of gender norms on FSWs both because they are women and because they engage in sex work.>

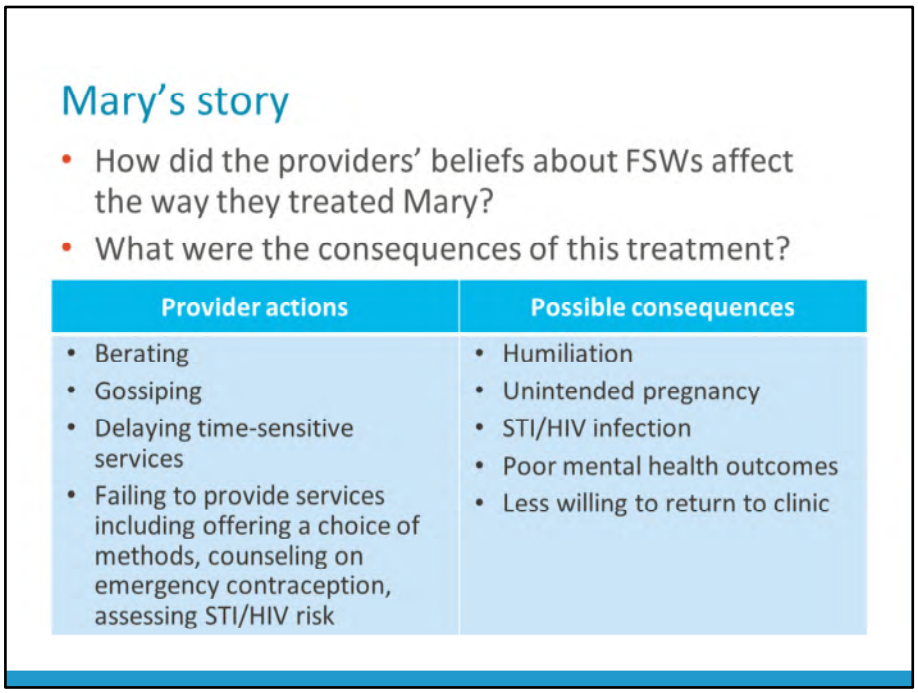
In any culture, some gender norms can cause harm when people conform to them and when people are punished or marginalized for not conforming. For example, FSWs can be negatively affected by gender norms because they are women and face the same challenges that all women do when they try to exercise their rights to reproductive health, including the use of contraception. They may also be negatively affected because of the unique ways in which FSWs do not meet society's expectations for women's sexual behavior.

We see that the negative effects of gender norms can be quite severe for FSWs and include stigma and discrimination in health facilities and an increased risk for unintended pregnancy. Further, the negative effects of gender norms on FSWs can be exacerbated in places where sex work is criminalized.



Speaker Notes:
In this activity, we have an opportunity to consider a concrete example of how providers' gender-based beliefs can negatively affect an FSW in a health care setting.

<Distribute the handout, Appendix 4: Mary's Story. Ask for volunteers to take turns reading aloud the paragraphs in the story. Encourage all participants to listen and be prepared to discuss the story.>

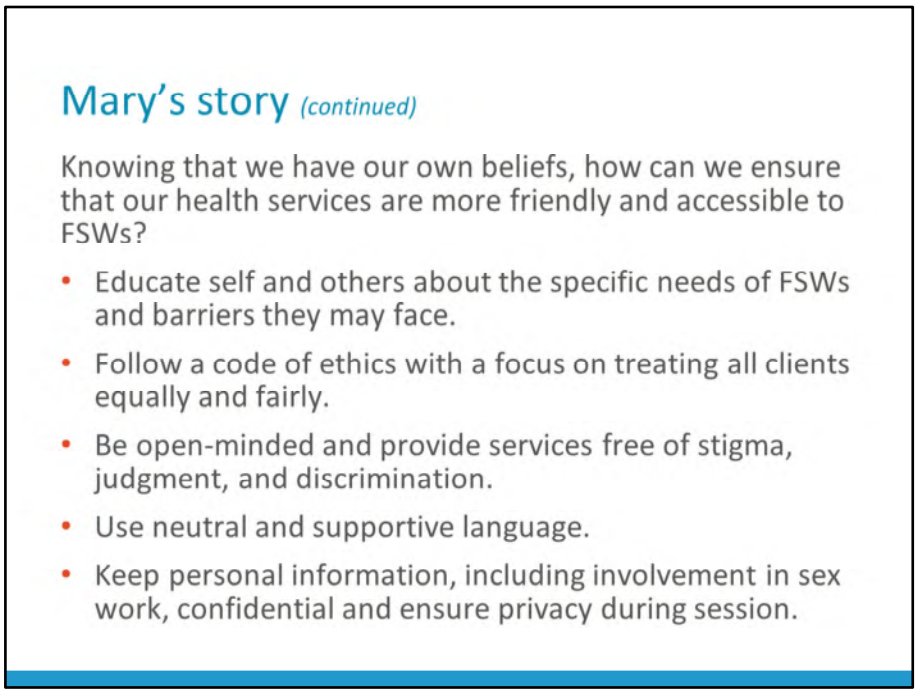


Speaker Notes:
How did the providers' beliefs about FSWs affect the way they treated Mary?
What were the consequences of this treatment?

<Solicit responses from participants; record responses on a blank flipchart; probe for the following responses:

- *The nurse berates and gossips about Mary. She delays time-sensitive services for Mary.*
- *The doctor berates Mary and, even though he gave her emergency contraceptive pills, he didn't explain how to use them or assess her STI/HIV risk. The doctor also didn't try to explore if she wants ongoing protection from pregnancy and didn't offer her a choice of contraceptive methods. Instead, he assumed that her only option is sterilization. Mary could go on to have an unintended pregnancy and acquire and/or transmit HIV or other STIs.*
- *Mary may experience a poor mental health outcome due to the judgment and mistreatment from the nurse and doctor.*
- *Mary is very unlikely to come back and seek services at that clinic.*
- *The larger FSW community may be unwilling to seek services at that clinic or any other if they believe all providers will engage in the same type of discriminatory behaviors.>*

<Click the mouse to reveal the answers.>



Speaker Notes:
Knowing that we have our own beliefs, how can we ensure that our health services are more friendly and accessible to FSWs?

<Solicit responses from participants; record responses on a blank flipchart; click the mouse to reveal the answers.>

<If time permits, ask participants: How do you think the beliefs in your community may have affected your own ideas about Mary and how she was treated during her visit to the clinic?>

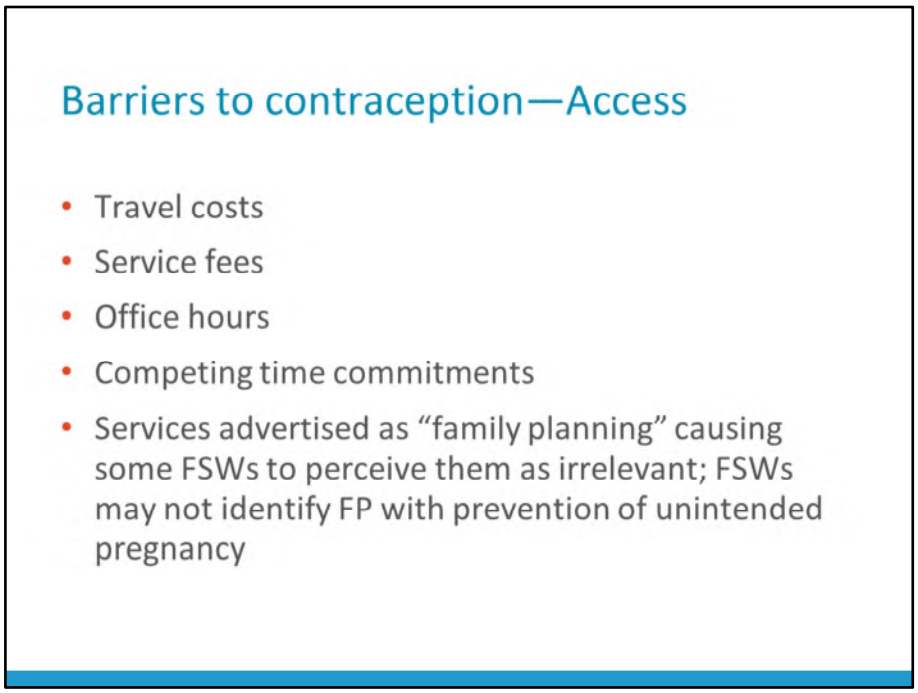
<Use the speaker notes below to wrap up this activity.>

We form opinions about others in many ways, including whether someone is following gender norms. Our opinions of others—which can also be based on race, class, religion, marital status, etc.—can affect how we treat them, and providers' opinions and actions determine who has access to quality and comprehensive health care. We need to be aware of our biases and act in a way that allows all people to exercise their rights and access vital services free of stigma, judgment, and discrimination.

This section focused on gender-related barriers at the personal, provider, and social levels, but other factors also have an important impact on reproductive health and contraception. These will be discussed in the next section.

Speaker Notes:
FSWs may face multiple barriers to having their contraceptive needs met including access barriers, barriers related to providers, personal, and social barriers. In this next activity, we're going to consider these barriers in detail.

<Ask each participant to think about what these barriers may be and use their marker to record their ideas on the prepared flipcharts posted around the room. Allow ~5 minutes.>

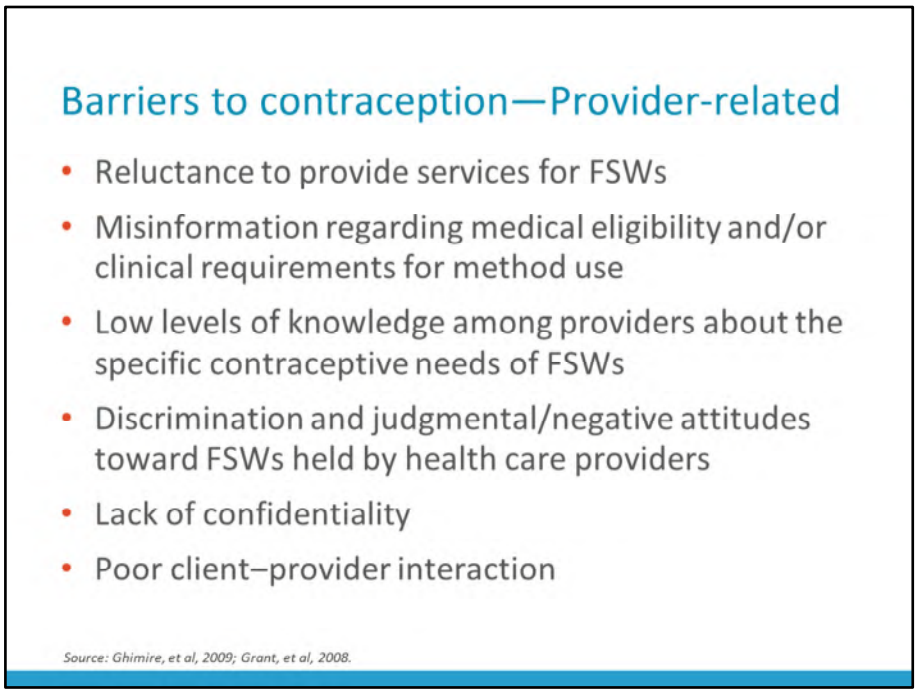


Speaker Notes:

<Compare the suggestions on the slide with the participant responses recorded on the flipchart; use the speaker notes below to summarize.>

Access barriers may include the cost of travel, the fees for services, office hours that are not convenient, and competing time commitments. Another access barrier is possible confusion created by how services are advertised. Often these services are promoted as "family planning" which may not resonate with FSWs who want to prevent unintended pregnancy, not plan a family.

<Acknowledge access barriers that are based on gender and reinforce the connection of many barriers to gender norms. For example, the traditional gender role of women as primary caregivers may mean that mothers who engage in sex work have competing time commitments, including childcare during the day and sex work in the evenings, that impede access to contraceptive services.>



Speaker Notes:

<Compare the suggestions on the slide with the participant responses recorded on the flipchart; use the speaker notes below to summarize.>

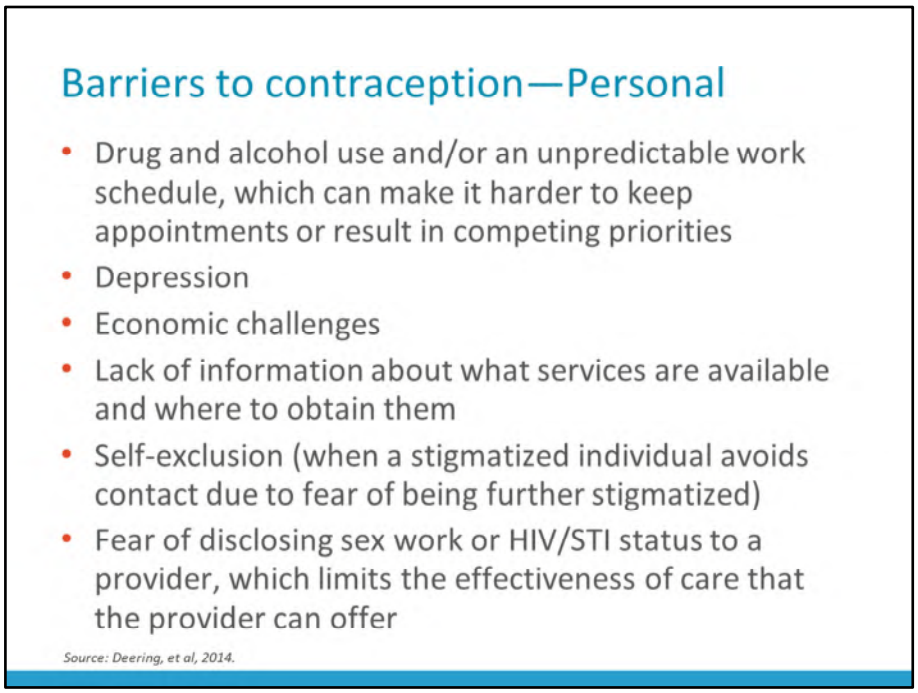
Barriers related to providers may include reluctance of some providers to provide services for FSWs, unmarried women, young women, and women with HIV due to misunderstandings of policies and standard operating procedures, community pressure, and personal biases. Providers may also lack accurate information regarding medical eligibility and/or clinical requirements for method use and have low levels of knowledge about the specific needs of FSWs. Some providers may be prone to discrimination, be judgmental, and hold negative attitudes toward FSWs. FSWs may have concerns that a provider will not keep their health information confidential. Some providers may lack the ability to interact appropriately with FSWs.

<Acknowledge provider-related barriers that are based on gender and reinforce the connection of many barriers to gender norms. For example, providers may judge and discriminate against FSWs because they do not meet society's expectations for women's sexual behavior.>

Sources:

L. Ghimire, E. van Teijlingen. Barriers to Utilisation of Sexual Health Services by Female Sex Workers in Nepal. Global Journal of Health Science, Vol. 1, No. 1, 2009.

J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L Herman, M. Keisling, supra note 3, at 76. 9 K. Rachlin, J. Green, & E. Lombardi, Utilization of Health Care Among Female-to-Male Transgender Individuals in the United States, 54 J. HOMOSEXUALITY 243, 252-53 (2008).



Speaker Notes:

<Compare the suggestions on the slide with the participant responses recorded on the flipchart; use the speaker notes below to summarize.>

Personal barriers may include drug and alcohol use, which can impair decision-making and make it harder to keep clinic appointments or result in competing priorities—such as using limited funds for drugs/alcohol rather than saving it for transportation or services.

Depression can be debilitating and affect how a person feels, thinks, handles daily activities, and perceives their self-worth. Although not the only cause of depression, FSWs worldwide experience higher rates of exposure to sexual violence that can result in anxiety, fear, trauma, and depression.

Many FSWs face economic challenges and lack the resources for health care, education, or to maintain a household, including food, shelter, clothing for themselves and their families.

Some FSWs may lack information about what services are available and where to obtain them.

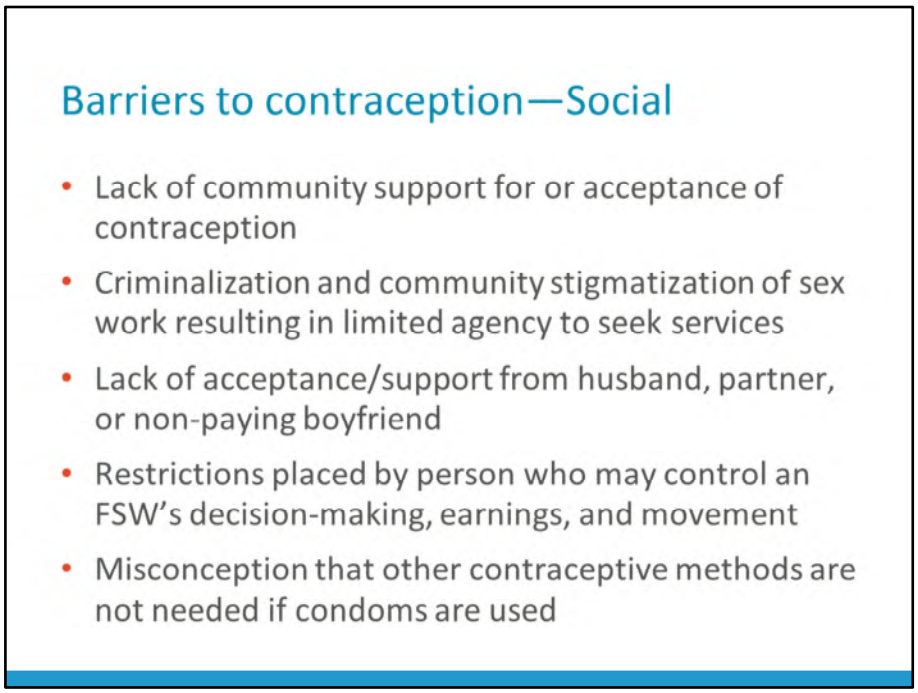
In addition to the social stigma FSWs may perceive, some FSWs may self-exclude and avoid services or opportunities due to fear of being further stigmatized.

FSWs may fear disclosing to health care workers that they engage in sex work due to the stigma commonly associated with sex work. In these cases, the health care workers are not getting full details of the patient's risk or behavior and are therefore unable to provide effective health care or treatment.

<Acknowledge personal barriers that are based on gender and reinforce the connection of many barriers to gender norms. For example, FSWs may avoid services because they fear further judgment and discrimination for deviating from society's expectation for women's sexual behavior.>

Source:

Deering KN, Amin A, Shoveller J, et al. A systematic review of the correlates of violence against sex workers. Am J Public Health. 2014;104(5):e42-e54. doi:10.2105/AJPH.2014.301909



Speaker Notes:

<Compare the suggestions on the slide with the participant responses recorded on the flipchart; use the speaker notes below to summarize.>

In some communities there is a general lack of support for or acceptance of contraception due to a belief that contraception means a woman is promiscuous or cheating on a husband/partner. In these communities, FSWs, like other women who seek contraception, may be stigmatized and discriminated against.

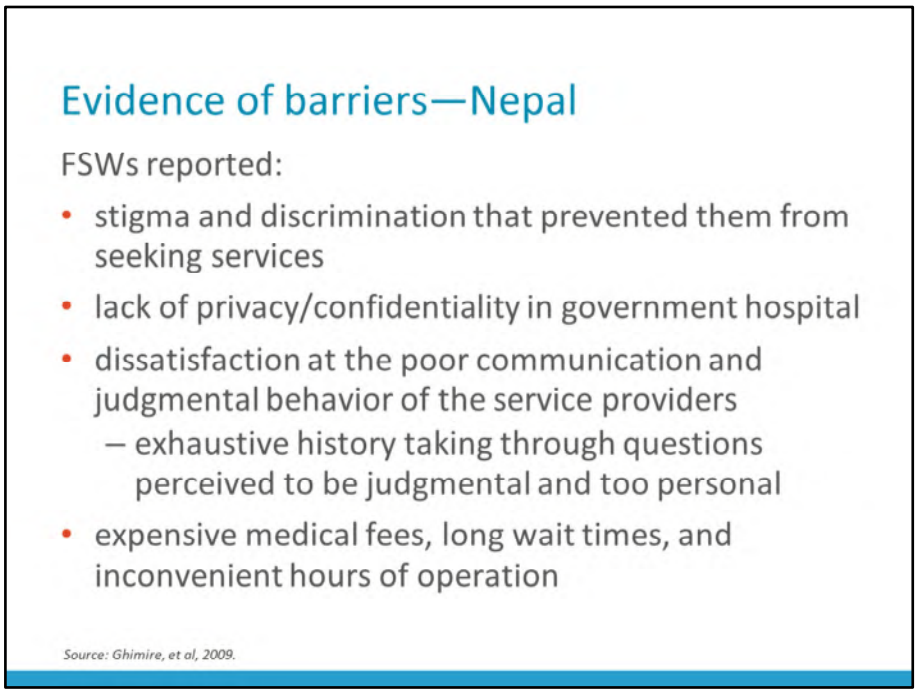
Criminalization of sex work and community stigmatization may result in FSWs feeling they have limited agency and support for seeking health services.

Like any woman, FSWs may lack acceptance/support for use of contraception from a husband, partner, or non-paying boyfriend.

FSWs often find themselves in circumstances where their decision-making, earnings, employment, and movement are controlled or restricted by someone else.

Some FSWs may perceive that they do not need another contraceptive method if they are using condoms. However, if an FSW is not able to use condoms consistently and correctly, or a condom breaks, they are at risk of unintended pregnancy. Emergency contraception or another method of contraception can help avoid unintended pregnancy in these situations.

<Acknowledge social barriers that are based on gender and reinforce the connection of many barriers to gender norms. For example, in some communities there is a general lack of support for or acceptance of contraception due to a belief that contraception means a woman is promiscuous or cheating on a husband.>



Speaker Notes:

FSWs in Nepal reported that stigma and discrimination were barriers that often prevented them from seeking treatment and health care services.

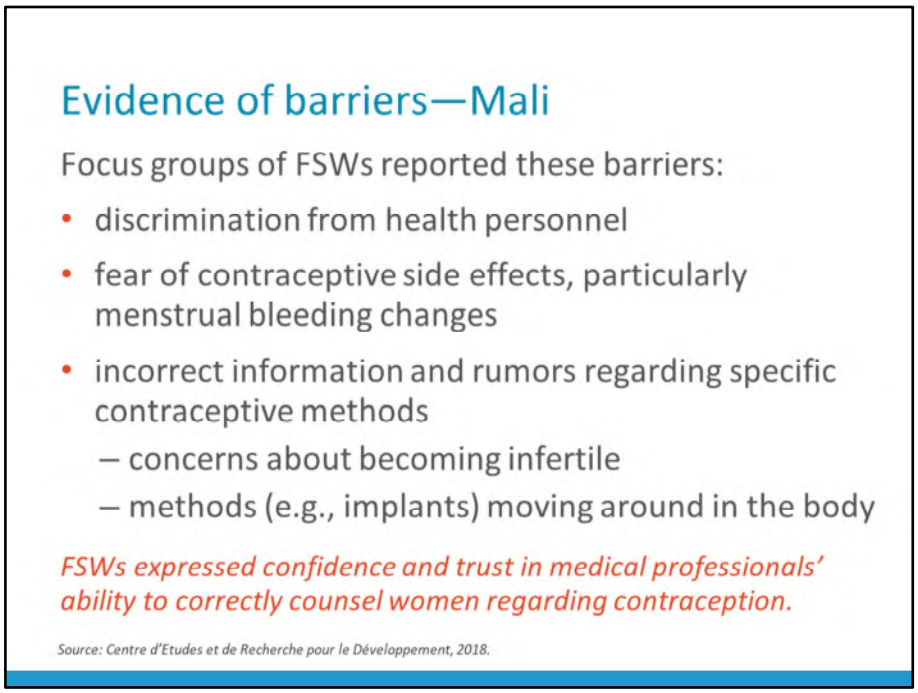
Most Nepalese FSWs felt a lack of privacy and confidentiality in the government hospital because of the crowd of patients and the behavior of the health care workers.

FSWs expressed dissatisfaction at the poor communication and judgmental behavior of the service providers. The exhaustive history taking, through questions perceived to be judgmental and too personal, was especially troublesome.

Expensive medical fees, long wait times, and inconvenient hours of operation also contributed to levels of dissatisfaction.

Source:

L. Ghimire, E. van Teijlingen. Barriers to Utilisation of Sexual Health Services by Female Sex Workers in Nepal. Global Journal of Health Science, Vol. 1, No. 1, 2009.



Speaker Notes:

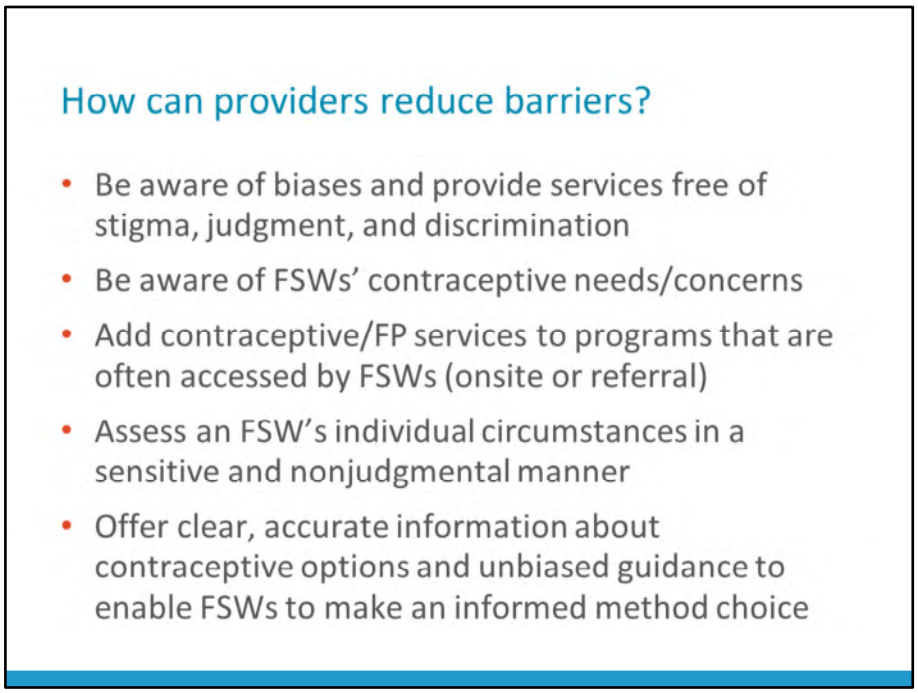
The LINKAGES project in Mali conducted four focus groups with FSWs in Bamako and Bougouni—including users and non-users of contraception. Many participants reported that discrimination from health personnel was a barrier to seeking services, particularly in public sector facilities. Most reported that they would prefer going to a facility that specifically serves FSWs where they know they will not be treated differently because of their work.

The most frequently cited barrier to use of contraceptives—among users and non-users alike—was fear of side effects, particularly concerns about changes to menstrual bleeding. Focus group participants also mentioned incorrect information and rumors regarding specific methods, including not being able to have children in the future, and methods such as implants moving around in the body.

However, almost all participants expressed confidence and trust in medical professionals' ability to correctly counsel women regarding their contraceptive choices and recommended that women seek professional advice rather than listen to rumors in the community.

Source:

Centre d'Etudes et de Recherche pour le Développement (CERD). Rapport de groupes de discussions dirigées avec les professionnelles de sexe sur l'utilisation de la contraception pour le projet LINKAGES-Mali (2018).



Speaker Notes:

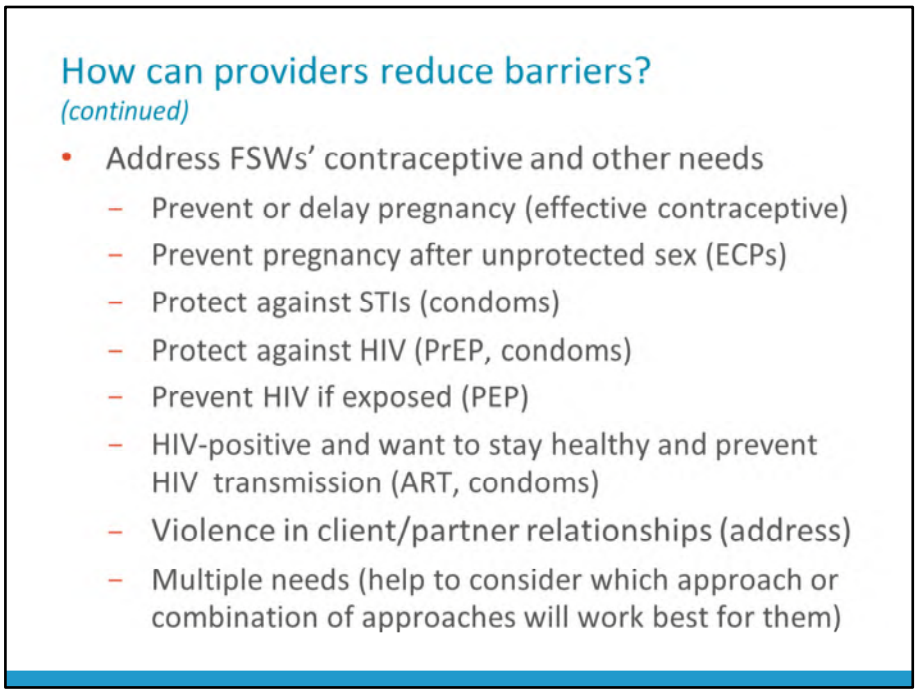
How can providers minimize/reduce barriers to contraception?

<Accept responses from several participants; click the mouse to reveal the answers on this slide and the next.>

While it may not be possible to address all barriers to contraceptive services, providers can minimize or eliminate some of these barriers by:

- Being aware of biases and providing services free of stigma, judgment, and discrimination
- Being aware of FSWs' contraceptive needs and concerns about how contraceptive use may impact their livelihood
- Integrating contraceptive/FP services, either onsite or through referrals, into programs that are often accessed by FSWs, such as HIV prevention, treatment and care programs or to STI services
- Assessing an FSW's individual circumstances in a sensitive and non-judgmental manner, and
- Using a lifecycle, client-centered approach to counseling and services that provides clear, accurate information about contraceptive options and support appropriate to an FSW's needs as they change throughout her reproductive years. In addition, providers should address common rumors and misconceptions and offer unbiased guidance during the decision-making process to enable FSWs to make an informed and voluntary choice of a contraceptive method or methods.

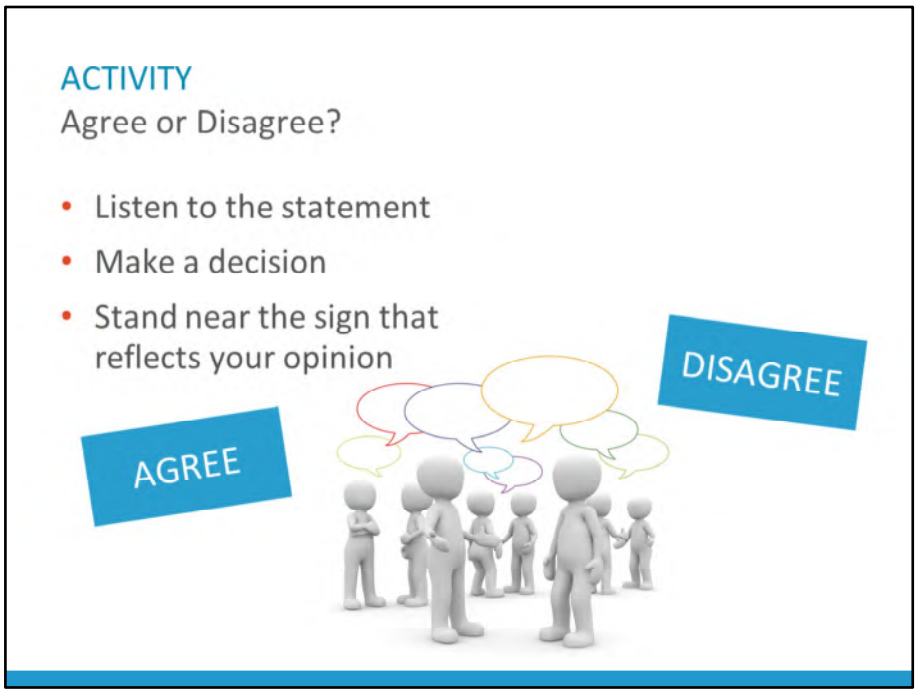
<If there are local examples of programs that have taken measures to minimize barriers, share those examples or solicit examples from the participants.>



Speaker Notes:

Providers can also reduce barriers by discussing the various options for addressing FSWs' contraceptive and other needs using a holistic approach. These needs may include:

- Preventing or delaying pregnancy using an effective contraceptive method
- Preventing pregnancy after unprotected sex using emergency contraceptive pills (ECPs)
- Protecting herself from STI acquisition or transmission using male or female condoms
- Protecting herself from HIV using pre-exposure prophylaxis (PrEP) and/or condoms
- Preventing HIV acquisition using post-exposure prophylaxis (PEP) if exposed during unprotected intercourse
- Being sensitive to an FSW's HIV-positive status and desire to stay healthy and prevent HIV transmission using antiretroviral therapy (ART) and/or condoms
- Acknowledging that FSWs may experience violence in their relationships with clients or partners and address the issue or refer if needed
- Recognizing that FSWs have multiple needs and help them to consider which approach or combination of approaches will work best for them

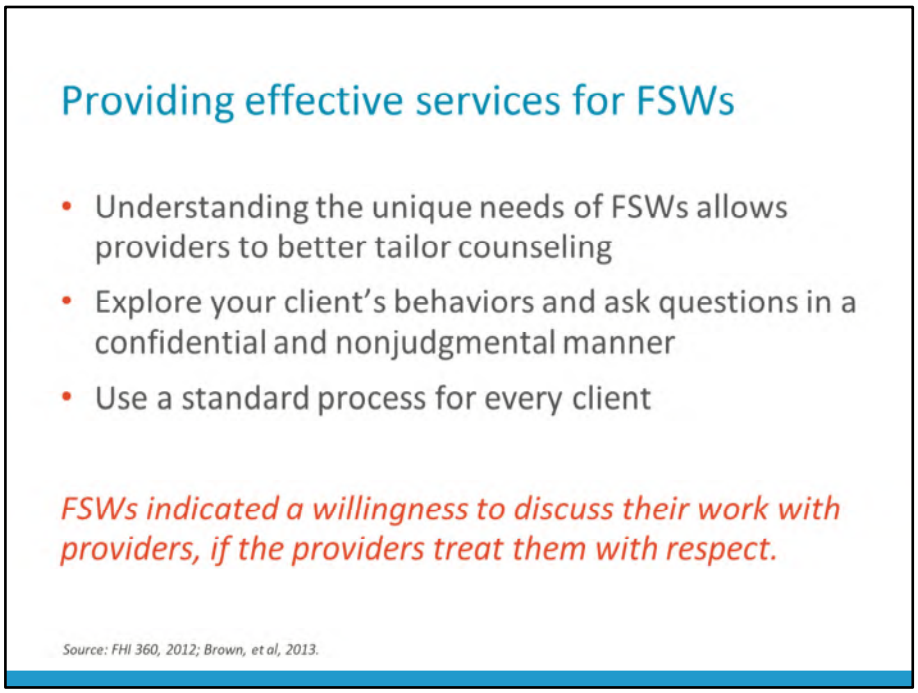


Speaker Notes:

To be able to effectively assess FSWs' needs and empower them to make an informed and voluntary choice of a contraceptive method, providers should be aware of their own biases, perceptions, and attitudes. This activity is designed to help you think about what some of your own biases, perceptions, and attitudes might be. I will read a statement and you should stand near the sign that reflects your feelings or opinion. As you consider each statement, think about how you can "defend" your choice.

This activity is not about correct or incorrect answers but is an opportunity to explore different perspectives and attitudes and consider how these can facilitate or hinder FSWs' access to contraception and their choice of method.

<Read the statements included in the session plan and ask each participant to think about their response and to stand near the sign—Agree or Disagree—that best reflects their feelings or opinion. If a participant is undecided, they can remain in the center. Challenge participants to describe why they agree or disagree with a statement; use the rationale included in the session plan to encourage discussion.>



Speaker Notes:

Understanding the unique needs of FSWs is necessary for health care providers to be able to offer effective contraceptive services. If health care workers are not aware of these needs, they will not be able to provide tailored counseling and, ultimately, may not be able to help clients to consider contraceptive options that will best fit their situations.

Providers should be able to ask sensitive questions about a client's situation and behavior in a confidential and nonjudgmental manner.

As much as possible, this should be a standard process for every client.

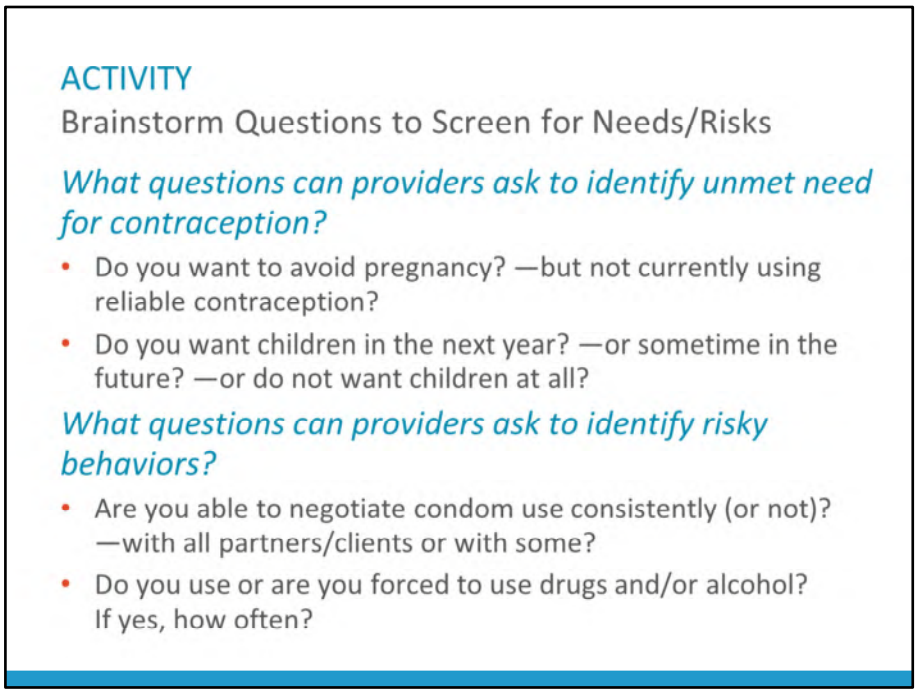
<Click the mouse to reveal the highlighted statement.>

During focus group discussions conducted by FHI 360, many FSWs indicated a willingness to discuss their work with providers, if the providers treat them with respect.

Sources:

The Positive Health: Prevention in Care Training Resources Package. FHI 360, 2012.

Brown, B; Duby, Z; Van Dyk, D; Health Care Provision for Men who have Sex with Men, Sex Workers, and People who use Drugs: An Introductory Manual for Health Care Workers in South Africa. The Desmond Tutu HIV Foundation 2013.



Speaker Notes:

Let's brainstorm...

What questions can providers ask to identify unmet need for contraception?

What questions can providers ask to identify risky behaviors (including behaviors that can make it harder to negotiate condom use or use a contraceptive method correctly)?

<Record the ideas for screening questions brainstormed by participants on the prepared flipchart(s). Use probing questions to ensure that the topics mentioned below are included. Click the mouse to reveal the sample questions and compare them with the questions brainstormed by the participants.>

During a counseling session, a provider should ask questions to explore if their client:

- Wants to avoid pregnancy? —but is not currently using reliable contraception?
- Wants children in the next year? —or sometime in the future? —or does not want children at all?
- Uses condoms consistently (or not)? —with all clients or with some clients? Explore with which partners condoms are used. For example, an FSW may not be using condoms with an uninfected primary partner but may use condoms with all commercial clients.
- Uses drugs and/or alcohol? If yes, how often? How much is their judgment is impaired?

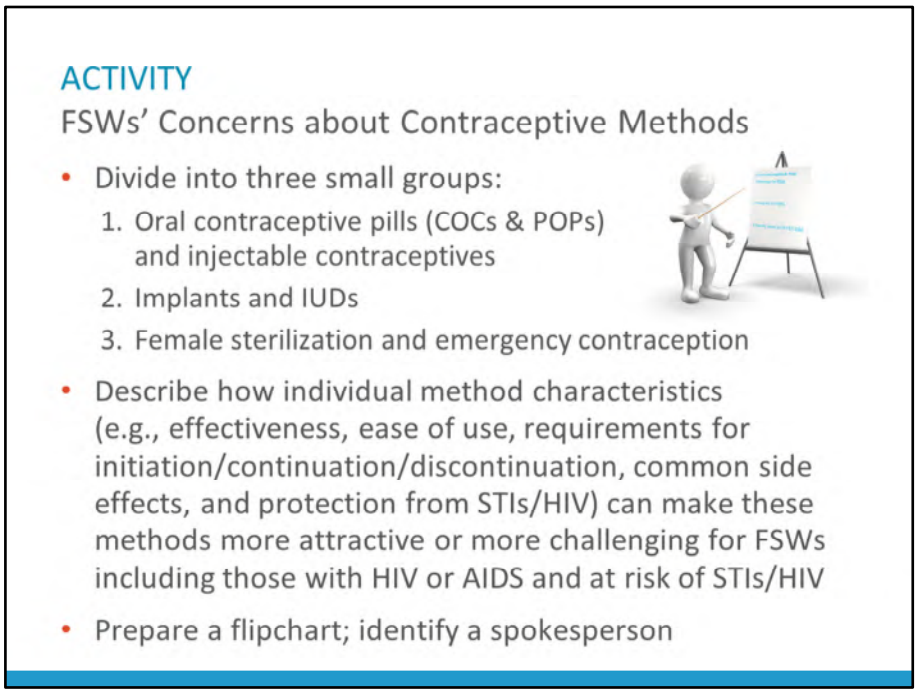
Remember that if you start a discussion with a closed-ended screening question, you should follow up with open-ended, probing questions/statements like: "What else would you like to share about your desires/concerns?" or "Please tell me more." Discussing these topics is very sensitive and personal by nature and the questions you ask could be easily perceived as stigmatizing; in the next activity we'll think about what we can do to minimize or avoid this perception.

Speaker Notes:

What can providers do to make FSW clients more comfortable and encourage open conversation about sensitive topics? Write one idea on a piece of paper or a sticky note and post it on the flipchart.

<Allow several minutes for participants to write and post their ideas. Read aloud the ideas shared by the participants. Discuss the ideas shared and ensure that the items below are posted or added.>

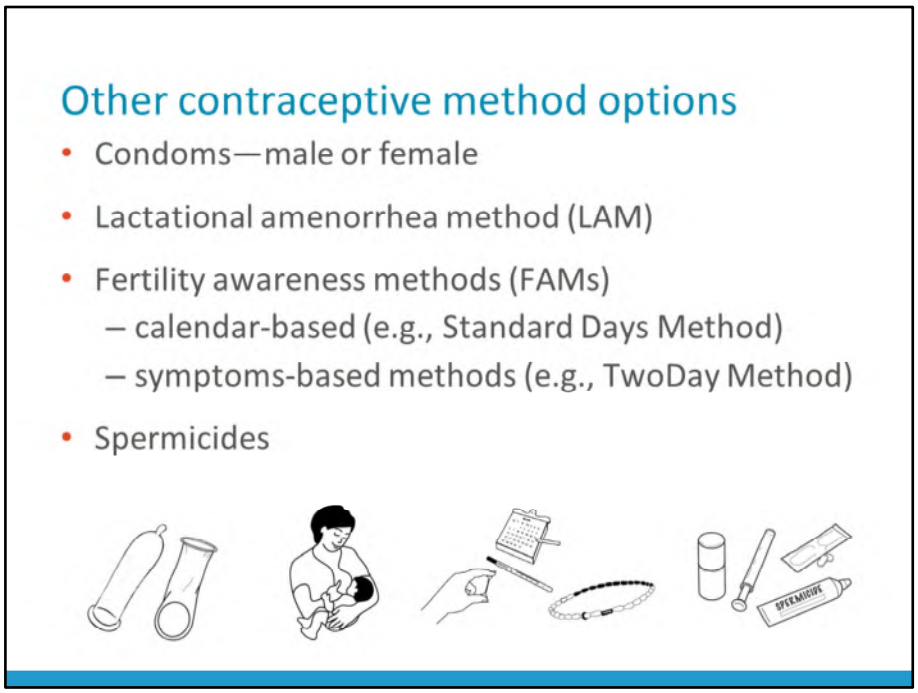
- Ensure privacy and reassure about confidentiality
- Reassure that these are the questions you ask all your clients and that you are asking because you want to help
- Explain that the answers to the questions will help you to better understand the unique needs of each client and to provide better services
- Use a friendly tone of voice, inclusive language, and open-ended questions (e.g., say, "Tell me about your partners," then explore the types of relationships and use of safe behaviors with the full range of partners—spouse, boyfriend, client)
- Be aware of your body language (e.g., maintain eye contact, smile, lean forward, nod along with the discussion, maintain a relaxed posture)
- Be open and nonjudgmental
- Listen without interrupting
- Paraphrase to check that you understand correctly



Speaker Notes:

In this activity we will consider how the characteristics of various contraceptive methods may be perceived by FSWs.

<Ask participants to divide into three small groups. Instruct the groups to take ~20 minutes to discuss their assigned methods and prepare a presentation that describes how individual method characteristics (e.g., effectiveness; ease of use; requirements for initiation, continuation and discontinuation; common side effects, and protection from STIs/HIV) can make these methods more attractive or more challenging for FSWs. Each group should summarize their key points on a flipchart and select a spokesperson. Allow each small group about 10 minutes to present their methods to the large group. As each method is presented, challenge all the participants to think of other characteristics that might make that method more attractive or challenging for FSWs. Probe for the issues included on the Handout: Contraceptive Options for Female Sex Workers. *Distribute copies of the handout to each participant to use during the activity and for future reference.>*



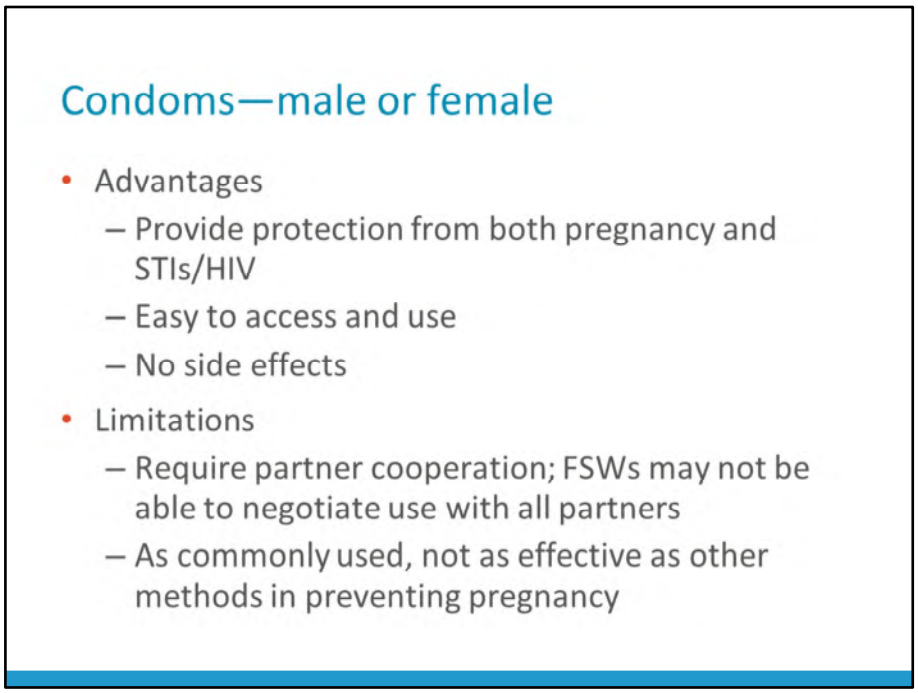
Speaker Notes:

There are several methods that were not discussed in your small groups…

<Click the mouse to reveal each of the methods.>

…including condoms, male and female; the lactational amenorrhea method (LAM); fertility awareness methods (FAMs) including calendar-based methods such as the Standard Days Method (CycleBeads), and symptoms-based methods such as the TwoDay Method; and spermicides.

We will review the advantages and limitations of those methods now—taking into account the perspective and needs of FSWs.



Speaker Notes:

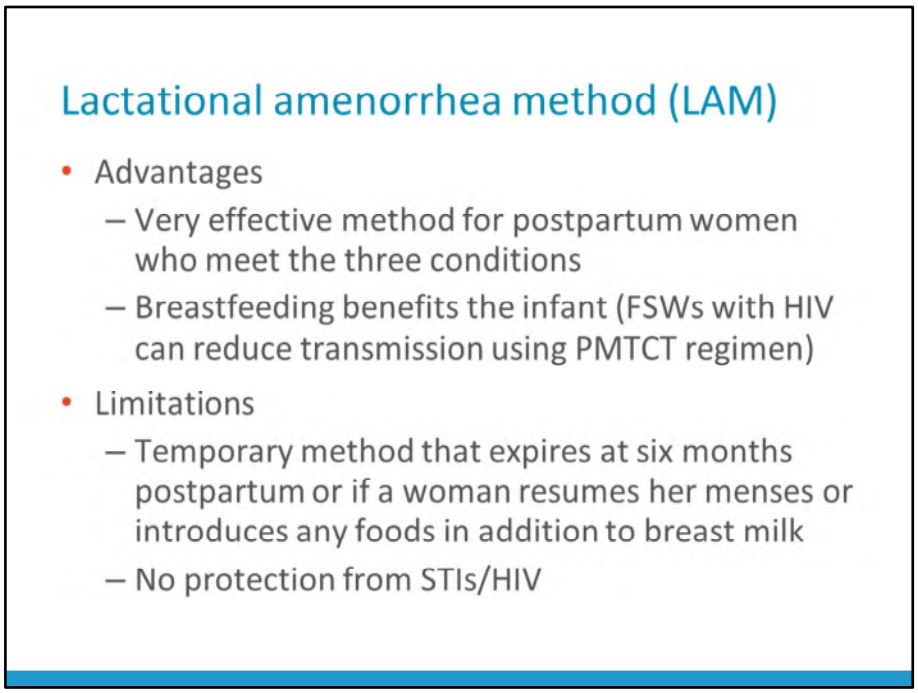
FSWs are always counseled to use condoms to protect themselves and their clients from STIs including HIV. A condom – male or female – is the only method that provides protection from both pregnancy and STIs/HIV. Condoms are usually readily available, safe, and effective. However, effectiveness heavily depends on how consistently and correctly condoms are used. It is common for FSWs to rely on condoms for both pregnancy prevention and prevention of STIs/HIV.

Why do you think FSWs may want to consider using another contraceptive method in addition to condoms, rather than relying on condoms alone?

<Probe for the following responses: As commonly used, condoms are less effective than other methods of contraception. While some FSWs are very successful negotiating condom use with their clients and using condoms consistently and correctly, many FSWs can't ensure consistent use because some of their clients may (and often do) refuse to use condoms, some clients may become violent if an FSW insists on using condoms, some FSWs may risk having unprotected sex with a partner who promises to pay more for sex without condom. In all of these cases, an FSW is exposed to the dual risk of pregnancy and STIs/HIV. If she uses another contraceptive method in addition to condoms, she at least can be protected from pregnancy, when condoms are not used.>

<Click the mouse to reveal the limitations.>

Informed choice counseling should always include a discussion of the benefits of using an effective contraceptive method for pregnancy prevention in addition to condoms.



Speaker Notes:

The lactational amenorrhea method (LAM) can be a good method for FSWs who just had a baby, because breastfeeding exclusively for six months after delivery provides effective contraception for women who haven't resumed their periods.

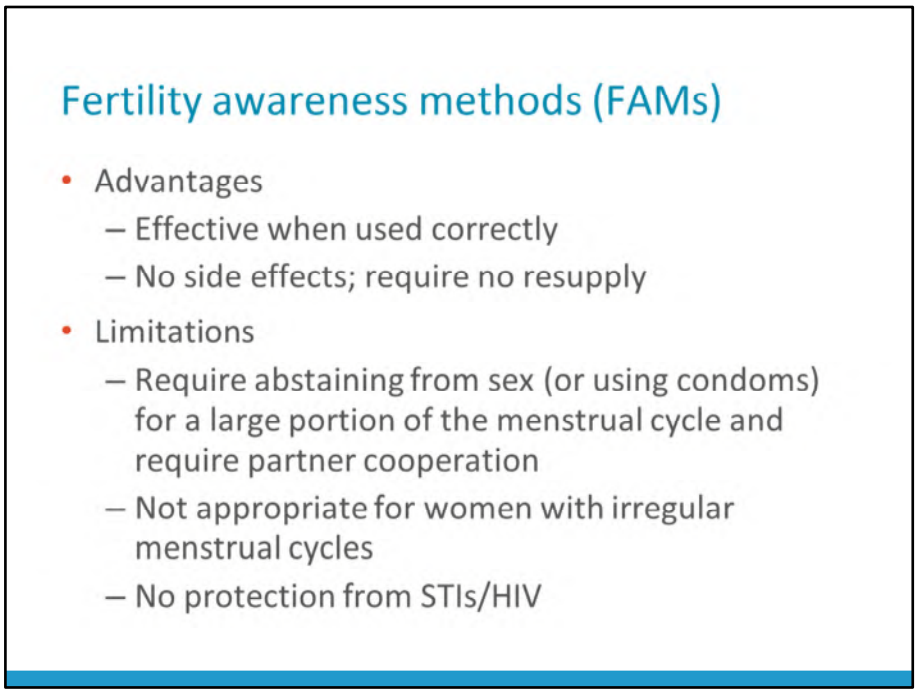
In which case is it appropriate for an FSW to use LAM?

<Probe for the following responses: LAM can be used by FSWs who are breastfeeding. Breastfeeding exclusively for 6 months after delivery provides effective contraception for women who haven't resumed their periods. LAM can serve as a bridge to another contraceptive method. Providers should help FSWs relying on LAM to choose a regular contraceptive method before any one of the LAM criteria expires—a baby turns 6 months old, a woman resumes menses, or she stops breastfeeding exclusively—whichever comes first.>

What if the FSW is HIV-positive?

<Probe for the following responses: An FSW who is HIV-positive can reduce HIV transmission to her infant by attending a PMTCT program, adhering to a PMTCT regimen/cascade, and avoiding giving her baby any foods other than breast milk until 6 months postpartum because mixed feeding carries a higher risk of HIV transmission than exclusive breastfeeding.>

FSWs should be considered at high individual risk of STIs/HIV and are strongly advised to use condoms even when they are already using another effective contraceptive method. FSWs who are HIV-positive or have AIDS should be advised to continue using condoms consistently to prevent HIV transmission to their partners and to prevent being infected with another strain of HIV.



Speaker Notes:

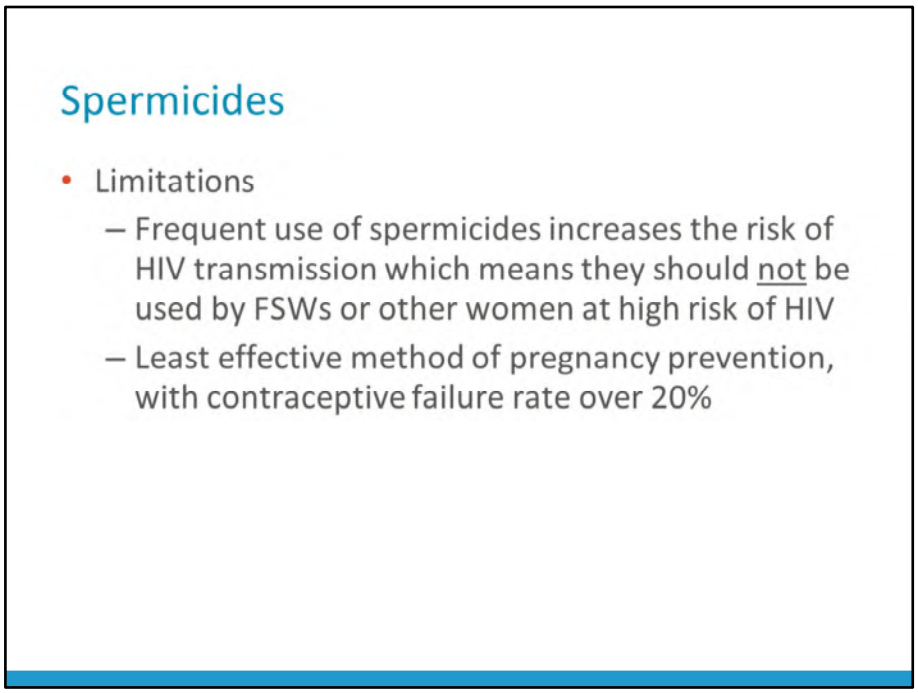
Fertility awareness methods can be very effective if used correctly. FAMs have no side effects and require no resupply.

Why do you think fertility awareness methods may not be the most appropriate option for FSWs?

<Probe for the following responses: Because these methods involve abstaining from sex or using condoms for a large portion of the menstrual cycle and require partner cooperation, FSWs may consider use of these methods unrealistic.>

<Click the mouse to reveal the limitations.>

FAM are not appropriate for women with irregular menstrual cycles. FAMs provide no protection from HIV and other STIs. Dual protection can be achieved by adding condoms, which is already a requirement for practicing fertility awareness methods effectively.



Speaker Notes:

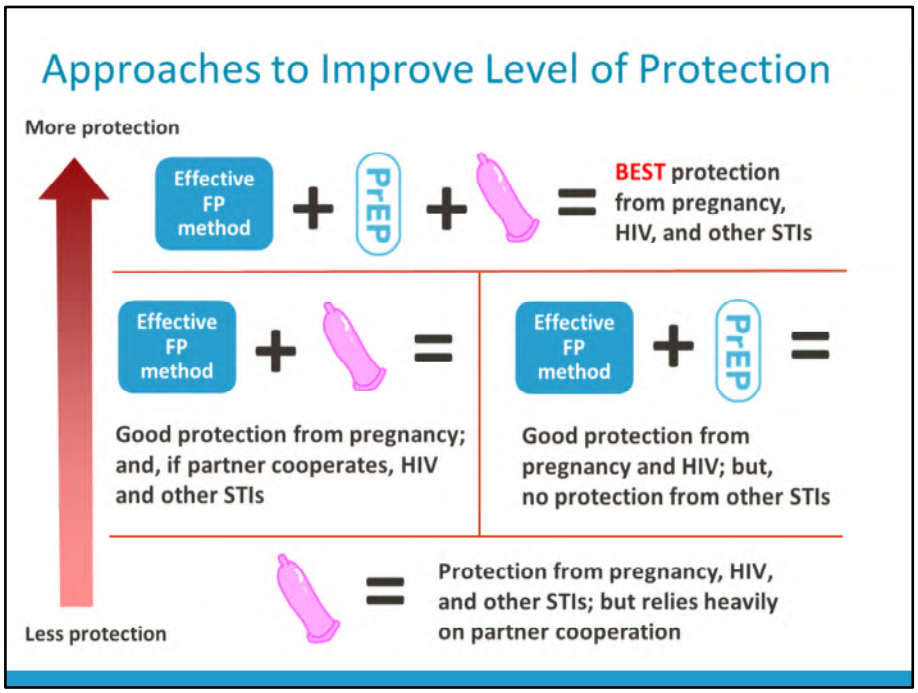
Why do you think FSWs should not use spermicides?

<Probe for the following responses: Because frequent use of spermicides increases the risk of HIV transmission, which means they should not be used by women at high risk of HIV. Spermicides are also one of the least effective methods of pregnancy prevention with a contraceptive failure rate over 20% as commonly used.>

<Click the mouse to reveal the limitations.>

Source:

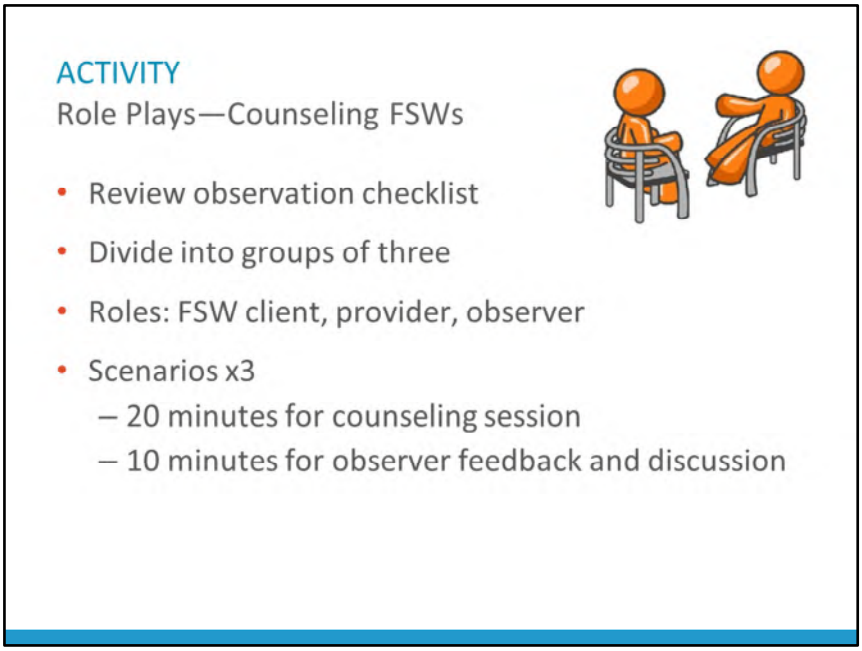
World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 update). Baltimore and Geneva: CCP and WHO, 2018.



Speaker Notes:
It is important to help clients to decide how they can protect themselves from pregnancy, HIV, and other STIs and what approach or combination of approaches will work best for them. This graphic can help explain the available options; let's review how various approaches provide less or more protection: *<Click the mouse to reveal the approaches.>*

- Condoms alone provide protection from pregnancy as well as from HIV/STIs, but only if used consistently and correctly every time you have sex. This requires partner cooperation and, unless a FSW can negotiate condom use with every partner, may not provide desired protection. In addition, it is not as effective for pregnancy prevention as some other methods.
- Using an effective family planning method and condom provides reliable protection from pregnancy. However, while a condom offers protection from HIV and other STIs, it will heavily depend on partner cooperation and you may or may not have control over it; even if you use a female condom, partner cooperation is still required.
- Using an effective family planning method (other than a condom) and taking a PrEP pill provides good protection from pregnancy and HIV. The advantage is that you can control how consistently you take PrEP to ensure good HIV protection; however, it doesn't protect from other STIs.
- Finally, using an effective FP method in combination with a condom and PrEP provides the best protection from pregnancy, HIV, and other STIs; even though reliable STI protection still depends on partner cooperation.

<Ensure that each participant receives a copy of the handout/job aid: Approaches to improve level of protection (Appendix 6).>



Speaker Notes:

*<Distribute resources in **BOLD** while providing instructions for conducting the role plays.>*

The **observation checklist** lists the communication behaviors used during counseling, reflects the general flow of a session, and specifies the tasks that a provider should complete when counseling FP clients. Look at the bold headings—listed first are the key behaviors used throughout a session, like showing respect, being friendly and encouraging client participation; after that are the steps that occur early in the session where the provider establishes rapport and determines the client's needs. Following that, the provider gives information that the client needs; then helps the client make an informed decision, and finally helps the client to carry out their decision. Notice that the observation checklist reflects many of the criteria that you brainstormed earlier—being non-judgmental, unbiased, and non-coercive.

The **role instructions** describe what a participant should do when playing each role—provider, FSW client, and observer. Each participant will have an opportunity to play each role. *<Read aloud the expectations for each role while participants follow along.>*

The **client information sheet** for each scenario provides a description of the client to be portrayed during the role play. The **observer information sheet** describes case-specific ideas about how a provider might approach a session with the FSW client described in the scenario and should be used by the observer along with the observation checklist.

<Follow the detailed guidance and use the resources in the session plan to conduct the role play activity as designed.>

There are three scenarios; each group will conduct and discuss each play. The role play should take about 20 minutes with 10 minutes for observers to provide feedback and the group to provide a constructive critique using the discussion questions on the next slide.

<Circulate through the room and monitor the activity of each small group. Provide periodic reminders about the time remaining so the groups remain in sync and finish on time.>

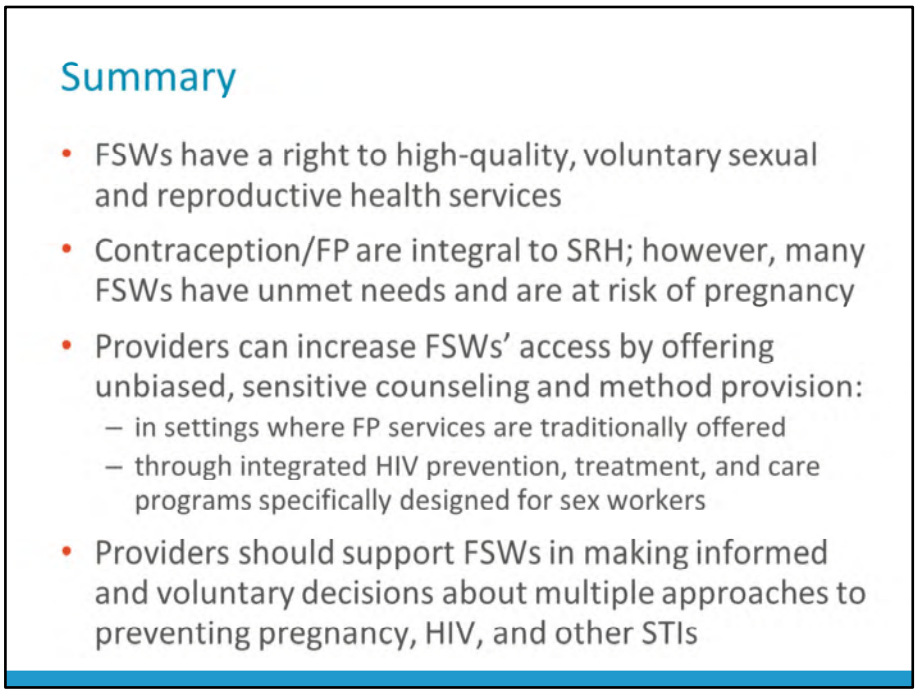
ACTIVITY

Role Play—Discussion Questions

- What did the provider do in this situation that was effective?
- What might the provider consider doing differently?
- How well did the provider attend to the items on the Observation Checklist and the case-specific observations included in the role play description?
- What was the client's perspective of the interaction —was the client comfortable and were her concerns addressed?

Speaker Notes:

At the conclusion of each role play, allow providers a moment to reflect on their own performance, then the observers will share the feedback that they have noted on the observation form. Use these questions to guide the discussion in your small groups after each role play.



Speaker Notes:

FSWs have a right to high-quality sexual and reproductive health services.

Contraception and family planning are an integral part of sexual and reproductive health services and yet, many FSWs have unmet needs and are exposed to the risk of unplanned pregnancy.

Health care providers can increase FSWs' access to services by offering unbiased, sensitive contraceptive counseling and method provision in settings where family planning services are traditionally offered and by integrating contraceptive and family planning services into HIV prevention, treatment and care programs specifically designed for sex workers.

Health care providers' responsibility is to guide FSWs through decisions around the multiple approaches to preventing pregnancy, HIV, and other STIs, while ensuring informed and voluntary choice.

Acknowledgments

This training resource is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the terms of cooperative agreement #AID-OAA-A-14-00045. The contents are the responsibility of the LINKAGES project and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government. The project is led by FHI 360 in partnership with IntraHealth International, Pact, and the University of North Carolina at Chapel Hill.