Integration of Family Planning into HIV Counseling and Testing, Prevention of Mother-to-Child Transmission, and Antiretroviral Therapy Services

Participant's Guide

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Acronyms

ART: Antiretroviral Therapy
ARV: Antiretroviral
COC: Combined Oral Contraceptives
DMPA: Depot Medroxyprogesterone Acetate
ECP: Emergency Contraceptive Pill
EFV: Efavirenz
FABM: Fertility-Awareness Based Method
FP: Family Planning
HCT: HIV Counseling and Testing
HIV: Human Immunodeficiency Virus
IUD: Intrauterine Device
LAM: Lactational Amenorrhea Method
NET-EN: Norethisterone Enanthate
NNRTI: Non-Nucleoside Reverse Transcriptase Inhibitors
NRTI: Nucleoside Reverse Transcriptase Inhibitors
NVP: Nevirapine
OCP: Oral Contraceptive Pills
PLHIV: Persons Living with HIV
PMTCT: Prevention of Mother-to-Child Transmission
POI: Progestin-Only Injectable
POP: Progestin-Only Pills
STI: Sexually Transmitted Infection
TB: Tuberculosis
VSC: Voluntary Surgical Contraception
WHO: World Health Organization

Background

Family planning (FP) integration—with HIV counseling and testing (HCT), prevention of mother-to-child transmission (PMTCT), and antiretroviral therapy (ART) services—presents an opportunity to meet the needs of clients in an efficient and appropriate manner. HIV service providers are able to discuss HIV risks and unintended pregnancy and fertility desires, helping clients make fully informed sexual and reproductive health decisions. FP/HIV integration also supports PMTCT of HIV through Prongs 1 and 2 of WHO's PMTCT strategy, as it promotes primary HIV prevention and prevention of unintended pregnancy through promoting of correct and consistent condom use among sexually active clients, and addressing unmet need for FP among HIV positive women.

To address training needs in FP/HIV Integration, Pathfinder developed a Training Package complete with a Training Facilitator's Guide, Participant Handbook, Job Aid, and Companion PowerPoint Presentation. This training package is designed to train practicing HIV service providers in FP counseling and service provision for FP/HIV integration. This training package is intended to train practicing HIV service providers working directly and regularly in HCT, PMTCT, and/or ART. This package is not intended to provide complete information on all FP methods. For this information, service providers should refer to copies of the World Health Organization and Johns Hopkins School of Public Health/Center for Communication Program's book *Family Planning: A Global Handbook for Providers* (2008 update).

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Unit 1: Family Planning Integration with HIV Services

Section 1.3.1: Definition and Essential Aspects of FP/HIV Integration

- Integration refers to the incorporation of aspects of 2 or more services as a single, coordinated, combined service.
- It involves offering FP and HIV services at the same facility, with the provider of each service actively encouraging clients to consider using the other service during the same visit.
- If services are not offered in the same room, strong referrals are required.
- Integration of FP and HIV programs requires coordination between HIV and FP managers, supervisors, and service providers.
- Integrated counseling is essential to integrated programs and services.

Section 1.3.2: Levels of FP/HIV Integration

- **Level 1:** Assessment of FP need; provision of FP counseling; provision of condoms, oral contraceptive pills (OCPs), and emergency contraception.
- **Level 2:** Includes all elements of the first level and the provision of injectable contraceptives.
- **Level 3:** Includes everything in level 2 as well as the provision of intrauterine devices (IUDs) and implants.
- **Level 4:** Includes provision of all contraceptive methods including permanent/surgical methods.

Section 1.4.1: Benefits of FP/HIV Integration

- Clients will appreciate that integration addresses their related needs in one venue.
- FP and HCT, PMTCT, and ART services have similar aims of reaching sexually active people, preventing unintended pregnancy, HIV, and sexually transmitted infections (STIs), and promoting safe, healthy, and responsible sexual behavior.
- People living with HIV (PLHIV) can use most contraceptive methods safely, but HIV service providers can help clients review special considerations specific to some contraindications.
- Both FP and HIV services promote and distribute condoms. Integration offers the opportunity for increased knowledge of dual method use (condom use and additional contraceptive method use for improved protection against HIV/STIs and unplanned pregnancy) and dual protection (using condoms for HIV/STI protection and contraception).
- For clients, pregnancy prevention may be an additional motivation for condom use.
- HCT attracts clients who would not otherwise normally access FP services. Thus, integration minimizes missed opportunities for addressing the contraceptive needs of HCT clients who could be atypical clients for FP services.
- HIV service providers are already trained in counseling and discussing reproductive health, skills that are essential for FP discussions.
- HIV service providers are trained in providing specialized services for PLHIV and are familiar with issues like common treatment protocols, privacy, and minimizing stigma.
- Integration can support the prevention of mother-to-child transmission of HIV by helping women with HIV who do not want to have children avoid unintended pregnancy.
- Integration is more cost effective. The cost of establishing integrated services is lower because of the similarities between FP and HIV services.

Section 1.5.1: Challenges of Integration

- May require financial resources to establish additional services
- May overburden staff—shortage of staff time
- May increase client waiting time
- Requires additional training
- Counselors without clinical training may be too intimidated to discuss contraceptive methods and how they work
- Requires additional records
- FP and HIV services are often implemented and funded by different programs
- Shortage of contraceptive commodities
- Stigma around HIV and condom use
- Provider bias against providing contraception to certain client types (e.g., prenuptial and newly married couples, adolescents)
- Providers may be uncomfortable offering contraceptive methods to HIV-positive people if they believe those clients should abstain from sexual activity. Alternatively, they may be uncomfortable talking about the decision of HIV-positive clients to have children. This may lead to providers only discussing abstinence or condom use for HIV prevention, instead of discussing contraceptive use or dual method use.
- Prevention of mother-to-child transmission (PMTCT) providers reach pregnant women who may not be thinking about contraception.
- ART providers may feel too burdened with very sick clients to take time to discuss FP.
- Clients and supervisors/managers may not be oriented to the benefits of the integration.

Section 1.5.2: Addressing the Challenges of FP/HIV Integration

- HIV service sites are already established and the counselors are already trained in counseling, making integration easier.
- It does not take double staff time, as counseling for both HIV and FP will take place at the same time. But if 2 different counselors address the 2 subjects independently, the time it takes and the cost will be twice as high from a programmatic perspective.
- Though client waiting time for the integrated service may be relatively increased as compared to that of a single service (e.g., FP or ART), it actually saves client time overall by reducing the time spent by the client to attend 2 different service sites and wait for his/her turn twice.
- HIV counselors already have training in counseling skills (e.g., confidentiality, health promotion) that could be applied to FP counseling. The additional training will be only for contraceptive methods and principles, including the relevance and safety of contraception for PLHIV.
- Adequate training and practice will reduce fears and bias.
- New or separate record keeping and reporting formats and procedures are not required for FP/HIV integration. However, the existing formats, forms, or procedures may have to be modified. *(**Note:** Record-keeping will be addressed as a later training topic and a reporting form will be shared.)*
- Contraceptive options (condoms, pills, and injectables) will be made available at HIV services sites.
- The current training on FP counseling for HIV service providers aims to address negative attitudes, values, and beliefs towards FP.
- While there may be challenges specific to individual service delivery points, manager and supervisor commitment can address these challenges through staff meetings and on-site problem solving.

Unit 2:
FP Counseling Principles and Skills

Section 2.1.1: Common Beliefs and Values about Contraceptive Use

- The decision to use contraception, choose a particular method, or stop or change a method are the client's right regardless of their age, marital status, and/or HIV status.
- Contraceptive choices and needs vary according to the stages of a woman's life (adolescence/ youth, single, prenuptial, newly married and before first child, after first child but before last child, after last child, perimenopause) and other issues related to her HIV status.
- FP must be based on volunteerism and the informed decision of the client, regardless of their HIV status.
- PLHIV are entitled to make their own reproductive decisions, have the right to a safe and satisfying sex life, and the right to a full range of sexual and reproductive health services.
- Health workers have a professional obligation to remain objective and non-judgmental with clients and to avoid letting their personal beliefs, values, and attitudes become barriers to providing compassionate and quality care to HIV-positive clients or those perceived to be HIV-positive or at risk.

Section 2.2.1: Basic Rights of FP Clients

All FP clients have the right to:

- **Information:** to learn about the benefits and availability of contraceptive methods.
- **Access:** to obtain services regardless of sex, age, marital status, creed, ethnic origin, color, or location.
- **Choice:** to decide freely whether to practice FP and which method to use.
- **Safety:** to use safe and effective contraception.
- **Privacy:** to have a private environment during counseling or services.
- **Confidentiality:** to be assured that personal information will remain confidential.
- **Dignity:** to be treated with courtesy, consideration, and attentiveness.
- **Comfort:** to feel comfortable when receiving services.
- **Continuity:** to receive contraceptive services and supplies for as long as needed.
- **Opinion:** to express views on the services needed.

Section 2.2.2: Reasons for Choosing Contraception

There are many reasons why individuals and couples decide to start, continue, or stop using contraception, including:

- Desire to delay the birth of a first child,
- To space the birth of children,
- To limit number of births/children,
- For PMTCT,
- To ensure dual method use/dual protection,
- To protect their sexual and reproductive health, and
- For economic reasons.

Section 2.3.1: Principles of FP Counseling

FP Counseling helps a client decide if he or she wants to use contraception, choose a method that is personally and medically appropriate, and understand how to correctly use the method of her or his choice.

During FP counseling, clients are given the opportunity to:

- Explore their contraceptive options;
- Obtain accurate and unbiased information about the methods;
- Clarify their feelings and values about using contraception;
- Identify their reproductive goals, and concerns about safety, effectiveness, and reversibility; and
- Come to his or her individual decision.

Good FP counseling occurs when:

- **Mutual trust** is established between client and provider. The service provider respects the client, and identifies and addresses the client's concerns regarding the use of contraception.
- Both the client and the service provider **give and receive relevant, accurate, and complete information** that enables the client to make a decision about FP.

Section 2.3.2: Informed Choice and Informed Consent

Informed choice means that a client has the right to choose any contraceptive method that s/he wishes based on a clear understanding of the characteristics of all the available methods, including the option not to adopt any method. For this, the client needs to know:

- The range of all methods available,
- Characteristics of each method,
- Effectiveness of each method,
- Possible side effects, and
- The risks of not using any method.

Informed consent implies that a client has been counseled thoroughly regarding all the components described in the section on informed choice, and that based on this information, s/he has freely and voluntarily decided which method s/he wants to use. This is particularly important when a client chooses voluntary surgical contraception (VSC) or any method that may have serious complications for a particular client (e.g., a woman over 35 who smokes and wants to use combined oral contraceptives (COCs)).

What are the advantages of a satisfied client for the service provider?

- Fewer unintended or high-risk pregnancies to handle
- Fewer clients with unintended pregnancies seeking PMTCT services
- Increased trust and respect between client and provider
- Promotion of FP and referral of other clients

Section 2.4.1: Skills of an Effective Counselor

- Possesses strong technical knowledge of contraceptive methods
- Listens actively
- Poses questions clearly, using both open- and closed-ended questions appropriately
- Recognizes and correctly interprets nonverbal communication and body language
- Interprets, paraphrases, and summarizes client comments and concerns
- Offers praise and encouragement
- Explains information in language the client understands in culturally appropriate ways
- Tailors counseling session to needs of client
- Demonstrates commitment to the principles of client rights
- Addresses clients in an accepting, respectful, nonjudgmental, and objective manner

Section 2.5.1: Screening for Need for FP

Screening for Need for FP means asking a series of brief questions to guide FP counseling in HIV services. It involves asking three questions to all clients. These questions are:

1. Are you currently pregnant?
2. Do you want to become pregnant in the next year?
3. Are you currently using a contraceptive method?

These questions help providers determine if the client has Unmet FP Need, No FP Need, or Met FP Need.

Instructions for Asking the Screening Questions

Begin by asking Question 1: "Are you (or your partner) currently pregnant?"

- If the client answers "yes," ask a follow-up question: "At the time you became pregnant, did you want to become pregnant then?"—If the client answers "yes," s/he has no FP need. If the client answers "no," s/he has unmet FP need.
- If the client answers "no," proceed to Question 2.

Continue with Question 2 for clients who are not pregnant (or who do not have a pregnant partner): "Do you (or your partner) want to become pregnant in the next year?"

- If the client answers "yes," s/he has no FP need.
- If the client answers "no," proceed to Question 3.

Continue with Question 3 for clients who do not want to become pregnant in the next year: "Are you currently using a contraceptive method?"

- If the client answers "yes," s/he has a met FP need.
- If the client answers "no," ask a follow-up question: "Can you tell me why you are not using a method?"—If the reason is "sterility or infertility," s/he has no FP need. If the reason is "not sexually active," s/he has no FP need; if the reason is anything other, s/he has unmet FP need.

Counseling Based on These Screening Questions

- **For clients with met FP need,** providers should ask if they are satisfied with their contraceptive method or would like to learn about other available methods.
- **For male and female clients with unmet FP need,** it is important to present the available contraceptive options, discuss clients' preferences, and offer FP services or referral.

- **For HIV-positive clients who desire a pregnancy, counsel on risk of mother-to-child transmission of HIV and safer pregnancy.** 2009 WHO guidelines recommend ART initiation for HIV-positive pregnant women with CD4 counts of 350 or less (or antiretroviral (ARV) prophylaxis for women who are not eligible or who are not on ART), which is able to reduce HIV transmission to 5% or less. Without any intervention or preventive measures and with continued breastfeeding transmission rates are approximately 35%. **Remember:** PLHIV, like any other people, have the right to decide whether to have children or not. It is very important that the service provider not be judgmental if a person living with HIV feels strongly that s/he wants to have children. If the provider is judgmental, the woman and family may not be willing to listen to advice on all the ways to be as safe and as healthy as they possibly can.
- **For pregnant clients,** it is appropriate to discuss HIV testing eligibility for ART and the effectiveness of ARVs during pregnancy to prevent PMTCT.

(IATT, 2009)

(WHO, 2009)

Section 2.6.1: FP for HIV-Positive Clients

Introduction

Clients with HIV may have similar motivation to consider or wish to prevent a pregnancy as clients who are not infected with HIV. They may also have additional reasons to consider or wish to prevent pregnancy. All clients have the right to learn about safe contraceptive methods that meet their needs and to learn about how to have a safer pregnancy.

Reasons Clients with HIV May Consider Pregnancy

- An emotional need to bear children
- Societal, familial, and/or other relationship expectations to have children
- Fear that the children they already have may die
- Concern about reduced fertility as HIV infection progresses
- Reassurance that PMTCT programs reduce the risk of having an HIV-infected child
- Expectations of receiving ART and living long enough to see their children grow up
- Concern that avoiding pregnancy might generate suspicion about one's HIV status
- Fear that the potential consequences of disclosing one's HIV-positive status to a partner might include violence, abandonment, and loss of finances for children

Reasons Clients with HIV May Want to Avoid Pregnancy

Many sexually active clients with HIV may not want to bear children, or they might want to wait, and therefore desire contraception. Their reasons to avoid or postpone pregnancy may include:

- Maintaining family economic status, achieving desired family size, and spacing the births of their children.
- Concern that pregnancy will further compromise her health, especially if it is already compromised by AIDS-related symptoms. In the absence of ART and treatment for opportunistic infections, her length and quality of life may be severely compromised.
- Fear of transmitting HIV to children.
- Fear of leaving orphans, because HIV infection is likely to shorten her life, particularly without treatment. Parents are naturally concerned about who will care for their children if they are no longer able to do so.

Factors Affecting Decision to Use Contraception

- Health/well-being of self, partner, and children
- Access to ART
- Fears related to disclosing HIV status (rejection, violence, financial loss)

- Knowledge of contraceptive methods (including cultural myths and misconceptions)
- Gender issues/partner opposition
- Stigma regarding condom use
- Economic impact of having a child

Factors Affecting Method Choice

PLHIV may consider:

- Safety and effectiveness of the method;
- Whether it is short term, long term, or permanent (return to fertility);
- Possible side effects;
- Ease of use;
- Cost and access to supplies of the method;
- Effect on breastfeeding (if postpartum);
- How it interacts with other medications, including ARVs;
- Whether it provides protection from transmission and acquisition of STIs, including HIV; and
- Whether partner involvement or negotiation is required.

Section 2.7.1: Addressing the FP Counseling Needs of Men

- Men have special counseling needs and should receive special attention from providers to motivate them to make responsible choices regarding FP.
- Men need to be encouraged to use contraception themselves (condoms or vasectomy).
- Men can strongly influence the decision of whether or not their partner will use contraception, so it is important for them to understand the role contraception can play in family health and well-being.
- Men can be encouraged to bring in their partners so they can decide on FP as a couple.
- Men are often concerned that women will become promiscuous if they use contraception.
- Many men do not know how to use condoms correctly. Providers should always demonstrate correct condom use, using a model when possible.
- The counselor should ask male clients about their marital/relationship status when counseling men, as the needs of unmarried men differ from married ones. (Though most of the above concerns also apply to them.)
- The counselor should give information about contraception to both married and unmarried men and motivate them to use contraception.
- The counselor should discuss the importance of dual method use/dual protection with both married and unmarried men and motivate them to practice dual methods.
- The counselor should make sure that all men understand their critical role in HIV prevention (for prevention of transmission to HIV-negative female partners and PMTCT).

Section 2.7.2: Addressing the FP Counseling Needs of Adolescents

- Adolescent HCT clients may not have much knowledge about contraceptive methods or sexual and reproductive health.
- Married adolescent clients may face strong pressure to prove their fertility.
- Adolescent PMTCT or ART clients may be more likely than older clients to desire a pregnancy because they may feel more healthy or may not have any children yet.
- Adolescents may be most comfortable with methods that are unlikely to be detected (such as injectables or IUDs), with methods that are easily reversible (such as pills or condoms), or with methods that are easily obtained and/or used only at the time of sexual intercourse (such as condoms).
- In many places there is a shortage of "youth-friendly" centers where young people can obtain confidential health services.
- The provider can help adolescents understand that they will be sexual beings their whole lives; they do not have to try, understand, or perfect everything now.
- Young people need to have life skills like saying "NO" to sex, negotiating for safer sex, and resisting peer pressure. The counselor can help adolescents who are not ready for sex learn how to refuse. Practicing conversations (i.e., role-playing with the client) can be an effective way to do this. Abstinence protects them from unintended pregnancy and HIV/STIs.
- If adolescents are sexually active, they need the full range of FP information and services. Counselors can discuss the possibility of secondary abstinence/postponing sexual activity with them.
- The counselor should ask the client about his/her marital and relationship status, and any plans for marriage. The counselor should present realistic views of relationships, marriage, and parenthood. A mutually-faithful sexual relationship with an uninfected partner and other means of risk reduction should be discussed and encouraged.

Unit 3:
FP Options in FP/HIV Integration

Section 3.2.1: Contraceptive Methods

- Male and female condoms
- Oral contraceptive pills (OCPs), including combined oral contraceptives (COCs) and progestin-only pills (POPs)
- Injectable contraceptives
- Implants (Jadelle, Implanon)
- Intrauterine contraceptive devices (IUDs)
- Permanent methods (tubal ligation and vasectomy)
- Emergency contraceptive pills (ECPs)
- Natural and fertility-awareness methods

Section 3.2.2: Essential Elements of FP Client Education

FP client education should include the following elements:

- How the method works,
- Method effectiveness,
- Advantages and disadvantages of the method,
- Side effects and complications of the method, and
- How to use the method correctly.

Section 3.3.1: Safer Pregnancy Counseling for HIV-Positive Clients

Following the initial FP/HIV integration screening for FP need, the provider will know if the client desires a pregnancy. If the client is HIV-positive and desires a pregnancy, the provider should first counsel the client on the risks of mother-to-child transmission of HIV. It is valuable to discuss fertility intentions with HIV-positive women and men. HIV-positive men seen in HCT or ART settings need to know about the risk of mother-to-child transmission and recommendations to reduce this risk, including partner disclosure.

HIV-positive clients desiring a pregnancy need to consider:

- HIV and STI transmission to their partner (HIV-positive clients can transmit HIV to uninfected partners, and can acquire STIs or new strains of HIV that make their disease advance more quickly.)
- HIV transmission to their baby (In the absence of medical intervention the risk of HIV transmission from mother-to-child is about 35%. This means that about 1 of every 3 of HIV-positive women pass virus to their baby without medicine. With medical intervention—ART for the mother during pregnancy or ARVs for prevention—transmission can be lower than 5%.)
- Client health status (HIV positive clients with active symptoms may consider starting ART to lower viral load and improve health before getting pregnant.)

If the client expresses the desire to have a pregnancy knowing the risks of transmission, the provider should then present recommendations for safer pregnancy:

HIV-positive clients desiring a pregnancy should:

- Reduce the risk of HIV transmission to their partner by:
  - Ensuring both partners have been tested for HIV and have disclosed their status to each other;
  - Getting appropriate care and treatment; and
  - Avoiding sex without a condom except during fertile days of the woman's menstrual cycle (for a woman with a 28 day cycle the most fertile day is the 13th day of her cycle).
- Reduce the risk of mother-to-child transmission by:
  - Making sure the HIV-positive woman's viral load is not high and CD4 count is not low (CD4 count more than 350 recommended); and
  - Having the HIV-positive pregnant woman attend regular ANC and PMTCT visits, especially to make sure she takes ARVs for PMTCT and she gets counseling about exclusive breastfeeding and alternative feeding.
- Reduce the risk of birth defects in the baby by:
  - Making sure an HIV-infected woman desiring a pregnancy is not taking EFV/Efavirenz (commonly used in some ART regimens).

Remember: Providers counseling HIV-positive clients should support clients who desire a pregnancy. We know that HIV-positive clients may desire a pregnancy, especially those women and couples who

are young, have no or few children, and have access to ART. We also know that pregnancy does not accelerate progression of HIV, ART improves health and longevity of adults and is becoming widely available, and that PMTCT drugs are more effective (including new recommendations about ART initiation during pregnancy). Finally, in some places artificial insemination may be available to help discordant couples reduce or eliminate the risk of transmission (though this may be costly).

(CDC, 2009)

(WHO, 2009)

Section 3.4.1: Dual Protection and Dual Method Use

Dual Protection

Dual protection is the use of condoms to protect against HIV/STIs and pregnancy. If used consistently and correctly, condoms are very effective at preventing HIV/STI transmission and pregnancy.

Dual Method Use

Dual method use means using condoms to protect against HIV/STIs and unintended pregnancy, as well as a second contraceptive method for better protection from unintended pregnancy. Dual method use is preferable for couples who do not desire a pregnancy because using a condom together with a second contraceptive method improves prevention of unintended pregnancy.

Dual method use reduces:

- Risk of unintended pregnancy,
- Transmission of HIV between partners, and
- Risk of acquiring or transmitting other STIs.

Dual method use is particularly important for:

- Sexually active adolescents,
- Men who put themselves and their partners at risk because of their sexual behavior,
- Sex workers,
- Women or men who are at risk because of the high-risk sexual behaviors of their partners,
- Individuals or partners of those who have an STI and/or HIV, and
- Sexually active people in settings where the prevalence of STIs and/or HIV is high.

Section 3.5.1: Characteristics of Male and Female Condoms

Male and Female Condoms

Condoms are the only method of contraception that also provides protection from STIs, including HIV.

A. Male Condom

It is a thin sheath usually made of rubber (latex) that is placed on an erect penis before sexual intercourse.

Important: *Oil-based lubricants should* ***not*** *be used with male latex condoms, because they will cause the condom to break. Clients* ***should not use*** *any of the following as lubricants: oils (like cooking or baby oil), petroleum jelly, lotions/creams, or butter/margarine. It is* ***safe to use*** *water, silicone-, or glycerin-based lubricants, or saliva.*

B. Female Condom

The female condom is a thin, soft, loose-fitting plastic (polyurethane) pouch that lines the vagina. It has two flexible rings:

- An inner ring at the closed end, used to insert the device inside the vagina and to hold the condom in place; and
- An outer ring which remains outside the vagina and covers the external genitalia.

Important: *The device is made from polyurethane. The female condom can be used with any type of lubricant (water- or oil-based) without causing the condom to break.*

How Condoms Work/Mechanism of Action

- Prevents sperm from entering the female reproductive tract, and
- Prevents transmission of STIs/HIV from one sexual partner to another.

Condom Effectiveness

Failure rate in a year (male condom):

- 15% typical use (reflects the common human errors or omissions of typical condom users)
- 2% perfect use (reflects using condoms consistently and correctly every time)

Failure rate in a year (female condom):

- 21% typical use
- 5% perfect use

Condom Characteristics

- Safe
- Prevent both pregnancy and STIs/HIV (when used consistently and correctly)
- Not as effective for pregnancy prevention as other methods in typical use
- Easy to initiate and discontinue
- Require motivation to use consistently and correctly
- Require partner's cooperation
- Must use a new condom each time you have sex. They cannot be reused.
- Does not affect fertility
- Have virtually no side effects
- May interrupt sexual activity or reduce sexual pleasure/sensation
- Require proper storage and resupply (i.e., Clients must have a sufficient, safe supply of condoms on hand before they need them.)

Additional Characteristics of the Female Condom

- Female-controlled
- May be more comfortable to men, less decrease in sensation than with the male latex condom
- Provides additional protection to external genitalia
- **Does not interfere with intercourse** (It may be inserted up to 8 hours before sex, however, most women insert it between 2 hrs – 20 minutes before sex.)

Note: *Female and male condoms should NOT be used at the same time. When both types of condoms are used together, it increases friction and can cause both condoms to break.*

Possible Side Effects of Condoms

- In rare cases, allergic reactions to latex (in male condoms) can occur.
- There are no known side effects with the female condom.

Section 3.6.1: Steps in Initiating Clients on Condoms

- Condoms are only effective if they are used properly every time you have sexual intercourse.
- When properly used, a condom can provide protection against transmission of HIV and other STIs, as well as pregnancy. It is important that PLHIV, caregivers, and everyone in the community, young and old, know how to use condoms properly.

Section 3.6.2: Steps to Correctly Use Male and Female Condoms

Male Condom Use

Use a penis model (or a banana or soda bottle) to demonstrate. Provide all the necessary information while you demonstrate how to put it on and remove it safely.

- **Be sure you have a condom before you need it!**
- Always use latex condoms because others don't protect completely against HIV. (Latex male condoms are the most common, but other condoms made from animal skin may be available and do not protect from HIV/STIs.)
- Look at the condom packet to make sure that it has not expired or that it hasn't been damaged (sticky or there are air pockets in the package).
- Roll the packet between your fingers. If it sounds crinkly, it is too dried out for safe use.
- Open the condom packet carefully along one side (to avoid tearing the condom) and take the condom out. Do not use your teeth or a sharp object to tear open the packet.
- Put on a condom only when the penis is erect.
- Hold the condom so that the nipple is facing up and the rolled part is on the outside, so it can be rolled down easily.
- Place the condom on the tip of an erect penis.
- Unroll the condom all the way to the bottom of the penis.
- Immediately after sex, the man or woman must hold on to the rim of the condom while the man carefully removes the penis without spilling the semen. The penis must be removed while still erect to ensure that the condom does not slip off.
- Remove the condom away from your partner.
- Tie the used condom in a knot to avoid spilling the semen and dispose in a latrine (not in a flush toilet because it may clog), or burn or bury it.

Remember:

- Put a new and unused condom on the penis for every act of sexual intercourse.
- If the condom tears at any time during sex, withdraw the penis immediately and put on a new condom.
- You do not need to use more than one condom at a time.

Tips to Help Prevent Male Condoms from Breaking or Leaking

- *Lubricants:* Most condoms come pre-lubricated. If additional lubricant is needed, use a water-based one (like glycerin). You can also use spit (saliva) for lubrication. Lubricants made with oil, like petroleum jelly (Vaseline), can cause condoms to break more easily. Tell people to never use petroleum jelly with a condom.

- *Storage:* Store condoms in a cool, dark, dry place, if possible. Heat, light, and humidity can damage condoms. It's not good to store a condom in your wallet.
- If you have a choice, choose a pre-lubricated condom that comes in a square wrapper and is packaged so that light does not reach it.
- Do not use condoms that are sticky, brittle, discolored, or damaged in any way. Throw them away.
- Keep condoms out of direct sunlight.

Female Condom Use

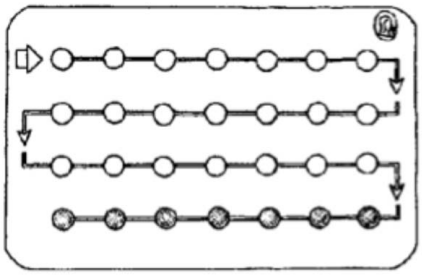
Some women like the female condom because they do not have to rely on their partner to use a condom. But, in some cases, female condoms may need to be negotiated with a partner because they are visible and make noise.

- The female condom covers the whole inside of the vagina and the outer lips of the vulva. It can be put in up to 8 hours before sex.
- It should be used only once, but if there are no other condoms available, it can be washed thoroughly with soap and water and reused. Make sure to wash off all the old lubricant on the outside of the condom, then turn the condom inside out and wash the other side. Let both sides dry completely. Because soap and water does not always get rid of all of the virus, one should only reuse a condom (with new lubrication) when there is no other option.
- It should not be used with a male condom because then both are more likely to tear with the friction.
- Carefully open the packet.
- Find the inner ring at the end of the condom.
- Squeeze the inner ring between the thumb and middle finger.
- Guide the inner ring all the way into the vagina with your fingers. The outer ring stays outside the vagina and covers the lips.
- When you have sex, carefully guide the penis through the inner ring. If it is outside the ring, it will not protect you from pregnancy or STIs.
- Immediately after sex, before the woman stands up, squeeze and twist the outer ring to keep the semen inside the pouch, and put the pouch out gently. Don't flush it down the toilet. Only burn, bury or put it in a latrine.

Who Should Not Use Condoms

Please refer to the WHO Medical Eligibility Criteria found in *FP: A Global Handbook for Providers*.

Section 3.7.1: Combined Oral Contraceptive Pills



Combined Oral Contraceptives (COCs)

- COCs are the most commonly used type of hormonal contraceptive.
- COCs contain both estrogen and progestin.
- COCs are safe, effective, reversible, and are one of the most extensively studied medications ever used by human beings. Serious side effects are very rare.
- Most women use COCs successfully, when properly counseled regarding how to use them and potential side effects.
- COCs are not recommended for breastfeeding women because they can reduce milk production.
- The non-contraceptive benefits of COCs are significant.
- COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teenage years and into their forties.
- The low-dose combined estrogen-progestin COCs (defined as containing 50 micrograms of estrogen or less and substantially lower progestin, ranging from 0.05 mg to 2.0 mg) are one of the most popular reversible contraceptives developed to date and are highly effective and safe for healthy, nonsmoking women.
- There are 2 types of pill packets; some packets have 28 pills. These contain 21 "active" pills that contain hormones, followed by 7 "reminder" pills of a different color that do not contain hormones. Other packets have only the 21 "active" pills. Women who use 21-pill packs should take a 7-day break after they finish one pack and before they start another.

How COCs Work/Mechanism of Action

- Stops ovulation (the release of an egg from the ovary)
- Thickens cervical mucus

COCs' Effectiveness

- *Effective as commonly used:* failure rate of 8 pregnancies per 100 women in first year of use (1 in every 12).
- *Very effective when used correctly and consistently:* failure rate of 0.1 pregnancies per 100 women in the first year with perfect use.

- Pills must be taken every day to be effective. Many women may not take the pills correctly and risk becoming pregnant.
- The most common mistakes are starting new packets late and running out of pills.
- Two generalizations concerning effectiveness of COCs:
  1. Failure rates decline as duration of use increases (so the longer a client uses COCs, the more effective the method is).
  2. Failure rates decline as age of user increases (so the older a client is, the more effective the method is).
- Non-nucleoside reverse transcriptase inhibitors (NNRTIs) in some second-line ARV therapies (Nevirapine, Efavirenz, Delavirdine, and Etravirine) may reduce the effectiveness of COCs somewhat—clients must be counseled to practice dual protection and make sure to take pills correctly.
- Ritonavir and Ritonavir-boosted protease inhibitors are contraindicated (should not be used) with COCs because Ritonavir reduces COC effectiveness significantly.
- Rifampicin and certain anti-convulsants are also contraindicated with COCs because they reduce COC effectiveness significantly.

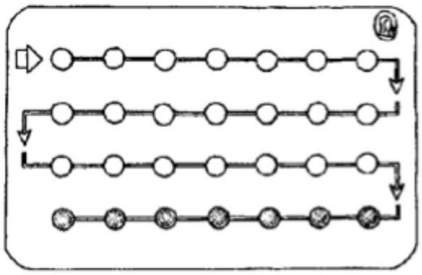
COCs' Characteristics

- Safe and very effective if used consistently and correctly
- Reversible, rapid return to fertility
- Does not interfere with intercourse
- Easy to discontinue use
- Have beneficial non-contraceptive effects:
  - Regular menstrual cycles
  - Lighter menses
  - Fewer menstrual cramps
  - Protection from ovarian and endometrial cancer
  - Protection from ectopic pregnancy, ovarian cysts, and symptomatic pelvic inflammatory disease
  - Protection from anemia and benign breast disease
- Require daily use
- Incorrect use is common (it is easy to miss taking a pill)
- Requires client to have enough stock on hand to last as long as she needs; she may have to return to a clinic for resupply
- No protection against STIs, including HIV
- Have common side effects (serious complications are very rare)

Possible Side Effects of COCs (generally not signs of a serious health problem)

- *Non-menstrual:* headaches, dizziness, nausea, acne, breast tenderness, mood changes, weight gain
- *Menstrual:* breakthrough bleeding or spotting, sometimes amenorrhea

Section 3.7.2: Progestin-Only Pills



Progestin-Only Pills (POPs)

- Commonly called the "mini-pill"
- Contains only one hormone (progestin)
- Taken continuously (no hormone-free interval)
- Progestin-only pills (POPs) contain a very small amount of only one kind of hormone, progestin. POPs contain one-half to one-tenth as much progestin as COCs. They do not contain estrogen.
- POPs are the best oral contraceptive for breastfeeding women. They do not seem to reduce milk production.
- If POPs are used by a woman who is not breastfeeding, she is likely to experience changes in vaginal bleeding, especially irregular periods and bleeding between periods.
- The success of a program offering POPs depends on counseling women in advance about possible menstrual changes.
- POPs are a good choice for breastfeeding women, are very effective during breastfeeding, and do not reduce a mother's milk supply or quality since they do not contain estrogen.
- POPs must be taken at approximately the same time every day (plus or minus 3 hours).

How POPs Work/Mechanism of Action

- Inhibits ovulation in about half of menstrual cycles.
- Causes thickening of the cervical mucus, making it difficult for sperm to pass through.

POPs' Effectiveness

- *For all women:* POPs are very effective **with perfect use**: 0.5 pregnancies per 100 women in the first year of use (1 in every 200). (Not quite as effective as COCs used correctly and consistently.)
- *For breastfeeding women:* POPS are very effective **as commonly used**: 1 pregnancy per 100 women in first year of use. (More effective than COCs as commonly used by breastfeeding women because breastfeeding itself provides protection against pregnancy.) *For non-breastfeeding women:* POPs are less effective **as commonly used** (as many as 9-12 pregnancies per 100 women in first year of use). (This is theoretical since conclusive data is not available.)

- NNRTIs in some second-line ARV therapies (Nevirapine, Efavirenz, Delavirdine, and Etravirine) may reduce the effectiveness of POPs—clients must be counseled to practice dual method use.
- Ritonavir and Ritonavir-boosted protease inhibitors are contraindicated (should not be used) with POPs because Ritonavir reduces POP effectiveness significantly.
- Rifampicin and certain anti-convulsants are also contraindicated with POPs because they reduce POP effectiveness significantly.

POPs' Characteristics

- Do not affect the quantity or quality of breast milk
- Reduce the amount of blood loss during menstrual periods
- Do not have estrogen-related side effects and complications, such as blood clots
- Very effective when taken as an emergency contraceptive
- Do not protect against STIs, including HIV
- Must be taken at approximately the same time every day (plus or minus 3 hours). Forgetfulness increases failure rate.

Important: Every pill contains hormones, and must be taken daily without interruption to be effective, because the small amount of progestin in them is used rapidly in the body. Little or none of it remains in the body after 24 hours.

Possible Side Effects of POPs (generally not signs of a health problem)

- *Non-menstrual:* nausea, dizziness, breast tenderness, headaches, mood changes (less common/ intense than COC effects), abdominal pain
- *Menstrual bleeding:* increase in breakthrough bleeding and frequency of prolonged bleeding or spotting, irregular cycles, amenorrhea

Section 3.8.1: Medical Eligibility Checklists for COCs and POPs

Steps in Initiating Clients on COCs

All clients should be screened using the COC medical eligibility screening checklist (below). An additional health assessment (e.g., laboratory tests, pelvic exam, etc.) is not required unless pregnancy status is in doubt, but could be offered as part of routine reproductive health services if medically indicated for other reasons and desired by the client.

Medical Eligibility Screening Checklist for COCs

If the client answers yes to any of the below questions 1-11 go immediately to the note after question 17.

1. Are you currently breastfeeding a baby less than 6 months old?
2. Have you given birth in the last 3 weeks?
3. Do you smoke cigarettes AND are you over 35 years of age?
4. Do you have repeated severe headaches, often on one side, and/or pulsating, causing nausea, and which are made worse by noise, light, or movement?
5. Have you ever been told you have breast cancer?
6. Have you ever had a stroke, or a blood clot in your legs or lungs, or a heart attack?
7. Do you regularly take any pills for tuberculosis (TB), seizures (fits), or ritonavir for ARV therapy?
8. Do you have gall bladder disease or serious liver disease or jaundice (yellow skin or eyes)?
9. Have you ever been told you have high blood pressure?
10. Have you ever been told you have diabetes (high sugar in the blood)?
11. Have you ever been told you have rheumatic disease, such as lupus?

If the client answered no to all the above questions she can use COCs. Proceed with the following questions to determine if she is not pregnant:

12. Did your last menstrual period start within the last 7 days?
13. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?
14. Have you abstained from sexual intercourse since your last period or delivery?
15. Have you had a baby in the last 4 weeks?
16. Have you had a miscarriage or abortion in the last 7 days?
17. Have you been using reliable contraception consistently and correctly?

If the client answered no to all of the questions 12-17 pregnancy cannot be ruled out—give her COCs but instruct her to start using them any time during the first 5 days of her next menstrual period and give her condoms to use in the meantime. If the client answers yes to any of the questions 12-17 and she is free of signs and symptoms of pregnancy, she can start COCs now. If her last menstrual period started within the past 5 days, she can start COCs now—no additional contraceptive protection is needed. If her last menstrual period began more than 5 days ago, tell her

to begin taking COCs now, and instruct her that she must abstain from sex or use condoms for the next 7 days. Give her condoms to use.

Note: *If the client answered yes to any of the first 1-7 questions, she is not a good candidate for COCs. Counsel about other available methods or refer. If she answered yes to any questions 8-11 COCs cannot be initiated without further evaluation. Evaluate or refer as appropriate and give condoms to use in the meantime.*
(FHI 2008)

Who Should Not Use COCs

All conditions which could make COCs unsafe are covered in the screening checklist. For a complete list of WHO Medical Eligibility Criteria, including who can use COCs, refer to *FP: A Global Handbook for Providers.*

Steps in Initiating Clients on POPs

All clients should be screened using the POP medical eligibility screening checklist (below). An additional health assessment (e.g., laboratory tests, pelvic exam, etc.) is not required unless pregnancy status is in doubt, but could be offered as part of routine reproductive health services if medically indicated for other reasons and desired by the client.

Medical Eligibility Checklist for POPs

If the client answers yes to any of the below questions 1-5 go immediately to the note after question 11.

1. Are you currently breastfeeding a baby less than 6 weeks old?
2. Have you ever been told you have breast cancer?
3. Have you ever had a stroke, or a blood clot in your legs or lungs, or a heart attack?
4. Do you regularly take any pills for tuberculosis (TB), seizures (fits), or ritonavir for ARV therapy?
5. Do you have serious liver disease or jaundice (yellow skin or eyes)?

If the client answered no to all the above questions she can use POPs, proceed with the following questions to determine if she is not pregnant:

6. Did your last menstrual period start within the last 7 days?
7. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?
8. Have you abstained from sexual intercourse since your last period or delivery?
9. Have you had a baby in the last 4 weeks?
10. Have you had a miscarriage or abortion in the last 7 days?
11. Have you been using reliable contraception consistently and correctly?

If the client answered no to all of the questions 6-11 pregnancy cannot be ruled out—give her POPs but instruct her to start using them any time during the first 5 days of her next menstrual period and give her condoms to use in the meantime.

If the client answers yes to any of the questions 6-11 and she is free of signs and symptoms of pregnancy, she can start POPs now. If her last menstrual period started within the past 5 days, she can start POPs now—no additional contraceptive protection is needed. If her last menstrual period began more than 5 days ago, tell her to begin taking POPs now, and instruct her that she must abstain from sex or use condoms for the next 2 days. Give her condoms to use.

Note: *If the client answered yes to any of the first 1-5 questions, she is not a good candidate for POPs. Counsel about other available methods or refer and give condoms to use in the meantime.*

Who Should Not Use POPs

All conditions which could make POPs unsafe are covered in the screening checklist. For a complete list of WHO Medical Eligibility Criteria, including who can use POPs, refer to *FP: A Global Handbook for Providers.*

Section 3.9.1: Progestin-Only Injectables

Progestin-Only Injectables (POIs)

- Contain no estrogen

The most commonly available preparation is *Depot Medroxyprogesterone Acetate* **(DMPA)**; each 1 ml dose contains 150 mg of DMPA and is given **every 3 months**.

In some countries *norethisterone enanthate* **(NET-EN)** is also very common; each dose contains 200 mg of NET-EN and is given **every 2 months**.

How POIs Work/Mechanism of Action

- Prevents ovulation
- Thickens cervical mucus (making it difficult for sperm to penetrate)

POIs' Effectiveness

- Very effective
- Failure rate:
  - 3% typical use (in one year, when some clients are late for their next injection or skip the next injection)
  - less than 1% perfect use
- Effectiveness is diminished when clients are late for injections, or miss injections.
- NNRTIs in some second-line ARV therapies (Nevirapine, Efavirenz, Delavirdine, and Etravirine) may reduce the effectiveness of NET-EN—clients must be counseled to practice dual method use and return on time for injections.

Characteristics of POIs

- Highly effective
- Easy to use
- Reversible, with some delay in return to fertility (i.e., pregnancy occurs on average four months later than other modern methods with DMPA and one month later with NET-EN)
- Have no affect on quality or quantity of breast milk

- Have beneficial non-contraceptive effects, including:
  - Protection from endometrial cancer, uterine fibroids, and ectopic pregnancy
  - May reduce sickle crises in women with sickle cell anemia
  - May protect from iron-deficiency anemia and symptomatic pelvic inflammatory disease
- Have common side effects
- Provide no protection from STIs, including HIV

Possible Side Effects of POIs (generally not signs of a health problem)

- Irregular menstrual bleeding or spotting, or heavy bleeding (more common during the first few months of use, less common with NET-EN than DMPA)
- Amenorrhea (common, especially after the first year of use, especially with DMPA)
- Weight gain
- Headaches, nausea, and breast tenderness (less common than with COCs)

Section 3.9.2: Medical Eligibility Checklist for POIs

Steps in Initiating Clients on POIs

All clients should be screened using the POI medical eligibility screening checklist (below). An additional health assessment (e.g., laboratory tests, pelvic exam, etc.) is not required unless pregnancy status is in doubt, but could be offered as part of routine reproductive health services if medically indicated for other reasons and desired by the client.

Medical Eligibility Checklist for POIs

If the client answers yes to any of the below questions go immediately to the note after questions.

1. Are you currently breastfeeding a baby less than 6 weeks old?
2. Have you ever been told you have breast cancer?
3. Have you ever been told you have high blood pressure?
4. Have you had diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes?
5. Have you ever had a stroke, or a blood clot in your legs or lungs, or a heart attack?
6. Do you have vaginal bleeding that is unusual for you?
7. Do you have serious liver disease or jaundice (yellow skin or eyes)?
8. Have you ever been told you have rheumatic disease, like lupus?

If the client answered no to all the above questions she can use POIs. Proceed with the following questions to determine if she is not pregnant:

9. Did your last menstrual period start within the last 7 days?
10. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?
11. Have you abstained from sexual intercourse since your last period or delivery?
12. Have you had a baby in the last 4 weeks?
13. Have you had a miscarriage or abortion in the last 7 days?
14. Have you been using reliable contraception consistently and correctly?

If the client answered no to all of the questions 9-14 pregnancy cannot be ruled out—she must take a pregnancy test or wait until her next menstrual period to get POIs. Instruct her to return with her negative test results or at the beginning of her next menstrual period, and give her condoms to use in the meantime. If the client answers yes to any of the questions 9-14 and she is free of signs and symptoms of pregnancy, she can start POIs now. If her last menstrual period started within the past 7 days, she can start POIs now—no additional contraceptive protection is needed. If her last menstrual period began more than 7 days ago, tell her to begin taking POPs now, and instruct her that she must abstain from sex or use condoms for the next 7 days. Give her condoms to use.

Note: *If the client answered yes to any of the first 1-8 questions, she is not a good candidate for POIs. If she answered yes to question 1, instruct her to return for POIs as soon as possible after the baby is 6 weeks old. Counsel about other available methods or refer and give condoms to use in the meantime.*

(FHI 2007)

Administering Injectables

If the client is medically eligible and opts for injectables, the provider should give her a deep intramuscular injection into the upper arm or buttock, following instructions on the package insert (do not rub afterwards). Be sure to follow standard infection prevention procedures and tell the client to return in 3 months for DMPA (2 months for NET-EN) for her next injection, or before if she has questions or concerns. Tell patient that she is at risk for becoming pregnant if she is late more than 4 weeks for DMPA (or 2 weeks for NET-EN) in getting her injection. Up to this time, she can have the injection as usual. If she is late more than this time, she can have her next injection if she is reasonably certain she is not pregnant.

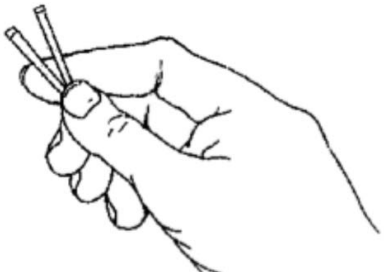
Who Should Not Use POIs

All conditions which could make POIs unsafe are covered in the screening checklist. For a complete list of WHO Medical Eligibility Criteria, including who can use POIs, refer to *FP: A Global Handbook for Providers.*

Section 3.10.1: Implants

Implants

Contraceptive implants consist of progestin-filled rods that are inserted under the skin in a woman's upper arm.



Types of Contraceptive Implants:

A. Jadelle

Jadelle consists of two thin, flexible rods made of silicone tubing and filled with levonorgestrel, a synthetic progestin. *Jadelle* is effective for up to 5 years. Each *Jadelle* rod is 43 mm long and 2.5 mm in diameter. Each rod contains 75 mg of levonorgestrel.

B. Implanon

Implanon consists of a single rod which releases etonogestrel. *Implanon* is effective for up to 3 years. It is 40 mm in length and 2 mm in diameter, and contains 68 mg etonogestrel.

How it Works/Mechanism of Action

- Partially prevents ovulation (in about half of menstrual cycles)
- Thickens cervical mucus (making it difficult for sperm enter the woman's womb and unite with an egg)

Effectiveness

- Failure rate: less than 1% (in one year)
- After the first year of implant use, the risk of pregnancy increases slightly for all implants.
- For *Jadelle*, the effectiveness diminishes for heavier women (who weigh over 70 kg). These women may need to get new implants more quickly than smaller women.

Section 3.10.2: Characteristics of Implants

- Highly effective
- Easy to use
- Long-term pregnancy protection, but easily reversible
- Do not interfere with intercourse, private
- Have no affect on quality or quantity of breast milk
- Have beneficial non-contraceptive effects, including protection from symptomatic pelvic inflammatory disease and iron-deficiency anemia
- In rare cases when the implant fails, there is a high chance (1 in 6) that the resulting pregnancy will be ectopic (when a fertilized egg implants outside of the womb; this can be dangerous)
- Insertion involves a minor surgical procedure and some discomfort for a day or two
- Trained provider needed to initiate and discontinue use (i.e., to insert the implant, and to remove the implant in 3-5 years)
- Provide no protection from STIs, including HIV

Possible Side Effects of Contraceptive Implants (generally not signs of a health problem)

- Light spotting or bleeding between monthly periods for the first several months
- Amenorrhea (common, but normal and not a sign of a problem)
- Prolonged bleeding (less common)
- Weight gain
- Headaches, nausea, and breast tenderness (less common than with COCs)

Who Should Not Use Implants

Please refer to the WHO Medical Eligibility Criteria found in *FP: A Global Handbook for Providers.*

Section 3.11.1: Characteristics of IUDs

Intrauterine Contraceptive Devices

Intrauterine Contraceptive Devices (IUDs) are small flexible devices made of metal and/or plastic. The most commonly available IUD is the Copper T (TCu 380A), which lasts up to 12 years.

How it Works/Mechanism of Action

Copper T (TCu 380A):

- Prevents sperm from uniting with egg by causing chemical changes that affect both sperm and egg, damaging them before they can unite.
- Inhibits sperm migration in the upper female genital tract.
- Affects ovum transport.

Effectiveness

- Failure rate: less than 1% in both typical and perfect use (in one year)

Characteristics of IUDs

- Highly effective
- No constant supplies needed
- Easy to use
- Does not interfere with intercourse
- Rapid return to fertility
- Trained provider needed to initiate and discontinue use (A health provider must insert the IUD, and remove it again no more than 12 years later.)
- Minor pain or discomfort during the insertion and removal procedures
- Major complications are rare, but may include pelvic inflammatory disease or uterine perforation
- No protection against STIs, including HIV
- May help protect from endometrial cancer (cancer of the lining of the womb)

Possible Side Effects of IUDs (generally not signs of a health problem)

- **During insertion:** some pain and cramping
- **During first few days of use:** mild cramping and spotting
- **During first few months of use:** heavier menstrual bleeding, mild cramping during menstruation, and bleeding
- ***Important:*** The client should be informed about the following early warning signs, and to consult their health provider as soon as possible if they experience any of these:
  - Late period (pregnancy), abnormal spotting, or bleeding
  - Abdominal pain or pain with intercourse
  - Abnormal vaginal discharge
  - Fever or chills
  - String missing, or string is shorter or longer

Who Should Not Use IUDs

Please refer to the WHO Medical Eligibility Criteria found in *FP: A Global Handbook for Providers.*

Section 3.12.1: Voluntary Surgical Contraception

Permanent Contraceptive Methods

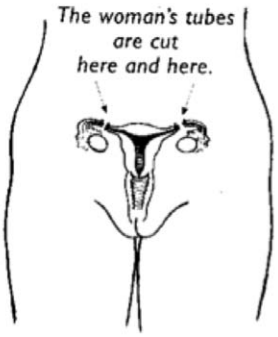
Voluntary surgical contraception (VSC) offers life-long protection against unintended pregnancy in a single procedure that can be provided at any healthcare facility with basic surgical capacity. VSC can be done for both males and females. The client should understand that this is a permanent method for pregnancy prevention, but it does not protect from HIV and STIs.

Female sterilization (tubal ligation) is a surgical procedure where the fallopian tubes, which carry eggs from the ovaries to the uterus, are blocked. (The tubes can be tied and cut, cauterized, or blocked/interrupted by a ring or clip).

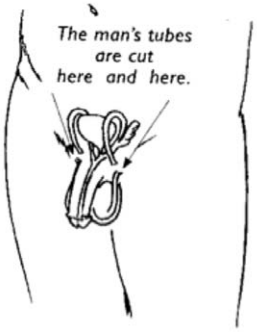
Male sterilization (vasectomy) is a minor surgical procedure that permanently ends fertility in men by making a small opening in the man's scrotum and closing off both tubes (the vas deferens) that carry sperm from his testicles.

How it Works/Mechanism of Action

Female sterilization: Blocks the fallopian tubes in order to prevent egg from uniting with sperm.



Male sterilization: Blocks the vas deferens (tubes). After sterilization, semen is ejaculated but it does not contain sperm, so it cannot unite with an egg.



Effectiveness

Tubal ligation:

- *Failure rate:* less than 1%

Vasectomy:

- *Failure rate:* 2-3% without medical examination of the semen 3 months post-surgery, less than 1% with medical examination of the semen 3 months post-surgery

Characteristics

- Highly effective
- Permanent
- Has no chemical or hormonal side effects
- Does not interfere with intercourse
- Easy to use
- Chance of regret
- Surgical procedure (with associated discomfort)
- No protection from STIs, including HIV
- Can be used by women and men of any age or reproductive parity, who are certain they do not want/must not have additional children.
- Female sterilization:
  - Has beneficial non-contraceptive effects (partial protection from ovarian cancer and pelvic inflammatory disease)
  - If the woman becomes pregnant because the operation is not successful, there is a higher chance of ectopic pregnancy
- Male sterilization:
  - Not effective in preventing pregnancy until approximately 3 months post-surgery (during this period a backup method is required)

Possible Side Effects of VSC (generally not signs of a health problem)

- Some pain and discomfort during and immediately after the surgical procedure
- Rare complications associated with the procedure itself

Who Should Delay VSC

Women who have the following conditions:

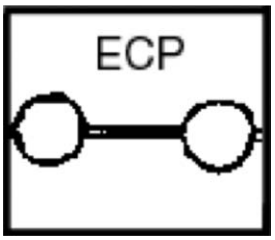
- Pregnancy
- Are between 7-42 days postpartum
- Postpartum or postabortion sepsis or severe hemorrhage
- Current deep vein thrombosis

- Current ischemic heart disease
- Gynecological cancer
- Current gonorrhea, Chlamydia, or pelvic inflammatory disease
- Current gallbladder disease or active viral hepatitis
- Acute respiratory disease

Men who have the following conditions:

- Local infection (scrotal skin infection, active STI, epididymitis, or orchitis)
- Systemic infection or gastroenteritis
- Intrascrotal mass

Section 3.13.1: Emergency Contraception



Emergency Contraceptive Pills (ECP) can be used by women to prevent an unintended pregnancy in the first few days after unprotected intercourse, or after a contraceptive accident (i.e., after a condom breaks, slips, or leaks). ECPs are effective when taken within 5 days (120 hours) after unprotected sexual intercourse. The sooner after unprotected intercourse they are taken, the more effective they are.

These pills are also called "morning-after" or "post-coital" pills.

Methods of Emergency Contraception:

The Levonorgestrel-Only Regimen

This is the method recommended by WHO, because of its efficacy and lower incidence of potential side effects.

It is much easier for the user and better compliance is obtained when the client can take a single dose of 1.5 mg levonorgestrel as soon as possible, but not later than 120 hours after unprotected sexual intercourse.

When pills containing 0.75 mg levonorgestrel are available (such as Postinor):

- 2 pills should be taken as soon as possible, but no later than 5 days (120 hours) after unprotected sexual intercourse. (OR, clients can take 0.75 mg levonorgestrel at once, followed by the same dose 12 hours later. Taking two pills at the same time is easier for the client to take and works just as well as 2 doses taken 12 hours apart.)

When pills containing 0.03 mg levonorgestrel (or 0.0375 mg levonorgestrel) are available:

- 50 pills should be taken as a single dose as soon as possible but no later than 5 days (120 hours) after unprotected sexual intercourse.

When pills containing 0.0375 mg levonorgestrel are available:

- 40 pills should be taken as a single dose as soon as possible but no later than 5 days (120 hours) after unprotected sexual intercourse.

When 0.075 mg norgestrel is available:

- 40 pills should be taken as a single dose as soon as possible but no later than 5 days (120 hours) after unprotected sexual intercourse.

Combined (Ethinyl Estradiol and Levonorgestrel) Regimen or Comparable Formulations (for instance, those containing norgestrel). This regimen is known as the "Yuzpe method" and has been studied and widely used since the mid 1970s.

When high dose pills containing 0.050 mg ethinyl estradiol and 0.25 mg levonorgestrel (or 0.50 mg norgestrel) are available:

- 2 pills should be taken as the first dose as soon as possible but no later than 5 days (120 hours) after unprotected intercourse. These should be followed by another 2 pills 12 hours later.

When high dose pills containing 0.02 mg ethinyl estradiol and 0.1 mg levonorgestrel are available:

- 5 pills should be taken as the first dose as soon as possible but no later than 5 days (120 hours) after unprotected intercourse. This should be followed by another 5 pills 12 hours later.

When only low dose pills containing 0.030 mg ethinyl estradiol and 0.15 mg levonorgestrel (or 0.30 mg norgestrel) are available:

- 4 pills should be taken as soon as possible but no later than 5 days (120 hours) after unprotected sexual intercourse. These should be followed by another 4 pills 12 hours later.

Effectiveness

- It is estimated that ECPs may decrease individual women's risk of pregnancy by as much as 75-95% after a single act of unprotected sexual intercourse.
- The progestin-only regimen is more effective than combined (Yuzpe).
- Effectiveness may vary, depending on how quickly a woman is able to access ECP after having sexual intercourse.

How ECPs work/Mechanism of Action

- Prevent or delay the release of eggs from the ovaries
- Do not work if a woman is already pregnant

Indications for the Use of ECPs

- When no contraceptive has been used
- In cases of rape/sexual assault
- When there is a contraceptive accident or misuse. Specifically:
  - Condom rupture, slippage, or misuse
  - IUD expulsion
  - Three OCPs missed consecutively
  - Late for DMPA injection by 4 weeks or more
  - Failure of a spermicidal tablet or film to melt before intercourse
  - Failed coitus interruptus (withdrawal)
  - Failure to abstain on a fertile day of the cycle in a woman who uses the calendar method

Possible Side Effects of ECPs (generally not signs of a health problem)

- Changes in menstrual bleeding including irregular bleeding within 1-2 days of taking ECP, or monthly menstruation that starts a few days earlier or later than expected
- In the week after taking ECPs, some women may experience nausea, vomiting, abdominal pain, tiredness/fatigue, headaches, breast tenderness, dizziness.

Characteristics of ECP

- Do not cause abortions (i.e., they will not affect an egg that has already implanted in the uterus)
- Will not cause birth defects if accidentally taken while already pregnant
- Do not protect against STIs, including HIV (i.e., if a woman has been exposed to STIs or HIV, taking EC will have no effect on transmission)
- Do not make women infertile
- Are a woman-controlled method
- Can be kept on hand (at home) in case they are needed. (a woman can obtain EC from a health provider before she needs it)
- Provide women with a second chance at preventing pregnancy

Section 3.14.1: Natural Family Planning

Natural FP methods include those that do not require medication, physical devices, or surgery to prevent pregnancy.

1. Abstinence

Abstinence is the practice of voluntarily refraining from some or all aspects of sexual activity. *(**Note:** with some natural or fertility awareness-based FP methods, clients may be advised to practice periodic abstinence, which means abstaining from sex for a specific time period.)*

How it Works/Mechanism of Action

When sexual intercourse does not occur, sperm cannot enter the female reproductive tract.

Effectiveness

- 0% failure rate (when practiced perfectly, meaning fully refraining from sexual intercourse)
- May be appropriate for young people at high risk for pregnancy and STIs, including HIV
- May be difficult to use for some couples, as it requires high motivation, self-control, and partner cooperation

2. Coitus Interruptus

Is the practice of deliberately interrupting sexual intercourse to withdraw the penis from the vagina prior to ejaculation. It is also known as the withdrawal method, or pulling out.

How it Works/Mechanism of Action

Prevents fertilization by preventing sperm from entering the female reproductive tract.

Effectiveness

- Failure rate: 4-18% typical use (in 1 year)
- Depends on willingness and ability of couple to use withdrawal with every act of intercourse
- May be difficult to use for some couples, as it requires high motivation, self-control, and partner cooperation

Characteristics

- Can be practiced and/or stopped anytime
- Promotes male involvement in FP
- No chemical or hormonal side effects
- No protection against STIs, including HIV
- Difficult to practice perfectly; some men may be unable to remove their penis before ejaculating
- There can be sperm in pre-ejaculate (Pre-ejaculate is clear, lubricating fluid that is issued from the penis during sexual arousal prior to ejaculating.)
- Efficacy may be improved by urinating and wiping the tip of the penis prior to sexual intercourse

3. Breastfeeding: Lactational Amenorrhea Method (LAM)

The lactational amenorrhea method relies on lactation-induced infertility to prevent pregnancy. It is a temporary method, and requires exclusive breastfeeding.

Three Primary Criteria to Use LAM

If any one of these 3 requirements is not present, the woman should begin another method of contraception:

- Woman must be **fully breastfeeding** on demand. (This means breastfeeding at least 8-10 times during the day and night, with no formula supplementing.)
- **Woman's menses have not yet returned.**
- Infant is **less than 6 months old.**

How it Works/Mechanism of Action

- Frequent breastfeeding suppresses the production of natural hormones required for eggs to be released from the ovaries.

Effectiveness

- Failure rate:
  - 2% typical practice
  - less than 1% perfect practice

Characteristics of LAM

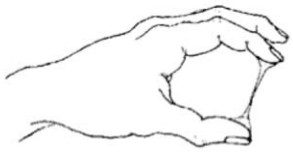
- LAM is a temporary method; it only lasts for 6 months postpartum, and only if a woman's menses have not returned.
- When a woman's menses have returned after pregnancy (even before 6 months expire), she can no longer use LAM for contraception.
- There are no known side effects of LAM.
- If a woman cannot fully breastfeed postpartum, the effectiveness of LAM is reduced and the woman should choose another method of contraception.
- Breastfeeding has health benefits for both mother and infant.
- For women who are HIV-positive, there is a risk of HIV transmission to the infant when breastfeeding, but it is significantly lower with exclusive breastfeeding.
- Does not protect against STIs, including HIV.

To make the best choice regarding LAM, HIV-positive women should:

- Receive counseling that includes information about both the risks and benefits of infant feeding options. Key messages include:
  - Exclusive breastfeeding is the best option and protects the baby from malnutrition and serious illnesses like diarrhea.
  - According to updated WHO guidelines, mothers known to be HIV-infected (and whose infants are HIV uninfected or of unknown HIV status) should exclusively breastfeed their infants for the first 6 months of life, introducing appropriate complementary foods thereafter, and continue breastfeeding for the first 12 months of life. Breastfeeding should then only stop once a nutritionally adequate and safe diet without breast milk can be provided.
  - Mixed feeding (giving breastmilk with any other drink or food) should be avoided as it increases risk of HIV transmission compared to exclusive breastfeeding.
- Receive guidance in selecting the most suitable option for their situation.
- Have access to follow-up care and support, including other contraceptive methods and nutritional support.
- Be counseled on the risks and benefits associated with breastfeeding and alternative feeding. They should be encouraged to make their own decisions after carefully weighing the advantages and disadvantages of each method of infant feeding.
- Be fully supported in whatever decision she has made.

(WHO, 2009)

Section 3.14.2: Fertility-Awareness Methods



Fertility-awareness based methods (FABMs) are techniques used to identify the time of the cycle when the woman can get pregnant (fertile time), and then to abstain from sexual intercourse or use another method (such as a condom) during this time. One FABM, called the Standard Days Method, was developed through scientific analysis of the fertile time in the woman's menstrual cycle. It uses Cyclebeads to help the woman track her cycle days, know which days she is fertile, and monitor her cycle lengths. Standard Days Method is very accurate when used properly and Cyclebeads help women with daily monitoring of signs of fertility.

How it Works/Mechanism of Action

- By tracking the woman's menstrual cycle, the couple learns the days that she is likely to get pregnant.
- The couple should abstain from sex or use a backup contraceptive method (usually condoms) during the days that the woman is fertile.

Effectiveness

- Overall, FABMs can have a failure rate of as high as 25% per year in common use. Specific rates for perfect use vary depending on the particular method, but some are much lower (Standard Days Method failure rate is 5% per year).
- Couples who practice periodic abstinence generally have a lower failure rate than couples who use a backup method during the fertile period.

Characteristics

- No side-effects
- Better understanding of menstrual/fertility cycle
- Shared responsibility between both partners for contraception
- Requires cooperation and commitment from both partners
- Once the client has been trained, no clinic visits or service providers are needed
- Difficult to practice
- Lower effectiveness
- Cannot be used by breastfeeding women until their regular menstrual cycles return
- No cost
- Should not be used in women with irregular cycles
- Requires use of periodic abstinence or another form of contraception during fertile periods
- No protection from STIs, including HIV

Section 3.15.1: FP Considerations Specific to HIV-Positive Clients

FP/HIV Integration Provider Reference Tool: Family Planning Considerations Specific to HIV-Positive Clients is a useful tool to show key messages for FP/HIV integration counseling and to identify the interactions between contraceptives and safer pregnancy, and ARVs and common opportunistic infection treatment.

For key messages for FP/HIV integration counseling, the tool reminds us:

- Good counseling should promote individual choice about family planning and fertility, as well as HIV prevention to HIV-negative partners and infants.
- Dual method use is important for good protection from HIV/STIs and unintended pregnancy. Good counseling on correct and consistent condoms use is also important; remember, the contraceptive failure rate of condoms is 15% for typical use.

For interactions between FP choices and HIV-related treatments/conditions, it shows that most FP choices are appropriate for HIV-positive clients with no reservations.

It also shows that it is **generally possible** for:

- Clients on non-nucleoside reverse transcriptase inhibitors (NNRTIs) (EFV and NVP) to use any hormonal methods, but COCs, POPs, and NET-EN users are advised to practice dual method use with condoms for better prevention of unintended pregnancy, and to practice perfect use of the method (e.g., taking pills at the same time every day, returning on time for injection).
- Clients who take anti-convulsants, Rifampicin, Ritonavir or Ritonavir-boosted protease inhibitors to use implants, but it is advisable to also use condoms to compensate for any possible reduction in contraceptive effectiveness.

Finally, it shows that it is **NOT recommended** for:

- HIV-positive clients desiring a safer pregnancy to use EFV, certain anticonvulsants, or oral antifungals. Also, clients desiring a safer pregnancy should not have Chlamydia and/or gonorrhea, or be in Stage 4 disease/AIDS.
- Clients on Ritonavir or Ritonavir-boosted protease inhibitors to use COCs or POPs.
- Clients with Chlamydia and/or gonorrhea, or Stage 4 disease/AIDS to initiate IUD use.
- Clients in Stage 4 disease/AIDS to undergo VSC, unless their health improves due to ART.

Note: *This training does not address spermicides or diaphragm because they are not commonly available. It is worth mentioning here, however, that women with HIV or at risk of HIV should not use spermicides (or diaphragm with spermicides) because they have been shown to increase the risk of HIV transmission when used often.*

Unit 4: Record Keeping and Making Referrals

Section 4.1.1: FP/HIV Recordkeeping

In order to keep track of FP services in HCT, PMTCT, and ART sites, it is useful to adapt client registers. Three columns are useful to collect FP counseling and service information:

1. Current FP Need—"Met," "Unmet," or "No need"

2. Method Provided—method name, also indicate new or continuing user

3. Referral—method name and facility location

Providers trained in FP/HIV integration should negotiate adaptations to register forms with local health management.

Section 4.2.1: Referrals

Types of Referral

As presented earlier, there are different levels of FP/HIV integration, from Level 1 (assessment of FP needs, provision of condoms/pills/EC, referral for other methods) to Level 4 (assessment of FP needs, provision of all methods, including permanent/surgical methods).

FP services can be co-located with HIV services, meaning that they are offered in the same physical location as HIV services. This can improve convenience, privacy, and confidentiality. Co-located services *may not require any referral*. Or, integrated services can be offered through different services within the same facility. For example, the HCT service probably will not offer long-acting methods, but the same facility may offer these methods in a different area. This service may require an *intra-facility referral*, meaning the client will have to see another provider in the same facility. Finally, some HIV service delivery sites may not be in a facility that offers all FP services, so some methods may require *inter-facility referral*, meaning the client will have to see another provider in another facility to get their method of choice. All sites should have *referral directories* that list which services are available—these should include intra- and inter-facility services, and should also indicate costs, distances, and contact persons, if possible.

Steps for Making a Referral

1. Identify what kind of referral the client requires (contraceptive method, contraceptive side effects, contraceptive complications, safe pregnancy).
2. Decide where the client can get the care needed (quality care that is as close as possible). Cost may also be a factor in deciding where to refer. It is important to know in advance which health centers offer the least expensive services, and to know if the client can pay for services.
3. Give the client a referral card (if available) that says what services they need and where they can get them.
4. If possible, go with the client to the referral site to ensure the client receives good care. Providers can talk with referral site providers about what care they have provided and what additional care is needed.
5. When possible, it is appropriate for providers to follow-up on referrals.

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