



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

**Training Facilitator'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

**Px:** Participants

**STI:** Sexually Transmitted Infection

**TB:** Tuberculosis

**VSC:** Voluntary Surgical Contraception

**WHO:** World Health Organization

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# Notes for Organizers and Trainers

## Background

Traditionally, family planning (FP) and HIV services have been offered separately. As more women of reproductive age become infected with HIV or are at risk of infection, the benefits of integrating these services have become very clear. Integration of FP and HIV services involves the provision of FP and HIV prevention and care services as part of a unified and coordinated strategy to address clients' risks of unintended pregnancies and HIV transmission and provide care and support during pregnancy and HIV-related illness.

Integrating FP with HIV services, such as HIV counseling and testing (HCT), prevention of mother-to-child transmission of HIV (PMTCT), and care and treatment—including antiretroviral therapy (ART)—provides an opportunity to affect many clients' sexual and reproductive health behavior and to meet their related sexual and reproductive health counseling and service needs. Contraception is a critical component in the continuum of HIV prevention, and AIDS care and support. The client-provider interaction in HIV services provides an opportunity to incorporate FP messages and contraceptive or safer pregnancy counseling, guided by the needs and readiness of the client. The prevention of unintended pregnancy and its role in PMTCT, as well as the benefits of healthy timing and spacing of pregnancy, can be discussed with both HIV-positive clients and their partners. When FP messages are provided as part of HIV services, counselors must address a range of options in accordance with principles of informed choice.

## Rationale

FP integration with HCT, PMTCT, and 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, unintended pregnancy, and fertility desires to help clients make fully informed sexual and reproductive health decisions, including about safer pregnancy for HIV-positive women. 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 correct and consistent condom use among sexually active clients, and addressing unmet need for FP among HIV positive women.

## Purpose

This training package is designed to train practicing HIV service providers in FP counseling and service provision for FP/HIV integration. At the end of this training, participants will be able to implement effective FP counseling and services for HCT, PMTCT, and ART clients. Specifically, participants will be able to:

- Explain the benefits of FP and the importance of integrating FP and HIV services;
- Describe characteristics of available contraceptive methods, including the value of dual method use;



- Explain contraceptive options for Persons Living with HIV (PLHIV);
- Present and explain key safer pregnancy messages for HIV-positive concordant or discordant couples desiring a pregnancy;
- Describe FP considerations specific to PLHIV, such as drug contraindications and the importance of dual method use;
- Recognize their personal values about FP and PLHIV decision-making about FP;
- Demonstrate principles and skills for counseling clients and couples on FP; and
- Present referral and record-keeping systems and standards for FP/HIV integration.

This training package is not intended to provide complete information on all FP methods. Further, this training does not include a facility practicum component, so it is appropriate that trainees be followed up by training organizers and supervisors to ensure accurate application of skills and knowledge.

For this information, the Training Content sections ask the participants to 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). Ideally, copies of this book should be given to all training participants for their use as a guide during their training and their practical application of FP/HIV integration. Also it is useful to note that the handbook is updated regularly and available in several languages (refer to WHO website and <http://info.k4health.org/globalhandbook/> for full text download).

## **Trainer and Participant Profiles**

This training package is intended to train practicing HIV service providers working directly and regularly in HCT, PMTCT, and/or ART. Ideally participants should be clinical staff based in public or private health facilities with at least three months experience providing HCT, PMTCT, and/or ART services. This can include HCT as provider-initiated counseling and testing (e.g., in in-patient services, PMTCT services in MCH) as per national policy and implementation guidelines. Each training should be organized to train 20-25 participants. Trainings with fewer than 20 participants do not allow for adequate small group work or group discussion exchanges. More than 25 participants become unwieldy for trainers to manage and these trainings do not allow for the application of participatory training methods. At least 2 trainers should lead the 3-day training. These trainers should commit to attending the complete training to ensure continuity. A trainer should be assigned to each unit. The trainers should have experience in interpersonal communication and counseling, stigma and discrimination reduction, and dynamic, interactive training methods.

## **Overview of the Units**

### **Unit 1: Family Planning Integration with HIV Services**

In addition to presenting the structure of the course and conducting a pre-test, this unit covers the rationale for and benefits of integrating FP and HIV services. It includes key messages for FP

counseling in HIV services, as well as specific benefits of FP integration in HCT, PMTCT, and ART facility services. Finally, this unit identifies challenges posed by integration and encourages discussion of how to address these challenges.

### **Unit 2: FP Counseling Principles and Skills**

This unit focuses on FP decision-making and the value of good counseling. It addresses childbearing decision-making rights of individuals, couples, and families, including PLHIV. The unit enables participants to clarify their values, beliefs, and attitudes toward HCT, PMTCT, and ART clients using contraception, and toward HIV-positive women desiring a safer pregnancy. This unit includes specific FP counseling guidance for addressing the needs of HIV-positive women, clients on ART, and men and adolescents.

### **Unit 3: FP Options in FP/HIV Integration**

This unit covers all available contraceptive methods, and their characteristics and common side effects. It provides important technical knowledge about contraceptive methods, preparing service providers to provide clients with the necessary information to choose a contraceptive method, as well as allow them to identify interactions between FP choices and antiretrovirals (ARVs) and common opportunistic infection treatments. In addition, this unit addresses safer pregnancy messages and considerations.

### **Unit 4: Record Keeping and Making Referrals**

This unit describes steps and presents guidance for keeping records and making referrals for FP/HIV integrated services.

## **Content Organization**

This training package has four parts: the Training Facilitator’s Guide, the Participant Handbook, PowerPoint Slides that summarize training content, and a job aid called *FP/HIV Integration Provider Reference Tool: Family Planning Considerations Specific to HIV-Positive Clients*.

The Training Facilitator’s Guide presents the information in two columns—the first column, called “Content,” contains the necessary technical information, and the second column, called “Methodology,” contains the training methodology (lecture, role-play, discussion, etc.) to be used and the time required to complete each activity. It includes key Trainer’s Tools (e.g., pre- and post-test forms). The Training Facilitator’s Guide includes PowerPoint slides with very limited key content to display during training sessions. While it is important that trainers prepare each Specific Objective’s methodology to appropriately convey technical content, PowerPoint slides will highlight key content and assist the flow of the training content. The Participant Handbook contains content from the Training Facilitator’s Guide that can be used as reference material by the participant.

## Where are We? and Reflections

At the opening and closing of each day of training, it is useful for the trainer to check in with participants. This helps the trainer to evaluate how participants are learning, and to explore any challenges or concerns that participants may be having. The trainer may want to ask a participant to volunteer to lead the morning re-cap each day.

- ➔ **Where are we?:** This exercise is intended to get participants to remember the highlights of the previous day of training. The exercise is not a review of the previous day, but is used to get the most out of each day's experiences. The participants conducting the review should use it as an opportunity to share insights, clarify issues, resolve problems, or review important material. Problems identified will be resolved before continuing with the day's work.
- ➔ **Reflections:** After a full day of activities, it is useful to take time to look over what has been accomplished and examine what it means to participants individually. This is a method to explore how the lessons participants have learned can be applied in a broader setting. It is also an opportunity for the trainers and participants to share feedback on the training activities and to identify areas that need reinforcement or further discussion. A reflections form is included as *Trainer's Tools VII* and should be completed by each participant anonymously each day.

## Course Evaluations

After the last unit of the training, it will be important for participants to complete the training evaluations. Evaluations give valuable information about the appropriateness and usefulness of the training content and methods. They will be useful in planning future trainings, so sufficient time and attention should be allowed for participants to complete evaluation forms and for trainers to review these forms and compile recommendations.

## Training Methodology

Different training techniques are used in the package to stimulate adult learning and provide participants with knowledge and skills about FP counseling and service provision. The training techniques include: trainer presentation (mini-lectures), group discussion, group work, role-plays, and brainstorming.

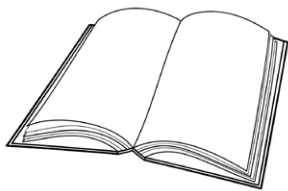
- ➔ **Presentations:** A presentation is used to convey new information, and also to review content that participants may be familiar with. This package includes a variety of participant materials for the participants to use to make lectures as interesting as possible. The trainer can use other reference materials to augment the presentation.
- ➔ **Discussion:** It is important to allow time for discussion at appropriate points during or at the end of presentations. This provides an opportunity for participants to ask questions and clarify issues that are unclear to them. It is also a chance for the trainer to evaluate the views and level of knowledge and understanding of the participants.
- ➔ **Group Work and Plenary Presentation:** Some Specific Objectives in the package include group work, which is usually followed by a session in which feedback is provided to the class as a whole. The groups should be kept as small as possible. The trainer may also ask the group

to appoint a chairperson to serve as facilitator of the discussion, and reporter to write notes and report back to the plenary.

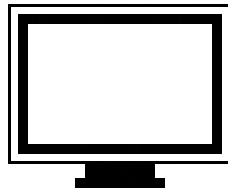
- **Role-Play:** Role-plays allow participants to practice the counseling skills they have learned. This technique is useful when practicing skills such as counseling. At the end of the role-play, the trainer should ask for feedback and draw the group's attention back to the objectives or to main points the role-play was designed to demonstrate.
- **Brainstorming:** Brainstorming involves generating ideas in a group quickly and without judgment (every idea is accepted). It is a technique that is proven to be very productive and useful to assess group knowledge and solicit contributions from participants.

## Guide To Symbols

References to the Participant's Handbook, PowerPoint slides, and Trainer's Tools occur as both text and symbols in the Methodology section. The symbols have number designations that refer to specific objectives and the sequence within the specific objectives. Participant's Handbook references, PowerPoint slides, and Trainer's Tools are arranged in chronological order and correspond to the numbered symbols in the Methodology section.



**Participant's Handbook**



**PowerPoint slide**



**Trainer's Tool**

# Unit 1:

## Family Planning Integration with HIV Services

### Specific Objectives

- 1.1: Introduce the Participants to the Objectives and Structure of the Course.
- 1.2: Identify the Benefits of FP and the Similarities Between FP and HIV Services.
- 1.3: Describe the Four Levels of FP/HIV Integration.
- 1.4: Identify the Benefits of FP/HIV Integration.
- 1.5: Identify the Challenges to Integration.

### Training/Learning Methodology

- ➔ Group discussions
- ➔ Trainer presentation
- ➔ Individual and small group exercises
- ➔ Brainstorming

### Resource Requirements

- ➔ Marking pens
- ➔ Flipchart
- ➔ Flipchart prepared with course objectives
- ➔ Flipchart prepared with the 4 levels of FP and HIV integration
- ➔ Copies of registration forms
- ➔ Copies of pretest questionnaire
- ➔ Colored cards

**Time Required:** 3 hours, 45 minutes

## Specific Objective 1.1: Introduce the Participants to the Objectives and Structure of the Course.

### CONTENT:

### METHODOLOGY:



The overall goal of this training is to equip HIV service providers with the knowledge and skills required to provide family planning (FP) counseling and services with HIV counseling and testing (HCT), prevention of mother-to-child transmission (PMTCT), and antiretroviral therapy (ART) services. After completion of this training, Px will be able to:

- ➔ Explain the benefits of FP and the importance of integrating FP and HIV services;


### ▶ Welcome and Registration (30 min.)

The trainer should:

- ➔ Welcome participants (Px) and invite the training organizers to provide a formal opening to the training course, if appropriate.
- ➔ Pass the registration form and ask Px to fill in the required information.
- ➔ Ask Px to introduce themselves to the group and say where they are from and what their experience is in FP and HIV work.


### Presentation (10 min.)

The trainer should:

- ➔ Explain the logistics of the course including arrangements for accommodation, meals, and transportation.
- ➔ Refer to *Trainer's Tool I: Training Agenda*. 

### Discussion and Presentation (15 min.)

The trainer should:

- ➔ Ask Px what they hope to gain from the training course.
- ➔ Write their responses on a flipchart paper and post it on the wall.
- ➔ Display and read *PowerPoint Slide 1*. 

**CONTENT: CONTINUED**

- ➔ Describe characteristics of available contraceptive methods;
- ➔ Explain contraceptive options for PLHIV;
- ➔ Present and explain key safer pregnancy messages for HIV-positive concordant or discordant couples desiring a pregnancy;
- ➔ Describe FP considerations specific to PLHIV, such as drug contraindications and the importance of dual method use;
- ➔ Recognize their personal values about FP and PLHIV decision-making about FP;
- ➔ Demonstrate principles and skills for counseling clients and couples on FP; and
- ➔ Present referral and record-keeping systems and standards for FP/HIV integration.

Group norms help create a safe learning environment for everyone in a course. They help the group meet the course objectives and set expectations about how the group will work together.

**Sample Group Norms:**

- ➔ Be punctual; start and end on time.
- ➔ Avoid side discussions.
- ➔ Show respect for differences of opinion.
- ➔ Have the right to make mistakes and recognize them.
- ➔ Encourage energizers (make it fun!).
- ➔ Speak one at a time.
- ➔ Full participation.
- ➔ Share experiences.

**METHODOLOGY: CONTINUED**

- ➔ Review the goals and objectives of the training course from the content and try to match them with Px' expectations on the flipchart.
- ➔ Ask for questions and clarify where necessary.


**Brainstorming (5 min.)**

The trainer should:

- ➔ Explain the purpose of group norms.
- ➔ Ask the group to brainstorm appropriate ground rules.
- ➔ Write their responses on a flipchart and post it on the wall. Leave this flipchart posted throughout the training.

**Pretest Questionnaire (30 min.)**

The trainer should:

- ➔ Distribute copies of *Trainer's Tool II: Pretest*. 
- ➔ Allow about 30 minutes for Px to complete the test, and then collect the papers. Use the information to adjust course content as needed.

## Specific Objective 1.2: Identify the Benefits of FP and the Similarities Between FP and HIV Services.

### CONTENT:

#### ▶ Family Planning

The decision taken by an individual or couple based on a voluntary and informed consent about when to have children, the number of children they want, and the interval between pregnancies using a contraceptive method of their choice.

#### FP Counseling and Services

FP counseling and services are important for the health and wellbeing of all youth and adults because they address the possibility of pregnancy and prevention of unintended pregnancies.

#### Benefits of FP

- ➔ Contraception protects against unintended pregnancies.
- ➔ FP supports the healthy timing and spacing of pregnancy, which helps women's health by allowing their bodies to begin childbearing when they are at a healthy age, and recover fully between pregnancies. (*Note: Pregnancies are safer for the mother and baby's health if a woman waits until age 18 to become pregnant, has 2 years spacing between childbirth and her next pregnancy, and has 6 months between a miscarriage or abortion and her next pregnancy.*)
- ➔ FP saves the lives of children by helping women space births and have healthy pregnancies.

### METHODOLOGY:

#### ▶ Unit Introduction

The trainer should:

- ➔ Display and read *PowerPoint Slide 2*.



#### Brainstorming (5 min.)

The trainer should:

- ➔ Ask Px to define FP.
- ➔ Allow 2-3 responses, and then post the prepared flip chart with the definition.
- ➔ Ask a volunteer to read the definition aloud.

#### Presentation and Group Exercise (25 min.)

The trainer should:

- ➔ Present an introduction of FP counseling and services using the description in the content column.
- ➔ Assign Px to 2 groups. Group 1 will brainstorm the benefits of FP and group 2 will brainstorm the similarities of FP and HIV services. Each group will have flipchart paper and markers.
- ➔ After 10 minutes ask the groups to return to their seats in the large group.
- ➔ Ask the groups to present their assignment through their group representatives.
- ➔ Allow 5 minutes for each presentation.
- ➔ Ask Px if they have anything to add.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- Some contraceptive methods provide additional health benefits, such as protection against some forms of cancer.
- Condoms prevent the spread of HIV, sexually transmitted infections (STIs), and unintended pregnancy.
- Having knowledge about contraception helps adolescents make responsible choices.
- May help men to share responsibility for reproductive health and child rearing.
- FP helps men and women provide a better life for their families by improving health and economic well-being.
- FP helps promote national development by allowing families to concentrate their resources on a smaller number of children.

**Similarities of FP and HIV Services**

- Behavioral risk assessment for HIV, STIs, and unintended pregnancy;
- Identification of options for reducing risk (HIV, STIs, and unintended pregnancy);
- Enabling clients to make their own decisions about safer sex practices; and
- Support for initiation and maintenance of behavioral changes.

## Specific Objective 1.3: Describe the Four Levels of FP/HIV Integration.

### CONTENT:

#### ▶ 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.

#### Levels of FP/HIV Integration

- ➔ **Level 1:** Assessment of FP need; provision of FP counseling; provision of condoms and 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.

### METHODOLOGY:

#### ▶ Brainstorming (10 min.)

The trainer should:

- ➔ Ask the group to brainstorm the definition of FP/HIV integration.
- ➔ Write Px' responses on the flipchart.
- ➔ Reinforce responses with the information provided in the content column.
- ➔ Refer to *Px Handbook Section 1.3.1: Definition and Essential Aspects of FP/HIV Integration.*



#### Presentation/Discussion (20 min.)

The trainer should:

- ➔ Display and read *PowerPoint Slide 3.*
- ➔ Refer to *Px Handbook Section 1.3.2: Levels of FP/HIV Integration.*
- ➔ Explain that FP integration with HIV services is an essential service, but that the level of integration can depend on circumstances. For example, all HIV service sites should offer assessment for FP need and refer for contraceptive services or safer pregnancy services, but not all sites need to directly offer all methods.
- ➔ Explain that types of FP/HIV integration are categorized in 4 levels and show a flipchart with descriptions (from the content column) of the 4 levels.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- Ask Px the level of integration they are comfortable providing, and what they are authorized to provide (for example, many national policies now encourage all HCT, PMTCT, and ART sites to offer at least Level 1 integration).

## Specific Objective 1.4: Identify the Benefits of FP/HIV Integration.

### CONTENT:

#### ▶ 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 STIs, and promoting safe, healthy, and responsible sexual behavior.
- ➔ 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.

### METHODOLOGY:

#### ▶ Individual Exercise and Discussion (35 min.)

The trainer should:

- ➔ Provide each Px with a small colored card.
- ➔ Tell them to write 1 benefit to integrating FP into HIV services on the card.
- ➔ Ask them to note if this benefit applies to HCT, PMTCT, ART, or multiple HIV services.
- ➔ Label 3 blank pieces of flipchart paper with the titles: “Benefits of Integrating FP Into HCT,” “Benefits of Integrating FP Into PMTCT,” and “Benefits of Integrating FP Into ART.”
- ➔ When they finish writing, have each Px read their card and tape it to the flipchart list it applies to. If the benefit applies to all three, the Px can write it on all three (e.g., promoting condom use).
- ➔ Open group discussion on each suggestion posted.
- ➔ Guide the discussion using the information provided in the content column.
- ➔ Refer to *Px Handbook Section 1.4.1: Benefits of FP/HIV Integration*.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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.

## Specific Objective 1.5: Identify the Challenges to Integration.

### CONTENT:

#### ► 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.

### METHODOLOGY:

#### ► Small Group Exercise (40 min.)

The trainer should:

- Divide the Px into 3 groups according to their primary job responsibility (HCT, PMTCT, ART).
- Ask each group to identify the challenges of integration of FP with HIV services and suggest ways to address these challenges.
- After 15 minutes, ask the group representatives to present to the entire class. Allow 5 minutes for each presentation.
- After the first group presentation, ask the rest to focus on points not touched on by the first group.
- Reinforce their responses with information from the content column.
- Encourage the discussions to focus on Px' roles in addressing the challenges.
- Note that Px' suggestions to address the challenges should be used for post-training follow-up visits with each participant.
- Explain that at the end of the training the Px will complete a planning worksheet to detail their ideas of how to begin FP integration in their work.
- Refer to *Px Handbook Sections 1.5.1: Challenges of Integration* and *1.5.2: Addressing the Challenges of FP/HIV Integration*.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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.

**Addressing the Challenges**

- 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.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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

### Specific Objectives

- 2.1: Identify Common Beliefs and Values towards Contraceptive Use.
- 2.2: Identify FP Client Rights.
- 2.3: Identify Principles of FP Counseling.
- 2.4: Describe the Skills Necessary for Effective FP Counseling.
- 2.5: Describe the Process of Routine Screening for Need for FP in HIV Services.
- 2.6: Describe the Skills and Knowledge Necessary for Effective FP Counseling for Clients with HIV.
- 2.7: Describe the Skills and Knowledge Necessary for Effective FP Counseling for Men and Adolescents in HIV Services.

### Training/Learning Methodology

- Brainstorming
- Group exercise
- Trainer presentation
- Discussion
- Role-Play

### Resource Requirements

- Marking pens
- Tape
- Transparencies, overhead projector, and/or LCD
- Flipchart

**Time Required:** 3 hours, 15 minutes

## Specific Objective 2.1: Identify Common Beliefs and Values toward Contraceptive Use.

### CONTENT:

- ▶ **Values Clarification** exercises are designed to encourage you to examine your attitudes, feelings, and values. It is important that providers are aware of and address their own values/beliefs so that they won't impose them on their clients. Also, it is important that clients feel safe and protected so that they can share their concerns and get the services they need.
  - ➔ 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-

### METHODOLOGY:

#### ▶ **Unit Introduction**

The trainer should:

- ➔ Display and read *PowerPoint Slide 4*.



#### **Large Group Exercise (30 min.)**

The trainer should:

- ➔ Post 3 signs that say “Agree,” “Disagree,” and “Not Sure” (in large print) at opposite ends of the room.
- ➔ Arrange the classroom so that there is a clear area on each side of the room where Px can stand by each sign.
- ➔ Explain to Px that this exercise is designed to help us understand viewpoints that are different from our own, and how our attitudes, feelings, and values influence our behavior toward clients seeking services.
- ➔ Explain that answers are not considered “right” or “wrong” but pose an opportunity to develop sensitivity to others.
- ➔ Explain that you will read a statement out loud and that Px should listen and decide whether they agree or disagree with the statement. Those who agree should stand in the area by the sign “Agree.” Those who disagree should stand in the area by the sign “Disagree.”
- ➔ Explain that for each statement you will ask 2 volunteers from each side to explain their rationale for agreeing or disagreeing, and that if they hear a rationale that makes them change

## CONTENT: CONTINUED

positive clients or those perceived to be HIV-positive or at risk.

## METHODOLOGY: CONTINUED

their opinion, they can move from one area of agreement to another.

- Read each statement below and allow time for participants to move to the side of the room that reflects their attitudes, feelings, and values. Remain neutral during the exercise; explain only factual information for clarification.
  1. Contraception encourages promiscuity.
  2. An HIV-positive woman should not have a baby.
  3. It is acceptable for a woman to use contraception without informing her husband.
  4. Contraception should be available for married people only.
  5. Contraception is not a good idea for women who have never had children.
  6. People with many partners should use only condoms and no other contraceptive methods.
  7. The service provider should guide the client to the method that is the right one for him/her.
- Reconvene the group and ask the following analysis questions: How did you feel participating in this exercise? Were you surprised by the range of attitudes/feelings and reasons? How did you feel when others expressed differing feelings? Why is this an important exercise for you? How might this exercise influence the way you relate to clients?
- Conclude by using the information in the content column to summarize the importance of recognizing our values and beliefs to provide respectful, high-quality FP counseling and services.
- Refer to *Px Handbook Section 2.1.1: Common Beliefs and Values about Contraceptive Use*.



## Specific Objective 2.2: Identify Client Rights for FP.

### CONTENT:

#### ▶ All clients for FP 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.

#### 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,

### METHODOLOGY:

#### ▶ Small Group Exercise (30 min.)

The trainer should:

- ➔ Divide the Px into small groups of 3-5 according to the area or health facility in which they work and assign each group one FP client right from the list in the content.
- ➔ Display and read *PowerPoint Slide 5*.
- ➔ Refer each pair or group to *Px Handbook Section 2.2.1: Basic Rights of FP Clients*.
- ➔ Ask each group to identify the barriers in their setting that might prevent the right from being fulfilled.
- ➔ Ask them to list specific steps that they can take in their health facility to remove each barrier.
- ➔ Ask each group to present briefly.
- ➔ Record Px' suggestions on a flipchart.
- ➔ Note that Px' recommendations to remove the barriers should be used for post-training follow-up visits with each participant.



#### Discussion (10 min.)



The trainer should:

- ➔ Ask Px why they think individuals and couples use contraception.
- ➔ Guide the discussion using the information provided in the content column.

**CONTENT: CONTINUED**

- 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.

**METHODOLOGY: CONTINUED**

- Display and read *PowerPoint Slide 6* to summarize. 
- Wrap up the discussion, highlighting the fact that access to contraception is a right of all individuals/couples regardless of their HIV status, age, economic situation, or marital status.
- Refer to *Px Handbook Section 2.2.2: Reasons for Choosing Contraception*. 

## Specific Objective 2.3: Identify Principles of FP Counseling.

### CONTENT:

▶ **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.

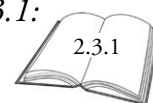
**Informed Choice** means that a client has the right to choose any contraceptive method that s/he wishes based on a clear understanding of the characteristics of all the available methods, including the

### METHODOLOGY:

#### ▶ **Presentation and Discussion (10 min.)**

The trainer should:

- Ask Px to define “FP counseling” and explain the components of FP counseling.
- Ask Px to describe good FP counseling.
- Write down their ideas on the flipchart.
- After 2-3 suggestions, correct and/or complete answers as needed.
- Reinforce the correct answers.
- Display and read *PowerPoint Slide 7*.
- Display and discuss the 2 major elements of good FP counseling (see the content column):
  - Mutual trust, and
  - Information sharing between the client and service provider.
- Refer to *Px Handbook Section 2.3.1: Principles of FP Counseling*.



#### **Discussion (10 min.)**

The trainer should:

- Ask Px to define *informed choice* and *informed consent*.

**CONTENT: CONTINUED**

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 contraceptive pills).

**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
- ➔ Fewer time-consuming minor complaints and side effects
- ➔ Increased trust and respect between client and provider
- ➔ Positive promotion of FP by the client to his/her community or peers

**METHODOLOGY: CONTINUED**

- ➔ Write down key ideas on a piece of flipchart paper.
- ➔ After 2-3 suggestions, correct and/or complete answers as needed. Reinforce the correct answers.
- ➔ Conclude by explaining that by respecting informed choice and informed consent in FP counseling we promote satisfied clients.
- ➔ Ask Px why client satisfaction is important for integrated services.
- ➔ List their answers on a flipchart and complete answers using the content.
- ➔ Refer to Px Handbook Section 2.3.2: *Informed Choice and Informed Consent*.
- ➔ Display and read *PowerPoint Slides 8 and 9* to summarize.



## Specific Objective 2.4: Describe the Skills Necessary for Effective FP Counseling.

### CONTENT:

#### ▶ Skills of an Effective FP 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

### METHODOLOGY:

#### ▶ Individual Exercise (15 min.)

The trainer should:

- Ask each participant to write 2-3 skills of an effective counselor in their notebook.
- When they finish writing, ask each to read aloud one quality from their list.
- Write their response on the flipchart.
- Reinforce their responses using the information provided in the content column and refer to *Px Handbook Section 2.4.1: Skills of an Effective Counselor*.





## Specific Objective 2.5: Describe the Process of Routine Screening for Need for FP in HIV Services.

### CONTENT:

#### ▶ Screening for Need for FP

Screening for current 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?”

### METHODOLOGY:

#### ▶ Trainer Presentation (20 min.)

The trainer should:

- Explain that the FP/HIV integration is an important service and that FP counseling in HCT, PMTCT, and ART should begin with screening for the need for FP.
- Using the content, present the three questions used for screening for the need for FP.
- Explain that these questions should be asked of all men and women at each HIV service visit.
- Explain that these questions help the provider determine if the client has: Unmet FP Need, No FP Need, or Met FP Need.
- Display and read *PowerPoint Slide 10*.
- Refer to *Px Handbook Section 2.5.1: Screening for Need*.
- Review the instructions for asking screening questions and their use in guiding FP counseling.
- Explain that counseling topics and recording of need for FP will continue to be discussed during the training.



**Note:** These screening questions can be adapted to match national policies or reporting tools. Additional questions can be added about the type of contraceptive method used or to confirm the client’s current pregnancy status. While these questions can be modified to meet the needs of facility or program managers, it is important to emphasize the importance of screening for FP need in HIV services, and recording/reporting FP need to assess gaps and progress.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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 ARV prophylaxis for women who are not eligible or who are not on ART), which is able to reduce HIV

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

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 and eligibility for ART and the effectiveness of ARVs during pregnancy to prevent PMTCT.

(IATT, 2009)

(WHO, 2009)

## Specific Objective 2.6: Describe the Skills and Knowledge Necessary for Effective FP Counseling for Clients with HIV.

### CONTENT:

#### ▶ 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

### METHODOLOGY:

#### ▶ Small Group Discussion (25 min.)

The trainer should:

- Introduce the session using the content.
- Divide the Px into small groups of 3-5.
- Give each group the following assignment:
  - **Group 1:** Reasons clients with HIV may consider pregnancy
  - **Group 2:** Reasons clients with HIV may want to avoid pregnancy
- Allow the groups 10 minutes.
- After 10 minutes, call the groups back to plenary.
- Let each group present their work on a flipchart for 3-5 minutes.
- Fill in where necessary from points in the content column.
- Refer to *Px Handbook Section 2.6.1: FP for HIV-Positive Clients.*



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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

**Brainstorming (15 min.)**

The trainer should:

- Ask the Px to brainstorm factors that could affect an HIV-positive client's decision to use contraception.
- Write their responses on the flipchart and validate their answers.
- Ask the Px to brainstorm possible factors that could affect contraceptive method choice for PLHIV.

**CONTENT: CONTINUED**

- 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.
- Whether partner involvement or negotiation is required.

**METHODOLOGY: CONTINUED**

- Correct or complete answers as needed using information provided in the content column.
- Summarize the importance of decision making rights of PLHIV using the content.

## Specific Objective 2.7: Describe the Skills and Knowledge Necessary for Effective FP Counseling for Men and Adolescents in HIV Services.

### CONTENT:

#### ▶ **FP Counseling for 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 often have less information or are more likely to be misinformed about contraception. Men often have serious misconceptions and concerns that contraception will negatively impact their sexual pleasure and/or performance.
- 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.

### METHODOLOGY:

#### ▶ **Small Group Discussion (30 min.)**

The trainer should:

- Explain that FP/HIV integration allows service providers in HCT, PMTCT, and ART to provide FP counseling to clients like men and adolescents who would not typically receive FP counseling (through HCT, and through partner testing in PMTCT and ART).
- Explain that this is an opportunity to introduce key FP messages to strategic groups, but requires some specific skills and knowledge for effective counseling.
- Divide Px into 4 groups. Assign one group to each of the following types of client: adolescent HCT clients, male ART clients, adolescent PMTCT clients, and male HCT clients.
- Ask each group to discuss and list the following:
  - Unique considerations when counseling clients from their group,
  - Unique FP needs of clients in their group, and
  - Ideas to motivate and counsel the clients from their group.
- Allow 10 minutes for group work.
- Reconvene the groups and allow 3-5 minutes for each group to present their list.
- Guide feedback and discussion after each group presents. Elaborate on the issues raised using key messages in the content column and refer to *Px Handbook Section*

**CONTENT: CONTINUED**

- ➔ 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).

**FP Counseling for 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).

**METHODOLOGY: CONTINUED**

*2.7.1: Addressing the FP Counseling Needs of Men and 2.7.2: Addressing the FP Counseling Needs of Adolescents.*



- ➔ Conclude by emphasizing that every client in HCT, PMTCT, and ART can use contraception and has a right to information and services in a manner that respects his/her needs.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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

### Specific Objectives

- 3.1: Present Key Messages and Principles that Summarize Family Planning Options for PLHIV.
- 3.2: Identify Available Contraceptive Methods and Essential Elements of FP Client Education.
- 3.3: Present the Essential Elements of Safer Pregnancy Counseling for HIV-Positive Clients.
- 3.4: Explain the Benefits of Dual Protection and Dual Method Use.
- 3.5: Identify the Characteristics of Male and Female Condoms.
- 3.6: Describe Steps Necessary to Demonstrate Condom Use and Initiate Clients on Condoms.
- 3.7: Identify the Characteristics of Oral Contraceptive Pills.
- 3.8: Describe Steps Necessary to Identify and Initiate Appropriate Candidates on Oral Contraceptive Pills.
- 3.9: Identify the Characteristics of Progestin-Only Injectables and Steps Necessary to Identify and Initiate Appropriate Candidates.
- 3.10: Identify the Characteristics of Contraceptive Implants.
- 3.11: Identify the Characteristics of Intrauterine Devices.
- 3.12: Describe the Characteristics of Voluntary Surgical Contraception.
- 3.13: Describe the Characteristics of Emergency Contraceptive Pills.
- 3.14: Describe the Characteristics of Natural and Fertility-Awareness Methods.
- 3.15: Describe FP Considerations Specific to HIV-Positive Clients.
- 3.16: Apply Skills and Knowledge Learned to Provide FP Counseling.

### Training/Learning Methodology

- Group discussions
- Trainer presentation
- Small group exercises
- Brainstorming
- Demonstration/return demonstration

### Resource Requirements

- Flipchart
- Markers
- Examples of contraceptive methods

**Time Required:** 10 hours, 15 minutes

## Specific Objective 3.1: Present Key Messages and Principles that Summarize Family Planning Options for PLHIV.

### CONTENT:

#### ▶ Essential Principles of FP Counseling in HIV Services

- ➔ Every HCT, ART, and PMTCT client should be assessed for FP need.
- ➔ HCT, ART, and PMTCT clients have the right to make their own FP choice, including safer pregnancy for HIV-positive women (using risk reduction measures like ARVs and exclusive breastfeeding), if desired.
- ➔ Quality FP counseling and services should reinforce clients' ability to limit HIV transmission to HIV-negative partners and to infants.

#### Key Messages for FP Counseling in HIV Services

- ➔ Generally, HIV-positive clients can use most contraceptive methods, even on ARVs.
- ➔ Dual method use, using condoms and a contraceptive method for good protection from infection and unintended pregnancy, should be included in FP counseling for clients with HIV.

### METHODOLOGY:

#### ▶ Unit Introduction

The trainer should:

- ➔ Display and read *PowerPoint Slide 11*.



#### Trainer Presentation (10 min.)

The trainer should:

- ➔ Explain that there are essential principles and key messages to remember as we present FP options for PLHIV, including the full range of contraceptive methods and guidance for safer pregnancy.
- ➔ Present the 2 essential principles and 2 key messages for FP counseling in HIV services by displaying and reading *PowerPoint Slides 12 and 13*.



#### Group Work (20 min.)

The trainer should:

- ➔ Divide Px into 2 groups.
- ➔ Ask group 1 to discuss the challenges to meeting the essential principles of FP counseling in HIV services.
- ➔ Ask group 2 to discuss why the key messages are important to communicate to clients.
- ➔ Give the groups 10 min. for their discussions.
- ➔ Ask each group to present in 3-5 min.
- ➔ Summarize the discussion.

## Specific Objective 3.2: Identify Available Contraceptive Methods and Essential Elements of FP Client Education.

### CONTENT:

#### ▶ Contraceptive Methods

- ➔ Male and female condoms
- ➔ 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

#### FP client education should include the following elements:

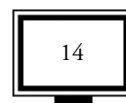
- ➔ How the method works,
- ➔ Method effectiveness,
- ➔ Advantages and disadvantages of the method,
- ➔ Side effects and complications of the method, and
- ➔ How to use the method correctly.

### METHODOLOGY:

#### ▶ Brainstorming (15 min.)

The trainer should:

- ➔ Ask Px to identify the contraceptive methods currently available in their area.
- ➔ Write Px' responses on the flipchart.
- ➔ Add to the list as necessary.
- ➔ Display and read *PowerPoint Slide 14*.
- ➔ Refer to *Px Handbook Section 3.2.1: Contraceptive Methods*.



#### Presentation (5 min.)

The trainer should:

- ➔ Present the essential elements of FP education and explain that these elements guide what service providers need to learn.
- ➔ Display and read *PowerPoint Slide 15*.
- ➔ Refer to *Px Handbook Section 3.2.2: Essential Elements of FP Client Education*.



## Specific Objective 3.3: Present the Essential Elements of Safer Pregnancy Counseling for HIV-Positive Clients.

### CONTENT:

#### ▶ Safer Pregnancy Counseling for HIV-Positive Women Desiring a Pregnancy

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%.)

### METHODOLOGY:

#### ▶ Trainer Presentation (20 min.)

The trainer should:

- Ask the participants what they know about how to help HIV-positive women who want to have a child.
- Ask the Participants to refer to *Px Handbook Section 3.3.1: Safer-Pregnancy Counseling for HIV-Positive Clients*.
- Complete their responses using the content.
- Summarize by displaying and reading *PowerPoint Slides 16 and 17*.
- Explain that the initial FP/HIV integration screening for FP need guides the provider to offer safer pregnancy counseling to clients desiring a pregnancy.
- Remind participants that providers should support HIV-positive clients who desire a pregnancy in a non-judgmental manner, and that providers should offer safer pregnancy counseling to both HIV-positive women and men who express desire for a child.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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)



## Specific Objective 3.4: Explain the Benefits of Dual Protection and Dual Method Use.

### CONTENT:

#### ☛ 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,

### METHODOLOGY:

#### ☛ Brainstorming (20 min.)

The trainer should:

- ➔ Ask Px what *dual method use* and *dual protection* mean.
- ➔ Ask Px who benefits from dual method use.
- ➔ Reinforce correct answers and correct/complete any incorrect responses if needed.
- ➔ Display and read *PowerPoint Slide 18*.
- ➔ Refer to *Px Handbook Section 3.4.1: Dual Protection and Dual Method Use*.
- ➔ Emphasize:
  - ➔ Consistent (every time!) condom use results in protection from both pregnancy and HIV/STIs; adding an additional contraceptive method to consistent condom use provides very good protection from pregnancy.
  - ➔ Provision of condoms, every day, at every opportunity.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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.

## Specific Objective 3.5: Identify the Characteristics of Male and Female Condoms.

### CONTENT:

#### ▶ 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.

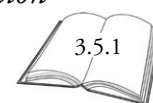
**Important:** *The device is made from polyurethane. The female condom can be*

### METHODOLOGY:

#### ▶ Trainer Presentation (30 min.)

The trainer should:

- Give a brief presentation on condoms (male and female).
- Display and read *PowerPoint Slide 19*.
- Ask Px to refer to *Px Handbook Section 3.5.1: Characteristics of Male and Female Condoms*.
- Ask Px if they have any questions.
- Correct/complete any outstanding responses/questions as needed.



*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

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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 hours – 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 (which is used in male condoms) can occur.
- ➔ There are no known side effects with the female condom.

## Specific Objective 3.6: Describe Steps Necessary to Demonstrate Condom Use and Initiate Clients on Condoms.

### CONTENT:

#### ► Facts to Know about 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.

#### 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.

### METHODOLOGY:


#### ► Demonstration (15 min)

Trainer should:

- Tell Px the basic *Facts to Know about Condoms* using the content.
- Ask Px to refer to *Px Handbook Section 3.6.1: Steps in Initiating Clients on Condoms* for important rules to follow to initiate male and female condom use. 
- Demonstrate how to use male and female condoms using the steps outlined in *Px Handbook Section 3.6.2: Steps to Correctly Use Male and Female Condoms*. Use a penile model (condom demonstration model) and female pelvic model for this. 

#### Return Demonstration (30 min)

The trainer should:

- Divide Px into small groups.
- Distribute condoms and demonstration models to each group.
- Instruct Px to give a return demonstration on initiating clients in condom use, following the steps and instructions in *Px Handbook Section 3.3.3*. Each participant should have a chance to practice their skills. 
- Observe Px practice.
- After each return demonstration, allow other Px and trainer(s) to give feedback.

**CONTENT: CONTINUED**

- ➔ 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.

**METHODOLOGY: CONTINUED**

- ➔ Tell Px that during client counseling it is important to do condom demonstrations and return demonstrations to ensure client learning and practice.

**Trainer Presentation (5 min.)**

The trainer should:

- ➔ Call Px back into plenary.
- ➔ Summarize the Specific Objective with an emphasis on:
  - a. Steps and instructions followed to initiate clients on condom use.
  - b. Women and men who are infected with HIV should use condoms to prevent HIV transmission to their partner and to avoid reinfection.
  - c. Consistent and correct use of condoms may compensate for any decrease in the effectiveness of hormonal contraceptive methods.
- ➔ Remind Px that detailed instructions on initiating condom use are included in *Px Handbook Sections 3.3.1 and 3.3.2.*



### 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



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

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*.

## Specific Objective 3.7: Identify the Characteristics of Oral Contraceptive Pills.

### CONTENT:

- ▶ There are two kinds of oral contraceptive pills: combined oral contraceptives (COCs) and progestin-only pills (POPs).

#### A. Combined Oral Contraceptives

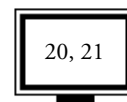
- ➔ COCs are the most commonly used type of hormonal contraceptive.
- ➔ COCs contain both estrogen and progestin.
- ➔ COCs are safe, effective, reversible, and are one of the most extensively studied medications ever used by human beings. Serious side effects are very rare.
- ➔ Most women use COCs successfully, 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.

### METHODOLOGY:

#### ▶ Small Group Exercise (30 min.)

The trainer should:

- ➔ Divide Px into 2 groups:
  - ➔ **Group 1:** Combined oral contraceptives
  - ➔ **Group 2:** Progestin-only pills
- ➔ Distribute flipchart paper and markers to each group.
- ➔ Refer to *Px Handbook Sections 3.7.1: Combined Oral Contraceptive Pills* and *3.7.2: Progestin-Only Pills*.
- ➔ Tell Px they have 15 minutes to select a leader and record the group's ideas about the advantages and disadvantages of each method on the flipchart.
- ➔ Call the Px back to the plenary.
- ➔ Give the recorder from each group 5 minutes to present the group work.
- ➔ Add points as appropriate from the content.
- ➔ Summarize by displaying and reading *PowerPoint Slides 20 and 21*.



#### Trainer Presentation (25 min.)

The trainer should:

- ➔ Ask Px to explain the mechanism of action of COCs and POPs, write correct responses on a flipchart, and clarify or add points as required.
- ➔ Discuss the content using a flipchart to point out the differences between

**CONTENT: CONTINUED**

- ➔ 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).

**METHODOLOGY: CONTINUED**

- COCs and POPs, between younger and older women, and various durations of use.
- ➔ Ask Px to give examples of ways a client and a provider may contribute to COC and POP failure, and what actions may be taken to address these problems.
  - ➔ Stress the importance of counseling to prepare women for potential side effects and the impact these may have on their daily lives.
  - ➔ Ask Px to name FP methods s/he would recommend to a COC or POP user as a back-up method.

**Note:** *Counseling practice on pills and other methods is covered under Specific Objective 3.16: Apply Skills and Knowledge Learned to Provide FP Counseling.*

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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)

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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

**B. 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 reduce milk production or quality since they do not contain estrogen.
- 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.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ POPs are a good choice for breastfeeding women, are very effective during breastfeeding, and do not reduce a mother's milk supply.
- ➔ 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.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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

## Specific Objective 3.8: Describe Steps Necessary to Identify and Initiate Appropriate Candidates on Oral Contraceptive Pills.

### CONTENT:

#### ▶ 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?

### METHODOLOGY:

#### ▶ Trainer Presentation (20 min.)

- Refer Px to *Px Handbook Section 3.8.1: Medical Eligibility Checklists for COCs and POPs.* 
- Explain to Px that the COC and POP eligibility checklists help the provider to determine whether the client has any known medical conditions that prevent use of COCs or POPs. It is not meant to replace counseling.
- The questions on the checklist refer to known conditions. Generally you can learn of these conditions by asking the client. You do not usually have to perform laboratory tests or a physical examination.
- Review the checklist and the instructions to give if a client answers “yes” to any question.

#### Case History Small Group Work (40 min.)

The trainer should:

- Following a discussion of indications, eligibility criteria, and history checklists, break the Px into three groups.
- Explain that this exercise will:
  1. Provide practice for Px in using a checklist when screening potential COC/POP clients.
  2. Help them identify problems when screening potential COC/



**CONTENT: CONTINUED**

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

**METHODOLOGY: CONTINUED**

POP clients and develop appropriate management plans.

3. Familiarize themselves with essential COC history questions.
  - Discuss what information should be included when writing a case history of a HCT, PMTCT, or ART client desiring COCs or POPs.
  - Ask each group to develop and write a case history, while trying to include the answers to as many of the questions found in the history checklist as possible.
  - After each group has written a case history, one member of the group will present the case history to the plenary.
  - Allow 15 minutes for the small groups to work and 5 minutes to present.
  - Each group should present its case study and ask the other Px whether COCs should be prescribed for the client presented in the case study.
  - Summarize the discussion by repeating key points made.

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.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED***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?

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

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*.

## Specific Objective 3.9: Identify the Characteristics of Progestin-Only Injectables and Steps Necessary to Identify and Initiate Appropriate Candidates.

### CONTENT:

#### ▶ 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

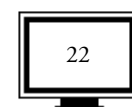
- Very effective
- Failure rate:
  - 3% typical use (in one year, when some clients are late for their next injection or skip the next injection)
  - less than 1% perfect use
- Effectiveness is diminished when clients are late for injections, or miss injections.
- NNRTIs in some second-line ARV therapies (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.

### METHODOLOGY:

#### ▶ Trainer Presentation (15 min.)

The trainer should:

- Ask Px to explain the mechanism of action of POIs, write correct responses on a flipchart, and clarify or add points as required.
- Discuss the content using a flipchart to describe the characteristics of POIs.
- Ask Px to give examples of ways a client and a provider may contribute to POI failures, and what actions may be taken to address these problems.
- Stress the importance of counseling to prepare women for potential side effects and the impact these may have on their daily lives.
- Ask Px to name what s/he would recommend to a COC user as a back-up method.
- Refer to *Px Handbook Section 3.9.1: Progestin-Only Injectables*.
- Summarize by displaying and reading *PowerPoint Slide 22*.



#### Trainer Presentation (15 min.)

- Refer Px to *Px Handbook Section 3.9.2: Medical Eligibility Checklist for POIs*.
- Explain that the POI eligibility checklist helps the provider determine whether the client has any known medical conditions that prevent use of POIs. It is not meant to replace counseling.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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)

- The questions on the checklist refer to known conditions. Generally you can learn of these conditions by asking the client. You do not usually have to perform laboratory tests or a physical examination.
- Review the checklist and the instructions to give if a client answers “yes” to any question.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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?

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

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.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

*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*.

## Specific Objective 3.10: Identify the Characteristics of Contraceptive Implants.

### CONTENT:

#### ▶ 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.

### METHODOLOGY:

#### ▶ Small Group Exercise (30 min.)

The trainer should:

- ➔ Divide Px into 2 groups:
  - ➔ **Group 1:** Jadelle
  - ➔ **Group 2:** Implanon
- ➔ Distribute flipchart paper and markers to each group.
- ➔ Refer to *Px Handbook Section 3.10.1: Implants* and *3.10.2: Characteristics of Implants*.
- ➔ Tell Px they have 15 minutes to select a leader and record the group's ideas on the advantages and disadvantages of each method on the flipchart.
- ➔ Call the Px back to the plenary.
- ➔ Give the recorder from each group 5 minutes to present the group work.
- ➔ Add points as appropriate from the content.
- ➔ Summarize by displaying and reading *PowerPoint Slide 23*.



#### Trainer Presentation (20 min.)

The trainer should:

- ➔ Ask Px to explain the mechanism of action of implants. Write correct responses on a flipchart and clarify or add points as required.
- ➔ Discuss the content using a flipchart to describe the characteristics of implants.

**CONTENT: CONTINUED**

- 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.

**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

**METHODOLOGY: CONTINUED**

- Ask Px to give examples of ways a client and a provider may contribute to implant failures, and what actions may be taken to address these problems.
- Stress the importance of counseling to prepare women for potential side effects and the impact these may have on their daily lives.
- Ask Px to name contraceptive methods s/he would recommend to an implant user as a back-up method.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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*.

## Specific Objective 3.11: Identify the Characteristics of Intrauterine Devices (IUDs)

### CONTENT:

#### ▶ Intrauterine Devices

Intrauterine 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.)

### METHODOLOGY:

#### ▶ Small Group Exercise (35 min.)

The trainer should:

- Divide Px into 2 groups.
- Distribute flipchart paper and markers to each group.
- Refer to *Px Handbook Section 3.11.1: Characteristics of IUDs*.
- Tell Px they have 15 minutes to select a leader and record the group's ideas on the advantages and disadvantages of each method on the flipchart.
- Call the Px back to the plenary.
- Give the recorder from each group 5 minutes to present the group work.
- Add points as appropriate from the content.
- Summarize by displaying and reading *PowerPoint Slide 24*.



#### Trainer Presentation (20 min.)

The trainer should:

- Ask Px to explain the mechanism of action of IUDs. Write correct responses on a flipchart, and clarify or add points as required.
- Discuss the content using a flipchart to describe the characteristics of implants.
- Ask Px to give examples of ways a client and a provider may contribute to IUD failures, and what actions may be taken to address these problems.

**CONTENT: CONTINUED**

- 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*.

**METHODOLOGY: CONTINUED**

- Stress the importance of counseling to prepare women for potential side effects and the impact these may have on their daily lives.
- Ask Px to name contraceptive methods s/he would recommend to an IUD user as a back-up method.

## Specific Objective 3.12: Describe the Characteristics of Voluntary Surgical Contraception.

### CONTENT:

#### ▶ 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.

### METHODOLOGY:

#### ▶ Trainer Presentation (20 min.)

The trainer should:

- Ask Px to explain the mechanism of action of VSC. Write correct responses on a flipchart and clarify or add points as required.
- Discuss the content using a flipchart to describe the characteristics of VSC.
- Ask Px to give examples of ways a client and a provider may contribute to VSC failures, and what actions may be taken to address these problems.
- Stress the importance of counseling to ensure clients understand the permanence of the method.
- Ask Px to name contraceptive methods s/he would recommend to a VSC user as a back-up method.
- Refer to *Px Handbook Section 3.12.1: Voluntary Surgical Contraception*.
- Summarize by displaying and reading *PowerPoint Slide 25*.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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

## Specific Objective 3.13: Describe the Characteristics of Emergency Contraceptive Pills.

### CONTENT:

▶ **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:

- 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

### METHODOLOGY:

#### ▶ **Brainstorming and Presentation (30 min.)**

The trainer should:

- Ask Px to brainstorm what emergency contraception means, and to say what they know about ECP.
- Reinforce correct responses.
- Correct/complete any responses as needed.
- Give a brief presentation on the mechanism of action for ECPs.
- Reinforce the content by asking Px to repeat what the trainer has just presented about ECP.
- Ask if Px have any questions.
- Provide additional information from the content column, if it is not covered through the questions and answers.
- Present the content on ECP indications, side effects, and their management from the content column.
- Summarize by displaying and reading *PowerPoint Slide 26*.



The trainer should emphasize:

- The mechanism that is active in a particular case depends on the time during the menstrual cycle when EC is used.
- ECPs do not interrupt or abort an established pregnancy.

**CONTENT: CONTINUED**

the client to take and works just as well as 2 doses taken 12 hours apart.)

When pills containing 0.03 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 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.

**METHODOLOGY: CONTINUED**

- ➔ ECPs should not be used as a regular contraceptive method.
- ➔ Tell clients at routine FP visits that ECPs are available at your facility. Ask them to share this information with their friends and family members.
- ➔ Providers should recommend EC if they see victims of rape or sexual assault.
- ➔ ECPs do not protect from STIs, including HIV.
- ➔ Clients should return to the clinic for follow-up care and evaluation after receiving EC.
- ➔ Refer to *Px Handbook Section 3.13.1: Emergency Contraceptive Pills*.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

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

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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)

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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

## Specific Objective 3.14: Describe the Characteristics of Natural and Fertility-Awareness Methods.

### CONTENT:

#### ▶ Natural FP

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.


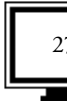

#### Effectiveness

- ➔ 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

### METHODOLOGY:

#### ▶ Trainer Presentation and Discussion (30 min.)

The trainer should:

- ➔ Ask the Px to brainstorm the mechanisms of action, effectiveness, characteristics, and indications of:
  - ➔ Abstinence
  - ➔ Coitus Interruptus
  - ➔ Lactational Amenorrhea Method (LAM)
- ➔ Reinforce what has been said using information from the content column.
- ➔ Refer to *Px Handbook Section 3.14.1: Natural Family Planning.* 
- ➔ Display and read *PowerPoint Slide 27.* 
- ➔ Ask Px about the issues that women with HIV experience related to breastfeeding.
- ➔ Ask a Px to read aloud from *Px Handbook Section 2.10.2: Issues for HIV-Positive Women to Consider Regarding Breastfeeding.* 

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- 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

**CONTENT: CONTINUED**

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)

### **Fertility Awareness-Based Methods (FABMs)**

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 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.

**METHODOLOGY: CONTINUED**

### **Presentation and Group Discussion (10 min.)**

The trainer should:

- ➔ Give a presentation on FABM mechanisms and effectiveness.
- ➔ Ask Px if they have any questions.
- ➔ Ask volunteers to answer any questions.
- ➔ Reinforce correct answers.
- ➔ Correct/complete any answers as needed.
- ➔ Refer to *Px Handbook Section 3.14.2: Fertility-Awareness Methods*.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED**

- ➔ 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

## Specific Objective 3.15: Describe FP Considerations Specific to HIV-Positive Clients.

### CONTENT:

#### ▶ 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

### METHODOLOGY:

#### ▶ Trainer Presentation and Discussion (45 min.)

The trainer should:

- Review key messages for FP/HIV integration counseling using the content.
- Remind Px that they have already learned that generally HIV-positive clients can use most contraceptive methods, even on ARVs. However, there are some known drug interactions that are important to share with HIV-infected men and women so they can engage in safer sex and make informed choices about becoming a parent.
- Explain that to support FP counseling for HIV-positive clients, and summarize interactions between contraceptives and safer pregnancy, and ARVs and common opportunistic infection treatment, a job aid has been developed. It is called the *FP/HIV Integration Provider Reference Tool: Family Planning Considerations Specific to HIV-Positive Clients*. 
- Refer to *Px Handbook Section 3.15.1: Contraceptives, ARVs, and OI Treatment*. 
- Explain the use of the Reference Tool. (To determine any interaction, read down the first column to find the FP choice and then across the top row to find the HIV-related treatment or condition.)

**CONTENT: CONTINUED**

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).

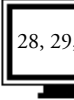
- ➔ Clients who take anti-convulsants, Rifampicin, Ritonavir or Ritonavir-boosted protease inhibitors to use implants, but it is advisable to also use condoms to compensate for any possible reduction in contraceptive effectiveness.

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.*

**METHODOLOGY: CONTINUED**

- ➔ Help Pxs practice use of the Reference Tool by:
  - ➔ Asking a volunteer Px to tell you the considerations specific to safer pregnancy.
  - ➔ Asking a volunteer Px to tell you what are the considerations specific to COCs.
- ➔ Ask Px if they have any questions on the use of the Reference Tool.
- ➔ Summarize by displaying and reading *Powerpoint Slides 28, 29, and 30.* 
- ➔ Remind participants of the importance of dual method use and good counseling about condom use using the content.
- ➔ Conclude by stating that before initiating a client on a method, providers need to consider all of the medical conditions and treatments that a client might be taking by following the medical eligibility checklists presented earlier.

## Specific Objective 3.16: Apply Skills and Knowledge Learned to Provide FP Counseling.

### CONTENT:


#### ▶ Case Studies

- G\_\_\_\_, 18 years old, is HIV positive and is healthy on ART (her regimen includes EFV). She is not with a regular partner and does not want any children now, although she might want them in the future if she ever marries.
- D\_\_\_\_, 30 years old, is HIV positive and is on ART but his wife does not know, and he is not ready to tell her. They have 3 children and although he is using condoms with his wife, he wants to make sure he doesn't have any more children.
- B\_\_\_\_, 45 years old, and W\_\_\_\_, 38 years old, are HIV positive. They have 2 healthy children and have decided they do not want any more children.
- A\_\_\_\_, 25 years old, is HIV negative but is married to a man who is HIV positive. He wants her to be pregnant. She does not want to have children who might be infected. She tried the pill, but got very nauseous on it.
- A\_\_\_\_, 19 years old, is a pregnant sex worker who does not know her HIV status and is afraid to accept the test. She is concerned about unintended pregnancy and HIV risk.

### METHODOLOGY:

#### ▶ Role-Plays (60 min.)

The trainer should:

- Break participants into groups of 3-5. Assign each group two case studies from *Trainer's Tool V: Specific Objective 3.16 Case Studies*. 
- Ask groups to discuss what they would do to help the client.
- Allow 10 minutes for group discussion for each of the two case studies.
- Ask each group to share their responses with the larger group.
- Correct or supplement any responses using the unit content.
- Ask each group to practice counseling one of the clients using role-play. During the role-play, groups should include both information about the method(s) and apply counseling skills and principles.
- Allow 20 minutes.
- Reconvene the larger group and ask each group to present their role-play.
- Allow only 5 minutes for each group.
- Ask other participants for feedback on what was good and what could be improved.
- Correct or add any missing points.
- Summarize the exercise.







## Unit 4:

# Record Keeping and Making Referrals

### Specific Objectives

- 4.1: Explain the Importance of Record Keeping in FP/HIV Integration.
- 4.2: Identify the Steps to Making Referrals.
- 4.3: Develop Workplans for Implementing FP/HIV Integrated Service Delivery.

### Training/Learning Methodology

- ➔ Group discussions
- ➔ Trainer presentation
- ➔ Discussion

### Resource Requirements

- ➔ Marking pens
- ➔ Flipchart
- ➔ Sample record keeping forms
- ➔ Sample referral follow-up forms
- ➔ Copies of Workplanning Forms (*Trainer's Tool VIII*) and Participant Training Evaluation Forms (*Trainer's Tool IX*)



**Time Required:** 2 hours, 30 minutes

## Specific Objective 4.1: Explain the Importance of Record Keeping in FP/HIV Integration.

### CONTENT:

#### ▶ FP/HIV Record Keeping

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.

#### Case Studies

##### Case 1: PMTCT client

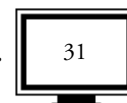
W\_\_\_\_\_ is a 23 year-old woman who gave birth two nights ago to her first baby. During antenatal care she tested positive for HIV and has been on a first-line regimen that includes nevirapine (NVP). W\_\_\_\_\_’s husband is HIV negative. They have decided to delay a next pregnancy. You have counseled W\_\_\_\_\_ and her husband on their contraceptive options and they have chosen to get an implant. You give them a referral slip for W\_\_\_\_\_’s long-acting method choice. You answer their questions about how to prevent condom slippage and demonstrate correct condom use on a penis model.

### METHODOLOGY:

#### ▶ Unit Introduction

The trainer should:

- ➔ Display and read *PowerPoint Slide 31*.



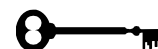
#### Small Group Work and Trainer Presentation (30 min.)

- ➔ Display and read *PowerPoint Slide 32*.



- ➔ Form groups of 3-5 Px for group work (groups should be: those who work in PMTCT, ART, and HCT).

- ➔ Refer each group to *Px Handbook Section 4.1.1: FP/HIV Recordkeeping* and provide copies of *Trainer’s Tool VI: Specific Objective 4.1 Case Studies*. Assign each group a case study.



- ➔ Ask each group to determine how they would fill in each of the three columns (FP need, Method Provided, and Referral) for their client.
- ➔ Explain that each facility may adapt this form as necessary and that it is valuable to discuss with your supervisor how the forms will be collected, shared with referral sites for long-acting methods, and how the data will be analyzed and shared.
- ➔ Explain that providers should work with managers and supervisors to consider adding FP recordkeeping on reporting forms, client cards, or client records.

**CONTENT: CONTINUED****METHODOLOGY: CONTINUED***Case 2: ART client*

A\_\_\_\_\_ is a 20 year-old woman who began ART six months ago. You discussed all of her contraceptive options and she decided to begin pills and use condoms. You gave her a 3 month supply of COCs and told her that she can return to the HIV care and treatment center for her re-supply of condoms and pills. You have counseled her on the importance of dual method use, and asked her to discuss her contraceptive options with her doctor if begins taking any new medications.

*Case 3: HCT client*

B\_\_\_\_\_ is a 35 year-old man with two wives and three children. He has taken an HIV test and has tested positive. You have counseled B\_\_\_\_\_ on follow-up services available for his HIV lab testing, HIV testing for his family, and about contraceptive options. He agreed to bring his wives for testing, begin to use condoms with his wives, and discuss contraceptive methods with his wives, including long-acting methods, which he thinks could be a good option given his financial and health situation. You have given him 30 condoms.

## Specific Objective 4.2: Identify the Steps to Making Referrals.

### CONTENT:

#### ► Types of Referral

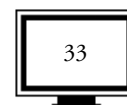
As presented earlier, there are different levels of FP/HIV integration, from Level 1 (assessment of FP needs, provision of condoms/pills/ECP, and referral for other methods) to Level 4 (assessment of FP needs and provision of all methods, including permanent/surgical methods).

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.

### METHODOLOGY:

#### ► Trainer Presentation (10 min.)

- Display and read *PowerPoint Slide 33* to present the types of referral and steps for making a referral.



#### Small Group Exercise (20 min.)

The trainer should:

- Divide Px into small groups according to the health facility in which they work.
- Ask each group to consider their facility and list which methods are available from each service delivery point (for example, which methods are available in HCT services, in PMTCT services, in maternal and child health services?).
- Also, ask each group to discuss current referral procedures in their facility, as well as current challenges and any proposed improvements.
- Ask each group to present their work.
- Explain that each group has just begun making their referral directory, and that each Px should share this with their facility supervisor to discuss their challenges and recommendations for improvements. Providers and supervisors can then establish referral mechanisms, including how to get feedback.
- Refer to *Px Handbook Section 4.2.1: Referrals*.



**CONTENT: CONTINUED****METHODOLOGY: CONTINUED****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.

## Specific Objective 4.3: Develop Workplans for Implementing FP/HIV Integrated Service Delivery.

### CONTENT:


#### ▶ Suggested Action Items for FP/HIV Integration

- Engage the facility FP manager in the AIDS care multidisciplinary team
- Create intra-/inter-facility referral forms for FP from HIV services
- Ensure FP commodity supply in HIV sites
- Create FP method posters to display in outpatient department/PMTCT/antenatal care/voluntary counseling and testing/ART rooms
- Develop FP referral directories for use in HCT, PMTCT, and ART services
- Meet with Community Health Supervisors and Community Health Committees to discuss FP/HIV integration
- Determine long-acting and permanent FP method staff training needs and request training
- Discuss revision of reporting to include FP and implement with health management
- Discuss number of HIV-positive clients with unmet need for FP during facility staff meetings or supervisory visits
- Add FP content to supervision tools
- Make job aids on FP for HIV-positive clients available

### METHODOLOGY:

#### ▶ Small Group Exercise (45 min.)

The trainer should:



- Ask Px to remain in the small groups according to the health facility or district in which they work.
- Ask each group to identify the action items (specific tasks) that will be required to implement FP integration where they work.
- Present the suggested action items in the content as examples of practical tasks they can initiate and implement to begin and improve FP/HIV integration.
- Ask them to fill out *Trainer's Tool VIII: Workplan for Implementing FP/HIV Integrated Service Delivery*. 
- Encourage the discussions to focus on Px' roles in ensuring FP integration is implemented quickly and smoothly.
- Ask each group to present, highlighting the major challenges they identified, as well as any creative solutions they will propose.
- Px should make three copies of this workplan: 1 for themselves, 1 for their supervisors to share upon returning to the facility, and 1 for the training organizers so they can follow-up on trainee implementation and discuss problem-solving with supervisors.



## CONTENT: CONTINUED

## METHODOLOGY: CONTINUED

**Training Conclusion (45 min.)**

- Administer *Trainer's Tool III: Post-Test*. 
- Distribute *Trainer's Tool IX: Participant Evaluation Form*. 
- Complete any presentation of certificates and final logistics.

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- ➔ WHO, Department of Reproductive Health and Research and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs, INFO Project. *Family Planning: A Global Handbook for Providers (2008 update)*. Baltimore and Geneva: CCP and WHO, 2008
- ➔ WHO, *Reproductive Choices and Family Planning for People Living with HIV: Counseling Tool*, World Health Organization, Department of Reproductive Health and Research, 2007



# Trainer's Tools

## Trainer's Tool I: Suggested Training Schedule

| <b>Time/Date</b>      | <b>Day 1</b>                              | <b>Day 2</b>                                   | <b>Day 3</b>   |
|-----------------------|---|--|--|
| 8:30-8:45 AM          | Opening/<br>Introduction                  | Recap  | Recap  |
| 8:45-10:30 AM         | Specific Objectives<br>1.1, 1.2           | Specific Objectives<br>3.1, 3.2, 3.3, 3.4, 3.5 | Specific Objectives<br>3.12, 3.13, 3.14                  |
| <b>10:30-10:45 AM</b> | <b>Tea/Coffee</b>                         | <b>Tea/Coffee</b>                              | <b>Tea/Coffee</b>  |
| 10:45-12:30 AM        | Specific Objectives<br>1.3, 1.4, 1.5      | Specific Objectives<br>3.6, 3.7                | Specific Objectives<br>3.15, 3.16                        |
| <b>12:30-2:00 PM</b>  | <b>Lunch</b>                              | <b>Lunch</b>                                   | <b>Lunch</b>   |
| 2:00-3:30 PM          | Specific Objectives<br>2.1, 2.2, 2.3      | Specific Objectives<br>3.8, 3.9                | Specific Objectives<br>4.1, 4.2, 4.3<br>(end at 4:30 PM) |
| <b>3:30-3:45 PM</b>   | <b>Tea/Coffee</b>                         | <b>Tea/Coffee</b>                              |  |
| 3:45-5:15 PM          | Specific Objectives<br>2.4, 2.5, 2.6, 2.7 | Specific Objectives<br>3.10, 3.11              |  |
| 5:15-5:30 PM          | Synthesis/Reflections                     | Synthesis/Reflections                          |  |

## Trainer's Tool II: Registration Form

Workshop/Training Dates \_\_\_\_\_ and Place \_\_\_\_\_

|    | Participant Name | Sex |   | Work Position | Qualification | Place of Work | Region | Signature |           |
|----|------------------|-----|---|---------------|---------------|---------------|--------|-----------|-----------|
|    |                  | M   | F |               |               |               |        | Morning   | Afternoon |
| 1  |                  |     |   |               |               |               |        |           |           |
| 2  |                  |     |   |               |               |               |        |           |           |
| 3  |                  |     |   |               |               |               |        |           |           |
| 4  |                  |     |   |               |               |               |        |           |           |
| 5  |                  |     |   |               |               |               |        |           |           |
| 6  |                  |     |   |               |               |               |        |           |           |
| 7  |                  |     |   |               |               |               |        |           |           |
| 8  |                  |     |   |               |               |               |        |           |           |
| 9  |                  |     |   |               |               |               |        |           |           |
| 10 |                  |     |   |               |               |               |        |           |           |
| 11 |                  |     |   |               |               |               |        |           |           |
| 12 |                  |     |   |               |               |               |        |           |           |
| 13 |                  |     |   |               |               |               |        |           |           |
| 14 |                  |     |   |               |               |               |        |           |           |
| 15 |                  |     |   |               |               |               |        |           |           |

## Trainer's Tool III: Pre- & Post-Test

Participant Name \_\_\_\_\_

**Instructions:** Circle the letter or letters corresponding with the correct answer (one correct answer for each question).

1. The benefits of FP/HIV integration include:
  - a. FP services and HIV have similar aims of reaching sexually active people
  - b. For PLHIV, pregnancy prevention may be an additional motivation for condom use
  - c. Cost of establishing integrated FP/HIV services is lower because of similarities between FP and HIV services
  - d. All of the above
  
2. Which of the following is the best choice for prevention of HIV and unintended pregnancy?
  - a. Use of condom
  - b. Use of condom and other contraceptive method
  - c. Combined oral contraceptive
  - d. Intrauterine Device (IUD)
  
3. As a provider, what should you do if a concordant HIV-positive couple decides to have a child?
  - a. Acknowledge their decision, discuss possible outcomes, and present safer pregnancy messages
  - b. Convince them not have children because of the danger of transmission
  - c. Wait until they come up with decision
  - d. Agree with their right to have a child and send them home
  
4. For most clients, the best FP method is:
  - a. the one that the health provider thinks is best for a particular client
  - b. the one that is most effective
  - c. the one that is most convenient for the provider
  - d. the one that the client chooses after learning about all the available methods
  - e. all of the above
  
5. "Informed Choice" means that a FP client:
  - a. has been informed about all methods and agrees to use the FP method the provider recommends
  - b. has been informed about the side effects of the method she has chosen
  - c. has informed you of the method she wants
  - d. has the right to choose any method she wants based on full information about all methods available (including the right not to use any method), and has been counseled on all aspects of the method chosen



6. Every FP counseling session should include:
  - a. Privacy
  - b. Confidentiality
  - c. Accepting and non-judgmental clinic staff attitude
  - d. Simple language
  - e. Sufficient time
  - f. All of the above
  
7. FP Counseling for women with HIV should include:
  - a. Discussion of all available FP methods
  - b. Encouragement of voluntary surgical contraception
  - c. Discussion of all FP methods except intrauterine devices (IUDs)
  - d. Discussing only the FP methods providing the best protection from pregnancy
  - e. Encouraging the use of condoms alone for contraception
  
8. Protection against pregnancy, HIV, and other STIs can be achieved by:
  - a. Condom use alone
  - b. Condom use PLUS another method of contraception
  - c. Avoiding penetrative sex
  - d. Using an effective method of contraception with an uninfected partner in a mutually monogamous relationship
  - e. All of the above
  
9. Providers should discuss these issues with HIV+ clients when they are considering FP:
  - a. Need for couples with HIV to abstain from sexual intercourse
  - b. Characteristics of FP methods, including possible side effects and complications
  - c. Ability to use a FP method correctly (e.g., take pills on schedule)
  - d. Advantages of dual method use
  - e. Partner's willingness to use condoms, and condom negotiation strategies
  - f. When to return for questions, problems, method resupply
  - g. All except A
  
10. The following statement about IUDs and PLHIV is true:
  - a. IUDs can be used by any PLHIV safely
  - b. IUD use by PLHIV is limited because of significant interaction with ARVs
  - c. IUDs can generally can be used by PLHIV with certain limitations
  - d. IUDs are not recommended at all for PLHIV

## Trainer's Tool IV: Pre- & Post-Test Answer Key

1. The benefits of FP/HIV integration include:
  - a. FP services and HIV have similar aims of reaching sexually active people
  - b. For PLHIV, pregnancy prevention may be an additional motivation for condom use
  - c. Cost of establishing integrated FP/HIV services is lower because of similarities between FP and HIV services
  - d. All of the above**
  
2. Which of the following is the best choice for prevention of HIV and unintended pregnancy?
  - a. Use of condom
  - b. Use of condom and other contraceptive method**
  - c. Combined oral contraceptive
  - d. Intrauterine Device (IUD)
  
3. As a provider, what should you do if a concordant HIV-positive couple decides to have a child?
  - a. Acknowledge their decision, discuss possible outcomes, and present safer pregnancy messages**
  - b. Convince them not have children because of the danger of transmission
  - c. Wait until they come up with decision
  - d. Agree with their right to have a child and send them home
  
4. For most clients, the best FP method is:
  - a. the one that the health provider thinks is best for a particular client
  - b. the one that is most effective
  - c. the one that is most convenient for the provider
  - d. the one that the client chooses after learning about all the available methods**
  - e. all of the above
  
5. "Informed Choice" means that a FP client:
  - a. has been informed about all methods and agrees to use the FP method the provider recommends
  - b. has been informed about the side effects of the method she has chosen
  - c. has informed you of the method she wants
  - d. has the right to choose any method she wants based on full information about all methods available (including the right not to use any method), and has been counseled on all aspects of the method chosen**

6. Every FP counseling session should include:
  - a. Privacy
  - b. Confidentiality
  - c. Accepting and non-judgmental clinic staff attitude
  - d. Simple language
  - e. Sufficient time
  - f. All of the above**
  
7. FP Counseling for women with HIV should include:
  - a. Discussion of all available FP methods**
  - b. Encouragement of voluntary surgical contraception
  - c. Discussion of all FP methods except intrauterine devices (IUDs)
  - d. Discussing only the FP methods providing the best protection from pregnancy
  - e. Encouraging the use of condoms alone for contraception
  
8. Protection against pregnancy, HIV, and other STIs can be achieved by:
  - a. Condom use alone
  - b. Condom use PLUS another method of contraception
  - c. Avoiding penetrative sex
  - d. Using an effective method of contraception with an uninfected partner in a mutually monogamous relationship
  - e. All of the above**
  
9. Providers should discuss these issues with HIV+ clients when they are considering FP:
  - a. Need for couples with HIV to abstain from sexual intercourse
  - b. Characteristics of FP methods, including possible side effects and complications
  - c. Ability to use a FP method correctly (e.g., take pills on schedule)
  - d. Advantages of dual method use
  - e. Partner's willingness to use condoms, and condom negotiation strategies
  - f. When to return for questions, problems, method resupply
  - g. All except A**
  
10. The following statement about IUDs and PLHIV is true:
  - a. IUDs can be used by any PLHIV safely
  - b. IUD use by PLHIV is limited because of significant interaction with ARVs
  - c. IUDs can generally can be used by PLHIV with certain limitations**
  - d. IUDs are not recommended at all for PLHIV

## Trainer's Tool V: Specific Objective 3.16 Case Studies

### Case 1

G\_\_\_\_, 18 years old, is HIV positive and is healthy on ART (her regimen includes EFV). She is not with a regular partner and does not want any children now, although she might want them in the future if she ever marries.

### Case 2

B\_\_\_\_, 45 years old, and W\_\_\_\_, 38 years old, are HIV positive. They have two healthy children and have decided they do not want any more children.

### Case 3

A\_\_\_\_, 19 years old, is a sex worker who does not know her HIV status and is afraid to go get tested. She comes to you for advice on preventing unwanted pregnancy.

### Case 4

A\_\_\_\_, 25 years old, is HIV negative but is married to a man who is HIV positive. He wants her to be pregnant. She does not want to have children who might be infected but is afraid to go against her husband. She tried the pill, but got very nauseous on it.

### Case 5

D\_\_\_\_, 30 years old, is HIV positive but his wife does not know, and he is not ready to tell her. They have 3 children and although he is using condoms with his wife, he wants to make sure he doesn't have any more children.

## Trainer's Tool VI: Specific Objective 4.1 Case Studies

### Case 1: PMTCT client

W\_\_\_\_\_ is a 23 year-old woman who gave birth two nights ago to her first baby. During antenatal care she tested positive for HIV and has been on a first-line regimen that includes nevirapine (NVP). W\_\_\_\_\_’s husband is HIV negative. They have decided to delay a next pregnancy. You have counseled W\_\_\_\_\_ and her husband on their contraceptive options and they have chosen to get an implant. You give them a referral slip for W\_\_\_\_\_’s long-acting method choice. You answer their questions about how to prevent condom slippage and demonstrate correct condom use on a penis model.

### Case 2: ART client

A\_\_\_\_\_ is a 20 year-old woman who began ART six months ago. You discussed all of her contraceptive options and she decided to begin pills and use condoms. You gave her a 3 month supply of COCs and told her that she can return to the HIV care and treatment center for her re-supply of condoms and pills. You have counseled her on the importance of dual method use, and asked her to discuss her contraceptive options with her doctor if begins taking any new medications.

### Case 3: HCT client

B\_\_\_\_\_ is a 35 year-old man with two wives and three children. He has taken an HIV test and has tested positive. You have counseled B\_\_\_\_\_ on follow-up services available for his HIV lab testing, HIV testing for his family, and about contraceptive options. He agreed to bring his wives for testing, begin to use condoms with his wives, and discuss contraceptive methods with his wives, including long-acting methods, which he thinks could be a good option given his financial and health situation. You have given him 30 condoms.

## **Trainer's Tool VII: Daily Reflections**

The one thing that I learned today that I do not want to forget is:

The information/activity that I found most interesting and useful was:

The one suggestion I have for improving today's training content is:

The trainer's style was:

Any recommendations for the logistics of the training?

## Trainer's Tool VIII: Workplan for Implementing FP/HIV Integrated Service Delivery

| Barrier Identified | Root Cause | Solutions/<br>Action Items | Implementation<br>Schedule | Who is<br>Responsible | Remarks |
|--------------------|------------|----------------------------|----------------------------|-----------------------|---------|
|                    |            |                            |                            |                       |         |
|                    |            |                            |                            |                       |         |
|                    |            |                            |                            |                       |         |
|                    |            |                            |                            |                       |         |
|                    |            |                            |                            |                       |         |
|                    |            |                            |                            |                       |         |

## Trainer's Tool IX: Participant Evaluation Form

Rate each of the following statements as to whether or not you agree with them, using the following key:

- |                             |                     |
|-----------------------------|---------------------|
| 5 Strongly Agree            | 2 Somewhat disagree |
| 4 Somewhat Agree            | 1 Strongly disagree |
| 3 Neither agree or disagree |                     |

| <b>Training Program</b>  | <b>Rating</b> |   |   |   |   |
|--|---------------|---|---|---|---|
| <b><i>I feel that...</i></b>   |               |   |   |   |   |
| The objectives of the training were clearly defined  | 5             | 4 | 3 | 2 | 1 |
| The material was presented clearly and in an organized fashion   | 5             | 4 | 3 | 2 | 1 |
| The pre- and post-tests accurately assessed my in-course learning  | 5             | 4 | 3 | 2 | 1 |
| <b>Technical Information</b>   |               |   |   |   |   |
| I learned new information from this course   | 5             | 4 | 3 | 2 | 1 |
| <b><i>I will now be able to...</i></b>   |               |   |   |   |   |
| Assess Need for FP in HIV services   | 5             | 4 | 3 | 2 | 1 |
| Dispel rumors and misconceptions about FP  | 5             | 4 | 3 | 2 | 1 |
| Provide FP services to men and adolescents   | 5             | 4 | 3 | 2 | 1 |
| Refer clients for long-acting methods  | 5             | 4 | 3 | 2 | 1 |
| Provide PLHIV on ART or OI medication with accurate information on considerations for contraceptive method use | 5             | 4 | 3 | 2 | 1 |
| Provide useful information to HIV-positive women who desire a safer pregnancy                                  | 5             | 4 | 3 | 2 | 1 |
| <b>Training Methodology</b>  |               |   |   |   |   |
| The trainer's presentations were clear and organized   | 5             | 4 | 3 | 2 | 1 |
| Class discussion contributed to my learning  | 5             | 4 | 3 | 2 | 1 |
| I learned practical skills in the role-plays and case studies  | 5             | 4 | 3 | 2 | 1 |
| The trainers encouraged my questions and input   | 5             | 4 | 3 | 2 | 1 |
| <b>Training Location and Schedule</b>  |               |   |   |   |   |
| The training site and schedule were convenient   | 5             | 4 | 3 | 2 | 1 |
| The necessary materials were available   | 5             | 4 | 3 | 2 | 1 |