Counseling Tool:
Reproductive Health Choices for Clients with HIV

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Purpose

This counseling tool, or flip book, is designed to be used by providers who are counseling people with HIV about their reproductive health choices. The tool includes guidance for providers and information for clients on a variety of reproductive health topics that may be of concern to clients with HIV and their partners. Depending on a client's needs, a provider may use this tool as a prompt to address the primary reason for the client's visit and explore other reproductive health issues of concern to the client.

Using this tool, providers can assist clients to:

- Identify their reproductive health goals
- Determine their risk for STIs and unintended pregnancy and how to protect against them
- Learn about HIV, AIDS, and ARV therapy and how to avoid HIV transmission to partners
- Find out how to achieve pregnancy safely and improve the chances of delivering a healthy infant
- Make an informed choice from available contraceptive methods and learn to use the chosen method properly

Using the counseling tool

Information in the counseling tool is grouped by topic. It is intended that providers will use the counseling tool in a nonlinear manner – using only the pages that are relevant to the client's concerns. It is unlikely that all the pages would be used with any one client.

The counseling tool contains "client messages" and "provider cue sheets." The client messages are intended to help explain and emphasize important information. Provider cue sheets include prompts, questions, and additional information for the provider to share with the client. The provider should study the cue sheets in advance and use them as a memory aide during a counseling session rather than read them to the client. The counseling tool should be placed so that both the client and provider can easily see the message pages and the provider can point to information on the page to help explain key information.

Note: To locate topics easily, users may want to add homemade tabs to mark the sections that they use most often. Users should also write on the last page the contact information for referral services in their community so that it is readily available when counseling clients.

Using the counseling tool with different types of clients

Use pages 1–6 to learn about the client's situation and goals. Then use the specific pages that address the client's identified needs. For example:

Client's Goal
Desires pregnancy but is concerned about transmitting HIV to her partner and the baby.

Use pages 7–13 to help her understand and reduce the risks to herself, her partner, and her baby and make an informed decision about pregnancy.

Client's Goal
Wants to avoid pregnancy but is not sure which method she can use while on ARV therapy.

Use pages 14–17 to help her select a method(s) that best suits her needs. Use the pages about the method to ensure that she knows how to use it correctly.

Client's Goal
Had unprotected sex and wants help making a plan and talking with her partner about using the Pill again.

Use pages 42–46 to determine if emergency contraception is desired, help her make a plan, and practice effective ways to talk with her partner. Use pages 25-28 to review information on the Pill.

Client's Goal
Wants to become sexually active but needs information about HIV and AIDS and how to have safe sex.

Use pages 50–52 to provide him with basic information about HIV and AIDS. Use pages 19–21 to counsel him about condoms.

Use only the pages that address the client's individual situation and goals.

Contents

WELCOME

Why have you come to the clinic today?

Welcome the client and inquire about or review the reason(s) for coming.

You mentioned that you came to the health care center for *<client's reason for coming to the clinic>* and we will be sure to address that concern.

Invite client's input.

Please feel comfortable telling or asking me about issues related to your sexual and reproductive health goals and concerns. Your concerns will guide our discussion.

Ensure confidentiality.

Everything we discuss is confidential. The information that you share becomes part of your medical record and will only be available to other health care workers directly involved in your care and treatment on an as-needed basis.

However, I would encourage you to consider "shared confidentiality" whereby this confidentiality agreement is extended to another person or a small team of supporters that you select – such as family members, loved ones, care providers, and trusted friends or neighbors – so that these people have the information that they need to help ensure that you receive proper care, support, and treatment.

Introduce the flip book.

From time to time during our conversation, I may use pages from this flip book to help explain information. Some of the images may also remind you about questions that you have.

What are your goals?

- ✓ Have a healthy and satisfying sexual life
- ✓ Become pregnant and have a healthy baby
- ✓ Prevent pregnancy using contraception
- ✓ Understand risks for STIs and unintended pregnancy
- ✓ Prevent STI or HIV transmission to partner
- ✓ Learn what it means to have HIV or AIDS

What are your reproductive health goals?

In addition to *<client's reason for coming to the clinic>*, we can also explore any other reproductive health goals or concerns that you may have including:

- Having a healthy and satisfying sexual life
- Becoming pregnant and having a healthy baby
- Preventing pregnancy using contraception
- Understanding risks for sexually transmitted infections (STIs) and unintended pregnancy
- Preventing STI or HIV transmission to your partner
- Learning what it means to have HIV or AIDS
- Or any other related issues or concerns

Questions about you

Ideal family size?

Partners?

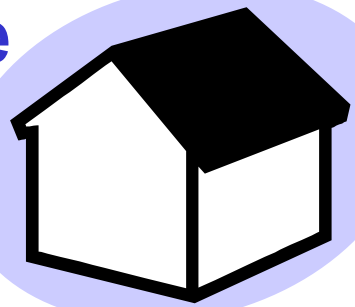
Sexual behavior?

+/-

unknown

HIV status?

Home life?



Brief medical history?

Gather other key information about the client and her or his situation.

I am going to ask you some personal questions now. I ask these questions of all my clients, because I need to fully understand your situation to help you.

Family: How would you describe your ideal family? Number of children you currently have or desire?

Partners: How many partners do you have now? How many in the past? Are your partners of the opposite sex, same sex, or both?

Sexual behavior: How do you feel about your current sexual relationship(s) and your ability to communicate with your partner(s) about sexual activity?

Home life: Tell me about your situation at home and whether you have anyone whom you can call for help or guidance if you need it?

Health history: Do you currently have any major health problems, illnesses, injuries, or symptoms that are concerning you?

Do you engage in any harmful or risky behaviors (such as smoking, drinking excessive amounts of alcohol, having unprotected sex)?

What, if anything, are you currently doing to prevent pregnancy and STIs?

Are you currently breastfeeding?

Are you or could you be pregnant? <*as appropriate, inquire about start date of last menstrual period*>

HIV status: What do you know about your HIV status? About your partner's status? When were you or your partner diagnosed? Are you currently well or unwell? Are you on antiretroviral therapy (ART)? If yes, what medications? When did you start therapy?

You can have a healthy and satisfying sexual life

- **Enjoy sexual intimacy**
- **Observe safer sexual practices**
  - have mutually faithful relationships
  - engage in safer sexual activities
  - use condoms consistently and correctly
  - limit number of sexual partners
  - delay first intercourse

Reassure the client that people with HIV can still have enjoyable sexual lives.

If you choose, you and your partner can still enjoy sexual intimacy and have safer sex. Abstinence is an option, not a requirement.

Some sexual practices are safer than others.

There are known ways to keep the risk of infection low, both the risk of infecting someone else and the risk of getting another infection yourself.

Know your partner and agree to be mutually faithful. Disclosing your HIV status to your partner and knowing your partner's status helps you decide how to have a healthy sexual life.

Do not assume that your partner has an STI or HIV unless tested. Protect your partner.

Do not assume a sexual partner does not have an STI or HIV. Protect yourself.

Engage in safer sexual acts such as massage, hugging, kissing on lips, thigh sex, mutual masturbation, penetrative intercourse using a condom.

Avoid riskier acts, such as anal or vaginal intercourse without a condom.

Condoms – used consistently and correctly – provide protection from STIs but are still not 100 percent effective.

Limit the number of sexual partners to reduce exposure to infection.

For adolescents, delaying first intercourse also reduces risk. Risk of infection is especially high for adolescent girls, who are more susceptible to some STIs for biological reasons (immature cervixes or cervical ectopy).

Consider your STI risk

- **Some situations are more risky than others:**
  - more than one sexual partner
  - a partner with other sexual partners
  - sex without a condom with an infected partner
  - dangerous sexual practices
  - you or your partner have ever had an STI or symptoms

Do you or your partner want to be tested for STIs or HIV?

- **People with STIs or HIV often look and feel healthy**

- **Some STIs have signs and symptoms:**

For WOMEN

- Pain in your lower belly?
- Sores in or around vagina?
- Vaginal discharge that is unusual for you?
- Pain during intercourse?

For MEN

- Pus coming from your penis?
- Open sores anywhere in your genital area?
- Pain or burning when you urinate?

Help the client consider his or her risk of STIs.

STIs are infections that can be spread from person to person by sexual contact.

Some situations are more risky than others. Let me ask you some questions to help determine your risk.*

- Do you have more than one sexual partner?
- Do you think your partner has had another sexual partner?
- Have you engaged in sex without a condom with a partner whose past sexual behavior you do not know?
- What kinds of sexual practices do you and your partner(s) do together?
- Have you or your partner ever had an STI, or do you know if she or he has had any symptoms?

* Alternatively, a provider may say:
Let me tell you about some of these risky situations and you can tell me if any of these may apply to you and your partner.

You may not know if you or your partner has STIs or HIV. A person with STIs or HIV often looks and feels healthy. However, some STIs have signs and symptoms

<ask women>

Do you have:

- Pain in your lower belly?
- Sores in or around your vagina?
- A vaginal discharge that is unusual for you?
- Pain during intercourse?

<ask men>

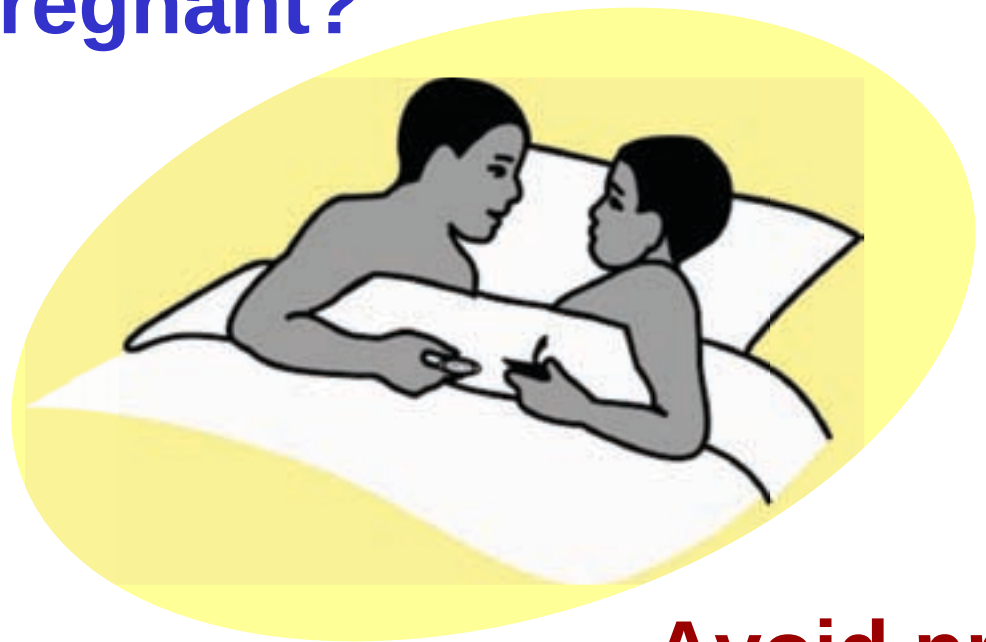
Do you have:

- Pus coming from your penis?
- Pain or burning when you urinate?
- Open sores anywhere in your genital area?

Consider the client's responses and discuss the level of risk. If the client is at risk, ask:
Would you like to be tested for STIs or HIV?

What do you want to do?

Become pregnant?



Avoid pregnancy?

Encourage the client to make a decision regarding fertility intentions.

If you decide to have sexual intercourse, you should decide whether you ***want to become pregnant***.

If you do not wish to become pregnant, you should decide on a contraceptive method to ***avoid an unintended pregnancy***.

An individual or couple's needs vary based on their HIV-status and fertility intentions. They may:

- Be HIV- and want to prevent pregnancy and HIV
- Be HIV+ and want to prevent pregnancy, and need to prevent HIV transmission
- Be HIV- and desire pregnancy, and need to prevent HIV
- Be HIV+ and desire pregnancy, and need to prevent HIV transmission
- Be HIV- and pregnant, and need to prevent HIV
- Be HIV+ and pregnant, and need to prevent HIV transmission
- Be HIV- and have no concerns about pregnancy (e.g., sterilized), and need to prevent HIV
- Be HIV+ and have no concerns about pregnancy (e.g., sterilized), and need to prevent HIV transmission

Considering pregnancy?

What you need to think about:

- **Your health**
- **If you want to disclose your HIV status**
- **Support from partner and family**
- **Access to medical care**
- **Rearing a child with HIV**

Encourage clients considering pregnancy to think about:

Your health

If health is good, pregnancy now may be fine – no signs or symptoms of HIV disease or opportunistic infections (i.e., tuberculosis), CD4 >200, or clinically well on ART.

If health is getting worse, consider delaying pregnancy – weight loss, recurrent upper respiratory tract infections, CD4 <200, or in first six weeks ART.

If health is poor, pregnancy now is not a good idea – HIV wasting, taking tuberculosis (TB) treatment, CD4 <100, or waiting to start ART.

Do you have any *other health conditions* (not related to HIV) that may complicate pregnancy (e.g., severe anemia, high blood pressure, diabetes, kidney disease, malaria, or are you currently taking medications that may be harmful to a developing fetus).

Telling others your HIV status

Whom have you told or are planning to tell?

Having a baby may make you reconsider whom you tell about your HIV status. You may want to or will need to share your HIV status with others whom you would not otherwise have told.

Some people feel pressured to have a baby to convince others that they are not infected. Are you being honest with yourself?

Support from your partner and family

Do you have a steady partner? Does your partner know your HIV status? Is your partner supportive? Will your partner help with the baby?

Does your partner know his or her status or are they willing to be tested? How is your partner's health?

Is your family supportive or would they reject a child with HIV?

Are family members near by and able to help, especially if you get worse and are not able to care for your child?

Medical care and other services for you and your baby

How available, accessible, and affordable are services?

Rearing a child with HIV

Do you have concerns about stigma and discrimination for yourself and your child?

Are you able to feed and care for the infant in the recommended way to lower chances of passing HIV?

Is there a guardian who can raise your child if something happens to you or your partner?

Considering pregnancy?

Risks you need to think about:

Mother
minimal risk for women without advanced HIV

Baby
risk of HIV infection, premature birth, low birth weight

Partner
risk of HIV infection if uninfected

Pregnancy risks for women with HIV are not as high as many people think.

Risks to mother

There is no increased risk of serious pregnancy-related complications for women with HIV infection who are clinically well.

Pregnancy will *not* speed the course of HIV infection.

Risks to baby

If the mother is living with HIV, the baby may get HIV during pregnancy, childbirth, or breastfeeding. Most babies do not become infected, and treatment can lower risk.

If mother is living with HIV, there is a greater chance of stillbirth, premature birth, or low birth weight.

Risks to partner

If a man is uninfected, he may have to risk getting HIV while the couple is trying to conceive. Artificial insemination will avoid risk to him.

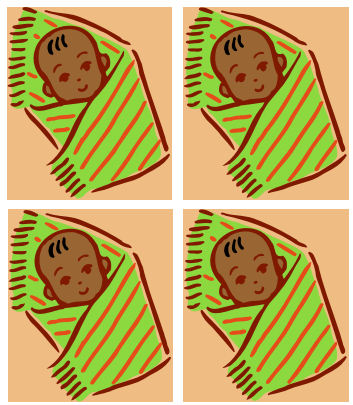
If a woman is uninfected, she may have to risk getting HIV to become pregnant.

There are ways to reduce risks for the woman, her partner, and the infant.

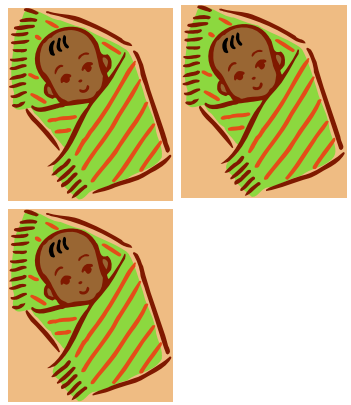
Risk of infant infection if mother with HIV is not treated

If 20 women with HIV have babies:

13 babies will be HIV-free



4 babies will be infected with HIV through pregnancy and delivery



3 more babies will be infected with HIV through breastfeeding

7 babies will be infected with HIV

However, with proper care of mothers and babies, only about 3 babies out of 20 will be infected.

A baby may get HIV during pregnancy, childbirth, or breastfeeding.

Most babies born to women with HIV do *not* become infected with HIV.

If 20 women with HIV have babies:

- 13 will not be infected
- 4 will be infected through pregnancy and delivery
- 3 will be infected through breastfeeding

However, if the mothers and babies are treated, and babies are exclusively breastfed for the first 6 months, only about 3 babies out of 20 will be infected.

Commonly used antibody tests cannot tell if a baby is infected with HIV until the baby is approximately 18 months old.

Reducing HIV risks – “safe” methods of conception

If the man is negative and the woman is positive, consider artificial insemination

If one partner is infected and the other is not, engage in unprotected sex *only* around the time of ovulation

If health is poor or the viral load is high, delay conception until health improves

Reduce risk while trying to conceive.

If the *man is uninfected,* artificial insemination will avoid risk to him.

If *either partner is uninfected*, have sex without condoms only right before or on the day of expected ovulation. <*see next page to help the client determine fertile time*>

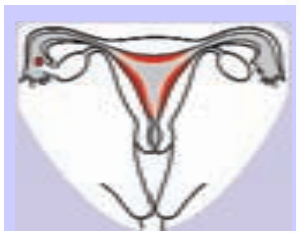
HIV infection can make it more difficult to become pregnant. Patience and caution are necessary.

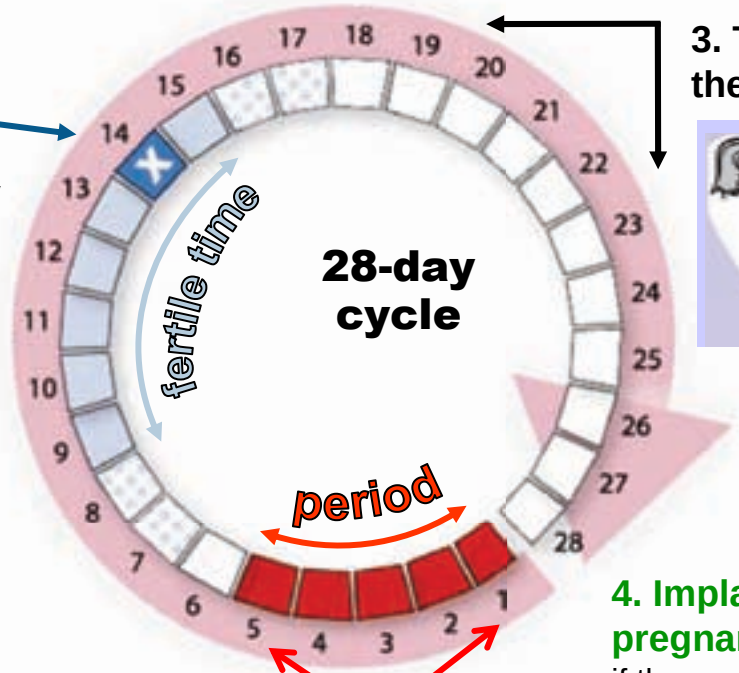
If the infected partner's health is poor, or the viral load is high, delay attempts to conceive until health improves or the viral load decreases.

Finding the fertile time of the menstrual cycle

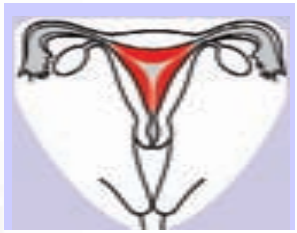
The fertile time is the time during the menstrual cycle when intercourse could lead to pregnancy. It starts 5 days prior to ovulation and continues for 1 day after ovulation occurs.

2. Ovulation
occurs between days 12 and 16 of a 28-day cycle, usually about 14 days before the next period

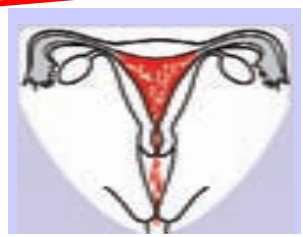




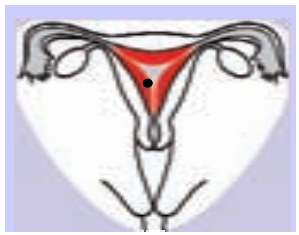
3. Thickening of the womb lining



1. Menstruation/period
can last 2 to 7 days, often about 5 days; first day of bleeding is first day of menstrual cycle

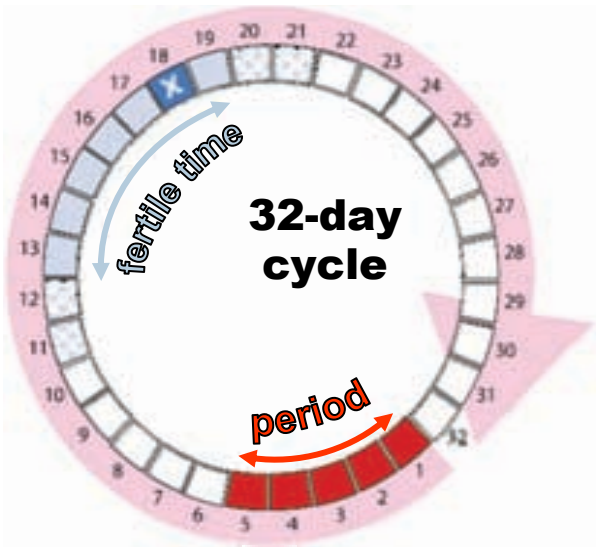


4. Implantation and pregnancy
if the egg is fertilized, it may attach to the lining of the womb; otherwise, the cycle repeats itself



Facts about the Menstrual Cycle

- Lasts 28 days on average – can range from 23 to 35 days
- Time from beginning of a period to ovulation may vary from woman to woman and from cycle to cycle
- Time from ovulation to the start of the next period is the same for everyone – about 14 days. For example, in a 28-day cycle, ovulation occurs about day 14; whereas in a 32-day cycle, it is about day 18.



Finding the fertile time of the menstrual cycle

The fertile time is the time during the menstrual cycle when intercourse could lead to pregnancy. It starts 5 days prior to ovulation and continues for 1 day after ovulation occurs.

Key Points

- The menstrual cycle is the process whereby a woman's body prepares for a possible pregnancy.
- Menstruation (periods) usually start between the ages of 11 and 17 and stop at the time of menopause (between the ages of 45 and 55).
- Each menstrual cycle begins on the first day of bleeding and ends on the day before the next bleeding.
- The menstrual cycle usually lasts around 28 days, but varies from woman to woman, and sometimes from month to month. It can range from 23 to 35 days.
- Ovulation usually occurs 14 days prior to the start of the next period. However, the precise day of ovulation cannot be predicted.
- Even women with regular cycles may experience slight fluctuations from one month to the next. The fertile time may occur 2 days earlier or later when the length of the cycle is shorter or longer. A woman trying to achieve pregnancy may want to chart her cycles for several months to calculate the times when she is most likely to be fertile and to have intercourse during that time.

1. Menstruation/period

can last 2 to 7 days, often about 5 days; first day of bleeding is first day of menstrual cycle

If there is no pregnancy, the thickened lining of the womb and some blood is shed through the vagina. This monthly bleeding is called menstruation (period).

Menstruation is variable; some women bleed for 2 days, while others bleed up to 8 days. Bleeding can be heavy or light and may be accompanied by cramping.

2. Ovulation

occurs between days 12 and 16 of a 28-day cycle; usually 14 days before period

Usually 1 egg develops fully and is released from an ovary during each cycle. After release from the ovary, an egg retains potential for fertilization for 12 to 24 hours.

3. Thickening of the womb lining

The lining of the womb (endometrium) becomes thicker to prepare for a fertilized egg. If there is no pregnancy, the unfertilized egg dissolves.

4. Implantation and pregnancy

if the egg is fertilized, it may attach to the lining of the womb; otherwise, the cycle repeats itself

If unprotected sex occurs and the woman's egg is fertilized by the man's sperm, the fertilized egg travels along the tube for 2 to 3 days and may implant in the lining of the womb. This is the beginning of pregnancy, and menstruation will stop for the duration of pregnancy. If no implantation takes place, another menstrual cycle begins.

Reducing risks during pregnancy and delivery

- **Avoid unprotected sex – infections can be harmful to the woman and the baby**
- **Get antenatal care (ANC)**
- **Use ARV drugs (for therapy or prophylaxis) as recommended**
- **Deliver the baby with help from a provider**

If you take efavirenz, you will have to switch to another ART regimen before becoming pregnant.

Reduce risk during pregnancy and delivery by taking care of yourself and getting treatment.

- Avoid unprotected sex during pregnancy by using condoms. It lessens the chance of becoming infected with an STI that could be dangerous to you and your baby.

  Among discordant couples where the woman is not infected with HIV, it is very important that she avoid becoming infected with HIV during pregnancy and breastfeeding. This is because when a person is newly infected with HIV, their viral load is very high and the risk of transmitting HIV is increased. Therefore, if a woman becomes infected with HIV during pregnancy or breastfeeding, the likelihood of transmitting HIV infection to the baby is greater.

- Visit an antenatal care facility for regular antenatal check-ups.

- Use antiretroviral (ARV) drugs for therapy or prophylaxis as recommended.

  Women who are eligible for and using ARV therapy are less likely to transmit HIV to their baby than women who are not on ARV therapy. Women who are not eligible for standard ARV therapy should use ARV prophylaxis at time of delivery. Typically, a woman takes prophylactic drugs at the onset of labor or when she arrives for delivery. All babies – those born to women on standard ARV therapy and those born to women using ARV prophylaxis – should receive prophylactic treatment after birth.

- Ensure that your delivery is attended by a skilled provider trained to reduce the baby's exposure to infection.

  Delivery by elective cesarean-section – at 38 weeks or before the rupture of membranes – may be an option for women with a high viral load at the time of delivery. For most women with HIV in low-resource settings, vaginal delivery with prophylaxis is the most appropriate option.

If you are taking efavirenz, your provider should adjust your ART regimen before you become pregnant. Efavirenz can cause birth defects if taken during first trimester of pregnancy.

Reducing HIV risks during infant feeding

Exclusive breastfeeding for 6 months

Feeding formula or pasteurized breast milk using cup and spoon or bottle

Mixed feeding increases HIV risk for your baby.

Reduce risk to the infant by choosing the feeding option that is best for your situation.

Formula feeding or replacement feeding – avoidance of all breastfeeding by HIV-positive mothers is recommended if replacement feeding is acceptable, feasible, affordable, sustainable, and safe. After 6 months, the infant should begin receiving complementary foods made from appropriately prepared and nutrient-enriched family foods. Infants should be assessed regularly, and the mother should receive infant feeding counseling at key points during the infant's development when feeding decisions may need to be reconsidered.

Exclusive breastfeeding – is recommended for the first 6 months of life when there is no other safe alternative to the mother's breast milk. Exclusive breastfeeding carries some risk of HIV transmission, but it is lower than mixed feeding. At 6 months, breastfeeding should be replaced by other foods; however, if replacement feeding is still not acceptable, feasible, affordable, sustainable, and safe, then continuation of breastfeeding with complementary foods is recommended. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided. Breastfeeding mothers of infants and young children who are known to be HIV-positive should be strongly encouraged to continue breastfeeding.

Mixed feeding with both breast milk and other feeds should be avoided – particularly for the first 6 months; it has been associated with a higher risk of HIV infection for the infant than exclusive breastfeeding; it increases the risk of both HIV transmission through breastfeeding and the risk of diarrhea and other infectious diseases from giving other foods.

Ensure that your client understands both the risks and benefits of various infant feeding options.

Definitions

Exclusive breastfeeding means feeding only breast milk – from the breast or expressed – day and night on request, not on schedule. Breastfeed as early as possible after delivery. Breastfeed without supplements until the infant is about 6 months of age. Avoid using pacifiers and bottles if you give the baby expressed milk. Pacifiers diminish the baby's need to suckle for comfort. Bottles may confuse the infant and can lead the baby to reject the breast. Feed only breast milk from the mother's or wet nurse's breast – or expressed breast milk from the mother, a breast milk donor, or a milk bank – and no other liquids or solids with the exception of drops or syrups consisting of vitamins, mineral supplements, or medicines.

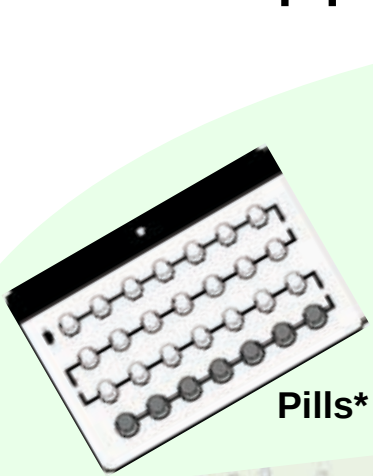
Replacement feeding refers to the process of feeding an infant who is not being breastfed by its mother with a diet that provides all the nutrients the infant needs. During the first 6 months, this should be with a suitable substitute for the mother's breast milk – commercial infant formula; home-prepared formula with micronutrient supplements; the mother's heat-treated/pasteurized, expressed breast milk; breast milk acquired from a milk bank; or breastfeeding by a wet nurse. The woman and her infant must have ongoing access to a sufficient, clean supply of this alternative form of milk, which is often not possible in many settings.

Partial breastfeeding or mixed feeding means giving a baby some breastfeeds and some artificial feeds of milk, cereal, or other food. Mixed feeding is believed to expose the infant to agents that cause inflammation and damage to the gut mucosal barriers – which can lead to HIV infection.

Delaying or avoiding pregnancy?

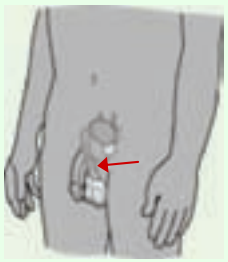
You can use almost any family planning method.

- In most cases, treatments and contraceptives do not conflict
- Condoms help prevent infection in addition to pregnancy

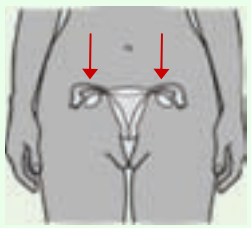


Pills*

Condoms



Vasectomy*



Tubal ligation*

Implants

IUDs*

Injectables

Fertility awareness methods

Abstinence

* IUDs and sterilization may not be immediately suitable for some clients with AIDS.

People with HIV can use almost any method except:

- Spermicides or diaphragm with spermicides – might increase the infection risk for an uninfected woman or the risk of HIV superinfection for a woman with HIV.

People with AIDS who are not clinically well should not initiate:

- The IUD – if the woman has an AIDS-related illness and is not taking ARVs.
- Sterilization – it should be delayed until condition improves.

There are no other limitations related to HIV status. However, clients with HIV may have other conditions or characteristics that would limit their eligibility to use a particular method.

In most cases, treatments and contraceptives do not conflict.

- Women on ART can become pregnant and should use contraception to avoid unintended pregnancy.
- Women taking any type of ARV drugs can use DMPA without restrictions because effectiveness of DMPA does not seem to be affected by ARV drugs.
- Women whose ART regimen contains ritonavir generally should not use oral contraceptive pills or combined injectables because ritonavir reduces the blood levels of the contraceptive hormones of these methods to the extent that it may reduce their effectiveness.
- Women who take ARV regimens without ritonavir can generally use oral contraceptives, implants, and NET-EN, however, correct and consistent use of the hormonal method and using condoms as a backup should be encouraged.
- Rifampicin and rifabutin (used for TB treatment) significantly lowers the effectiveness of oral contraceptives. The client should be counseled to choose another method. Other antibiotics cause no problem.

Condoms can help prevent both pregnancy and infection.

- Male and female condoms are the only contraceptive methods that also help prevent infections.
- It is important to use a condom correctly and consistently with *every* act of vaginal or anal intercourse.

Which method is best for you?

Consider these features:

- Can have more children later
- Good while breastfeeding
- Nothing to do before sex
- Very effective
- Protects against STIs or HIV
- Private
- Acceptable side effects
- Easy to use
- Easy to stop
- Used only when needed
- Avoids touching genitals
- Other features

Do you have a method in mind?
If you do, let's talk about how it suits you.

- What do you like about it?
- What have you heard about it?

Check if the client understands the method.

- What does the client know about the method and does she or he need more information, especially on how to use the method and possible side effects?
- If the client's answers suggest a misunderstanding or incorrect information, discuss and clarify it.

Ask questions to see if the method suits the client.

For example:

- Are you sure that you could remember to take a pill every day?
- Will bleeding changes be acceptable?
- Will you be able to come back for injections?

Check if the client would like to know about other methods.

If you do not have a method in mind, we can discuss your life situation and what features are the most important to you.

- What you have heard about family planning methods?
- What are your experiences or concerns with family planning?
- What are your partner's or family's attitudes?
- What are your plans for having children?
- How important is it to not get pregnant now?
- What is your need for protection from STIs and HIV?
- Do you have other needs and concerns?

Ask questions to see if the method suits the client.

For example:

- Here are some things to consider when choosing a family planning method – effectiveness, temporary or permanent, private, ease of use, common side effects, etc.
- What is most important to you?
- The choice is yours. I want you to be happy with your choice.

Ask these questions to help clients focus on the methods most suited to their needs:

- Do you wish to have children in the future?
- Are you breastfeeding an infant less than 6 months old?
- Do you have the cooperation of your partner in family planning?
- Are there any methods that you do not want to use or have not tolerated in the past?
- Do you need protection from STIs and HIV?

For clients who desire protection from STIs and HIV, see next page.

Ways to avoid both pregnancy and STIs or HIV

Options using family planning methods:

1 Condoms

Male or Female

2 Condoms AND another family planning method

For example:

AND

3 Any family planning method with a mutually faithful partner*

Some other options:

4 Other safe forms of intimacy

5 Delay or avoid having sex

*** An uninfected partner in a mutually faithful *discordant* couple may become infected with HIV.**

Dual protection (avoiding pregnancy and STIs or HIV) can be achieved in several ways:

1. Consistent and correct use of condoms can be very effective for contraception, and condoms are the only method that also protect against STIs and HIV when used during vaginal, anal, and oral intercourse. When using this option, emergency contraception should be available to prevent pregnancy should a condom accident occur.

2. Use of condoms *and* another family planning method – also known as dual method use – offers more protection from pregnancy than condoms alone and protects against STIs.

3. Any contraceptive method can be used if an individual and his or her partner are mutually monogamous. If a couple is discordant, the uninfected partner is at risk of HIV infection. If both partners are HIV-positive, there is some risk of reinfection with a different strain of HIV.

4. Sexual intimacy that avoids contact with a partner's semen or vaginal secretions can be satisfying without spreading STIs or HIV. Unprotected anal and oral sex should also be avoided.

5. Delaying or avoiding sexual activity, also known as abstinence, can be a good choice for some adolescents or unmarried adults.

   If a client chooses option 4 or 5, be sure to advise on the need for protection should she or he decide to have sex. Advise to always keep condoms at hand, just in case.

Compare method effectiveness and ease of use

More effective

Less than 1 pregnancy per 100 women in 1 year

Implants

IUD

Female Sterilization

Vasectomy

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months

Injectables

LAM

Pills

Patch

Vaginal ring

Injectables: Get repeat injections on time

Lactational Amenorrhea Method (for 6 months): Breastfeed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time

Male condoms

Diaphragm*

Female condoms

Fertility awareness methods

Condoms, diaphragm: Use correctly every time you have sex

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and TwoDay Method) may be easier to use.

Withdrawal

Spermicides*

Withdrawal, spermicides: Use correctly every time you have sex

* *Spermicides and diaphragms with spermicide should not be used by women with HIV or at risk of HIV.*

Less effective

About 30 pregnancies per 100 women in 1 year

Encourage the client to compare effectiveness and ease of use when deciding which method to use.

- The effectiveness of some methods depends on the user. Do you think you can use the method correctly?
- How important is it to you to avoid pregnancy?
- Will your partner approve, help, or take responsibility?
- Do you want a method that can be used without the knowledge of your partner?
- Are the possible side effects of the method something that you find tolerable?
- Is there anything about using the method that you find challenging, such as touching your genitals, having to take a pill every day, or getting an injection?

Male methods and cooperation

- Male condoms and vasectomy are used by men.
- The male partner must cooperate for use of male and female condoms, withdrawal, and fertility awareness methods.

Permanent, long-acting, or short-acting

- Tubal ligation and vasectomy are permanent.
- IUDs and implants can stay in place for many years if desired.
- Short-acting methods can be easily discontinued when pregnancy is desired, although with the injectable DMPA, there is a delay in return to fertility.

Protection from STIs

- Male and female condoms – if used consistently and correctly – are the only contraceptives that help protect against many STIs.

Special considerations for clients with HIV

Spermicides and diaphragm with spermicide – should not be used by women with HIV or at risk of HIV; could increase the chances of HIV infection (or superinfection).

IUD – may be inserted if a woman has HIV or AIDS and is doing clinically well on ARV therapy, does not have gonorrhea or chlamydia, and is not at very high individual risk of these infections.

LAM – breast milk can pass HIV to the baby, but exclusive breastfeeding for the first few months is safer than mixed feeding.

Sterilization – should be delayed if a client currently has certain conditions or an opportunistic infection.

Source: World Health Organization/Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs/INFO Project (CCP). *Family Planning: A Global Handbook for Providers*. Baltimore, MD and Geneva: CCP and WHO, 2007.

Not having sex: abstaining or delaying

Be ready in case you decide to have sex

Some clients choose to protect themselves from pregnancy and STIs by avoiding sex.

Avoiding sex may be an appropriate choice for some clients – for example, clients with no regular sexual partner or young clients who are not in a long-term relationship. Abstinence may not be an option for many married couples.

How will it work? Will it keep working?

If avoiding sex by choice, can the client maintain this behavior?

Does the partner (if any) agree? <*see page 46 on talking with the partner*>

What makes avoiding sex difficult? What could help?

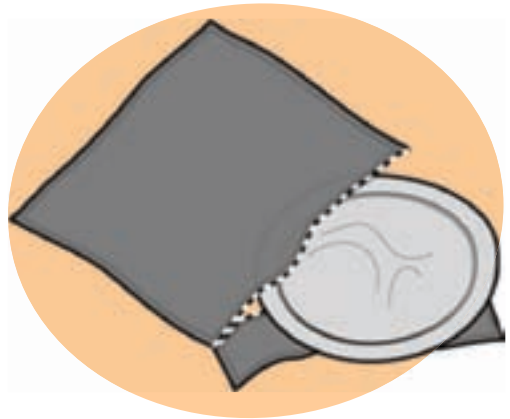
If the client's situation changes, how will the client protect himself or herself?

What are other possible choices now and in the future?

What kinds of sexual activity would be acceptable and safe?

Encourage the client to keep a supply of condoms and emergency contraceptive pills, just in case.

Male condom



- **Very effective when used correctly every time you have sex**
- **Protects you and your partner from infection and pregnancy**
- **Can be used alone or with another method**
- **Easy to get, easy to use**
- **Partners usually need to discuss**

Facts you should know about male condoms:

- Condoms are rubber (latex) sheaths that cover the penis during sex. Condoms work by collecting semen, thus preventing sperm from fertilizing the woman's egg.
- Correct and consistent use of condoms protects you and your partner from STIs and pregnancy.
- If you and your partner rely on another family planning method (except the female condom), adding male condoms will provide protection from infection. Condoms can also be used as a backup method when pills are missed, you are late getting an injection, or you are taking ARVs and may need additional protection from pregnancy.
- Condoms are sold in many shops and health clinics. It is easy to learn how to use condoms.
- Using condoms is a responsible act that shows your concern for your own and your partner's health. Proposing condom use does not mean a person is infected with HIV; it means that the person is responsible and caring. It should not imply mistrust.

Clarify common myths and misunderstandings:

- Condoms do not contain or spread HIV.
- Most people who use condoms do not have HIV and are healthy.
- Many married couples use condoms. They are not only for sex outside marriage.
- Using condoms may change the sensation of sex, but sex is still enjoyable. Some couples find sex even more enjoyable with condoms.
- Condoms (so long as they are not expired) are typically very high in quality and do not have holes. When properly cared for and used according to the instructions, condoms rarely break.
- Nearly everyone can use male condoms, regardless of penis size.
- Male condoms do not make men sterile, impotent, or weak and do not decrease their sex drive.

Possible questions to ask:

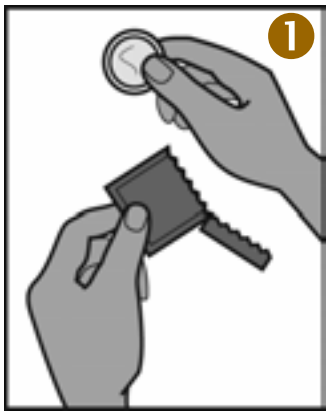
What have you heard about condoms? Do you have concerns?

Would you be able to use condoms consistently and correctly?

Would your partner agree to use condoms?

Would you be able to keep a supply of condoms on hand?

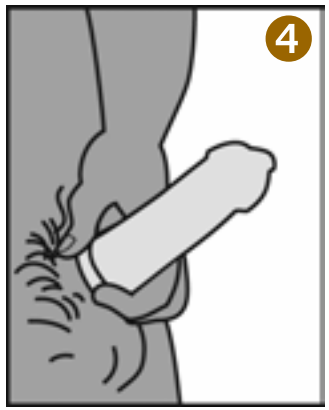
How to use a male condom



Use a new condom for each sex act.

Before any contact, place the condom on the tip of the erect penis with the rolled side out.

Unroll the condom all the way to the base of the penis.



After ejaculation, hold the rim of the condom in place and withdraw the penis while it is still hard.

Throw the used condom away safely.

How to use a male condom

❶ Use a new condom for each sex act.

- Check the date on the package to ensure that the condom is not expired; condoms should be used within 5 years of the manufacturing date.
- Open the package carefully.

❷ Before any contact, place the condom on the tip of the erect penis with the rolled side out.

- Before placing the condom on penis, unroll it slightly to make sure that it unrolls in the right direction.
- Place the condom on the penis (before the penis touches the vagina or the anus).

❸ Unroll the condom all the way to the base of the penis.

- If the condom does not unroll easily, it may be backward or too old. Use a new condom.
- Lubricants (water-based, not oil-based for latex condoms) can be used and should be always used during anal intercourse.

❹ After ejaculation, hold the rim of the condom in place and withdraw the penis while it is still hard.

- Slide the condom off without spilling semen on the vaginal opening or the anus.
- Check the condom for damage. If the condom breaks, falls off, or leaks, consider the risk of STIs and the need for emergency contraception.

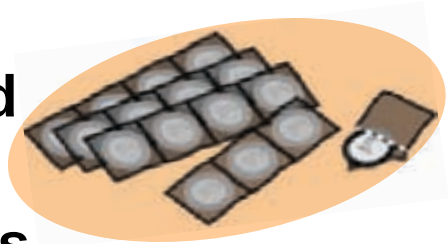
❺ Throw the used condom away safely.

- Wrap the condom in tissue (if possible) and throw it away in a bin or trash can, as appropriate.

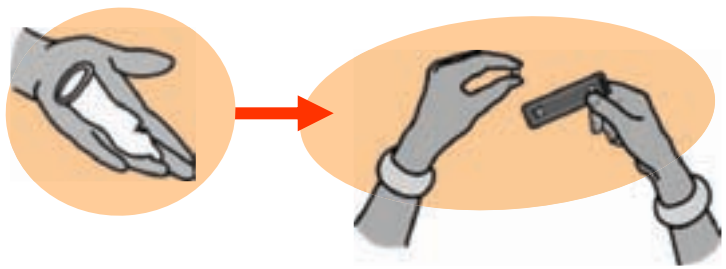
Male condoms: what to remember

- Use correctly every time

- Keep plenty on hand



- If the condom breaks, consider emergency contraception



- Water-based lubricants only

- No oil-based lubricants

- Store away from sun and heat

Remind clients:

Use a condom correctly every time.

- Use every time you have vaginal or anal sex to avoid unintended pregnancy and infection. If you cannot use a condom every time, another method of family planning can prevent pregnancy but not infection.

Make sure you always have enough condoms.

- Condoms should be used only once. Get more condoms before your supply is gone.

If a condom breaks, use emergency contraception as soon as possible.

- Condoms rarely break if used properly. Review instructions for proper use and make sure the condom is not damaged or old. Do not use if an unopened package is torn or leaking, or the condom is dried out. Although most condoms are lubricated, you can apply additional water-based lubricant on the outside of the condom.

Offer emergency contraceptive pills to take home in case the condom breaks or slips.

Use only water-based lubricants.

- Adequate lubrication is important. Oils weaken condoms and can cause breakage. Do not use oil-based materials such as mineral oil, baby oil, body lotion, petroleum jelly, cooking oil, palm oil, coconut oil, or butter. Water-based materials include glycerin, certain commercial lubricants, and saliva.

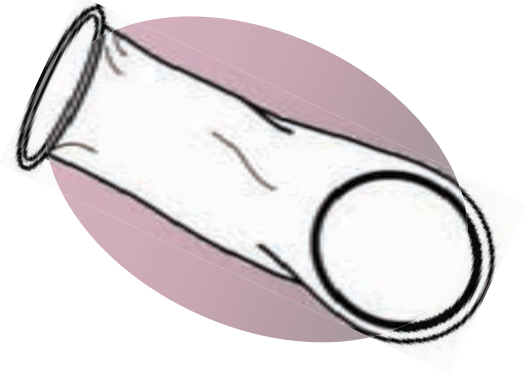
Tell clients whether condoms supplied at your facility are lubricated or not.

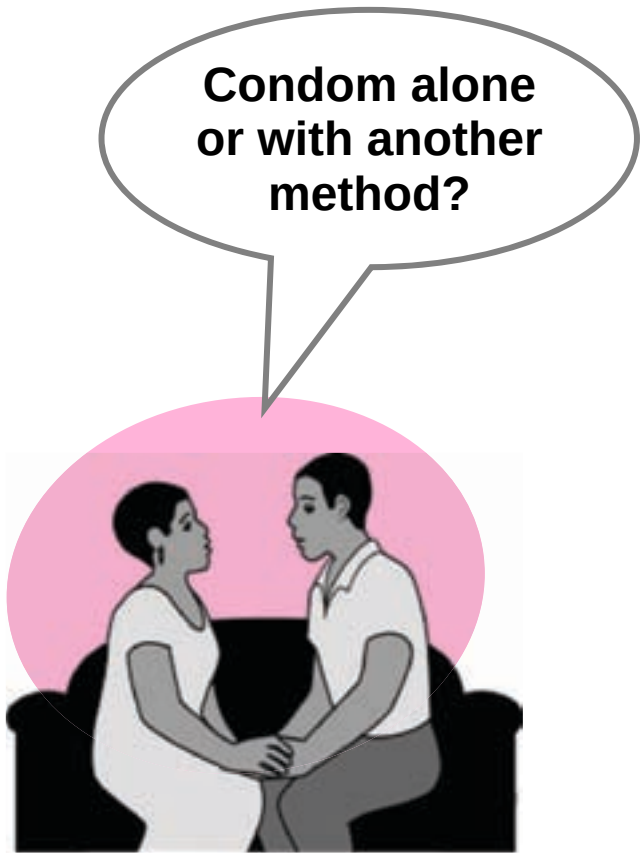
Store condoms away from direct sunlight and heat.

- Sunlight and heat can make condoms weak and cause breakage. Condoms may expire earlier than the date indicated on the package if they are not properly stored.
- Check the expiration or manufacture date on the box or individual package of condoms. Expiration dates are marked as “Exp”; otherwise, the date is the manufacture date (MFG). Latex condoms should not be used beyond their expiration date or more than 5 years after the manufacturing date. Condoms in packages that are damaged or show obvious signs of deterioration (e.g., brittleness, stickiness, or discoloration) should not be used regardless of the expiration date.

Female condom

- Effective when used correctly every time you have sex
- Protects you and your partner from infection and pregnancy
- Can be used alone or with another method
- May be expensive and hard to find
- Inserted by the woman but needs her partner’s cooperation





Facts you should know about female condoms:

- Female condoms are loose plastic sheaths that are inserted into the vagina before any sexual contact. Female condoms work like male condoms by collecting semen, thus preventing sperm from fertilizing the woman's egg. No medical conditions limit their use. There are no allergic reactions because they are made of plastic, rather than the latex of most male condoms.
- Correct and consistent use of condoms protects you and your partner from pregnancy and STIs. Female condoms may be less effective than male condoms because sometimes the penis is unknowingly inserted outside the condom.
- If you and your partner rely on another family planning method (except the male condom), adding female condoms will provide protection from infection. Condoms can also be used as a backup method when pills are missed, you are late getting an injection, or you are taking ARVs and may need additional protection from pregnancy.
- Female condoms are more expensive and are frequently not as available as male condoms.
- Like male condoms, female condoms require partner cooperation.

Possible questions to ask:

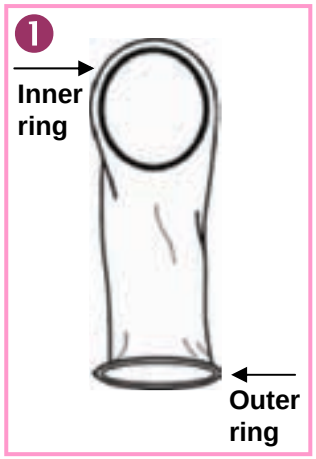
What have you heard about condoms? Do you have concerns?

Would you be able to use condoms consistently and correctly?

Would your partner agree to use condoms?

Would you be able to keep a supply of condoms on hand?

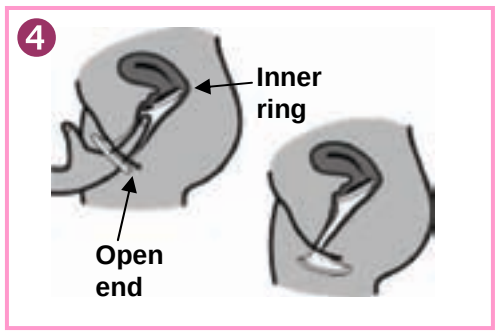
How to use a female condom



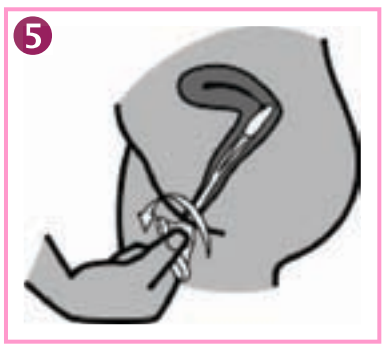
- Make sure the condom is well-lubricated inside.

- Squeeze the inner ring at the closed end of condom.

- Choose a comfortable position – squat, raise one leg, sit, or lie down.
- With the other hand, separate the outer lips of the vagina.



- Gently insert the inner ring into the vagina.
- Place the index finger inside the condom and push the inner ring up as far as it will go.
- Make sure the outer ring is outside the vagina and the condom is not twisted.
- Be sure that the penis enters the condom and stays inside it during intercourse.



- To remove, twist outer ring and pull gently.
- Reuse is not recommended.
- Throw used condom away safely.

How to use a female condom

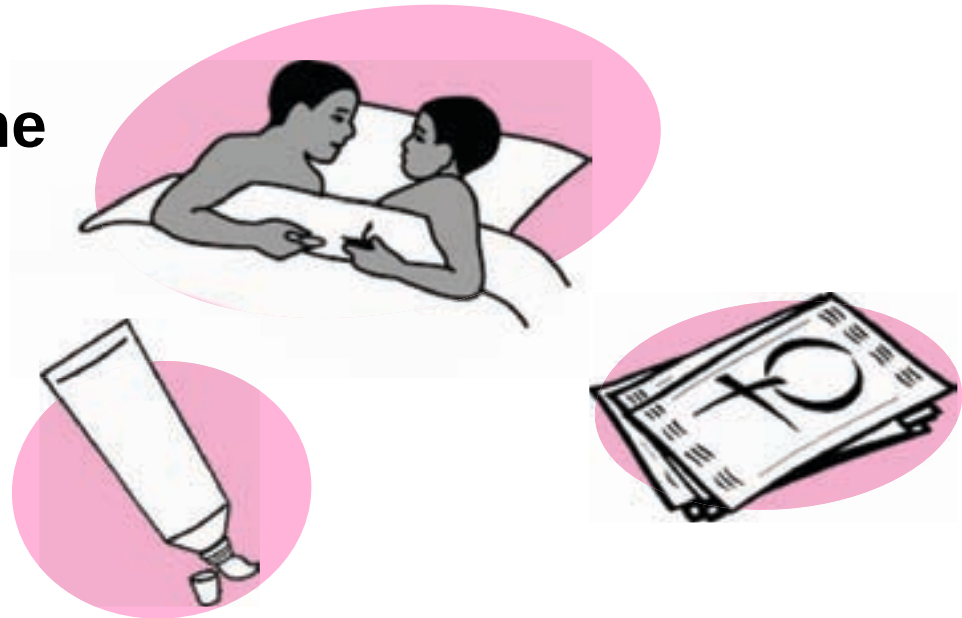
1. Check the expiry or manufacturing date.
   - Open the package carefully.
   - Make sure the condom is well-lubricated inside.
2. Squeeze the inner ring at the closed end of condom.
3. Choose a comfortable position – squat, raise one leg, sit, or lie down.
   - With the other hand, separate the outer lips of the vagina.
4. Gently insert the inner ring into the vagina.
   - Place the index finger inside the condom and push the inner ring up as far as it will go.
   - Make sure the outer ring is outside the vagina and the condom is not twisted.
   - Be sure that the penis enters the condom (not between the side of the condom and the vaginal wall) and stays inside it during intercourse.
5. To remove, twist the outer ring and pull gently.
   - Throw used condom away safely.

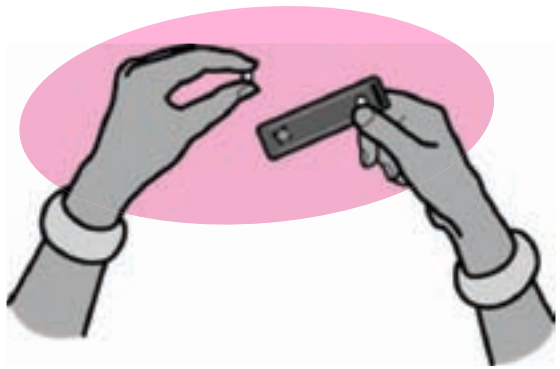
Additional hints for using female condoms:

- Use a new condom for each act of intercourse.
- Female condoms have a shelf life of 5 years from the date of manufacture. They are made of plastic, rather than latex, so there are no special storage requirements.
- Insert the condom *before* the penis touches the vagina.
- Insert the condom up to 8 hours prior to intercourse.
- If necessary, add more lubricant either inside the condom or on the penis. The condom is lubricated, but it may need extra lubricant inside so it is not moved out of place during sex. Lubricant can be water-based or oil-based.
- Following intercourse, move away from your partner and take care not to spill semen on the vaginal opening.
- Dispose of the condom properly in a bin or trash can.

Female condoms: what to remember

- **Use correctly every time**
- **Keep plenty on hand**
- **Use more lubricant if needed**
- **If not used correctly, consider emergency contraception**





Remind clients:

Use a condom correctly every time.

- Use every time you have sex to avoid pregnancy and infection. If you cannot use a condom every time, another method of family planning can prevent pregnancy but not infection.
- If using a condom every time is a problem, discuss reasons and possible solutions.

Make sure you always have enough condoms.

- Get more condoms before your supply is gone.

If a condom is not used or is not used correctly, use emergency contraception as soon as possible.

- If a condom was not used, does not stay in place, or gets pushed inside the vagina, or if the penis was not inside the condom, emergency contraception can help prevent pregnancy.

Offer emergency contraceptive pills to take home in case of problems with a condom.

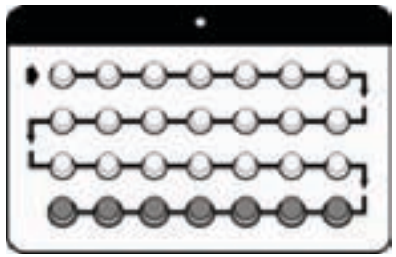
Use more lubricant if necessary.

- All female condoms are lubricated, which may make it slippery at first.
- If necessary, use additional lubricant inside the condom or on the penis.
- Any kind of lubricant, oil-based or water-based, can be used with the female condom.
- Lubricant may also reduce noise during sex and make sex smoother.

Combined oral contraceptives (COCs)

- **Work by stopping ovulation and thickening cervical mucus**
- **Reduce menstrual bleeding and cramps**
- **Most common side effects are headaches, nausea, spotting**
- **Provide health benefits**
- **Can be used safely and effectively by women with HIV unless taking ritonavir as part of ARV regimen**
- **With other ARVs, correct COC use combined with condom use ensures effectiveness**
- **Condom use also prevents infection**

also called “The Pill”



Facts you should know about combined oral contraceptive pills:

- Combined oral contraceptives (COCs) contain two hormones, estrogen and progestin, which are similar to the natural hormones found in a woman's body. The Pill works primarily by stopping the production of eggs. It also thickens cervical mucus, making it difficult for sperm to enter the uterus.
- COCs reduce the amount of menstrual bleeding, which can help reduce anemia.
- The most common side effects of COCs include: headaches, nausea, spotting between menstrual periods.
- Users may also experience: tender breasts, dizziness, mood changes, slight weight gain or loss, amenorrhea (no monthly bleeding).
  - About half of all users never have any side effects.
  - Side effects often go away or diminish within 3 months.
  - Missing pills may increase spotting between menstrual periods and increase the risk of unintended pregnancy.
- COC users experience health benefits, including a reduced risk of developing benign breast disease, ovarian cancer, cancer of the endometrium, and functional ovarian cysts. COCs also lower a woman's chances of having an ectopic pregnancy and acquiring symptomatic pelvic inflammatory disease, or PID. COCs can also improve menstrual problems (i.e., heavy, painful, or irregular periods) and some gynecologic conditions (i.e., endometriosis).
- Severe adverse effects are rare and the risk is concentrated among women with particular conditions or characteristics.
- COCs can safely be used by most women, including women with HIV. Some ARV drugs interact with COCs; one drug, ritonavir, reduces the blood levels of the contraceptive hormones in pills to a much greater extent than other ARVs. For this reason, women whose ART regimen contains ritonavir generally should not use pills. Women using other ARV drugs should be careful to take a pill every day at the same time and be encouraged to use condoms for added protection.
- Male or female condoms can also be used with COCs to prevent STI/HIV transmission between partners.

Possible questions to ask:

What have you heard about the Pill? Do you have concerns?

If side effects, such as headaches or nausea, happened to you, what would you think or feel about it? What would you do?

Would you remember to take a pill each day? What would help?

Would you be able to use condoms consistently to prevent STIs?

What would you do if you run out of pills?

Who should not use the Pill

Smokes cigarettes AND age 35 or older

Gave birth in the last 3 weeks

Breastfeeding 6 months or less

Taking rifampicin, rifabutin, medicine for seizures, or ritonavir

Severe headaches that are made worse by light, noise, or movement

High blood pressure

Other serious health conditions:

- heart disease, stroke, or blood clot
- diabetes (complicated)
- certain types of liver disease
- breast cancer
- gall bladder disease
- rheumatic disease (lupus)

Pregnant*

* pill use will not harm fetus

In general, women with HIV can use the Pill unless they have certain health conditions.

Conditions and characteristics for which the Pill is usually not recommended or should not be used include:

Smokes cigarettes and is age 35 or older.

Gave birth in the last 3 weeks.

Is breastfeeding a baby less than 6 months old.

Is taking rifampicin, rifabutin, medicine for seizures, or ritonavir.

Rifampicin or rifabutin (used for TB treatment), certain epilepsy drugs (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, lamotrigine), or ritonavir (as part of antiretroviral regimen for AIDS) make the Pill less effective.

Has severe headaches (migraine) that are made worse by light, noise, or movement.

Women over age 35 with migraine headaches, or at any age if she has migraines with an aura, should not take the Pill. If a woman develops migraines while taking the Pill, she should switch to another method.

Has high blood pressure.

Check blood pressure (BP), if possible. If systolic BP is 140+ mm Hg or diastolic BP is 90+ mm Hg, help her choose another method if there are other available and acceptable methods. If systolic BP is 160+ mm Hg or diastolic BP is 100+ mm Hg, she should not use the Pill under any circumstances.

If a BP check is not possible, ask about high BP and rely on her answer.

Has other serious conditions:

- Heart disease or has several risk factors for heart disease, such as high blood pressure, diabetes, smoking, older age. Ever had a stroke or problem with heart or blood vessels, including a blood clot in the lungs or deep in the legs.
  Note that women with superficial clots, including varicose veins, can use the Pill.
- Diabetes for more than 20 years or with vascular complications.
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells).
- Breast cancer (history of or current).
- Symptomatic gallbladder disease when medically-treated and/or current.
- Systemic lupus disease if not on immunosuppressive treatment; due to concerns about possible increased risk of thrombosis.

Women who are pregnant do not require contraception. Before starting the Pill, use the pregnancy checklist or a pregnancy test to be reasonably certain the woman is not pregnant.

How to use the Pill

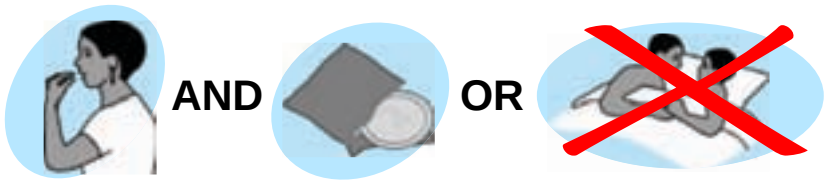
Take one pill each day.

If you miss 1 or 2 active pills in a row or start a pack 1 or 2 days late:

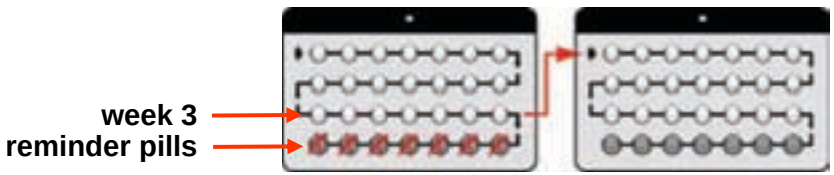
- Always take a pill as soon as you remember
- Continue to take one pill every day
- No need for additional protection

If you miss 3 or more active pills in a row or start a pack 3 or more days late:

- Take a pill as soon as possible, continue taking 1 pill each day, and use condoms or avoid sex for the next 7 days



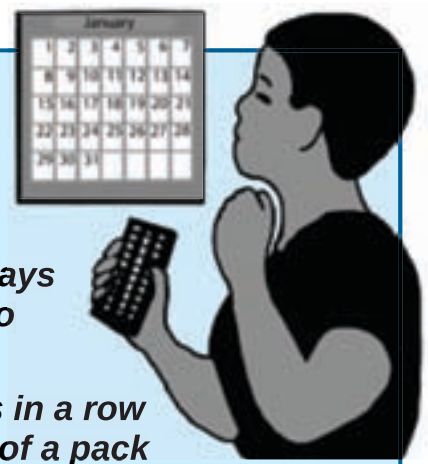
- If you miss these pills in week 3, ALSO skip the reminder pills and start a new pack



Remember:

When you miss 3 or more active pills in a row, hormonal pills must be taken for 7 days in a row to get back to full protection.

If you miss three pills in a row during the first week of a pack and have unprotected sex, consider using emergency contraception.



If you miss any reminder pills:

Reminder pills →

Throw away the missed pills and continue taking pills, 1 each day.

Instruct the client on how to use the Pill

- Tell the client to take 1 pill each day, preferably at the same time so that it is easy to remember. Taking pills with food may prevent nausea.
- Show which pill to take first and how to follow the arrows on the packet.
- Explain that the active pills are in weeks 1, 2, and 3. The pills for week 4 are "reminder pills" and do not contain hormones. Her period will occur during week 4.
- Remind her to obtain more pills before her supply is gone.

If you miss 1 or 2 active pills in a row or start a pack 1 or 2 days late:

- Always take a pill as soon as you remember, even if it means taking 2 pills the same day or at the same time.
- Continue to take 1 pill every day.
- There is no need for additional contraceptive protection.

If you miss 3 or more active pills in a row or start a pack 3 or more days late:

- Continue taking 1 pill each day and use condoms or avoid sex for the next 7 days.
- If you missed these pills in week 3, finish the active pills in the pack, skip the reminder pills, and start a new pack. You may have no menstrual bleeding that month.
- If you missed these pills in the first week of a new pack and had unprotected sex, consider using emergency contraception.

If you miss any reminder pills:

- Throw away the missed pills and continue taking pills, 1 each day.

When to start pills

A woman can start the Pill on any day of the menstrual cycle if it is reasonably certain that she is not pregnant. Use the pregnancy checklist or a pregnancy test as necessary.

If menstrual bleeding started in the past 5 days:

- She can start now; no extra protection is needed.

If menstrual bleeding started more than 5 days ago or if she is amenorrheic (not having menstrual periods):

- Start pills now if reasonably certain she is not pregnant; no need to wait for the next menstrual period.
- She should avoid sex or use condoms for 7 days after taking the first pill.

Postpartum

- If she is breastfeeding, delay pills until the infant is 6 months or until breastfeeding is discontinued.
- If she is not breastfeeding, delay pills 3 weeks.

Important:

- Prolonging the pill-free interval increases the risk of pregnancy.
- These missed pill instructions apply to pills containing 30–35µg ethinyl estradiol. For pills with 20µg estrogen or less, women missing one pill or starting a new pack one day late should follow the same guidance as missing one or two 30–35µg pills. Women missing two or more pills in a row or starting a pack two or more days late should follow the same guidance as missing three or more 30–35µg pills.

When to return to the clinic

- For resupply of pills
- If you have any questions
- Immediately if you experience **ACHES**:

  Abdominal pain (sharp)

  Chest pain (severe)

  Headache (severe)

  Eye problems (blurred vision, brief loss of vision)

  Sharp leg pain

Stop taking pills, use a backup method, and return to the clinic immediately.

Advise COC users when to return to the clinic.

Return for a resupply of pills.

Return if you have any questions.

Return immediately if you experience **ACHES**:

Abdominal pain (sharp)

Chest pain (severe)

Headache (severe)

Eye problems (blurred vision, brief loss of vision)

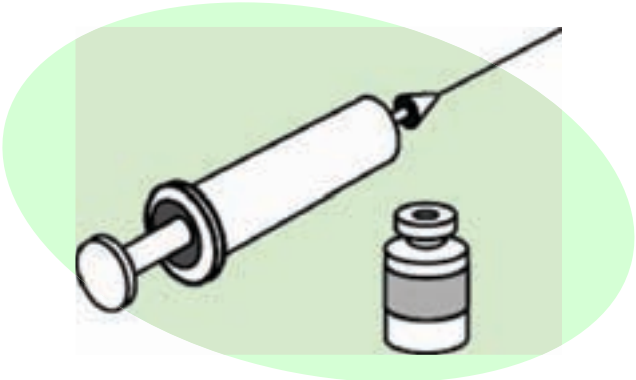
Sharp leg pain

Stop taking pills, use a backup method, and return to the clinic immediately.

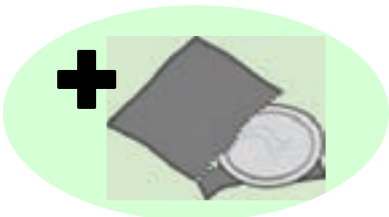
On rare occasions, women who use COCs can develop serious complications, usually due to thrombosis or thromboembolism – a blood clot that may form in the blood vessels of the heart, brain, leg, or abdomen. Warning signs of such complications include: severe abdominal pain; severe chest pain or shortness of breath; severe headache with dizziness, weakness, numbness, or eye problems, such as temporary vision loss or blurred vision; and severe pain in the calf or thigh.

If a woman taking COCs experiences any of these symptoms she should stop taking the pills, begin using a backup method, and return to the clinic immediately.

Long-acting injectables



- Work by stopping ovulation and thickening cervical mucus
- Require an injection every 2 or 3 months
- Often take longer to become pregnant after stopping
- Provide health benefits
- Do not protect against STIs or HIV; use condoms to prevent infection



- Can be used safely and effectively by women with HIV or on ART

Facts you should know about long-acting injectables:

- Long-acting injectables – DMPA (3 months/13weeks) and NET-EN (2 months) – contain only 1 hormone, progestin. Injections are give in the upper arm or buttocks. Injectables primarily work by stopping the production of eggs, although the cervical mucus also thickens to prevent the passage of sperm. Because they do not contain estrogen, they are safe for breastfeeding women (after 6 weeks postpartum).
- Injections are given every 3 or 2 months depending on type. Reinjections can be given up to 2 weeks early or 2 weeks late for NET-EN and 4 weeks late for DMPA. If a woman returns after this grace period, she can receive an injection if the provider is reasonably sure she is not pregnant. Suggest the woman use backup contraception for 7 days and counsel her that delaying injections increases the risk of pregnancy.
- It often takes longer to get pregnant after stopping injectables. On average, women can become pregnant 9 to 10 months after their last DMPA injection.
- Users of injectables also experience health benefits, including reduced:
  - risk of endometrial cancer
  - risk of ectopic pregnancy
  - risk of acute pelvic inflammatory disease (PID)
  - frequency and severity of sickle cell crises
  - frequency of epileptic seizures
  - symptoms of endometriosis
  - risk of vaginal yeast infections
- Male or female condoms can be used with injectables to prevent STIs and as added pregnancy protection if a client is late for an injection or is taking ARVs when on NET-EN.
- Injectables can safely be used by most women, including women with HIV and on ARV therapy. However, women on ARV therapy who are using NET-EN should be counseled to return for reinjections on or before the scheduled reinjection date.

Possible questions to ask:

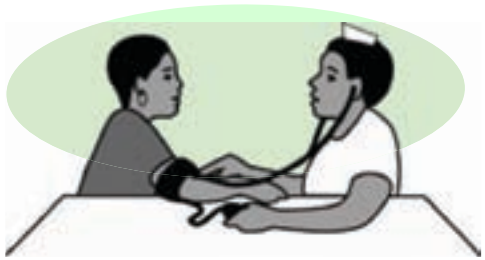
What have you heard about injectables? Do you have concerns?

If side effects, such as bleeding changes or weight gain, happened to you, what would you think or feel about it? What would you do?

Would you be able to come back on time for injections? How would you remember?

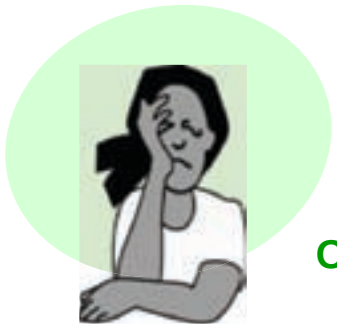
Would you be able to use condoms consistently to prevent STIs?

Who should not use long-acting injectables



Very high blood pressure

Breastfeeding 6 weeks or less



Other serious health conditions:

- **stroke, blood clot in your legs or lungs, or heart attack**
- **diabetes (complicated)**
- **breast cancer**
- **certain types of liver disease**
- **unexplained bleeding between menstrual periods**
- **rheumatic disease (lupus)**

Pregnant*

*** injectable use will not harm fetus**

In general, women with HIV can use injectables unless they have certain health conditions.

Conditions and characteristics for which injectables are usually not recommended or should not be used include:

Very high blood pressure.
Check blood pressure (BP), if possible. If systolic BP is 160+ mm Hg or diastolic BP is 100+ mm Hg, help her choose another method. If a BP check is not possible, ask about high BP and rely on her answer.

Breastfeeding a baby less than 6 weeks old, because of a theoretical concern that newborn infants may not be able to metabolize DMPA received in breast milk. Ask the client to come back when the baby is 6 weeks old. If client is partially breastfeeding or concerned about becoming pregnant, offer the client another method.

Other serious conditions:

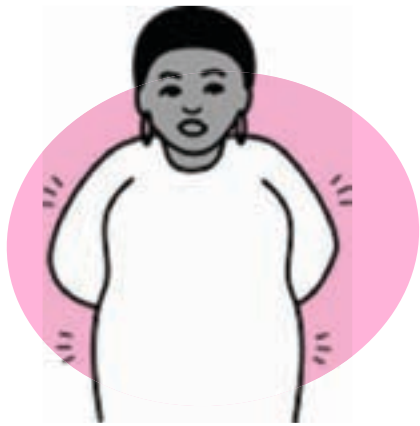
- Heart disease or several risk factors for heart disease, such as high blood pressure, diabetes, smoking, older age.
- Stroke, heart attack, or blood clot in the legs or lungs (unless on established anticoagulant therapy).
  Note that women with superficial clots, including varicose veins, can use progestin-only injectables without restrictions.
- Diabetes for more than 20 years or with vascular complications.
- Breast cancer (history of or current).
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells).
- Unexplained bleeding between menstrual periods. If the bleeding suggests a serious condition, help the woman choose a method without hormones to use until the unusual bleeding is evaluated.
- Systemic lupus disease if not on immunosuppressive treatment; due to concerns about possible increased risk of thrombosis.

Women who are pregnant do not require contraception. Before starting injectable contraceptives, use the pregnancy checklist or a pregnancy test to be reasonably certain the woman is not pregnant.

Side effects of long-acting injectables

Most common side effects:

more bleeding and spotting at first and then no monthly bleeding



weight gain

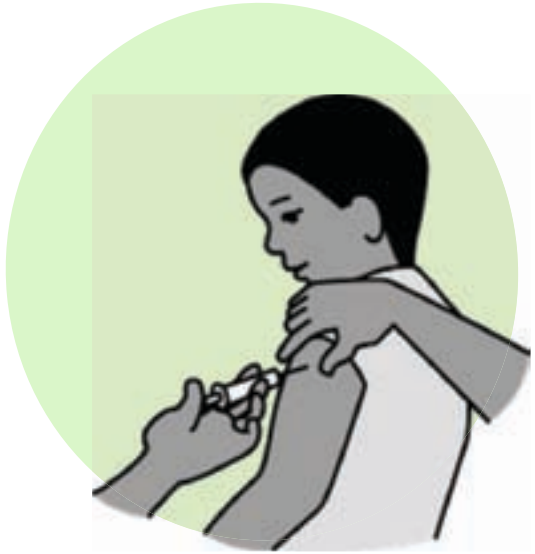
Users may also experience mild headaches, dizziness, nausea.

Facts you should know about the side effects of long-acting injectables:

- The most common side effects of injectables include:
  - heavy or irregular bleeding and spotting (initially) followed by amenorrhea (after several injections)
  - weight gain (average of 1 to 2 kilos or 2 to 4 pounds each year)
- Users may also experience:
  - mild headaches, dizziness, nausea

One-third of injectable users discontinue during the first year because of side effects. Reassure clients that these side effects are not harmful. The absence of a menstrual period does not mean that toxic blood is collecting inside her body, she has not become infertile, and she has not reached premature menopause.

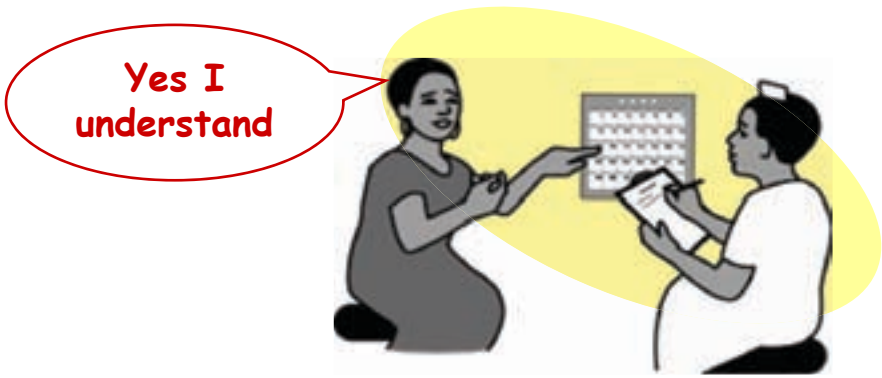
How to use injectables



- Injection in your arm or buttock
- Do not rub afterwards
- Important to come back on time

Remember:

- Name of injectable is _____
- Date of next injection is _____
- Come back even if late



See a nurse or doctor if:

- Bright flashes in your vision before bad headaches

- Unusually heavy or long bleeding

- Yellow skin or eyes

Instruct the client on how to use injectables

- Inform the client not to rub the injection site.
- Clients should return for reinjection on scheduled date – every 3 months/13 weeks for DMPA and every 2 months for NET-EN. Can return for reinjection up to 2 weeks early. Return even if late.
- Write the type of injectable and the return date on a card and give the card to the client. Discuss how she can remember the next injection date.
- Remind client that injectables often cause bleeding changes. Tell the client to return if she has questions or concerns.

Late for reinjection

- If the client is up to 2 weeks late for a NET-EN injection and 4 weeks late for a DMPA injection, give her the injection; no need for extra protection.
- If the client is more than 2 weeks late for a NET-EN injection or 4 weeks late for a DMPA injection, give her the next injection if reasonably certain she is not pregnant. She should use condoms or avoid sex for 7 days after the injection. Consider offering emergency contraception if she had sex after the grace period.

See a nurse or doctor if you experience:

- Bright flashes in your vision before bad headaches (migraine aura)
- Unusually heavy or long bleeding (bleeding that is more than 8 days long or twice as heavy as usual)
- Yellow skin or eyes

When to start injectables

A woman can start injectables on any day of the menstrual cycle if it is reasonably certain that she is not pregnant. Use the pregnancy checklist or a pregnancy test as necessary.

If menstrual bleeding started in the past 7 days:

- She can start now; no extra protection is needed.

If menstrual bleeding started more than 7 days ago or if she is amenorrheic (not having menstrual periods):

- Start injectables now if reasonably certain she is not pregnant; no need to wait for the next menstrual period.
- She should avoid sex or use condoms for 7 days after the first injection.

Postpartum

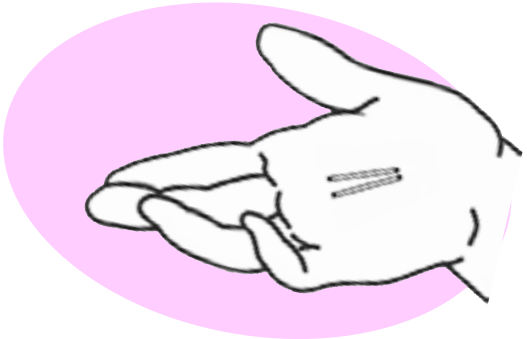
- If she is breastfeeding, delay injectables until infant is 6 weeks old.
- If she is not breastfeeding, begin injectables immediately after delivery.

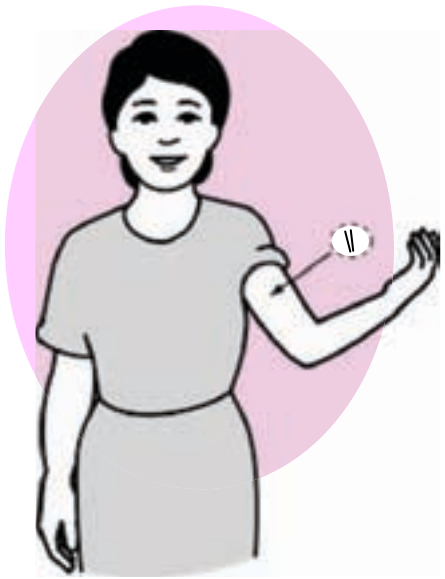
Important:

- Delaying the next injection by more than 2 weeks for NET-EN or 4 weeks for DMPA can increase the risk of pregnancy.
- Emergency contraception can be an option if a woman had sex after the grace period.
- Emergency contraceptive pills can be provided to clients in advance of need.

Implants

- **Small plastic capsules or rods placed under the skin of the upper arm**
  (6, 2, or 1 capsules or rods depending on type)
- **Work by thickening cervical mucus and stopping ovulation**
- **Last 3 to 5 years**
- **Most common side effect is change in bleeding pattern**
- **Provide health benefits**
- **Do not protect against STIs or HIV; use condoms to prevent infection**
- **Can be used safely and effectively by women with HIV or on ART**





Facts you should know about implants:

- Small plastic tubes are placed under the skin of the upper arm (6, 2, or 1 rods or capsules) by a specially trained provider during a minor surgical procedure. Removal of the implants also requires a specially trained provider. Implants do not leave a noticeable scar if inserted and removed correctly. Implants can be removed at any time; it is the woman's choice. The woman can become pregnant soon after the tubes are taken out. Implants contain only one hormone, progestin. Types include: Norplant (6 capsules), Jadelle (2 rods), Sinoplant (2 rods), and Implanon (1 rod).
- Implants primarily work by thickening cervical mucus, blocking sperm from meeting an egg, and by preventing or disrupting the release of eggs from the ovaries. Because they do not contain estrogen, they are safe for breastfeeding women (after 6 weeks postpartum).
- Implants last 3 to 5 years, depending on the type of implant and the woman's weight. Heavier women may need implants replaced sooner. Implants are among the most effective and long-lasting methods. Less than 1 pregnancy per 100 women occurs during the first year.
- The most common side effect is a change in bleeding pattern including prolonged irregular bleeding for the first year, then lighter, more regular bleeding or infrequent bleeding and sometimes amenorrhea.

Some women also experience:

- Headaches
- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea
- Abdominal pain (due to enlarged ovarian follicles)

- Health benefits include increased protection against symptomatic pelvic inflammatory disease (PID) and risks of ectopic pregnancy; they may also help protect against iron-deficiency anemia.
- Male or female condoms can be used with implants to prevent STIs.
- Implants can safely be used by most women including women who are HIV-positive, have AIDS, or are on ARV therapy. However, because is not certain whether some ARV drugs reduce the effectiveness of implants, urge these women to use condoms along with implants. In addition to STI prevention, condoms will provide extra contraceptive protection for women on ARV therapy.

Possible questions to ask:

What have you heard about implants? Do you have concerns?

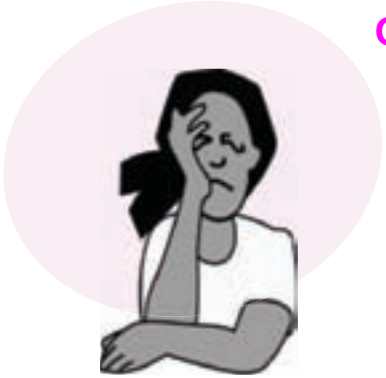
If side effects, such as bleeding changes, happened to you, what would you think or feel about it? What would you do?

Will you be able to keep track of when the implant needs to be replaced? How would you remember?

Would you be able to use condoms consistently to prevent STIs?

Who should not use implants

Breastfeeding
6 weeks or less



Other serious health conditions:

- **blood clot in your legs or lungs**
- **certain types of liver disease**
- **breast cancer**
- **unexplained bleeding between menstrual periods**
- **rheumatic disease (lupus)**

Pregnant*

*** implant use will not harm fetus**

In general, women with HIV can use implants unless they have certain health conditions.

Conditions and characteristics for which implants are usually not recommended or should not be used include:

Breastfeeding a baby less than 6 weeks old, because of a theoretical concern that newborn infants may not be able to metabolize the hormones received in breast milk. Ask the client to come back when the baby is 6 weeks old. If client is partially breastfeeding or concerned about becoming pregnant, offer the client another method.

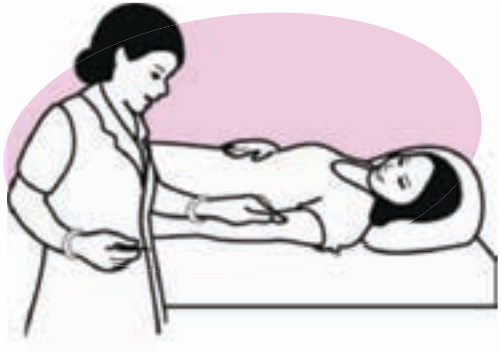
Other serious conditions:

- Blood clot in the lungs or deep veins in the legs (unless on established anticoagulant therapy).
  Note that women with superficial clots, including varicose veins, can use implants without restrictions.
- Systemic lupus disease if not on immunosuppressive treatment; due to concerns about possible increased risk of thrombosis.
- Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells).
- Breast cancer (history of or current).
- Unexplained bleeding between menstrual periods. If the bleeding suggests a serious condition, help the woman choose a method without hormones to use until the unusual bleeding is evaluated.

Women who are pregnant do not require contraception. Before starting implants, use the pregnancy checklist or a pregnancy test to be reasonably certain the woman is not pregnant.

How to use implants

- Start any day of the menstrual cycle, if not pregnant
- Insertion and removal should be quick, easy, and painless
- Provider puts capsules just under the skin of the inside upper arm
- Provider bandages the opening in the skin – no stitches
- Side effects are common but rarely harmful; come back if problems
- Return any time you have problems or want the implant removed or replaced



See a nurse or doctor if:

- Bright flashes in your vision before bad headaches

- May be pregnant, especially if pain or soreness in belly

- Infection or persistent pain at insertion site

- Unusually heavy or long bleeding

- Yellow skin or eyes

Instruct the client on how to use implants

- Explain that the procedure will be done by a specially trained provider.
- Insertion usually takes 5 to 10 minutes.
- Removal usually takes about 15 minutes, sometimes longer.
- Let her feel a sample rod/capsule and if possible, show her a photo of capsules under skin.
- Local anesthetic stops pain during insertion; she stays awake.
- Insertion and removal are done gently, with just a small opening in the skin. There may be slight pain, swelling, or bruising for a few days.
- Keep the area dry for 5 days; remove bandage after 5 days.
- Come back if the arm stays sore for more than 5 days or if the opening becomes red or has yellow liquid.

See a nurse or doctor if you experience:

- Bright flashes in your vision before bad headaches (migraine aura)
- Signs of pregnancy, especially if pain or soreness in the belly
- Infection or continued pain at the insertion site
- Unusually heavy or long bleeding
- Yellow skin or eyes

When to start implants

A woman can start implants on any day of the menstrual cycle if it is reasonably certain that she is not pregnant. Use the pregnancy checklist or a pregnancy test as necessary.

If menstrual bleeding started in the past 7 days (5 days for Implanon):

- She can start now; no extra protection is needed.

If menstrual bleeding started more than 7 days ago (5 days for Implanon) or if she is amenorrheic (not having menstrual periods):

- Insert the implant now if reasonably certain she is not pregnant; no need to wait for the next menstrual period.
- She should avoid sex or use condoms for 7 days after the insertion.

Postpartum

- If she is breastfeeding, delay the implant insertion until the infant is 6 weeks old.
- If she is not breastfeeding, insert immediately after delivery.

When to remove or replace implants

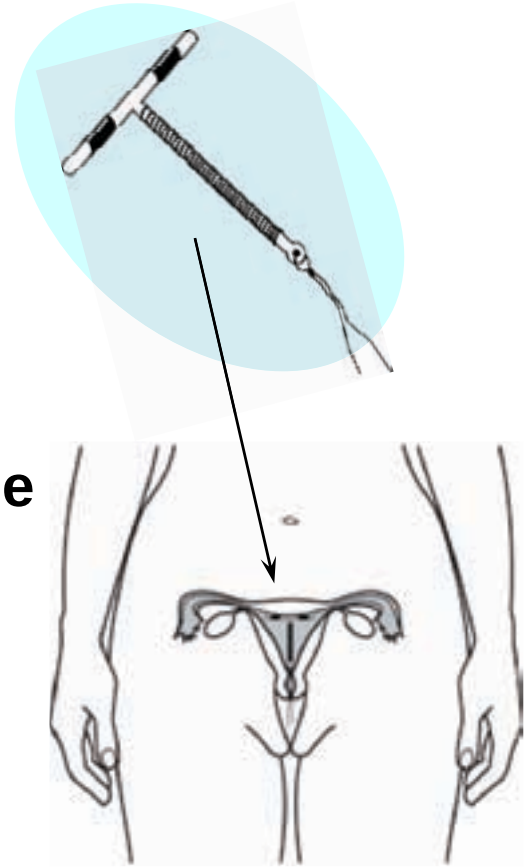
Implants need to be removed or replaced 3 to 5 years after insertion, depending on the type of implant and the client's weight. The method becomes less effective more quickly in heavier women.

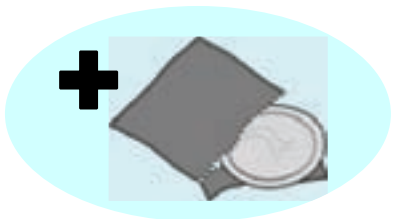
Important:

A woman can have the implant removed whenever she desires.

Intrauterine device (IUD)

- **Small device that fits inside the womb**
- **Very safe and effective**
- **Keeps working up to 12 years, depending on type**
- **Provider can remove it whenever you want**
- **Might increase menstrual bleeding or cramps**
- **Does not protect against STIs or HIV; use condoms to prevent infection**
- **Can be provided to a woman with HIV:**
  - **if she has no symptoms of AIDS or**
  - **if she has AIDS but is doing clinically well on ARVs**





Facts you should know about the copper IUD:

- The IUD is a small, flexible, plastic frame with copper sleeves or wire that is inserted in the uterus by a specially trained provider. *<Give client a sample IUD to hold.>*
- IUDs are very safe and effective. There is little for the client to remember; it works mainly by stopping sperm and egg from meeting.
- IUDs are long-lasting. The Copper T-380A lasts for 12 years.
- A provider can remove it whenever you want. The woman can soon become pregnant when the IUD is taken out. For older women, the IUD should be removed 1 year after the last menstrual period (menopause).
- Side effects, increased menstrual bleeding or cramps, usually decrease after the first 3 months.
- Male or female condoms can be used with an IUD to prevent STIs.
- Most women can use IUDs, including women who have never been pregnant. An IUD can be provided to a woman with HIV if she has no symptoms of AIDS. A woman who developed AIDS while using an IUD can continue to use the device. A woman with AIDS who is doing clinically well on ARV therapy – meaning that she has no symptoms of AIDS – can both initiate and continue IUD use.

Check for concerns, rumors: *What have you heard about the IUD?*

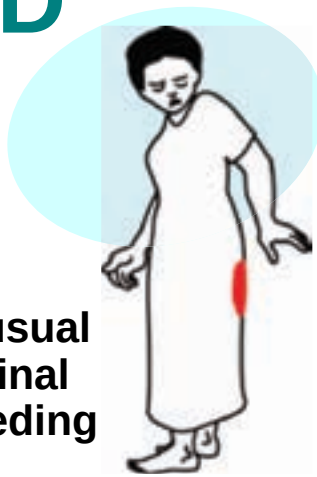
Explain common myths:

- An IUD does not leave the womb and move around inside the body.
- An IUD does not get in the way during intercourse, although sometimes the man may feel the strings.
- An IUD does not rust inside the body, even after many years.

Who cannot begin use of the IUD

May be pregnant

Gave birth recently
(more than 2 days and less than 4 weeks since delivery)



Unusual vaginal bleeding

Has AIDS and is not on ARV therapy

At high risk for STIs

Infection or problem in female organs

In general, the copper IUD is safe to initiate for the majority of women, including women with HIV, with the exception of women who have AIDS and are not on ARV therapy.

Other health conditions and characteristics for which IUDs are usually not recommended or should not be used include:

May be pregnant.

- If in any doubt, use the pregnancy checklist or perform a pregnancy test. An IUD should never be inserted in a woman who is pregnant, as it may result in a septic miscarriage.

Gave birth recently (more than 2 days and less than 4 weeks since delivery).

- An IUD should not be inserted between 48 hours and 4 weeks after childbirth, because of expulsion and perforation risk.

At high risk for STIs (unless gonorrhea and chlamydia can be reliably ruled out at the time of insertion).

- An IUD should not be inserted if the woman is at high risk for chlamydia or gonorrhea infection. Those at high risk for these STIs include anyone who:
  - has more than 1 sex partner without always using condoms
  - has a sex partner who may have sex with others without always using condoms.

Unusual and undiagnosed vaginal bleeding (which could indicate a serious condition).

- Bleeding between menstrual periods that is not typical or occurs after intercourse should be evaluated before IUD insertion.

Infection or problem in female organs.

STIs or Pelvic Inflammatory Disease (PID)

- Treat PID, chlamydia, gonorrhea or purulent cervicitis BEFORE inserting an IUD. Offer to treat the partner too.
- Can insert an IUD if the client has genital ulcer disease or vaginitis (bacterial vaginosis, trichomoniasis), but check for risk of chlamydia or gonorrhea. Treat infections.

HIV or AIDS

- If the client has HIV, can insert an IUD.
- If the client has AIDS, do not insert an IUD. But if the client is being treated with antiretroviral drugs and is healthy, can insert an IUD.

Infection after childbirth or abortion

- Any infections should be fully treated before IUD insertion.

Cancer in female organs or pelvic tuberculosis (TB)

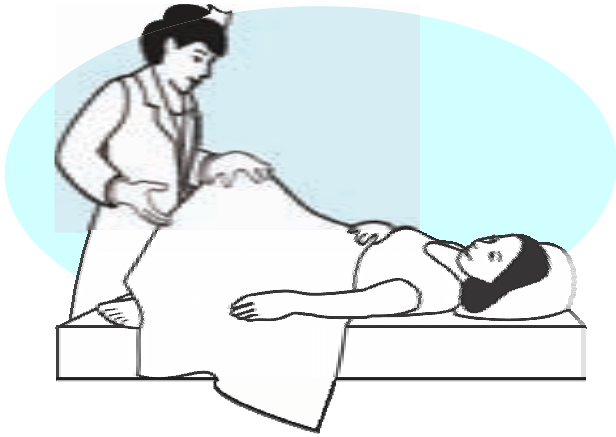
- Do not insert an IUD if known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; or pelvic TB exist.

Abnormality of the uterine cavity

- Any abnormality (e.g., uterine fibroid, cervical stenosis) that will not allow appropriate insertion.

How to use IUDs

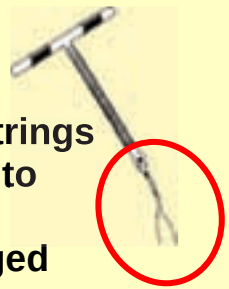
- Start any day of the menstrual cycle, if not pregnant
- Procedure
  - pelvic examination
  - clean the vagina and cervix
  - place IUD in the womb through the cervix
- May hurt at insertion; may have cramps for several days and spotting for a few weeks after
- Side effects: longer and heavier periods, bleeding and spotting between periods, and more cramps
- Return any time you have problems or want the IUD removed or replaced



See a nurse or doctor if:

- Missed a menstrual period, or think you may be pregnant

- Could have an STI or HIV/AIDS



- IUD strings seem to have changed length or are missing

- Bad pain in lower abdomen

Instruct the client on how to use copper IUDs

- Explain that the procedure will be done by a specially trained provider.
- No anesthesia is needed; she stays awake.
- Ask if she has any questions or concerns.
- If it is her first pelvic exam, explain the exam, including her position during the exam. Let the client hold a speculum while you explain its use.
- Insertion is done slowly and gently. Explain the process and show a sample IUD with arms folded in inserter.
- Any immediate pain, if present, lasts for a few minutes; she may have cramps for several days and spotting for a few weeks.
- Instruct the client on how and when to check the IUD strings: once a week during the first month, and from time to time after a menstrual period.
- Review the possible side effects: longer and heavier periods, bleeding and spotting between periods, and more cramps.
- Instruct the client to return for any problems and for a follow-up visit in 3 to 6 weeks or after the next period.

See a nurse or doctor if you experience:

- A missed menstrual period or think you may be pregnant
- Signs of or concerns about an STI or HIV/AIDS
- IUD strings that seem to have changed length or are missing
- Pain in lower abdomen

When to start copper IUDs

A woman can start an IUD on any day of the menstrual cycle if it is reasonably certain that she is not pregnant. Use the pregnancy checklist or a pregnancy test as necessary.

If menstrual bleeding started in the last 12 days, can insert the IUD now.

If menstrual bleeding started more than 12 days ago, can insert the IUD now if reasonably certain she is not pregnant; no need to wait for the next menstrual period.

Postpartum

- Can insert within 48 hours after birth. Special training is needed.
- Can also insert after 4 weeks postpartum. Must be reasonably certain she is not pregnant.
- Delay insertion between 48 hours and 4 weeks after birth. Offer condoms or another method if she is not fully breastfeeding.

When to remove or replace copper IUDs

Copper T-380A IUDs need to be removed or replaced 12 years after insertion. Ensure that the client knows what type of IUD she has and when she needs to have it taken out.

Important:

A woman can have the IUD removed whenever she desires.

Lactational amenorrhea method (LAM)

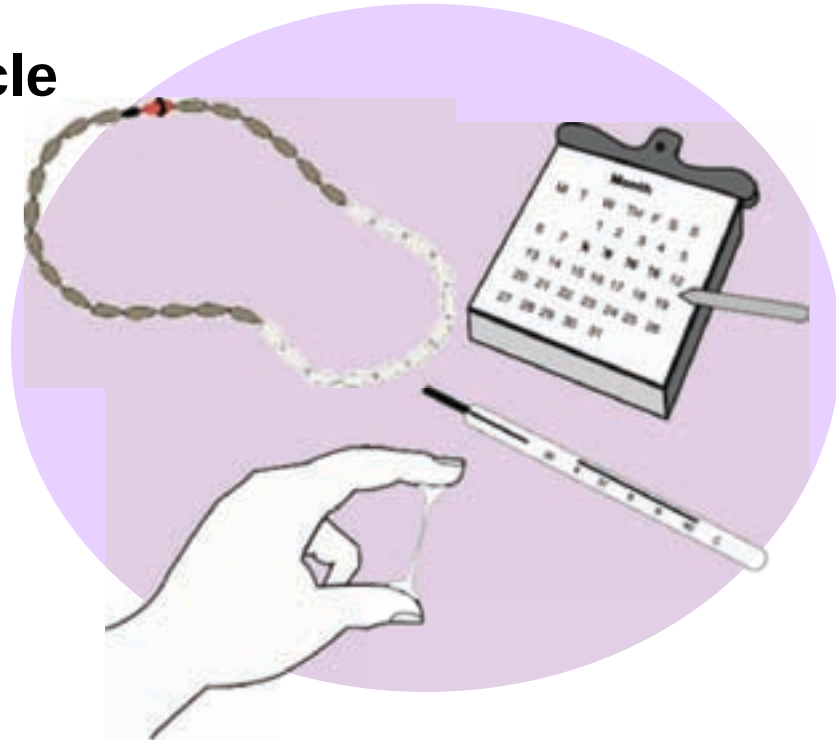
- **Temporary contraceptive method based on breastfeeding**
- **Depends on breastfeeding often, day and night, and giving no other food or liquids**
- **Effective if all 3 criteria are met:**
  - **woman is exclusively breastfeeding**
  - **infant is less than 6 months old**
  - **menstrual periods have not returned**
- **Breastfeeding risks passing HIV to the baby, but exclusive breastfeeding is safer than mixed feeding**
- **Avoid slow weaning**
- **Use condoms to avoid infection**

Facts you should know about LAM:

- LAM is a temporary contraceptive method based on breastfeeding. “Lactational” means related to breastfeeding; “amenorrhea” means not having monthly bleeding. LAM can be used for up to 6 months postpartum by women who are fully or nearly fully breastfeeding and who continue to have no menstrual periods. HAART therapy (for women eligible for ARV treatment) can be used during breastfeeding and may help protect the baby from HIV infection.
- LAM depends on breastfeeding often, day and night, and giving no other food or liquids. Using LAM means choosing to breastfeed in this way to prevent pregnancy. LAM works by preventing the release of eggs from the ovaries. Frequent breastfeeding temporarily prevents the release of natural hormones that cause ovulation. When breastfeeding is reduced, the chance of ovulation rises.
- LAM is effective for up to 6 months after childbirth if monthly bleeding has not returned and the woman exclusively breastfeeds. If any one of the three LAM criteria change, the woman can no longer rely on LAM to prevent pregnancy and must switch to another method of her choosing.
- Breastfeeding risks passing HIV to the baby, but exclusive breastfeeding is safer than mixed feeding. Women with HIV should be counseled to choose the feeding option that best suits their situation:
  - If safe replacement feeding is available (acceptable, feasible, affordable, sustainable, and safe), it avoids all risk of passing HIV to the baby (assuming that the baby is HIV-free at birth).
  - If no safe replacement feeding is available, a woman with HIV should breastfeed exclusively for the first 6 months. At 6 months, it is recommended to switch to replacement feeding. However, if replacement feeding is still not acceptable, feasible, affordable, sustainable, and safe, continuation of breastfeeding with complementary foods is recommended. All breastfeeding should stop once a nutritionally adequate and safe diet without breast milk can be provided.
  - Breastfeeding mothers of infants and young children who are known to be HIV-positive should be strongly encouraged to continue breastfeeding.
- Avoid slow weaning. Stop breastfeeding over 2 days to 3 weeks. Rapid weaning decreases the risk of transmitting HIV to the baby.
- Male and female condoms can be used with LAM to prevent STIs.

Fertility awareness methods

- **Learn the days of the menstrual cycle when you can get pregnant**
- **To prevent pregnancy, either avoid sex OR use a condom on days that you could get pregnant**
- **Can be effective if used correctly**
- **No side effects**
- **Needs partner's cooperation**
- **Do not protect against STIs or HIV; use condoms to prevent infection**



Facts you should know about fertility awareness-based (FAB) methods:

- Fertility awareness-based methods require that the woman learn the days of the menstrual cycle when she can get pregnant. There are different ways to identify the fertile days:
  - Calendar methods use the cycle length to calculate the fertile days of each cycle.
  - Symptoms-based methods identify fertile days from changes in cervical secretions and basal body temperature.

  These methods can be used alone or in combination. Depending on the method(s), the woman assumes she is fertile for 7 to 18 days each cycle, on average. If a woman becomes unwell or begins taking ARV or other medications, these methods may be less reliable. Refer her for further advice or counseling.
- To prevent pregnancy, either avoid sex or use a condom on days that you could get pregnant.
- FAB methods can be effective if used correctly. However, FAB methods are some of the least effective family planning methods in typical use (when not always used correctly).
- There are no side effects. FAB methods do not involve any medication.
- FAB methods require a partner's cooperation. Both partners must agree to avoid intercourse or use a condom on fertile days.

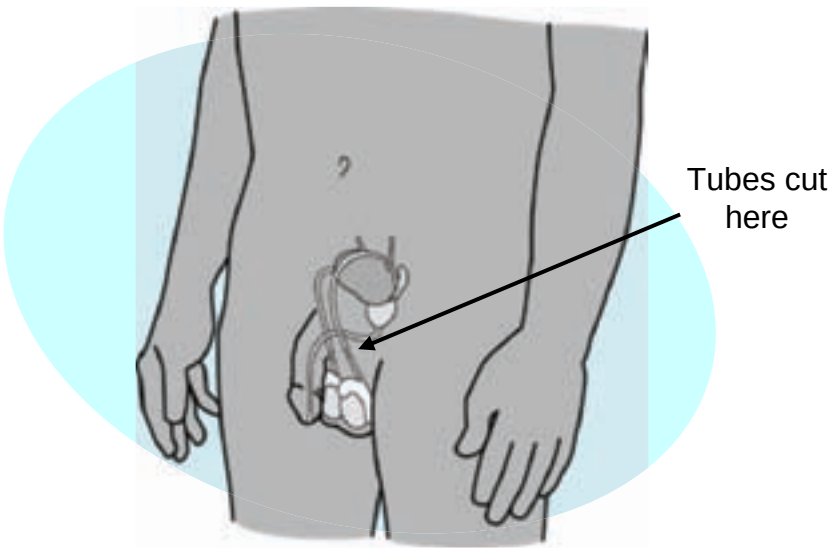
Possible questions to ask:

What have you heard about these methods? Do you have concerns?
Do you think you can abstain or use condoms on all fertile days?
Would you need to use condoms all the time to prevent HIV and STIs?

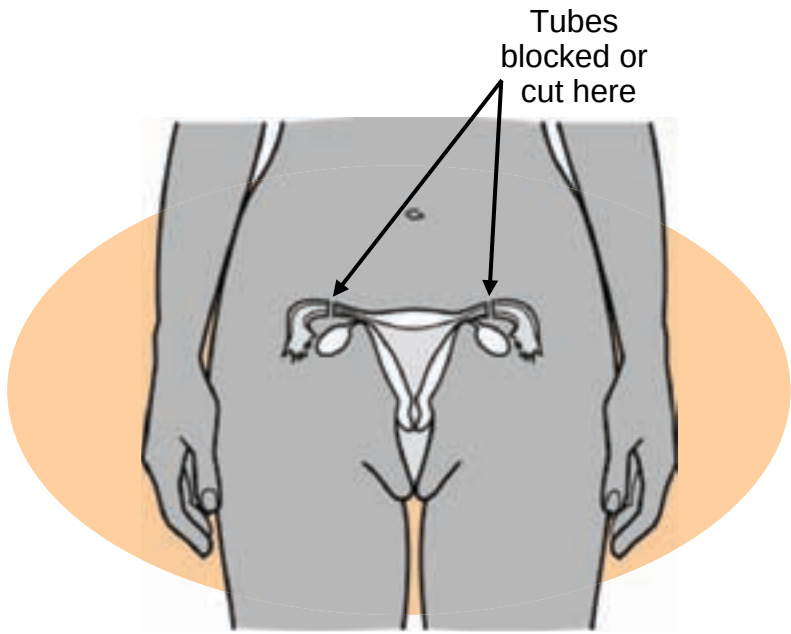
- To avoid infection, use condoms all the time.
  - If the woman is at risk for HIV and STIs, advise her to use condoms all the time, on both fertile and non-fertile days.
  - If she is not at risk of STIs, she can use male or female condoms on fertile days only to prevent pregnancy.
  - Faithful couples who are both HIV-positive may also decide to use condoms on fertile days only to prevent pregnancy.

Male and female sterilization

Vasectomy



Female sterilization



Facts you should know about male sterilization (vasectomy) and female sterilization (tubal ligation):

- Both procedures block the tubes making it impossible for the egg and sperm to meet.
- These methods are often provided through referral because they must be done in a health care facility by a specially trained health care provider using specialized equipment.
- Neither of these methods prevents STIs, so clients should be counseled to use condoms consistently and correctly.

Male sterilization (vasectomy)

- Simple surgical procedure (simpler than female sterilization).
- Very effective and permanent; it is for men or couples who will not want more children.
- Most men with HIV can safely have a vasectomy.
- Should be delayed for men with AIDS symptoms.
- No effect on erections or ejaculation.
- Becomes fully effective after 12 weeks (a backup contraceptive method is required during the interim).

Female sterilization (tubal ligation)

- Safe surgical procedure.
- Very effective and permanent; it is for women or couples who will not want more children.
- Most women with HIV can safely have a tubal ligation.
- Should be delayed for women with AIDS symptoms.
- Effective immediately.

Counsel clients according to their reproductive health goals.

- If the clients are very sure that they want no more children, describe vasectomy and female sterilization.
- If the clients have any doubts about whether they want more children or do not want a surgical procedure, describe reversible methods. There are several long-acting, reversible methods – implants and the IUD – that are almost as effective as sterilization.
- Provide a referral to a provider or facility based on the clients' desires.

Emergency contraception (EC)

- **Safe ways to prevent pregnancy soon after unprotected sex**
- **Two options:**
  - **POP regimen**
  - **COC regimen**

Inform all sexually active clients that there are safe ways to prevent pregnancy after unprotected sex.

A woman may want to consider emergency contraception if:

- No method was used.
- A method was used incorrectly (e.g., the client missed pills, or was late for an injection).
- A method failed (e.g., a condom slipped or was broken, or an IUD was expelled).
- Sex was forced.

If she can answer yes to any of the questions on the pregnancy checklist (page 49), she is probably not fertile and would not need emergency contraception. But if she is worried, she can still use emergency contraception.

If the client has recently had unprotected sex, ask how long ago did it occur.

If sex occurred up to 5 days ago, the client has 2 emergency contraceptive options: a POP regimen or a COC regimen.

- Take emergency contraceptive pills (ECPs) as soon as possible after unprotected intercourse (see instructions and regimens).

If sex occurred more than 5 days ago.

- Advise her that emergency contraception can be used only up to 5 days.
- Ask her to come back if her next monthly bleeding is more than 1 week late.

Explore whether the client could have been exposed to STIs.

- If exposure to STIs is a possibility, offer presumptive STI treatment (same as treatment dosage), if available, or refer her for further counseling, support, and treatment.

Possible questions to ask:

Could unprotected sex happen again?

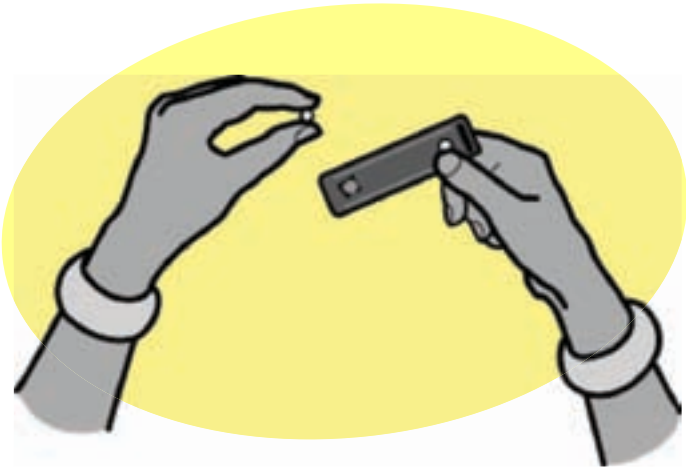
Can I give you a supply of emergency pills that you can use if you need them?

Do you need dual protection from pregnancy and STIs and HIV?

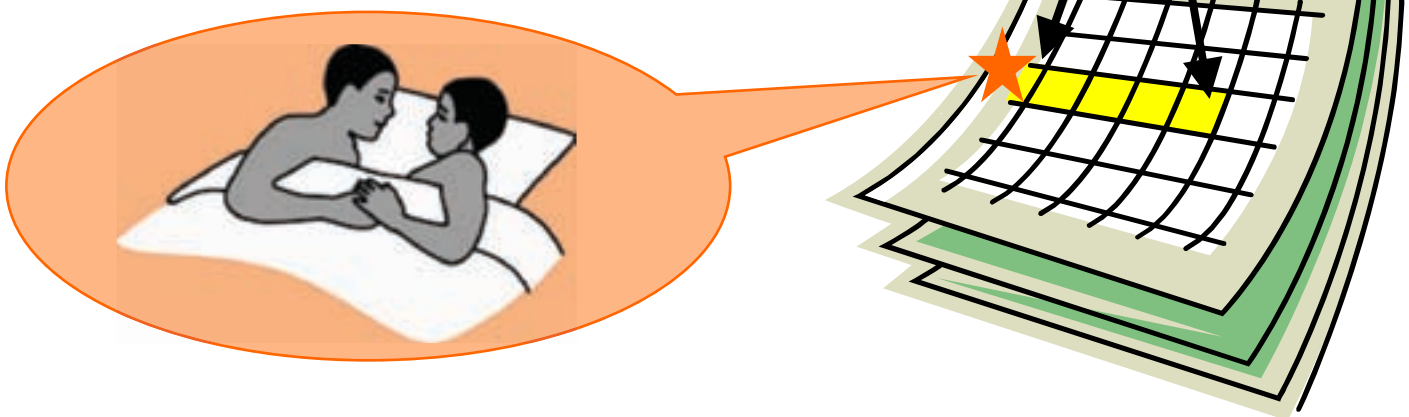
Do you have a regular method? Are you satisfied with it? If not, would you like to start using a method or switch methods?

How to use EC

- **Take as soon as possible**
- **Will not cause abortion**
- **May cause nausea and vomiting**
- **Next period may come a few days earlier or later**



5 days to use EC after unprotected sex



Facts you should know about using emergency contraceptive pills:

Instruct the client to take ECPs as soon as possible after unprotected sex. They can be taken up to 5 days after, but become less effective with each day that passes.

Counsel the client that EC pills:

- Will not cause abortion – they work mainly by stopping the release of an egg.
- Are less effective than most regular methods.
- May cause nausea and vomiting.
- May cause spotting or bleeding a few days after taking the pills.
- May cause the next menstrual period to come a few days earlier or later than expected.
- Do not offer protection from STIs.
- Do not provide pregnancy protection for subsequent acts of sexual intercourse.
- Are not for regular use; counsel about initiating a contraceptive method.

Any woman can take ECPs, even if she cannot take the Pill regularly, because ECPs are a one-time dose that is not enough to cause any negative long-term effects.

If the client had other acts of unprotected sex since her last menstrual period, she may already be pregnant and ECPs will not work. If she takes ECPs when already pregnant, they do not harm the pregnancy. She should return if her next menstrual period is more than 1 week late.

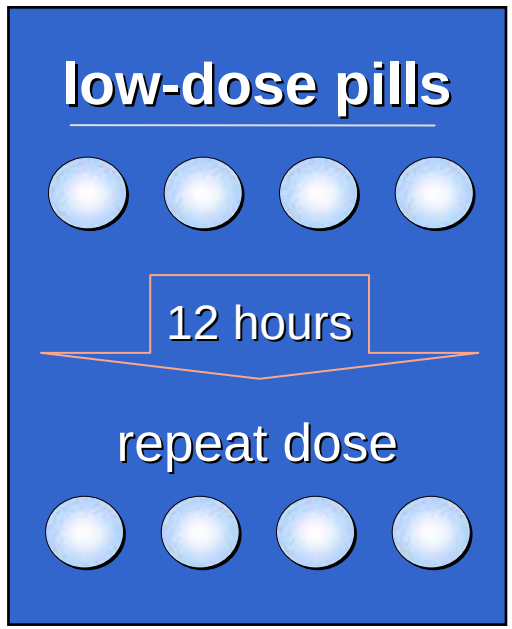
EC regimens

Start within 120 hours (5 days) after unprotected intercourse – most effective when used early

POP regimen

2 pills taken together as one dose

COC regimen



2 doses are taken 12 hours apart

More effective than COC regimen.

Facts you should know about emergency contraceptive pill regimens:

There are 2 types of regimens: POPs and COCs.

Levonorgestrel-only ECPs (POPs)

Work better and cause less nausea and vomiting than COC pills.

Dosage: 1.5 mg of levonorgestrel in a single dose

Combined estrogen-progestogen ECPs (COCs)

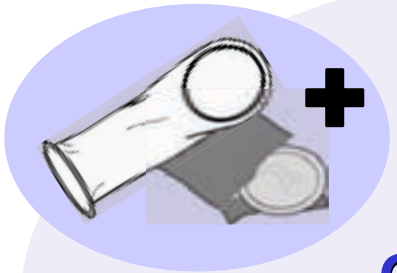
Use if levonorgestrel-only pills are not available.

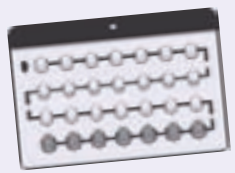
Dosage: 2 doses of 0.1 mg of ethinyl estradiol plus 0.5 mg of levonorgestrel, 12 hours apart; the number of pills depends on the type of Pill used; also known as the "Yuzpe regimen"

- If a client is taking combined ECPs, she can take medicine (meclazine hydrochloride) to prevent nausea.
- If she vomits within 2 hours after taking ECPs, she should return for another dose as soon as possible.

Making a choice and a plan

- **What is your plan?**
- **How will you deal with challenges?**
- **Are you ready?**





One method or two?

Adopt safer sexual activities?

Delay or avoid sex?

Encourage the client to consider and discuss all options.

Do you have a method or a plan in mind? Are you considering:

- A single method or dual method to prevent both pregnancy and STIs and HIV?
- Adopting safer sexual practices?
- Delaying or avoiding sexual intercourse?

Make a plan, considering these questions:

- What questions or concerns do you have about using the method?
- How will you learn to use condoms and other methods of your choosing?
- How will you get supplies?
- What steps will you take (examples: disclose status, learn partner's status, and discuss plan with partner)?
- What will be your first step? When will you take this step?
- Can your partner help?
- Do you wish to start a method today?

Decide how to deal with challenges.

- What could prove difficult?
- How will you handle difficulties? Think about what to say or do.
- What will you do if your first choice does not work for you?
- Can I tell you about and provide you with emergency contraception?

Confirm commitment.

- Are you ready and able to carry out your plan?

Talking with your partner

- **Decide where, when, and how**
- **Be prepared; rehearse if needed**

Prepare clients to talk with their partners:

- Offer suggestions but let the client decide what can work.
- Discuss doubts and fears. Do not dismiss them.
- Reassure the client that she or he can succeed. Without using names, tell stories of others who have succeeded.
- Suggest that seeing a health care provider together as a couple is sometimes very helpful.
- Arrange a follow-up visit to discuss what happened.

Tips for talking with your partner

Decide where

- Choose a place that is comfortable for both of you.
- Suggest a quiet place, but close to safety if needed.
- Find a neutral ground.

Decide when

- Talk when you are both relaxed and comfortable.
- Avoid distractions or rushing.
- Discuss over a period of time, if needed.
- Discuss before sex starts.

Decide how

- Stress the good things.
- Emphasize your partner's caring, your concern.
- Start with what you both agree on.
- Focus on safety and good health, not mistrust.
- Talk about good examples, such as people that your partner respects.
- Try to reach agreement.

Be prepared

- **Stay safe**
  - Do not risk your safety.
  - Consider having another trusted person nearby.
  - Start with general facts and watch reactions.
- **Get the facts right**
  - Your provider can answer your questions.
- **Plan**
  - Decide where, when, and how to start the plan.
  - Be prepared if the discussion goes badly. Decide what you will do if it turns violent.
  - Consider counseling as a couple.
- **Practice**
  - Rehearse with your provider or friends.

Help using your method

- **How satisfied are you with your method?**
- **Any questions or problems?**
- **Any side effects?**

Bleeding changes?

Nausea or vomiting?

Headaches?

- **Any problems using condoms?**

Ask returning family planning users if they need any help using their method.

Ask the client how satisfied she or he is with her or his method. Ask if she or he has any questions, problems, or side effects. Assess the client's complaints, manage, and reassure the client that side effects are normal.

- Side effects are not harmful or signs of illness and often go away after about 3 months.
- The client may have more than 1 side effect.
- For pill users, switching to a different brand may help.
- Ask about signs of possible complications. If any are present, treat or refer as appropriate.

Ask the client if she or he has any problems using condoms?

- Explain the infection and pregnancy risks of not using a condom every time and help the client prepare to discuss condom use with her or his partner if necessary.
- Suggest using another family planning method in addition to condoms and review protection strategies.

If the client has problems or concerns, listen to the client and discuss the concerns.

- Take all comments seriously. Answer questions respectfully.
- Reassure a woman that she can switch family planning methods at any time.
- If you suspect a serious underlying condition, diagnose and treat or refer.

Family planning after childbirth

- **Best to wait at least 2 years before trying to become pregnant again**
- **If not breastfeeding, you can get pregnant again soon, unless you use family planning**
- **If breastfeeding, you can rely on LAM to prevent pregnancy**

Be sure to discuss these topics when counseling postpartum women.

- Ask the client if she has had infant feeding counseling and discuss her decision. If not, counsel her or refer her for counseling.
- Inform the client that waiting at least 2 years before trying to become pregnant again is healthiest for both mother and child.
- Discuss her thoughts about having more children. Ask what her partner thinks.
- Listen carefully to the client's views.
- If the client and her or his partner have decided that they want no more children, discuss vasectomy and female sterilization.
- As appropriate, advise the client to use condoms correctly and consistently to avoid infection.

If not breastfeeding, the client could become pregnant again soon.

- If not breastfeeding, the client can use any method. She can start any progestin-only methods (the mini-pill, injectables, or implants) immediately, or combined pills after 3 weeks. The IUD can be inserted within 2 days of childbirth or after 4 weeks.

If breastfeeding, exclusive breastfeeding is safest for the baby.

- Exclusive breastfeeding also can prevent pregnancy for the first 6 months (as long as all LAM criteria are met).
- Breastfeeding exclusively for the first 6 months is safer than mixed feeding.
- Discuss other methods in case she stops LAM or wants additional protection.
- Progestin-only methods (the mini-pill, injectables, or implants) can be used safely while breastfeeding, starting 6 weeks after childbirth. Use of combined pills should be delayed until 6 months.
- Other good methods while breastfeeding are nonhormonal methods such as condoms or the IUD, which can be inserted within 2 days of childbirth or after 4 weeks.

When to start contraceptive methods postpartum

Family planning method	Fully or nearly fully breastfeeding	Not breastfeeding
Lactational amenorrhea method	Immediately	(Not applicable)
Vasectomy	Immediately or during partner's pregnancy*	
Male or female condoms	Immediately	
Copper-bearing IUD	Within 48 hours; otherwise wait 4 weeks	
Female sterilization	Within 7 days; otherwise wait 6 weeks	
Fertility awareness-based methods	Start when normal secretions have returned (for symptoms-based methods) or she has had 3 regular menstrual cycles (for calendar-based methods). This will be later for breastfeeding women than for women who are not breastfeeding.	
Progestin-only pills **Progestin-only injectables** **Implants**	6 weeks postpartum**	Immediately
Combined oral contraceptives	6 months postpartum**	3 weeks postpartum**

* *If a man has a vasectomy during the first 6 months of his partner's pregnancy, it will be effective by the time she delivers.*

** *Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.*

Source: Family Planning: A Global Handbook for Providers, 2007.

You can start the method now if ANY ONE of these is true

1. Menstrual period started in the past 7 days

or

2. Gave birth in the past 4 weeks

or

3. Fully or nearly fully breast-feeding AND gave birth less than 6 months ago AND periods have not returned

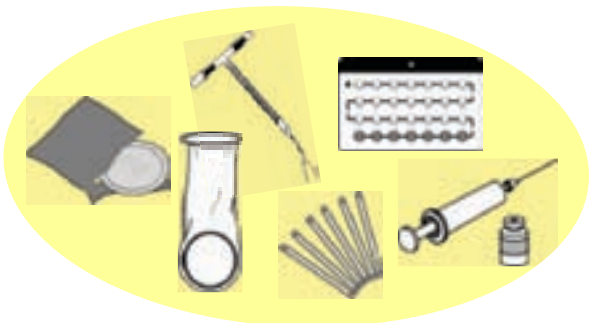
or

4. Miscarriage or abortion in the past 7 days

or

5. No sex since the last menstrual period or delivery

or



6. Using another method consistently and correctly

Making reasonably sure a woman is not pregnant

Women who are not currently menstruating may still be able to start hormonal methods (pills, injectables, or implants), receive an IUD, or have a tubal ligation without delay. (All other methods can be started at any time.)

If a woman answers NO to ALL of these statements, pregnancy cannot be ruled out. She should wait until her next menstrual period (and avoid sex or use condoms) or take a pregnancy test.

If a woman answers YES to AT LEAST ONE of these statements and she has no signs or symptoms of pregnancy,* provide her with the method.

No	Screening Statements	Yes
	1. Last menstrual period started within the past 7 days (12 days for the IUD)	
	2. Gave birth in the last 4 weeks	
	3. Fully (or nearly fully) breastfeeding AND gave birth less than 6 months ago AND has had no menstrual period since then	
	4. Miscarriage or abortion in the past 7 days (12 days for the IUD)	
	5. No sexual intercourse since last menstrual period or delivery	
	6. Using a reliable contraceptive method consistently and correctly	

*Signs of Pregnancy

If a woman missed her menstrual period, she may be pregnant. She may also have several other signs or symptoms of pregnancy. Confirm pregnancy by test or physical examination.

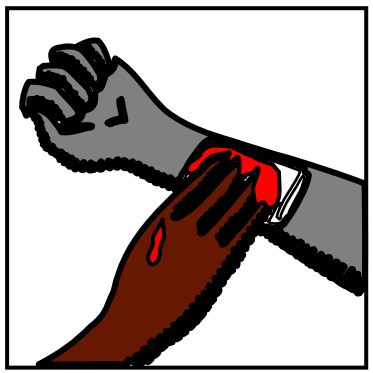
Missed menstrual period(s)	Larger breasts	Changed eating habits	Always tired
Weight change	Breast tenderness	Nausea	Mood changes
Urinating more often	Darker nipples	Vomiting	

What are HIV and AIDS?

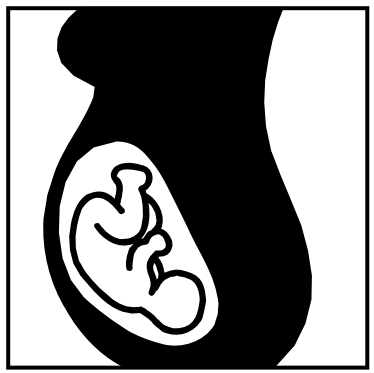
- **HIV = H**uman **I**mmunodeficiency **V**irus
- **AIDS = A**cquired **I**mmune **D**eficiency **S**yndrome
- **No cure**
- **Tests determine if infected**

How is HIV transmitted?

Unsafe sex



Infected blood



Pregnancy and delivery

Breastfeeding

What are HIV and AIDS

HIV, the human immunodeficiency virus, is the virus that causes AIDS.
The virus attacks the body's immune system, making it hard to fight off diseases and infections.

AIDS stands for:
Acquired (means it is something you get)
Immune (refers to the system in your body that fights infection)
Deficiency (means not enough, absence, lack of ability)
Syndrome (means signs and symptoms of an illness)

There is no cure for HIV. Viruses cannot be killed with antibiotics.

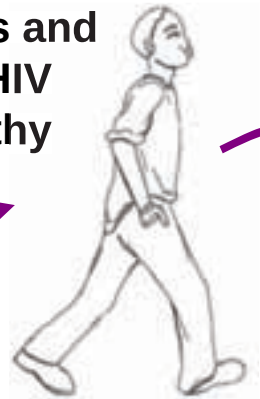
Specific tests determine if a person is infected:
Antibody test (most common) – checks the blood for the presence of antibodies to the HIV virus. It takes several months after infection for the body to produce detectable amounts of antibodies.
PCR/polymerase chain reaction tests (more complex and expensive) – checks the blood for the presence of the virus itself. The test is sometimes used on infants born to HIV-positive mothers.

HIV is **transmitted**:	HIV infection can be **prevented** by:
Through sexual contact (anal, vaginal, or oral sex)	Practicing safer sex and using condoms; circumcision reduces acquisition in men
Through infected blood (a puncture or cut with a sharp instrument with HIV-infected blood on it, a transfusion with HIV-infected blood, or exposure of an open cut or mucous membrane to HIV-infected blood)	• Following standard precautions • Blood screening
From mother to child during: • Pregnancy • Delivery • Breastfeeding	Using: • ARV therapy • Safe delivery practices • Infant feeding guidelines

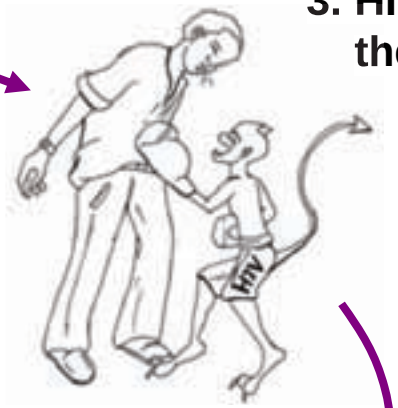
Stages of HIV disease

1. Person is exposed to HIV

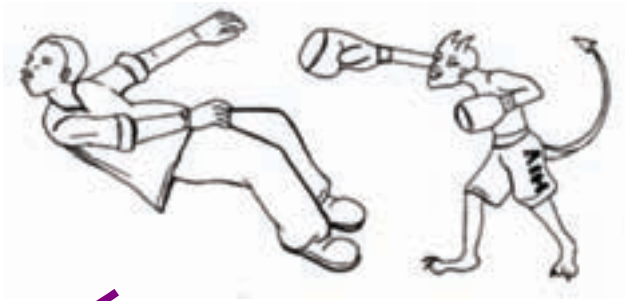
2. Person carries and can transmit HIV but feels healthy



3. HIV starts to “beat up” the immune system

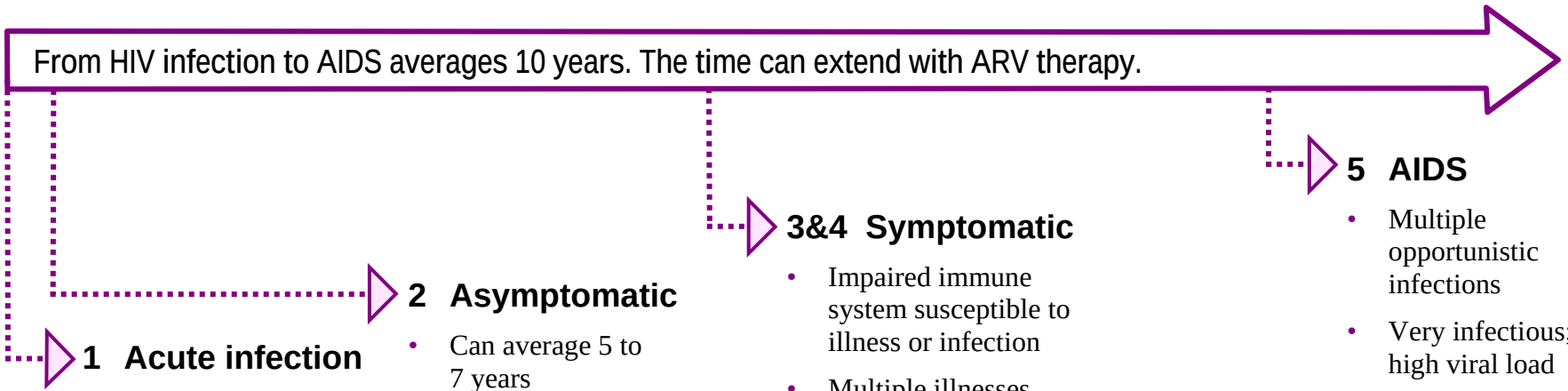


4. HIV grows and person gets weaker, needs medicine and care



5. Person develops AIDS and opportunistic infections

Stages of HIV disease



1 Acute infection

- From exposure to ~3 months is the window period (infected people may test negative on an antibody test during this time)
- Few or no symptoms (some people have a brief flu-like illness, with fever and a slight red rash for 2 to 4 weeks post-infection)
- Very infectious; high viral load.

2 Asymptomatic

- Can average 5 to 7 years
- Feel fine; no obvious symptoms (however, immune system damage occurs)
- Will test positive for HIV
- Infectious; can transmit HIV to others
- Follow-up at HIV/AIDS care and treatment center for tests to determine when to start ART

3&4 Symptomatic

- Impaired immune system susceptible to illness or infection
- Multiple illnesses requiring treatment
- Likely eligible for ARV therapy

5 AIDS

- Multiple opportunistic infections
- Very infectious; high viral load
- ARV therapy to reduce viral load and improve quality of life

Illustrations: Sutida Boonjindasap/Pathfinder International, 2006.

Treatment of HIV

- **Get tested to determine when to start**
- **ARV therapy**
  - slows disease and improves quality of life
  - take multiple drugs at the same time
  - important to take drugs correctly
- **Eat well, get plenty of rest and exercise, practice good hygiene, avoid exposure to germs**
- **Seek prompt treatment for infections and illnesses**

ARVs reduce but do not eliminate the risk of HIV transmission. Continue using condoms consistently and correctly.

ARV therapy

- Slows disease progression and improves quality of life.
- Tests determine when to start. CD4 counts or viral-load tests are available at HIV care and treatment facilities.
- Multiple drugs are taken at the same time and work in different ways to keep the virus from multiplying.
- Take the drugs correctly to avoid developing resistance. Compliance is key. Follow the doctor's instructions and return for follow-up visits on schedule.

Eat well, get plenty of rest, practice good hygiene, avoid exposure to germs

- Learn about healthy living from a counselor, nutritionist, or support group for persons living with HIV and AIDS.
- Wash hands with soap after using the toilet, take baths daily, and brush teeth after eating.
- Preventing illness is the best option. Drink clean water and eat properly prepared foods. Abstain or use condoms to avoid STIs.

Opportunistic infections

- Opportunistic infections occur when the immune system is weakened by the HIV virus.
- They require prompt treatment.
- They include shingles, malaria, diarrhea, pneumonia, tuberculosis (TB), and various cancers.
- Signs and symptoms include dizziness, pain when swallowing, trouble breathing, frequent or very bad headaches, problems seeing, tiredness, fever, chills, cough that lasts longer than 2 weeks, weight loss, frequent or watery diarrhea, vomiting, sore mouth or tongue, problems with balance, sores on genitals or unusual or smelly discharge from the vagina, or pain during intercourse.

Contact List for Referral Services

In the spaces below, record contact information for services that are available to clients in the community where you work. When referring clients for services that you cannot provide, be sure to explain: where to go, when to go, whom to see, directions to the facility, distance involved, transportation options, approximate time needed for the visit, what to take to the visit, and any costs for services. As appropriate, provide a referral form that includes clear instructions for the client. Ensure that your clients know how to reach you for follow-up care.

Testing and treatment for STIs	HIV support group(s)
Counseling and testing for HIV	Psychological support
ARV therapy	Home-based care
Antenatal/PMTCT	Child health and parenting
Family planning (including community-based distribution)	Men's health
Infertility treatment	Adolescent program
Management of abortion-related complications	Domestic violence or rape crisis
Other sexual and reproductive health (cancer screening and treatment)	Alcohol and drug abuse
Infant feeding support (i.e., milk bank, formula, breastfeeding coaching)	Legal and financial support
Nutritional counseling and support	Pharmacy