# Fulfilling The Contraceptive Needs Of Sex Workers

## Family Planning and HIV Integration in the Aastha Project

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**Title:** Fulfilling the Contraceptive Needs of Sex Workers: Family Planning and HIV Integration in the Aastha Project

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# FOREWORD

Most often, HIV prevention projects for female sex workers (FSWs) are vertically-oriented and focus only on HIV-related activities such as STI screening and condom promotion. However, meeting the contraceptive needs of FSWs is a critical part of meeting their sexual and reproductive health needs, preventing unintended pregnancies and unsafe abortions, and for FSWs with HIV, to prevent new infant HIV infections.

Since 2004, the Aastha Project (funded by the Bill & Melinda Gates Foundation and implemented by FHI 360) has been providing STI and HIV prevention and management services to FSWs in Mumbai and Thane districts in Maharashtra, India, via project supported clinics and outreach activities. In 2005, to address the documented felt needs of FSWs, Aastha also began to offer client-initiated FP counseling services during HIV counseling and STI management sessions. In 2010, the project strengthened the integrated model by offering provider-initiated FP screening, counseling, and referrals to all eligible FSWs.

This FHI 360 monograph highlights the experiences of FP-HIV integration within the Aastha Project, and provides lessons learned on working with high risk groups in an effort to provide access to STI / HIV prevention and reproductive health services under one roof. Tools such as a tailored strategic behavior communication (SBC) package and various screening and record forms are included for illustrative purposes.

We hope this document will be found useful by Program Managers and Project Officers working with most-at-risk populations.

**Dr. Sanjeevsingh B Gaikwad,**
Director Maharashtra Program, FHI 360

## LIST OF TERMS

| | |
|---|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ART | Anti Retroviral Treatment |
| CoC | Continuum of Care |
| DIC | Drop in Center |
| EFPC | Eligible for Family Planning Counseling |
| FP | Family Planning |
| FSW | Female SW |
| HIV | Human Immuno Deficiency Virus |
| HRG | High Risk Group |
| ICTC | Integrated Counseling and Testing Center |
| IEC | Information Education Communication |
| IP | Implementing Partner |
| IUCD | Intra-uterine Contraceptive Devices |
| NACO | National AIDS Control Organization |
| NEFPC | Not Eligible for Family Planning Counseling |
| OCP | Oral Contraceptive Pill |
| ORW | Outreach Worker |
| PLHIV | People Living with HIV |
| PPP | Public Private Partnership |
| PPTCT | Prevention of Parent to Child Transmission |
| PTA | Prevention Technologies Agreement |
| SBC | Strategic Behavior Communication |
| SOP | Standard Operating Procedure |
| STI | Sexually Transmitted Infection |
| TI | Targeted Intervention |
| WHO | World Health Organization |

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# CONTENTS

## Background

By definition, a female sex worker (FSW) is the female partner of a contractual, non-familial, sexual activity performed in exchange for money. Sex work is a source of income and a means of livelihood and can be entered into voluntarily or as a result of coercion. Female sex workers have many of the same reproductive health needs as all women, with a few additional concerns that arise from their occupation. For example, given the high frequency of sexual activity, the chances of conception are very high for a FSW as compared to a woman with a single partner.

In sex work, the reality is that the onus to remain within the non-reproductive, non-familial, pleasure-giving domain rests on the sex worker rather than the client. FSWs are thus made responsible for taking precautions against and managing the consequences of unprotected intercourse. Without the corresponding level of empowerment needed to always negotiate such protection, sexually transmitted infections (STIs) and unintended and terminated pregnancies are common among FSWs. Thus, their knowledge and awareness of, access to, and uptake of modern family planning (FP) is a critical and core component of their overall well-being.

The Aastha Project (funded by the Bill & Melinda Gates Foundation and implemented by FHI 360) was initiated in 2004, with the goal of reducing the incidence of HIV and other STIs among FSWs and their partners. Initially, Aastha clinics provided such HIV/STI services as referrals for counseling and testing and medications for anti-retroviral therapy (ART). In 2005, Aastha also began to offer FP screening, counseling, and referral services in its clinics in Mumbai. Over the past six years, the Aastha Project has provided integrated FP/HIV services to tens of thousands of FSWs through 16 clinics, 36 satellite clinics, and hundreds of monthly health outreach camps. Clients have consistently expressed their satisfaction with the integrated services, emphasizing the importance of “one-stop-shopping.”

**SECTION I**

**BACKGROUND AND RATIONALE**

## Benefits for integrating FP into the STI/HIV

### A. Benefits of integrating FP and STI/HIV services for FSWs

- Enhanced ability to prevent new HIV infections, especially among infants.
- Improved access to and better-quality of HIV and FP services customized to meet the needs of people at risk or people living with HIV (PLHIV).
- Enables tailoring of FP messages and methods to the client’s HIV status and desire to prevent a pregnancy or conceive as safely as possible.
- Greater support for dual protection against unintended pregnancy and STIs.
- Better coverage of FSWs in areas of high HIV prevalence.
- Enhanced community involvement and participation.
- Reduces stigma in accessing care and treatment, and promotes increased uptake of HIV services.
- Maximized productive use of available resources.

### B. Benefits for the Prevention of Parent to Child Transmission (PPTCT) of HIV

Typical PPTCT services include working with the mother or couple from the antenatal care period through the first two years after child birth. Comprehensive PPTCT also includes FP counseling for women living with HIV to

prevent unintended pregnancies, or in the postpartum period for pregnant clients. As a result there are multiple opportunities that arise to counsel HIV positive FSWs on FP, including:

- Period of antenatal care.
- Before the mother is discharged from the health facility.
- When she brings the baby in for checkups and immunizations.

Integrating FP directly with PPTCT is especially important for the following reasons:

- Outreach programs encourage all FSWs regardless of their HIV status to seek antenatal care, to return to the clinic for postpartum care, and to use an effective FP method.
- FP/PPTCT integration enables HIV positive FSWs who desire a pregnancy to practice dual-method use until their level of infection has been effectively lowered through anti-retroviral drugs and it becomes safer to conceive.
- Encourages exclusive breast feeding (as appropriate) and the initiation of an effective contraceptive method before the return of fertility (six months after child birth for women who are exclusively breast feeding).
- Helps FSWs avoid a subsequent unintended pregnancy through the use of short-acting, long-acting, and permanent contraceptive methods for both males and females.

*"The health of brothel-based sex-worker women became a cause for concern only when male health was impaired from the diseased, infectious bodies of the sex-workers. This was true historically, in colonial times as well as in post-colonial India."*

Swati Ghosh
Abortion Assessment Project - India
Centre for Enquiry into Health and Allied Themes, Research Centre of Anusandhan Trust

### C. Benefits of FP in Positive Prevention programs

With access to care and treatment, many people living with HIV maintain a good quality of life and continue to have sexual relationships. For FSWs, the latter can mean sustaining both domestic and commercial sexual activity. Because unmet need for FP is high among this population, positive prevention activities present a good opportunity to provide FP services.

The benefits of incorporating fertility screening and FP into care and treatment, including positive prevention, for HIV-positive FSWs include:

- Prevents unintended pregnancies and reduces the risk of new HIV infections among infants;
- Helps FSWs who desire a pregnancy to conceive more safely and encourages them to space pregnancies; and
- Higher uptake of dual method use (FP method plus condoms) can help prevent HIV transmission to uninfected partners.

## Hormonal contraception and HIV acquisition, progression and transmission

During January 31 - February 2, 2012, the World Health Organization (WHO) convened an expert meeting to review existing evidence on use of hormonal contraception (HC) and risk of HIV acquisition. Subsequently, WHO added a clarification to its previous classification of progestin-only injectable contraception for women at high risk of HIV infection. The clarification states that while this method is recommended for use without restriction, women at high risk of HIV who choose progestin-only injectable contraceptives to meet their family planning intentions should be strongly advised to also use condoms and other HIV-preventive measures. This means that women who are at high risk for HIV can still use progestin-only injectable contraception without

restriction, but that providers serving these women need to provide enhanced counseling on the concurrent use of condoms and other HIV-preventive measures. Contraceptive and HIV service providers and educators should redouble their efforts to counsel women and couples about the importance of family planning and the consistent use of condoms. Concurrent use of condoms (male or female) with other family planning methods is necessary for preventing HIV and other sexually transmitted infections. Other HIV risk reduction measures include voluntary adult medical male circumcision, knowing one's HIV infection status, knowing one's sex partner's status, diagnosis and treatment of other sexually transmitted infections and a reduction in the number of sexual partners. In addition, strategies to improve access to highly effective, lower-dose hormonal (implants) and non-hormonal (IUDs, sterilization) 3 contraceptive methods should be a priority.

## Contextualizing the FP needs of FSWs versus those of the general population

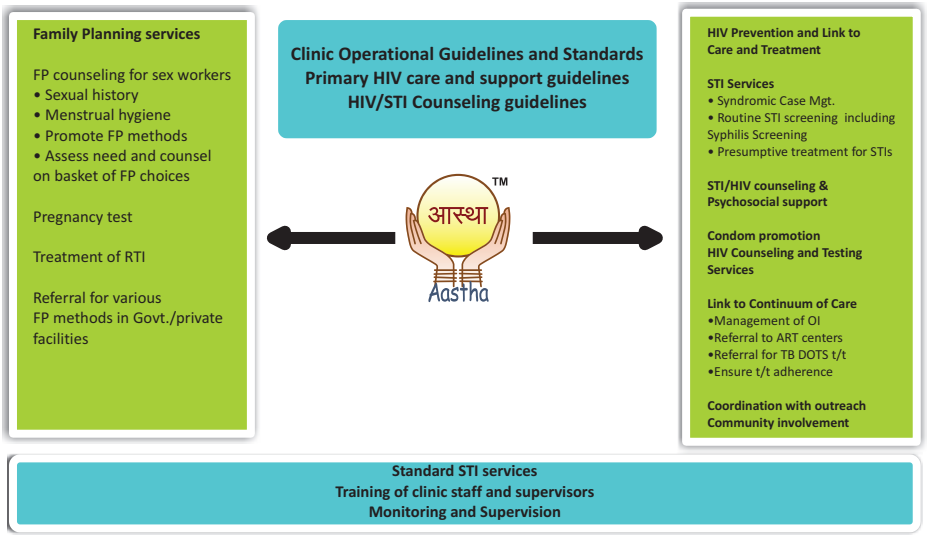
According to the WHO, unsafe abortion accounts for 12 percent of all maternal or pregnancy-relateddeaths in Asia, claiming the lives of 38,000 women each year. Unsafe abortions are among the major preventable causes of maternal morbidity and mortality in India. To complicate matters, many abortions are not reported, making the available statistics of abortions in India of varying reliability. According to the Consortium on National Consensus for Medical Abortion in India, the number of medical termination cases has increased by 78.9% from 1995 to 2000. This signifies a significant amount of unmet need for FP services among women in the reproductive age group. Women in high risk groups (such as FSWs) reporting abortions in 2011 is 3% according to the Aastha FP-HIV screening data.

## SECTION II:

# STRENGTHENING HIV INTERVENTIONS THROUGH INTEGRATION: THE AASTHA APPROACH

In 2005, Aastha commenced client-initiated FP counseling services as part of the HIV counseling and STI management package of services. This included need-based provision of information on contraceptive options and referrals for FP methods. Clients were also given reproductive health services like pregnancy tests if needed. Through this initial intervention, the project reached more than 3,000 FSWs with pregnancy tests; 600 FSWs were referred for medical termination of pregnancy (MTPs) and hemoglobin tests were conducted for 3,500 FSWs. In the same time period, over a hundred thousand counseling sessions were conducted to address safe sex practices, including family planning options.

Aastha Phase I Model of client initiated FP-HIV integration




In December 2010, with support from USAID under the Prevention Technologies Agreement (PTA) the Aastha team expanded and strengthened the integrated model by offering provider-initiated FP screening, counseling, and referrals to all eligible FSWs in the 18-49 year age group in seven Aastha sites. Rather than only providing FP information and referrals to clients who requested it, every FSW presenting at an Aastha health care setting for HIV prevention services is screened for her FP needs by the health care provider.

The team implemented the following activities to introduce the new provider-initiated model:

- Training of doctors, counselors, nurses and outreach workers on FP for most-at-risk populations and to screen FSWs for unmet FP need using a specially designed screening tool;
- Development of customized client communication materials and provider job aids;
- Provision of FP counseling and orientation to FP methods from a basket of choices;
- Referrals made based on the FP method chosen by the FSW.

### Screening for unmet FP need

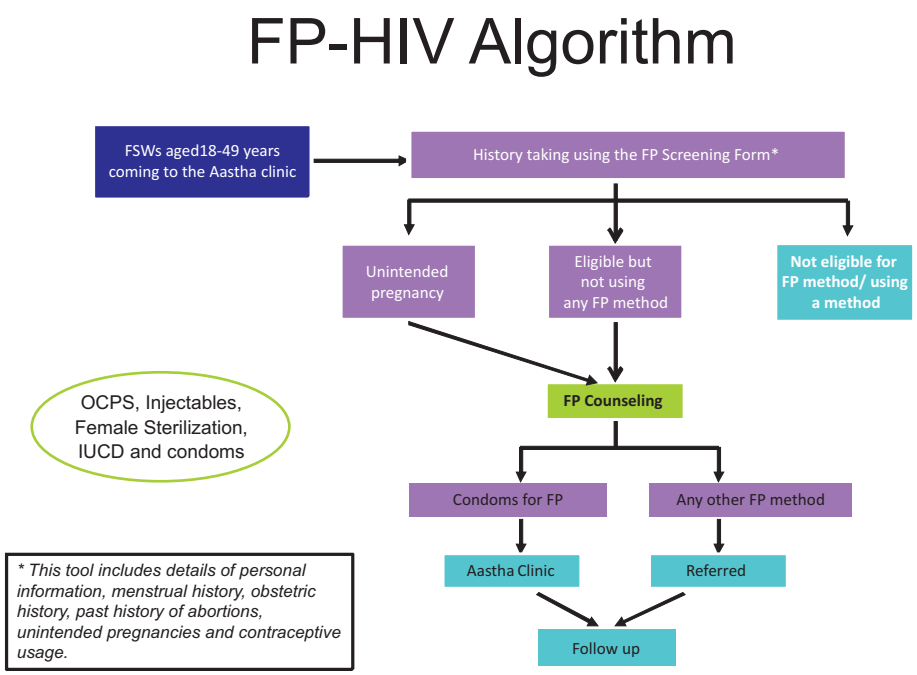
The Aastha Project team introduced an FP screening form (Refer Annexure 1) to assess the unmet need for FP among FSW clients and to provide information on contraceptive choices. Every FSW presenting at an Aastha clinic for HIV

prevention services is screened for her FP needs by the health care provider using the FP screening form. The form was developed to collect data related to personal information, menstrual history, obstetric history, past history of abortions, unintended pregnancies and contraceptive usage and includes information on the current relationship status and whether she cohabits with her partner.

Based on the information shared by FSWs during the screening process, healthcare providers identify FSWs either as 'Eligible for FP Counseling' (EFPC) or 'Not Eligible for FP Counseling' (NEFPC). Any SW who has either undergone sterilization or hysterectomy is categorized as permanently NEFPC and is not screened again. Those who are currently pregnant and wanting to have the child also fall under the NEFPC category. These FSWs will undergo a repeat screening after delivery. FSWs reporting current use of OCPs, injectables and Intra-uterine Contraceptive Devices (IUCDs) are also categorized as NEFPC, but will continue to be screened each time they visit the clinic to monitor continuity.

Given that Aastha is an HIV prevention project, condoms are promoted and distributed to FSWs for protection against STI and HIV from their regular partners and clients. In order to ensure a comprehensive understanding of male condom usage as dual protection, FSWs reporting use of male condoms as an FP method during their first screening are categorized as EFPC and referred for FP counseling. FSWs who are not currently using any FP method to avoid getting pregnant or those who report an unintended pregnancy are categorized as EFPC, including PLHIV FSWs.

Eligible FSWs are then provided with FP counseling by the health care provider and referred for FP methods accordingly. Systems have been put in place to ensure that healthcare providers administer tool to all EFPC FSWs each time they visit the clinic.



## Addressing FP knowledge and beliefs through information and counseling

Often, FSWs and brothel owners believe that contraceptives and related programs are only for "formal" families and therefore only to be used as a preventive device within families. Moreover, FSWs have historically opted for traditional methods of contraception such as oral consumption of roots, leaves or stems of herbs and plants in powdered or paste form. Until recently, modern methods of contraception have not been popular among FSWs and are plagued by myths and misconceptions. Even condoms often present a challenge, and it remains difficult for FSWs to negotiate condom use with men.

Moreover, many experienced FSWs believe that they can manipulate clients into using the withdrawal method, or promote vaginal washing as a means of FP. As a close-knit community, the more FSWs shunned the use of modern methods and relied on ineffective techniques to prevent pregnancy, the more pervasive the myths became.

Given this history, accurate, detailed, and comprehensive counseling on FP is critical for FSWs. In Aastha, after a FSW is deemed eligible for FP counseling through the screening process, she is given full informed choice FP counseling by her provider. Counseling focuses on information regarding contraceptive method benefits and drawbacks, the efficacy of each method, and the eligibility of the FSW to use each based on any existing contraindications. The FSW is then supported to make an informed choice for her desired method and given a referral to receive it.

## FP Communication Materials and Job Aids

FSWs are encouraged to come for STI screening every month. These visits have been routinized and the health seeking behavior has been generally adopted by the FSWs reached in the Aastha Project. These routine screening visits are used as the best opportunity for FP screening. The project has specially designed strategic behavior communication (SBC) materials to support the implementation of the integrated FP-HIV model.

The communication materials are used by the Outreach Workers (ORWs) and counselors to help FSWs understand the importance of FP for their physical and mental well being. The various FP methods are explained in detail in relation to STI and HIV prevention information. A basket filled with real examples of FP method choices is presented to the FSWs to help them make informed choices. Training programs for all levels of staff are necessary to ensure correct messages are conveyed to the community as well as to orient them to the new material.

## SBC Material One: Jewelry Box

This is used by the Outreach team to start a discussion around FP methods with FSWs and to promote use of FP methods with regular partners and spouses.

An outreach team member will show the jewelry box to the FSW and build a conversation as follows: "What is there in the box? What do you think the box contains? It contains something precious – jewelry and even more precious - information."

Images with key messages on the relationship with regular partners and the

need to practice safe sex behavior with them are on the leaflet inside the box. These images are to be shown to the FSW and discussed. The other side of the leaflet has images of FP methods – male condom, female condom, OCP, Copper T, Injectables and permanent methods for both men and women as a basis for information sharing and discussion. The fact that only condoms provide dual protection is also discussed.

## SBC Material Two: Basket of choices

This material is used by the counselor at the time of FP counseling to help the FSW to make an informed FP choice. Before the session begins, the counselor needs to ensure that all the necessary contraceptive methods are in the basket: male and female condoms, injections, Copper T and OCPs.

First the counselor establishes rapport with FSW. The counselor should begin with asking questions such as how many children the FSW has, their ages, whether the FSW wants any more children and so on. Then she takes the FSW through each method in the basket – giving their advantages and disadvantages, price (in the case of injection) and where it is available. Sterilization should be mentioned and prescribed only after ensuring both partners are willing to give consent. It should be mentioned that all the contraceptives, except condoms, do not give protection against HIV and STIs.

The counselor can carry the basket along with her when she is planning on conducting counseling sessions in an outreach setting.

## Job Aid

A board of FP methods giving detailed information regarding all FP methods is prominently displayed in the static clinic and referred to during FP counseling sessions.

# Family Planning Methods

More effective

Less effective

### Male and female sterilization

**Male and female sterilization** are surgical procedures. Both procedures block the tubes making it impossible for the egg and sperm to meet. Sterilization provides permanent effective protection from pregnancy and may be a good choice for couples who are certain they don't want any more children.

### IUD & Contraceptive

IUD is a small, flexible, plastic frame with copper sleeves or wire that is inserted in the uterus by a specially trained provider. IUDs are very effective and provide protection from pregnancy for as long as 12 years. However, if woman wants to get pregnant, IUD can be removed any time.

### Long-acting injectables – DMPA

**Long-acting injectables – DMPA**– contain only 1 hormone, progestin. Injections are give in the upper arm or buttocks every 3 months (DMPA). Injectables primarily work by stopping the production of eggs. They are very effective in preventing pregnancy. The only thing woman needs to remember, is to return for her next injection as scheduled.

### Oral Contraceptive Pills

**Combined oral contraceptives (COCs)** are pills containing 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. Pills should be taken every day to be very effective. When pills are missed, women may get pregnant. Should not be taken if on ARV drug – ritonavir.

**Progestin-only pills (POPs)** contain one hormone, progestin, and require strict daily schedule. They may be a good choice for breastfeeding women because they don't affect milk production. Moreover, they may be more effective in breastfeeding women due to additional pregnancy protection provided by lactational amenorrhea. Should not be taken if on ARV drug – ritonavir.

### 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. Effective if used correctly every time couple has sex. Partner cooperation is a key.

### Fertility awareness-based methods

**Fertility awareness-based methods** require that the woman learn the days of the menstrual cycle when she can get pregnant and avoid sex or use condoms on these days. As with condoms, partner cooperation is required.

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*Mala* is a 30 year old brothel based sex worker working in the Simplex building of Kamathipura area in Mumbai for the last one year. Marriage in early 20's, abusive husband and the responsibility of a son made Maya decide to leave her husband and run away from Kolkata. She left her son in her mother's custody and put her trust in a friend who brought her to Mumbai to earn a living. She was betrayed. Her friend sold her to a brothel owner for 20,000 rupees.

Being new to the sex work profession combined with a lack of adequate knowledge and perennially under debt, she would at times not use condoms with her clients. Within three months she had an unwanted pregnancy. With the help of another sex worker from the same brothel, she managed to get the pregnancy terminated at a Govt. hospital. After that, there was a nagging fear in her mind of getting pregnant again. The Aastha outreach team was meeting her regularly for STI / HIV prevention services but she never expressed her FP needs until February 2011. She was pro-actively screened by the Aastha doctor to find out whether she had an unmet FP need. After their talk, she was referred for and received injectable family planning.

*"Thanks to the ORWs and clinic team of Aastha who educated me on both protection against STIs and HIV transmission and prevention of unwanted pregnancy. I visit the clinic regularly for STI and HIV testing and use a condom with all my clients. I have also opted for quarterly contraceptive injectables to avoid getting pregnant. Taking the injection every three months is easy, convenient and has no side effects. I have been taking the injections regularly since March 2011. Just one dose and I am tension free for three months."*

***- Mala, FSW***

## SECTION III:

## TESTIMONIALS

*Priyanka* has experienced many changes in her identity as an adult. A bar dancer, a sex worker, wife, a person living with HIV, mother.

*"Being a wife brought a sense of security into my life. We fell in love at the bar and decided to spend our lives together. Ramesh is a dedicated husband and desperately wanted a child. Beginning of 2011, I found out that I was pregnant. I was very excited. And then I felt extreme shock. The same hospital doctor told me that I was HIV positive. I had no idea before then. I was disturbed. I didn't want to die, I was only 24.What would happen to my child? These thoughts kept circling in my mind.*

*Shattered, I turned to my friend, a Peer Educator who took me to the Aastha clinic to link me with care and support services. While I was at the clinic, the doctor pro-actively explained to me the significance of positive prevention as well as the importance of using condoms consistently for dual protection. He gave me advice about living positively and referred me to the PPTCT. The peer nurse accompanied me to the PPTCT center and we jointly discussed prevention of infection to my unborn child. Some months later my baby was born. Thanks to the timely intervention by Aastha, my daughter has been born healthy.*

*Fortunately my husband tested negative. I get condoms from the counselor every month which we use regularly as a means of dual protection and will continue this way."*

***- Bar girl (name changed on request)***

*Mehrunissa* was 17 at the time of marriage and her husband, Aslam was 36. They had three children within 10 years of marriage, adding considerable stress to their economic situation. Poverty plagued them continuously. Aslam's auto rickshaw earnings were just not enough to manage their household expenses. In a desperate attempt to keep his ever-growing family regularly fed, he forced Mehrunissa to solicit sex work clients at the nearby bus depot to supplement their meager income.

Their latest new born was only three months old when Aslam passed away. In the midst of her grief, Mehrunissa received another shock. She was pregnant again! How could she have another child? She could barely feed her family in the current situation.

Mehrunissa went to the clinic for her regular monthly check-up at which time the doctor talked to her about FP. After discussing all her options and weighing the pros and cons; she decided to undergo an operation for termination of pregnancy and permanent sterilization at the young age of 27. The importance of consistent use of condoms with her clients for STI and HIV prevention was reinforced by the counselor.

*"[Even though I'm protected from pregnancy], I always use condoms because I have to ensure that I'm safe and healthy. Who else will look after my children?"*

***- Street based sex worker (name changed on request)***

*Amina* is 30 and has been married for five years to Mehmood, her second husband. Her first marriage was full of violence and sadly her second has not been much of an improvement. She is Mehmood's second wife and is expected to manage her own household expenses. She has two sons who live with her brother who has taken the responsibility of educating them. She lives alone and her husband visits her sometimes.

No one in her family knows that she is a sex worker. Not even her husband, who thinks she works in a store as a sales person. Amina uses condoms but on some occasions the need for extra money would make her agree to sex without condoms. In 2011, Amina had an unplanned pregnancy and aborted in a private facility.

Although she did not usually place a priority on her own health, after her abortion she visited an Aastha clinic. The doctor screened her for her FP needs, and a nurse counseled her on the basket of FP choices. Amina opted for OCPs since it is a temporary method of contraception, and committed to using them along with condoms in order to protect herself from STIs and HIV.

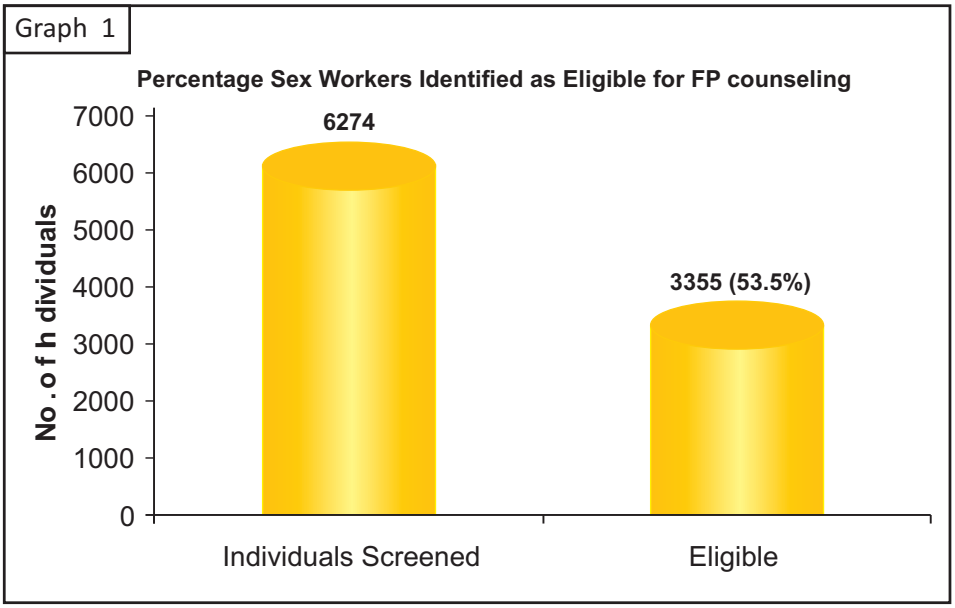
"*Popping one pill a day saves me from an unwanted pregnancy and the pain of undergoing an abortion*."

***- Home based sex worker (name changed on request)***

The combination of essential family planning and STI / HIV services helps to meet the comprehensive needs of FSWs while reducing the potential stigma that these services can carry. The use of the Aastha logo and the niche marketing of the Aastha Kendra as a center for women with no apparent connection to STIs / HIV / FP made FSWs feel comfortable while accessing services. Integration has led to increased access to and uptake of services including use of contraceptives (primarily condoms), increased HIV testing, and improvement in overall quality of services.

During the period January –December 2011, a total of 12,549 unique individuals visited the Aastha clinic for STI / HIV services. Of these, 6,274 (50%) were screened for their FP needs, and 53% of those were identified as eligible

Graph 1




Of the 6,274 FSWs screened for FP need:

- 185 FSWs reported having undergone abortion in the last one year
- 239 FSWs reported being currently pregnancy, 35 of which were characterized as unwanted

## Characteristics of FSWs who are identified eligible for FP counseling

- The mean age of FSWs identified with an unmet need was 27.83 years.
- Ninety-one percent (3,045) reported that they were in a relationship with a regular partner or spouse.
  - 63% reported married and living with husband
  - 25% reported relationship with regular partner/ lover
  - 3% reported married and living with husband and relationship with RP/lover

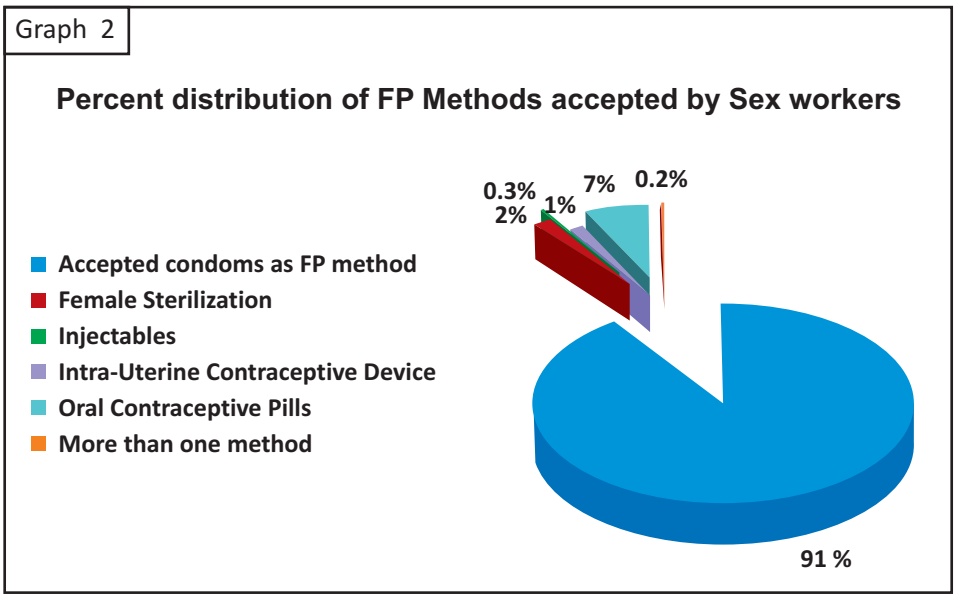
Ninety-eight percent (3,284) of eligible FSWs were provided counseling on a basket of FP choices, the typology wise break-up of which is as follows:

- 54% bar-based
- 16% brothel-based
- 15% street-based
- 13% home-based
- 0.3% lodge-based

## SECTION IV

## INTEGRATION OUTCOMES: JANUARY – DECEMBER 2011

Graph 2




Graph 2 shows the distribution of FP methods accepted by the FSWs after undergoing FP counseling. After receiving comprehensive FP counseling, 91% (2,936) decided to use only condoms as their FP method. In addition to the above, 7% (216) were referred for OCPs, 0.3% (09) for injectables, 2% (59) for female sterilization, 1% (49) for IUCD and 0.2% (07) for more than one method.

The data indicates that condoms continue to be the preferred method of FP for majority FSWs, thereby making this a potentially useful entry point for increasing condom use with regular partners. The preference for condoms shown by FSWs indicates that they see a major advantage as it not only protects them from STIs and HIV but also protects them from unintended pregnancy. However, due to the extremely low use of condoms with regular partners of FSWs, intensive counseling and behavior change will be necessary to ensure their correct and consistent use for the purposes of pregnancy prevention (rather than HIV prevention with commercial clients).

Our experiences show that FSWs in the Aastha program have very significant unmet needs for family planning. In the absence of systematic FP screening and counseling, there are likely to be unwanted pregnancies with associated consequences resulting in morbidity and mortality. The choices desired by FSWs do not pose any logistical challenges as these can be easily addressed by HIV prevention projects themselves directly (dual protection of condoms) or through strengthened referrals (OCPs, Injectables, Female sterilization, IUCD) to FP clinics. Based on the Aastha experience, it is strongly recommended that HIV prevention and care projects operating in concentrated epidemics and serving at-risk populations introduce routine screening, counseling and referrals for FP. Furthermore, such programs should take particular care in implementing the following recommendations from the WHO Technical Statement on Hormonal Contraception and HIV:

### Recommendations for women at high risk of HIV infection

- Women at high risk of HIV can continue to use all existing hormonal contraceptive methods without restriction.
- It is critically important that women at risk of HIV infection have access to and use condoms, male or female, and where appropriate, other measures to prevent and reduce their risk of HIV infection and sexually transmitted infections (STIs).
- Because of the inconclusive nature of the body of evidence on progestogen-only injectable contraception and risk of HIV acquisition, women using progestogen-only injectable contraception should be strongly advised to also always use condoms, male or female, and other preventive measures. Condoms must be used consistently and correctly to prevent infection.

### Recommendations for women living with HIV infection

- Women living with HIV can continue to use all existing hormonal contraceptive methods without restriction.
- Consistent and correct use of condoms, male or female, is critical for prevention of HIV transmission to non-infected sexual partners.
- Voluntary use of contraception by HIV-positive women who wish to prevent pregnancy continues to be an important strategy for the reduction of mother-to-child HIV transmission.

## SECTION V:

## CONCLUSION & RECOMMENDATIONS

APPENDIX

## Appendix 1:

## Standard Operating Procedure for FP-HIV Integration

This SOP explains how Aastha FP-HIV integration activities are implemented in a TI setting while maintaining high quality standards.

### Key features:

- Systematic FP screening and informed-choice counseling.
- Networking and linkages to facilitate FP related referral services.

### SOP Objectives:

- To provide strategic and operational guidelines on how to integrate FP services in HIV interventions with FSWs.
- To describe the essential requirements and processes for effective integration of FP services.

### Pre-requisites for effective integration:

- High stakeholder involvement: inputs from the project team, staff, and from the FSWs as clients to provide insights on integrated program design.
- High-quality services delivered through in-service training and supportive supervision.
- FP-oriented staff in place at each organizational level – doctor, nurse and outreach team.
- Doctors or intake nurses trained to screen clients for FP need and to assess FP eligibility of the FSWs.
- Nurses equipped with counseling skills, knowledge on FP methods, and knowledge of referral facility capabilities and locations.
- Outreach team members trained to identify FSWs in the field requiring FP services and to use FP SBC and IEC materials.
- Regular and continuous supply of condoms for FSWs who choose condoms as an FP method, and for other method users for dual protection.
- Local FP centers mapped and linkages established for effective referrals.

### Procedure

***Step 1: Screening***

1. All FSWs aged 18 to 49 years to visit the Aastha clinics once a month for regular STI screening.
2. During their routine checkup, the doctor to screen the FSWs to assess the FP eligibility of the FSWs using **FP screening form**.
3. After proper FP screening, the doctor to identify the FSWs as 'Eligible for FP counseling' if she falls into any of the following criteria:
   a. During screening, the FSW reporting a current unwanted pregnancy
   b. During screening, the FSW reporting not using any FP method
   c. During screening, the FSW reporting only using male condoms

   A FSW will be considered 'Not Eligible for FP counseling' under the following circumstances:

a. During screening, the FSW reporting current use of a FP method other than condoms
b. During screening, the FSW reporting having undergone sterilization

(tubectomy)
c. During screening, the FSW reporting in the menopausal age
d. During screening, the FSW reporting a current wanted pregnancy
e. During screening, the FSW reporting planning to have a child

4. The Eligible FSW is then referred to the nurse for FP counseling.

*(Refer Annexure 1 for FP screening form)*

***Step 2: Counseling***

1. The FP counseling to be provided by the nurse.
2. During counseling, the nurse to advise the FSW about the basket of FP methods including:

- **Condoms**
  a. Male condoms
  b. Female condoms
- **Other methods**
  a. Oral contraceptive pills
  b. Injectables;
  c. Female sterilization; and
  d. Intra-uterine contraceptive device.

3. The nurse to provide the following information of each method:
   - effectiveness of the method;
   - the benefits and limitations of the method;
   - reversibility;
   - short and long-term side effects;
   - warning signs and symptoms; and
   - the need for protection against STI / HIV / AIDS
4. During counseling, the nurse explains the importance of Dual Protection using condoms correctly and consistently with clients and regular partners as it reduces:
   - FSWs' risk of unintended pregnancy
   - Transmission of HIV between partners
   - Risk of acquiring or transmitting other STIs
5. The nurse to provide condoms free to FSWs opting to use condoms for FP
6. For FSWs opting for other FP methods, the nurse to provide referral to the nearest family planning clinic.

***Step 3: Referral***

1. The nurse to provide referral slip signed by the doctor to FSWs opting for an FP method other than condoms.
2. Referral should be made to the nearest family planning clinic and the nurse to provide all necessary information about the referral centre including:
   - Address and timing of the family planning clinic
   - Name of the contact person
   - Cost of services if any, for e.g., registration fee, baseline investigations, charges towards the FP method etc.
   - Any other essential information
3. If needed, accompanied referrals to be provided by the outreach team.

***Step 4: Follow up***

1. Follow up is to be done with the FSWs to monitor:
   a. Initiation of the chosen FP method
   b. Their adherence to the method
   c. And encourage them to start using another method of their choice if they have discontinued use of a previous method.
2. Follow up is to be done by at 2 levels:
   a. Field level: by the outreach team.
   b. Clinic level: by the doctor and the nurse.

***Step 5: Documentation and Reporting***

The following registers should be maintained at the project level:

| | | |
|---|---|---|
| 1. | For Referrals: | FP Referral Register |
| 2. | For Follow- up: | FP services case sheet |
| 3. | For Monthly Reporting: | FP monthly reporting format |

(Refer Annexure 3 for FP reporting formats)

## Appendix 2: FP Screening Form

# Family Health International
# Aastha Project
# Family Planning Screening Form

| | | | |
|---|---|---|---|
| 01 | Name of IP | | |
| 02 | Date of Visit | ------- / ------- / ---------- | |
| 03 | Aastha ID | ☐☐☐☐☐☐☐☐☐☐☐☐ | |
| 04 | Age | ☐☐ years | |
| 05 | Are you currently in a relationship? | ○ No ▶ **Go to Q 07**<br>○ Yes | |
| 06 | If yes, then with whom? | ○ Married and living with husband<br>○ Regular Partner / Lover<br>○ Any other ( specify ) | Notes |
| 07 | Date of last Menstrual period (LMP) | ------- / ------- / ---------- | Notes |
| 08 | Do you have children? | ○ **No** ▶ **Go to Q 10**<br>○ **Yes** | |
| 09 | If yes, number of children | Number | |
| 10 | Have you undergone a hysterectomy and/ or female sterilization?<br>*(If response is female sterilization, record the response in Q17 and then end)* | ○ **No**<br>○ **Yes** ▶ **Go to Q 19 (✓ ) Not eligible for FP** | |
| 11 | Are you currently pregnant? | ○ **No** ▶ **Go to Q 14**<br>○ **Yes** | |
| 12 | Is the current pregnancy wanted or unwanted? | ○ Wanted ▶ **Go to Q 19 and (✓ ) Not eligible for FP**<br>○ Unwanted | |
| 13 | If unwanted what do you opt to do?<br>*If the response is any of the two, record the response, ask Q14, go to Q19 and ( ) Eligible for FP counceling.* | ○ Continue with pregnancy<br>○ Opt for termination of pregnancy | Notes |
| 14 | Have you undergone any terminations in the last one year? | ○ No<br>○ Yes | Notes |
| 15 | Are you planning to have a child? | ○ No<br>○ Yes ▶ **Go to Q 19 and (✓ )) Not eligible for FP** | |
| 16 | Are you currently using any family planning method/s to avoid getting pregnant? | ○ No ▶ **Go to Q 18**<br>○ Yes | |
| 17 | If yes , which methods are you using?<br>*( Multiple choices can be ticked, probe here for use of other FP methods if use of condom is reported.)* | ○ Female Sterilization<br>○ Oral contraceptive Pills<br>○ Intra - Uterine Contraceptive Device<br>○ Injectibles<br>○ Implants<br>○ Male Condom<br>○ Female Condom<br>○ Locational Amenorrhea<br>○ Foam / Jelly<br>○ Diaphragm<br>○ Rhythm method<br>○ Withdrawal<br>○ Other ( specify) | Notes |
| 18 | Are you willing to start a family planning method to avoid getting pregnant? | ○ No<br>○ Yes | |
| 19 | Conclusion: | ○ Eligible for FP Counseling<br>○ Not eligible for FP Counseling | Notes |
| 20 | Referred for FP counseling : | ○ No<br>○ Yes | Notes |
| 21 | Received FP counseling | ○ No<br>○ Yes | |
| 22 | Outcome of FP counseling | ○ Accepted condoms as FP method<br>○ Referred for another method | |
| 23 | If referred, which was the method referred for? | ○ Oral Contraceptive Pills<br>○ Injectables<br>○ Female Sterilization<br>○ Intra - Uterine Contraceptive Device | |

# Appendix 3: FP Reporting Formats

**Table: FP-HIV Integration - FHI**

| | Indicator | Definition | Category | Rep Month: ----------2011 | Source for data collection |
|---|---|---|---|---|---|
| 1 | Number of Aastha clinics with FP/HIV integrated services | ***Numerator:*** Number of Aastha clinics that systematically **screen clients (FSWs aged 18-49) for FP need** | | | |
| | | ***Denominator:*** Total number of Aastha clinics | | | |
| 2 | Number of Aastha clinics clients (FSWs aged 18-49) **screened for FP need** | ***Numerator 2.a.):*** Number of Aastha clinics clients (FSWs aged 18-49) screened for FP need | 18-19 years | | FP Screening Form |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| | | ***Numerator 2.b.):*** Number of Aastha clinics clients (FSWs aged 18-49) identified with unmet need for FP | 18-19 years | | FP Screening Form |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| | | ***Numerator 2.c.):*** Number of Aastha clinics clients (FSWs aged 18-49) provided FP Counseling | 18-19 years | | FP Services Register |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| 3 | Number of Aastha clinics clients (FSWs aged 18-49) who received FP method or referral after FP Counseling | ***Numerator: 3.a.)*** Number of Aastha clinics clients (FSWs aged 18-49) referred for FP services | 18-19 years | | FP Services Register |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| | | ***Numerator: 3.b.)*** Number of Aastha clinics clients (FSWs aged 18-49) received FP method **(will include those who received condoms as FP method at Aastha clinic + those who received FP method after referral)** | 18-19 years | | FP Services Register and FP services Case sheet |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| 4 | Number of Aastha clinics clients (FSWs aged 18-49) attending Aastha clinics with unmet need for family planning | ***Numerator:*** Number of Aastha clinics clients (FSWs aged 18-49) with **unmet FP need** receiving HIV- related services | 18-19 years | | FP Screening Form and Clinic Encounter Form (CEF) |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| | This denominator is common for indicators 2, 3 & 4 | ***Denominator:*** Total Number of Aastha clinics clients (FSWs aged 18-49) provided with services at the site | | | Clinic Encounter Form (CEF) & Table 2 |
| | | | | | |
| | To be reported by the counselor only | | | | |
| 5 | Number of repeat care and treatment clients (FSWs aged 18-49) reporting unintended pregnancy | ***Numerator:*** Number of repeat PLHIV clients (FSWs aged 18-49) reporting unintended pregnancy | 18-19 years | | FP Screening Form |
| | | | 20-24 years | | |
| | | | 25- 29 years | | |
| | | | 30-34 years | | |
| | | | 35- 39 years | | |
| | | | 40- 44 years | | |
| | | | 45- 49 years | | |
| | | | Husband | | |
| | | | Regular Partner/ Lover | | |
| | | | Any other | | |
| | | ***Denominator:*** Total number of repeat PLHIV clients (FSWs aged 18-49) receiving care & treatment services | | | PLHIV Diary |

## FP Services Case Sheet

| Sr. No. | Aastha ID No. | Name | Age | Date of clinic visit | Services provided: (Please put a (√) for the service/s provided) | | | Referral Information | | | Follow- up information | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | FP Counseling | Provided condoms as FP method | Referred for FP (Y/N) If No, what was the reason? | Date of referral | Method referred for | Referred to (Name of the facility) | Date when services were received | Status (continuing the method/ discontinued) | Date of follow-up counseling |
| 1 | | | | | | | | | | | | | |
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## FP Services Register

| Sr. No. | Aastha ID No. | Name | Age | Date of clinic visit | Services provided: (Please put a (√) for the service/s provided) | | | Referral Information | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | FP Counseling | Provided condoms as FP method | Referred for FP (Y/N) If No, what was the reason? | Date of referral | Method referred for | Referred to (Name of the facility) |
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