Module 11 Family Planning and PMTCT Services for Adolescents

Session 11.1:	**Family Planning Counseling for ALHIV**
Session 11.2:	**PMTCT Counseling for ALHIV**

Learning Objectives

After completing this module, participants will be able to:

- List the risks of adolescent pregnancy
- Discuss childbearing choices and safe childbearing with adolescent clients
- Understand the contraceptive issues and challenges faced by ALHIV
- Counsel adolescent clients on prevention of mother-to-child transmission of HIV (PMTCT)

Session 11.1 Family Planning Counseling for ALHIV

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Risks of Adolescent Pregnancy[1]

Health risks:

- Pregnancy complications — because adolescents are not fully developed and their bodies may not be prepared to handle childbearing. Pregnant adolescents have a greater risk of obstructed delivery and prolonged labor, which increases their risk of hemorrhage, infection, and fistula.
- Pre-eclampsia (hypertension during pregnancy), which can progress if left untreated to extreme hypertension, seizures, convulsions, and hemorrhage
- Anemia
- Complications associated with unsafe abortion
- Premature birth and low birth weight
- Spontaneous abortion and stillbirth, especially among adolescents under the age of 15
- Mother-to-child transmission — ART and ARVs reduce but do not eliminate the risk of a pregnant adolescent transmitting HIV to her fetus or baby (see Session 11.2 for more information on PMTCT)

Psychological, social, and economic risks:

- Pregnant adolescents, especially those living with HIV, may face intense stigma from family, friends, community members, and health workers. This can cause emotional distress and can create a barrier to receiving needed HIV and PMTCT care and medicines.
- Pregnancy often means the end of an adolescent's formal education. If not expelled from school during the pregnancy, young women — and young men — often have to drop out to care for their infant.
- Adolescent pregnancy can change a young woman's and a young man's academic aspirations and choice of career. For young women, adolescent pregnancy can affect future marriage prospects.
- With limited career prospects, some young mothers resort to low-paying and risky jobs (such as prostitution) or marriage in order to support their children.
- Early marriages that result from an unplanned pregnancy are frequently unhappy and unstable.
- Some men refuse to take responsibility for their partner's pregnancy, which can contribute to hardship for the mother and child.
- Young parents are often not prepared to raise a child, which, in extreme cases, can lead to child-rearing problems like child abuse or neglect.

- Fathers of children born to adolescent mothers are more likely than other fathers to experience:
  - Decreased earnings[2]
  - Less education[3]
  - Depression[4]
- Compared to older fathers, adolescent fathers are:[3]
  - Less likely to have plans for a future job
  - More likely to have anxiety
  - More likely to be homeless or living in very unstable households

Counseling Adolescents on the Safest Times to Have Children in the Future

Many ALHIV have questions about whether or not they can safely have children in the future. Health workers should provide adolescent clients with education and counseling on the safest times to become pregnant and have children.

- It is safest to wait until adulthood to become pregnant and have children. There are many health-related, psychological, social, and economic risks associated with having a baby during adolescence (see above).
- The safest time to get pregnant is when the woman with HIV:
  - Has a CD4 cell count above 500
  - Is healthy — she does not have any opportunistic infections (including TB) or advanced AIDS
  - Is taking and adhering to her ART regimen, and her ART regimen is **NOT** EFV-based
- If her partner is HIV-infected, then the safest time to get pregnant is when he also:
  - Has a CD4 cell count above 500
  - Is healthy —he does not have any opportunistic infections (including TB) or advanced AIDS
  - Is taking and adhering to his ART regimen
- It is healthiest for a mother to wait until her child is at least 2 years old before getting pregnant again.

EFV and pregnancy

Because of the theoretical risk of EFV causing neural tube defects:

- Women at risk of conception or women for whom contraception is not ensured should be given an ART regimen that does **not** include EFV.
- EFV should **not** be initiated in the first trimester of pregnancy, but it may be initiated in the second or third trimester.
- If a woman on an ART regimen containing EFV is diagnosed as pregnant before 28 days of gestation, EFV should be stopped and substituted with NVP or a PI. If a woman is diagnosed as pregnant after 28 days of gestation, EFV should be continued.
- There is no indication for termination of pregnancy in women exposed to EFV in the first trimester of pregnancy.[5]

It is important that ALHIV know the facts about pregnancy and preventing mother-to-child transmission BEFORE they become pregnant. These are good topics to discuss in ALHIV support groups and during individual counseling sessions. Adolescent clients should be encouraged to talk with health workers about pregnancy and PMTCT if they are thinking of having children. Health workers should also encourage the partners of these adolescent clients to come to the clinic for education and counseling on these topics.

Providing Contraceptive Services to Adolescents: Important Considerations

"One-stop shopping" (as discussed in Module 3) is particularly important for adolescents seeking contraceptive counseling and/or a contraceptive method. When adolescents are provided with contraceptive services as part of another service (in this case HIV care and treatment), they are able to access these services conveniently and in confidence (without having to go to a family planning clinic, which may be uncomfortable for them).

Key screening questions for family planning counseling sessions with ALHIV are included in *Appendix 11A: Family Planning Screening Questions and Counseling Points*.

When discussing family planning methods with adolescents, it is important to remember:

- Adolescents have special needs when choosing a contraceptive method and social, behavioral, and lifestyle issues need to be considered. For example, because of adolescents' unpredictable sexual activity and their common need to conceal intimacy and contraceptive use, methods that do not require a daily regimen may be more appropriate for adolescents. In addition, sexually active adolescents who are unmarried have very different needs from those who are married and want to postpone, space, or limit pregnancy.
- In general, adolescents have been shown to be less tolerant of side effects and to have high family planning discontinuation rates. Expanding the number of methods to choose from can improve adolescents' satisfaction and increase their contraceptive acceptance and use. Proper education and counseling — both before and at the time a method is selected — can help adolescents make informed, voluntary decisions.
- At a minimum, all adolescents should be counseled on correct condom use and clearly instructed that condoms or abstinence are the only ways to prevent HIV transmission.
- Every effort should be made to prevent the cost of services or the cost of contraceptive methods from limiting adolescents' options.

Additional Issues for ALHIV, Including Use of Hormonal Contraceptive Methods

- Women living with HIV can safely use most forms of hormonal contraceptives. However, ARVs may adversely affect the efficacy of combined oral contraceptives (COCs) and hormonal implants and/or increase their side effects. Further information about family planning considerations specific to clients living with HIV, including contraindications with ARVs and common opportunistic infection drugs, can be found in *Appendix 11B: Family Planning Considerations for People Living with HIV*.
- Health workers prescribing hormonal contraceptives should:
  - Counsel their HIV-infected clients who are on ART about possible interactions between hormonal contraceptives and certain ARV drugs. Clients should understand that the clinical significance of these interactions is unclear and that adherence to the hormonal method of contraception is very important.[6]
  - **Recommend the use of hormonal methods WITH condoms.**
  - Provide women taking rifampicin for TB with a back-up method of contraception, such as condoms. Rifampicin can lower the efficacy of some hormonal contraceptives (pills, monthly injectables, and implants).

Always follow national guidelines when providing family planning counseling and when prescribing family planning methods.

Contraceptive Options

Table 11.1 provides a summary of common contraceptive options for ALHIV. A more detailed description of contraceptive options, which includes special considerations for adolescent clients and advice on counseling adolescent clients about condoms, can be found in *Appendix 11C: Survey of Family Planning Methods for Adolescents.*

Note: In countries where abortion is legal and safe, adolescents who have an unplanned and unwanted pregnancy should be informed of the option of having a first trimester abortion.

Table 11.1: Summary of contraceptive options for ALHIV

Male and female condoms		
Advantages	**Disadvantages**	**Summary**
• Provides protection from both pregnancy and STI (including HIV) transmission and acquisition • Highly effective when used consistently and correctly	• Correct and consistent condom use may be difficult to achieve and failure rates can be high. • Partner involvement is required; need to negotiate their use • Does not interfere with medications	• Good method for adolescents • Requires demonstration on proper use
Combined oral contraceptives (COCs) and progestin-only oral contraceptive pills (POPs) — pills taken daily*		
Advantages	**Disadvantages**	**Summary**
• Highly effective when taken daily and on time • POPs may be a good choice for adolescents who cannot tolerate the estrogen in COCs or who are breastfeeding • Does not interfere with sex	• Failure rates are highest for adolescents due to confusion about how to take pill • Side effects can include nausea, weight gain, breast tenderness, headaches, spotting • Cannot be taken by clients on rifampicin • ARVs may adversely affect the efficacy of low-dose COCs and/or increase their side effects	• Women taking ARVs who want to use COCs should be counseled about the importance of taking COCs on time, every day and about consistent condom use • POPs are safe for adolescents but because they must be taken at exactly the same time every day, they are not the best choice
Injectables — "shot" given every 2–3 months*		
Advantages	**Disadvantages**	**Summary**
• Highly effective when used correctly • Does not interfere with sex • As it is an injection, there are no pills to take (i.e., reduced pill burden)	• Side effects can include spotting at first, then amenorrhea and weight gain	• Can be used by ALHIV without restrictions • Remind adolescent when to return for next injection
Emergency contraceptive pills (ECP) — 2 doses of pills taken within 120 hours of unprotected sex		
Advantages	**Disadvantages**	**Summary**
• Reduces risk of pregnancy after unprotected sex by 75% • Safe for all women, including those living with HIV and those taking ART	• For emergency use only! • Side effects can include nausea, vomiting, cramps, headache, breast tenderness, and changes in the menstrual cycle	• Should be widely and easily available to ALHIV • Provide counseling on adopting a regular contraceptive method as well as on condom use for dual protection

Hormonal implants — small rods inserted under skin, last 3–7 years*		
Advantages	**Disadvantages**	**Summary**
• Highly effective • Can be reversed • Does not interfere with sex	• Effectiveness of implants may be reduced by ARVs • Side effects can include nausea, weight gain, and changes in the menstrual cycle • Usually need to be inserted and removed at a family planning clinic	• Can be used by ALHIV who do not take ART • Can be used by ALHIV on ART, but they should use condoms as a back-up method • Provide counseling to prepare client for possibility of irregular bleeding
Intra-uterine device (IUD) — device inserted into uterus, lasts up to 12 years*		
Advantages	**Disadvantages**	**Summary**
• Highly effective • Does not interfere with sex	• Should not be initiated in a woman with AIDS who is not taking ART • Side effects can include heavy bleeding, discharge, cramping, and pain during the first months • Usually needs to be inserted and removed at a family planning clinic	• Appropriate for adolescents in stable, mutually monogamous relationships • Not recommended for ALHIV with advanced HIV disease or AIDS, especially if not on ART
Male and female sterilization — surgery*		
Advantages	**Disadvantages**	**Summary**
• Safe and effective • Free of side effects • Does not interfere with sex	• Permanent and requires surgery	• Permanent methods are not recommended for adolescents
Lactational amenorrhea method (LAM)*		
Advantages	**Disadvantages**	**Summary**
• Temporary, natural contraceptive option for women who are less than 6 months postpartum, who are exclusively breastfeeding, and whose periods have not yet returned	• Most adolescents will not be breastfeeding (unless they have infants), so this is not a likely option for ALHIV	• Appropriate only for adolescents who have given birth within the past 6 months and who are exclusively breastfeeding
Fertility awareness methods*		
Advantages	**Disadvantages**	**Summary**
• No health risks or side effects	• Requires a woman to identify her fertile days, which takes time and effort • Requires considerable commitment, calculation, and self-control, both by the woman and her partner	• A difficult method for most adolescents to implement correctly and consistently • Not reliable for pregnancy prevention • Do not recommend
* Health workers should recommend and provide condoms for dual protection.		

Adapted from: Senderowitz, J., Solter, C., & Hainsworth, G. (2002, revised 2004). *Comprehensive reproductive health and family planning training curriculum: Module 16: Reproductive health services for adolescents, Unit 7*. Watertown, MA: Pathfinder International.

Contraceptive Side Effects

Some adolescents may experience side effects from contraceptive methods (for example, weight gain, spotting, menstrual changes, etc.). These side effects can be uncomfortable, annoying, or worrisome to clients. Side effects are the major reason that adolescent clients stop using contraceptive methods. Therefore, it is important that health workers:[1]

- Treat all client complaints with patience and seriousness.
- Offer clients an opportunity to discuss their concerns.
- Reassure clients that side effects are manageable and reversible.
- Help clients differentiate between normal contraceptive side effects and complications that require a return visit to the clinic.
- Offer clients information and advice on how to prevent/manage side effects.
- Always provide follow-up counseling.

Session 11.2 PMTCT Counseling for ALHIV

Session Objective

After completing this session, participants will be able to:

- Counsel adolescent clients on prevention of mother-to-child transmission of HIV (PMTCT)

PMTCT Services for Adolescents

Health workers should follow national PMTCT guidelines when providing services to pregnant ALHIV, their partners, and their family members. Where there are no national guidelines, health workers should follow the WHO's guidelines. Key PMTCT concepts are summarized below.

Table 11.2: Key PMTCT concepts*

Key Concept 1 — Keep mothers healthy
• The healthier the mother (the less HIV she has in her blood and the higher her CD4 cell count), the less likely it is that her baby will acquire HIV during pregnancy, labor, delivery, or breastfeeding. Conversely, the sicker the mother (the more virus she has in her blood and the lower her CD4 cell count), the more likely it is that her baby will become HIV-infected. • A healthy mother is able to take care of herself, her baby, and her family. Without healthy mothers, we will not have healthy families or communities!
Key Concept 2 — Reduce risk at every stage
The risk of passing HIV from a mother living with HIV to her baby depends on timing: • **During pregnancy, labor, and delivery,** about 20-25 out of every 100 babies will get HIV in the absence of PMTCT services, including ARVs. • **During breastfeeding,** about 12-15 out of every 100 babies will get HIV from their mothers in the absence of PMTCT services, including ARVs. Risk of transmission depends on how the baby is fed (mixed feeding in the first 6 months of life dramatically increases risk), how long the baby is breastfed, and if the mother or infant is on ARVs. **Breastfeeding exclusively during the first 6 months of life (not giving the baby any food or drink other than breast milk) can lower the risk of HIV transmission.** **It is important to help mothers reduce the risk of transmission at every stage.**

* Note to training managers: this table should be revised to reflect national PMTCT guidelines and the WHO options deleted.

Key Concept 3 — All mothers need ARVs

- One of the best ways to lower the amount of HIV in a mother's body, to increase her CD4 cell count, and to make her healthy and less likely to pass HIV to her baby is to provide her with the care and treatment she needs to be as healthy as possible. All pregnant women living with HIV need to take ARVs.
- If the mother has a CD4 cell count **at or below 350**, her baby is at high risk of getting HIV. According to WHO PMTCT guidelines, she should start ART as soon as possible and should stay on ART for life.
- If the mother has a CD4 cell count **above 350**, her baby has a lower risk of getting HIV. According to the WHO, she should be started on ARV prophylaxis at 14 weeks gestation or as soon as feasible thereafter to prevent the baby from acquiring HIV. The WHO describes 2 options and national ministries of health decide which option is preferred. These 2 options are:
  - **Option A:**
    - Twice daily AZT starting from as early as 14 weeks gestation and discontinued at delivery **and**
    - sd-NVP at onset of labor combined with initiation of twice daily AZT + 3TC "tail" for 7 days postpartum (Note: Some countries omit the sd-NVP and AZT + 3TC tail in mothers who receive more than 4 weeks of AZT.)
  - **Option B:**
    - Triple ARV prophylaxis starting from as early as 14 weeks gestation and continued until delivery or, if breastfeeding, continued until 1 week after all infant exposure to breast milk has ended

Key Concept 4 — All babies of HIV-infected mothers need ARVs and CTX

- All babies need to take ARV prophylaxis at the time of birth and for the first 4–6* weeks of life to help prevent them from becoming HIV-infected:
  - If the mother is on an **ARV prophylaxis** regimen that is stopped at delivery or 7 days postpartum and…
    - **She is breastfeeding:** then baby will take once daily NVP from birth until 1 week after all exposure to breast milk has ended
    - **She is formula feeding:** then baby will take once daily NVP or sd-NVP + twice-daily AZT* from birth until 4–6* weeks of age
  - If the mother is on **ART or triple ARV prophylaxis that will be continued postpartum,** her baby will take once daily NVP or twice daily AZT* for the first 4–6* weeks of life
- Either the mother or the baby needs to take ARV prophylaxis for the **entire time the baby is breastfeeding and should stop 1 week after cessation of breastfeeding**. This helps protect the baby from getting HIV during breastfeeding.
- HIV-exposed babies need to have HIV virological testing at 4–6 weeks of age or as soon as possible thereafter. Babies who test HIV-positive and who are under the age of 12 months** should begin ART as soon as possible.
- HIV-exposed babies need to take CTX starting at 4–6 weeks of age to prevent other infections that may make them very sick or lead to a rapid death. Babies should take CTX until it is certain they are not HIV-infected.

* The actual regimen (whether NVP or AZT) and duration of regimen (whether 4 weeks or 6) is stated in the national PMTCT guidelines.

** Some countries recommend automatically starting ART in all children who test HIV-positive and are under the age of 24 months.

Challenges Adolescents May Face with PMTCT

Pregnant adolescents and new adolescent mothers (and **their** partners) face many of the same challenges adults face with PMTCT. However, health workers should keep in mind particular challenges that could constitute barriers to adolescent clients in PMTCT programs, including:

- Difficulty adhering to ART or ARV prophylaxis
- Difficulty giving the baby medicines every day
- Challenges with safe infant feeding, especially exclusive breastfeeding for the first 6 months of life
- Fears about having a baby who is HIV-infected and guilt about possibly passing HIV to the baby
- Facing stigma for having HIV and becoming pregnant — and for being pregnant at a young age (especially if unmarried)
- Difficulty foreseeing the future adhering to lifelong HIV care while also caring for a child
- Lack of emotional and financial support from family and/or the child's father
- Financial instability and the possibility of dropping out of school
- Inadvertent disclosure of HIV-status to others
- Lack of access to youth-friendly PMTCT information and services

Safety of ARVs during pregnancy

Pregnant adolescents should be reassured that, with the possible exception of EFV, ARVs are safe to use during pregnancy. The benefits of using ARVs far outweigh the risks of not initiating ART.

Exercise 1: Providing Family Planning and PMTCT Services to Adolescent Clients: Case studies, role play, and large group discussion	
Purpose	To provide participants with an opportunity to discuss and role play strategies to provide ALHIV with childbearing, contraceptive, and PMTCT information, counseling, and services

Case Study 1:
P___ is a 19-year-old young man who comes to the ART clinic regularly. You learn from one of the Adolescent Peer Educators at your clinic that P___ has been bragging that he has been with "about 10 women" but never uses condoms because they are “good girls” who don’t insist on using them. When you offer him some condoms at the end of his next appointment, he says he doesn’t need them. He says that he has a steady girlfriend now because he is feeling pressure from family to "get serious." *How do you proceed with P___?*

Case Study 2:
K___ is a 17-year-old young woman living with HIV. She is on ART and is doing very well. She has a boyfriend who knows about her HIV-status and who is accepting of it. K___ used to take oral contraceptives, but stopped taking them recently because she said they made her feel nauseous and gain weight. Now K___ and her boyfriend usually use condoms, but they have had sex a few times without them. K___ and her boyfriend do not want children right now, but they talk about getting married and having children in the future, once she finishes school. K___ is getting a lot of pressure from her family to never have kids because of the risk that they would be HIV-infected. *How would you proceed with K___?*

Case Study 3:
Z___ is a 21-year-old woman who has been living with HIV since she was 16. She has been in a stable relationship with R___ since she was 18. R___ is also living with HIV. Although Z___ attends the adult ART clinic now, she comes back every now and again to visit you, the health worker, at the adolescent clinic. Today you get the feeling that there’s something she wants to talk about so you invite her into the counseling room. You ask her how she’s doing and then ask her about R___. After some small talk, she finally tells you that she and R___ have decided that they would like to have a baby. After asking her some more questions, you realize that she is very serious about this and you agree that this was a mature, well-thought through decision that the two of them made together. *How would you proceed with Z___?*

Case Study 4:
E___ is 19 years old and was perinatally infected with HIV. She has been adherent to ARVs for many years. She has come to the clinic today for a checkup and, during the visit, she tells you that she thinks she is pregnant. She is happy to be pregnant, but is afraid that her baby will become HIV-infected. She is also worried about how her ARVs might be affecting her unborn child and tells you that her boyfriend — who is not infected with HIV — told her to stop taking them so they wouldn’t hurt the baby. *How would you proceed with E___? (Assume her pregnancy test is positive.)*

Module 11: Key Points

- Given the risks of adolescent pregnancy, it is important that health workers counsel their young clients to delay childbearing, if possible, until they are adults and to use contraceptive methods if they are sexually active.
- Health workers can provide adolescent clients with counseling on the safest times to become pregnant, such as when they have reached physical adulthood, when their CD4 cell count is high (above 500), when they are well, and when they are stable on and adhering to ART.
- Good education and counseling both before and at the time a contraceptive method is selected can help adolescents make informed, voluntary decisions that they are more likely to adhere to in the long term. Counseling should always include a discussion of side effects.
- The following contraceptive methods are good options for ALHIV: condoms, COCs/POPs, injectables, hormonal implants, and IUDs.
- Counsel all clients on correct condom use, whether condoms are their primary contraceptive choice or whether they will be used for dual protection.
- Ensure that all adolescent clients know about emergency contraceptive pills, including where they can get them and when they should be used.
- Provide counseling on PMTCT and refer all pregnant ALHIV to the ANC clinic for PMTCT services (if they cannot be provided directly in the adolescent HIV clinic).
- Pregnant adolescents should be reassured that, with the possible exception of EFV, ARVs are safe to use during pregnancy.
- The aim of PMTCT services is to reduce the risk that a pregnant woman will transmit HIV to her baby during pregnancy, labor, delivery, or breastfeeding.
- PMTCT services include care, treatment, and support for mothers with HIV, including ARVs for the mother; safer infant feeding information, counseling, and support; ARVs for the infant; and infant testing.

Appendix 11A: Family Planning Screening Questions and Counseling Points

Family Planning Screening Tool

ART ID#: _____ On HAART: ☐ YES ☐ NO Date of Visit: ____/____/_____

Gender: ☐ Male ☐ Female → *If female, Date of Last Menstrual Period (LMP) (dd/mm/yy):* ____/____/_____

INSTRUCTIONS:

- **For Females:** Assess pregnancy status and pregnancy intentions at every visit. Depending on patient's pregnancy status and intentions, you will provide contraceptive services or referrals, or advise on the safest times and ways to become pregnant.
- **For Males:** Ask about pregnancy status of their partners and about their and their partner's pregnancy intentions. Encourage male clients to discuss contraception with their partners and, when possible, recommend couple to come to clinic for couples counseling around family planning.

<table>
<tr>
<th>1. Are you sexually active?
☐ Yes ☐ No</th>
<th>2. Are you (or your partner) pregnant or could you (or your partner) be pregnant?
☐ Yes ☐ No</th>
<th>3. Do you (and/or your partner) desire to have a baby in the next 6 months?
☐ Yes ☐ No</th>
<th>4. Are you (and/or your partner) currently using a modern method of contraception?
☐ Yes ☐ No</th>
<th>5. Conclusion</th>
</tr>
<tr>
<td>If YES → Go to Question 2.</td>
<td>If NO → Go to Question 3.

If Don't Know → Go to Question 3.

If YES → Was this an intended pregnancy?

☐ Yes →Tick "(a)" in column 5
<u>Action:</u> Review counseling points D&D2; Refer to PMTCT.
STOP <u>questionnaire</u>

☐ No →Tick "(b)" in column 5
<u>Action:</u> Review counseling points D&D2; Refer to PMTCT.
STOP <u>questionnaire</u></td>
<td>If NO → Go to Question 4.

If Don't Know → Go to Question 4.

If YES → Tick "(a)" & "(d)" in column 5
<u>Action:</u> Review counseling point C.
STOP <u>questionnaire</u></td>
<td>If NO → If not using a FP method but want to delay or prevent a future pregnancy, can you tell me why are you not using a method? (Do not read response categories)
a) Cannot get pregnant – tick "(a)" in column 5
b) Menopausal – tick "(a)"
c) Has had hysterectomy – tick "(a)"
d) No sex – tick "(a)"
e) If none of the above answers mentioned — tick "(b)"
<u>Action:</u> Review counseling point A. STOP <u>questionnaire</u>

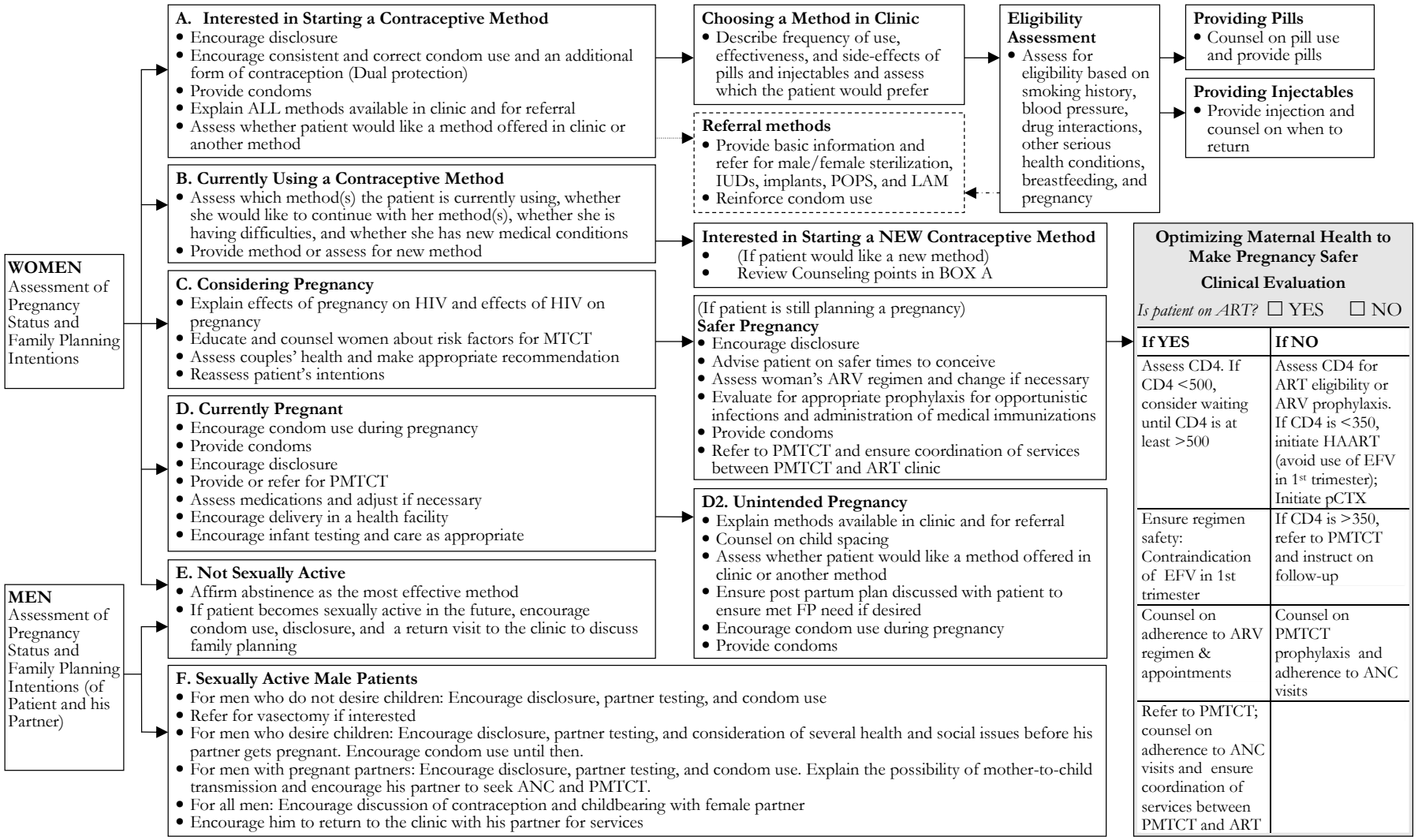
If YES → Tick "(c)" in column 5.
Which methods are you using? (do not read options out loud):
a) Female sterilization
b) Male sterilization
c) Pill
d) IUD
e) Injectables
f) Implants
g) Condom
h) Female condom
i) Diaphragm
j) Foam/jelly
k) Lactational amenorrhoea method
l) Rhythm method
m) Withdrawal
n) Other _____

Are you comfortable with your current FP method: ☐ Yes ☐ No
<u>Action:</u> Review counseling point B. STOP <u>questionnaire</u></td>
<td>☐ (a) No current FP Need
☐ (b) Unmet FP Need
☐ (c) Met FP Need
☐ (d) Pregnancy intention

Met need is defined as women that are at risk for pregnancy and wanting to space or limit their childbearing who are currently using a modern method of contraception.

Unmet need is defined as women that are at risk for pregnancy and wanting to space or limit their childbearing who are not using modern method of contraception.</td>
</tr>
<tr>
<td colspan="2">If NO → Tick "(a)" in column 5.
<u>Action:</u> Review counseling point E.
STOP <u>questionnaire</u></td>
<td></td>
<td></td>
<td></td>
</tr>
</table>

Family Planning Counseling Points



Flow Chart Adapted from: CDC. (2008). *Family planning and safer pregnancy counseling for people living with HIV/AIDS: A tool for health care providers in HIV care and treatment settings.*

Appendix 11B: Family Planning Considerations for People Living with HIV

(Including contraindications with ARVs and common opportunistic infection drugs)

Essential Principles of FP Counseling in HIV Services:	**Key Messages for FP Counseling in HIV Services:**
• Every HCT, ART, and PMTCT client should be assessed for FP need. • Quality FP counseling and services should reinforce clients' ability to limit HIV transmission to HIV-negative partners and infants. • HCT, ART, and PMTCT clients have the right to make their own FP choice, including safer pregnancy for HIV-positive women (using risk reduction measures like ARVs and exclusive breastfeeding), if desired.	• Dual method use — using condoms and a contraceptive method for good protection from infection and unintended pregnancy — should be included in FP counseling for clients living with HIV. • Generally, HIV-positive clients can use most contraceptive methods (even if on ART).

	HIV-Related Treatments and Conditions								
	NNRTIs								
FP Options	**NVP**	**EFV**	**NRTIs (AZT, D4T, 3TC, ABC, TDF)**	**Ritonavir or Ritonavir-Boosted Protease Inhibitors**	**Rifampicin (common for TB)**	**Certain Anti-Convulsants (Carbamazepine, Phenytoin, Barbituates)**	**Systemic Anti-Fungals (Azoles)**	**Untreated Chlamydia and/or Gonorrhea**	**Clinical AIDS/not doing well on ART**
Male/Female Condoms									
COCs				**X**	**X**	**X**			
POPs				**X**	**X**	**X**			
Implants									
EC									
DMPA Injectables									
NET-EN Injectables									
IUD Insertion								**X**	**X**
Tubal Ligation									
Vasectomy									
Natural Family Planning									
Fertility Awareness									
Client Desires Safer Pregnancy		**X**				**X**	**X**	**X**	**X**

Legend:

	Method appropriate for client; No reservation of drug interaction
	Possible reduced contraceptive effect or increased side effects of hormonal method; Recommend dual method use with condoms and perfect use of method
X	Do not use the method

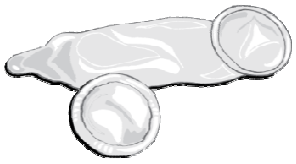
Adapted from: Pathfinder International. *FP/HIV Integration provider reference tool: Family planning considerations specific to HIV-positive clients.* Watertown, MA: Pathfinder International.

Appendix 11C: Survey of Family Planning Methods for Adolescents

Barrier Methods

Male and female condoms:

- Only condoms provide protection from both pregnancy and STI (including HIV) transmission and acquisition.
- Male and female condoms are highly effective when used consistently and correctly every time.
- In real-life situations, and especially among adolescents, correct and consistent condom use may be difficult to achieve. Partner involvement is required and some people (more often men than women) report diminished sensation when using condoms during sex.
- Condom use does not interfere with medications and there are no common side effects for male or female condoms unless a person is allergic to latex.



- **Special considerations for adolescent clients:** Male and female condoms are safe and appropriate for ALHIV. They are a good method for adolescents because condoms are available without a prescription and are the only method that offers dual protection. It is important that condoms are always available to adolescents for free and without having to ask an adult for them. Adolescents require skill development and practice to learn how to use condoms and to negotiate their use with sexual partner(s). Adolescent girls are frequently not assertive about the use of condoms if their partner rejects the idea — they require counseling and peer support to feel empowered to negotiate condom use and to overcome cultural and other barriers. Consistent and correct condom use is effective in providing dual protection, but failure rates (i.e. unintended pregnancy) for condoms are high, especially among adolescents who often do not use them consistently or correctly.

- **Counseling adolescent clients about condoms:** Always demonstrate, step-by-step, how condoms are used and explain how to dispose of them correctly. Tell clients to return to the clinic if there is any problem, if they need more condoms, if they are unhappy with the method, or if they think they or their partner may have been exposed to an STI. Always ask adolescent clients to repeat the instructions back to you so you can check their understanding.

Spermicides and diaphragms with spermicides:

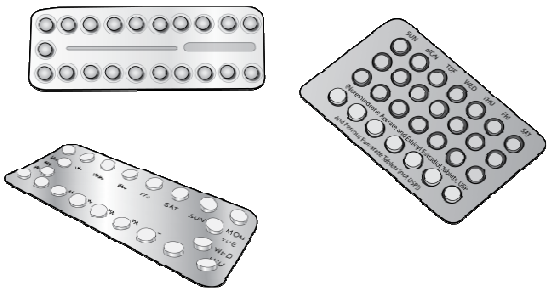
- These methods are NOT recommended for adolescents or adults living with HIV because they may increase the risk of HIV transmission.

Hormonal Methods

Hormonal contraceptives, including combined oral contraceptives (COCs), progestin-only oral contraceptive pills (POPs), emergency contraceptive pills (ECP), injectables, and implants are appropriate and effective contraceptive methods for many ALHIV. They are generally easy to use, are suitable for short- and long-term use, are reversible, and provide non-contraceptive health benefits.

COCs and POPs:

- These are pills that a woman takes once a day to prevent pregnancy.
- They contain the hormones estrogen and progestin (in the case of COCs) and progestin only (in the case of POPs).
- Both types are very effective at preventing pregnancy when taken on schedule.



- **Special considerations for adolescent clients:** Low-dose COCs are appropriate and safe for ALHIV. Many adolescents choose to use a type of COCs because of the low failure rate, the relief from painful periods, and the ease of using a method that is not directly related to sex. Failure rates for COCs are higher for adolescents than for all other age groups. Failure to take pills at the same time, every day, is often due to lack of knowledge or confusion about how to take the pills. Health workers should stress that COCs can prevent pregnancy but that they should always be used in combination with condoms to provide STI/HIV protection. Health workers can help adolescent clients decide where to keep their pills and how to remember to take them at the same time every day (similar to their ARVs). COCs are available in 21- or 28-day regimens. Most adolescents do better with 28-day regimens because it makes it easier to remember to take a pill every day rather than stopping for 7 days.

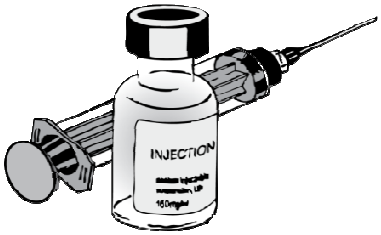
  COCs should not be taken by clients taking rifampicin for TB treatment.

  ARVs may adversely affect the efficacy of low-dose COCs and/or increase their side effects. Women taking ARVs who want to use COCs can be given a formulation with at least 30mcg of estrogen and should be counseled about the importance of taking COCs on time every day (without missing pills) and about consistent condom use.

  POPs are also safe for adolescents, but since they must be taken at exactly the same time every day to be effective, they may not be the best choice for adolescents. POPs may, however, be a good choice for adolescents who cannot tolerate estrogen in COCs or who are breastfeeding.

- **Counseling adolescent clients about oral contraceptive pills:** The most important counseling issue is to make sure adolescents understand the importance of taking the pills correctly. Show the client the pill packet and explain in detail when to start taking the pills and how to take them. Explain that if she forgets to take her pills, she may become pregnant. Instruct her on what to do if she misses pills (for example, if she misses one, to take it as soon as she remembers and, if she misses 2, to take 2 pills as soon as she remembers and to use a back-up method, etc.). Always review possible side effects, including that breakthrough bleeding may be common during the first cycles, but that it is not a reason to stop taking the pills. Like with ARVs, the client should be encouraged to talk with a health worker about any side effects (nausea, weight gain, breast tenderness, headaches, spotting, etc.) and should be told that these will usually decrease over time. Review the times when she should return to the clinic, including if she thinks she may be pregnant or if she has chest pain, shortness of breath, severe headaches with blurred vision, or swelling/severe leg pain. Make sure the client understands when to come back for re-supply and that she should not wait until she is out of pills (just like with ARVs). Always ask the client to repeat information back to you so you can check her understanding and always promote dual protection with male or female condoms.

Injectables:

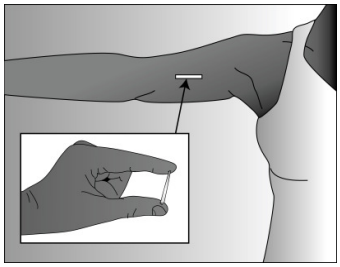


- Progestin-only injectable contraceptives, such as Nur-Isterate and Depo-Provera (depot medroxyprogesterone acetate, aka DMPA or 'the shot'), contain no estrogen.
- To prevent pregnancy, a shot is given to the woman in the arm or upper buttock every 2–3 months, depending on the type of injectable.
- Injectables are highly effective when used correctly.
- ALHIV can use progestin-only injectables without restrictions. Adolescents on ART can also use progestin-only injectables safely and effectively.
- It is important to counsel adolescents to come for their next injection on time and without delay.
- Side effects of injectables may include spotting at first and then amenorrhea and weight gain.
- Injectables do not offer protection from STIs/HIV, so they should always be used with male or female condoms.

- **Special considerations for adolescent clients:** Injectables are safe and appropriate for adolescents. Many adolescents like this method because they do not have to remember to take a contraceptive pill every day and no one needs to know they are using the method. It is important that adolescents are reminded when to return for their next injection and, ideally, this can be combined with their routine HIV care appointments.

- **Counseling adolescent clients about injectables:** Health workers should show their clients the vial of the injectable and explain how it is used. It is important to stress that the injections need to be given every 3 months and that they can be given early if a client thinks she will not be able to return at the 3 month point. The injection will take effect immediately if she is between day 1–7 of her menstrual cycle. If the injection is given after day 7 of her cycle, she should use a back-up method for at least 24 hours. It is important for adolescents to understand possible side effects, which include irregular bleeding and prolonged light to moderate bleeding with the first few cycles of injectables. With time, this should stop and many women stop getting their menstrual cycle altogether while they continue on this method. Some women may also experience weight gain or headaches. Health workers should encourage clients to return to the clinic if they have any questions or problems, or if they have very heavy bleeding, excessive weight gain, or severe headaches. Make sure clients repeat this information back to you to check their understanding. As with all hormonal methods, health workers should recommend and provide condoms for dual protection.

Hormonal implants:

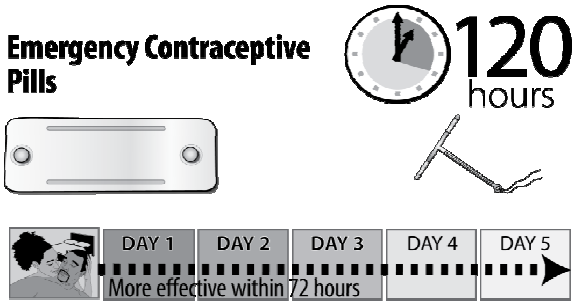


- Progestin-only implants (e.g., Implanon, Norplant) consist of hormone-filled, matchstick-like rods that are inserted under the skin in a woman's upper arm. Depending on the type of implant, there may be only 1 rod or as many as 6 rods.
- Hormonal implants can prevent pregnancy for between 3–7 years, depending on the type.
- Highly effective at preventing pregnancy, implants are a long-term contraceptive method that can easily be reversed.
- ALHIV who do not take ART can use progestin-only implants without restrictions. ALHIV on ART can also use progestin-only implants, but should use condoms as a back-up method in case the effectiveness of the implants is reduced by the ARVs.
- Side effects of implants may include nausea, weight gain, and changes in monthly bleeding. As with all hormonal methods, women should be encouraged to use condoms for dual protection.

- **Special considerations for adolescent clients:** Hormonal implants are safe for adolescents. The main reason adolescents discontinue their use of implants is irregular bleeding, so it is important that health workers counsel clients to prepare them for this potential side effect. Programs must ensure that adolescents have access to services to remove the implants whenever they need or want them to be removed.

- **Counseling adolescent clients about implants:** Health workers at the HIV clinic will likely have to refer adolescents to a family planning clinic for implant insertion and removal. It is important to explain how the implants work, what the insertion and removal procedures are, and how long the method will last. Adolescents should also be counseled on care of the insertion area and the possibility of bruising or swelling after insertion. Adolescents should know where to go if they have problems or questions, or if they want the implants removed. Health workers should give clients information on common side effects and on serious side effects requiring immediate care, such as severe pain in the lower abdomen, very heavy bleeding, bad headaches, and yellowing of the skin or eyes.

Emergency contraceptive pills (ECP):



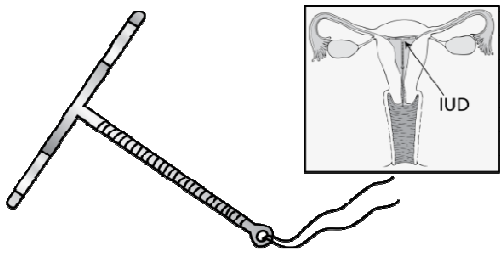
- ECP are used to prevent pregnancy after unprotected sex.
- ECP can be used if no contraceptive method was used during sex or if a contraceptive method failed, for example, if a condom broke.
- ECP should be taken as soon as possible after unprotected sex (although it can be taken up to 120 hours after sex).
- When used correctly and in a timely fashion, ECP can reduce the risk of pregnancy by 75%.
- ECP are usually a combination of oral contraceptives, taken in 2 doses.
- ECP do not cause an abortion, they prevent an egg from implanting in the uterine wall.
- ECP are safe for all women, including those living with HIV and those taking ART.
- Side effects of ECP may include nausea, vomiting, and changes in the menstrual cycle.
- Adolescents receiving ECP should be counseled on adopting a regular contraceptive method and on condom use for dual protection.

- **Special considerations for adolescent clients:** ECP should be widely and easily available to adolescents, including at the HIV clinic. Adolescents should be educated about the availability of ECP and the importance of coming to the clinic for ECP as soon as possible after unprotected sex. The earlier ECP are taken after unprotected sex, the more effective they will be in preventing pregnancy. ECP can be provided in advance to adolescents who are at high-risk of unprotected sex, but these clients should be counseled that ECP are for emergency use only. ECP do not provide dual protection and all adolescents using ECP should be counseled on more effective contraceptive methods and condom use for dual protection.

- **Counseling adolescent clients on ECP:** Health workers should explain how ECP work and how the client should take them (for example, the first dose should be taken as soon as possible after unprotected sex, up to 120 hours afterward, and the second dose should be taken 12 hours after the first dose). If more than 120 hours have passed since unprotected sex, the client should not be given ECP. If the client vomits within 2 hours of taking a dose, the dose should be repeated. Taking the doses after eating or before bed will help reduce nausea. Health workers should review what adolescents can expect after taking ECP — they may have nausea, vomiting, cramping, breast tenderness, or headaches, but these should not last more than 24 hours. The adolescent's period should come on time (or a few days late or early) and, if she does not get her period within one week of when she expected it, she should return to the clinic because she could be pregnant.

Long-term and Permanent Methods

Intra-uterine devices (IUDs):



- This small device, which is inserted into a woman's uterine cavity, is highly effective at preventing pregnancy.
- The copper-containing CuT 380A, the most commonly used IUD, remains effective for up to 12 years.
- IUDs that release hormones are becoming more widely available. These IUDs work differently than the copper IUD and may cause side effects different from those listed below.
- An IUD can be provided to a woman living with HIV if she has no symptoms of AIDS and no STIs. A woman who develops AIDS while using an IUD can continue to use the device. A woman with AIDS who is doing well clinically on ART can both initiate and continue IUD use, but may require follow up.
- An IUD generally should not be initiated in a woman with AIDS who is not taking ART.
- Side effects of IUDs may include heavy bleeding and pain during the first months of use as well as spotting.
- Encourage women choosing an IUD to use condoms for dual protection.

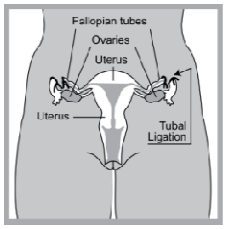
- **Special considerations for adolescent clients:** IUDs are appropriate for adolescents in stable, mutually monogamous relationships. Careful screening for STIs before insertion is critical and IUDs are not recommended for ALHIV with advanced HIV disease or AIDS (especially if they are not on ART).

- **Counseling adolescent clients about IUDs:** It is important to explain that the IUD is a long-term method that lasts for 10–12 years and that it is most appropriate for adolescents who are in stable, monogamous relationships. Health workers may have to refer adolescent clients for IUD insertion, but they should provide counseling and follow up within the HIV clinic. It is important that adolescent clients understand how the IUD works and how to check for the strings. Health workers should explain side effects, including cramping and pain after insertion, a heavier and longer menstrual flow for the first few months, vaginal discharge, and possible infection. Bleeding usually decreases during the first and second years of IUD use, but some women may not have regular periods. Adolescents should know the warning signs of potential complications with IUDs, including abnormal bleeding and discharge, pain, pain during sex, fever, and strings missing/shorter/longer. Ask the client to repeat this information back to you so you can check her understanding. It is very important that clients using an IUD use condoms to prevent STIs, which can cause infection and complications.

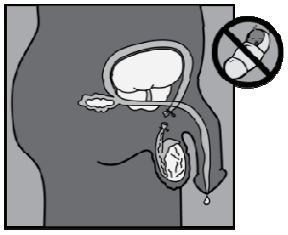
Male and female sterilization

- These permanent methods are not usually recommended for adolescents, who may change their mind about wanting to have children in the future.
- Some ALHIV may request sterilization, in which case counseling should be provided and all options explored.

Female Sterilization (Tubal Ligation)



Vasectomy (Male)



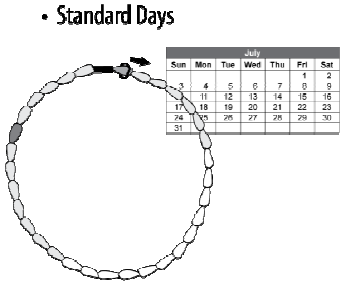
Traditional and Other Methods

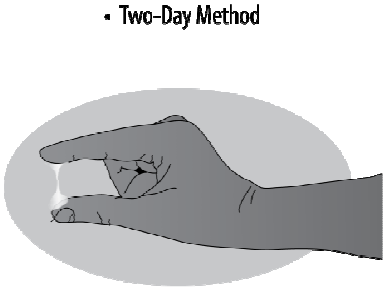
Natural methods do not require any materials (for example, the withdrawal method or a woman learning to recognize when she is fertile and agreeing with her partner to avoid sex during that time). In general, natural methods are not as effective in preventing pregnancy as "modern" methods. In some places, there are also **traditional methods**. These mostly include using traditional herbs to prevent pregnancy. They are not reliable because the dosage is not controlled and their effectiveness has not been scientifically proven.

Lactational amenorrhea method (LAM):

- LAM is a temporary, natural contraceptive option for women who are less than 6 months postpartum, who are exclusively breastfeeding, and whose period has not yet returned.
- Any clients practicing LAM should be advised to use condoms for dual protection.
- Most adolescents will not be breastfeeding (unless they have infants), so this is not a likely option for ALHIV.

Fertility awareness methods:





- These methods require a woman to identify the fertile days of her menstrual cycle and to abstain from sex during the time identified.
- To do so, she can observe fertility signs like the consistency of her vaginal mucus or she can follow the calendar.
- This is a difficult method for many adolescents to implement correctly and consistently. It is also not very reliable for pregnancy prevention and does not protect against STIs and HIV.
- Encourage ALHIV to use condoms as dual protection, especially during fertile days, or to abstain during fertile days.
- Also counsel on the availability of more reliable contraceptive methods, emphasizing the importance of using condoms for dual protection.

Adapted from: Senderowitz, J., Solter, C., & Hainsworth, G. (2002, revised 2004). *Comprehensive reproductive health and family planning training curriculum: Module 16: Reproductive health services for adolescents, Unit 7*. Watertown, MA: Pathfinder International.

Illustrations courtesy of: Karen A. Forgash, François-Xavier Bagnoud Center, School of Nursing, University of Medicine and Dentistry of New Jersey. (2011).

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[1] Senderowitz, J., Solter, C., & Hainsworth, G. (2002, revised 2004). *Comprehensive reproductive health and family planning training curriculum: Module 16: Reproductive health services for adolescents, Unit 7*. Watertown, MA: Pathfinder International.

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[4] Heath D.T., Mckenry P.C., & Leigh G.K.. (1995). *The consequences of adolescent parenthood on men's depression, parental satisfaction, and fertility in adulthood*. J Soc Serv Res. *20(3-4)*, 127-48.

[5] WHO. (2010). *Antiretroviral therapy for HIV infection in adults and adolescents: Recommendations for a public health approach*.

[6] See also: Panel on Antiretroviral Guidelines for Adults and Adolescents. U.S. Department of Health and Human Services. (October 14, 2011). *Guidelines for the use of antiretroviral agents in HIV-1-infected adults and adolescents*. "Table 15a. Drug Interactions between PIs* and Other Drugs," page 135. Available at: http://www.aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL.pdf.