Differentiated service delivery for family planning services and contraceptive methods

Including opportunities for integration of ART and PrEP

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"Differentiated service delivery for family planning services and contraceptive methods including opportunities for integration of ART and PrEP" is a supplement to *A Decision Framework for antiretroviral therapy delivery*. It outlines how models of differentiated service delivery (DSD) can be leveraged towards strengthening family planning services including through integrated DSD for HIV treatment and pre-exposure prophylaxis (PrEP).

The aim is to provide:

- **An overview of differentiated service delivery**
- **An overview of DSD for family planning (FP) services**
- **Guidance on how DSD for family planning and antiretroviral therapy (ART) may be integrated**
- **Guidance on how DSD for family planning and PrEP may be integrated**
- **Case studies and country examples**

This supplement is intended for the use of national and district FP and HIV programme managers, implementing partners, community partners and donors. It should be read in conjunction with the comprehensive *A Decision Framework for antiretroviral therapy delivery.*

ABBREVIATIONS

ART	Antiretroviral therapy
CAG	Community ART group
CHW	Community health worker
DMPA	Depot medroxyprogesterone acetate
DSD	Differentiated service delivery
FP	Family planning
HAS	Health surveillance assistant
HCW	Healthcare worker
IM	Intramuscular
IUD	Intrauterine device
LARC	Long-acting reversible contraceptive
MCH	Maternal and child health
MMD	Multi-month dispensing
MMS	Multi-month scripting
NET-EN	Norethisterone enanthate
OTC	Over-the-counter
PHC	Primary healthcare
PrEP	Pre-exposure prophylaxis
SI	Self-injection
STI	Sexually transmitted infection
S/C	Subcutaneous
UHC	Universal health coverage
WHO	World Health Organization

Introduction

What is differentiated service delivery?

Differentiated service delivery (DSD) is a client-centred approach that simplifies and adapts HIV services across the cascade in ways that both serve the needs of people living with HIV and reduce unnecessary burdens on the health system.

The principles of DSD were never intended to be applied only to the delivery of antiretroviral therapy (ART) and can be used for any health need requiring ongoing medication, including of family planning (FP) services.

The building blocks of differentiated service delivery

When designing differentiated service delivery models for continuation of medication needed for extended periods four building blocks should be considered:

Differentiated service delivery for clients requiring long-term medication

For people living with HIV who are established on ART (see Box 1), ministries of health have scaled up four models of DSD for HIV treatment as recommended by the World Health Organization (WHO). The same models are increasingly being used to deliver medication refills for pre-exposure prophylaxis (PrEP) and other chronic diseases. These models may also be used for the delivery of family planning services and contraception methods that need ongoing medication supplies. The four models are classified as follows:

Individual models based at facilities (for example, fast-track, quick pick-up)	Individuals collect their medication refill directly from the clinic pharmacy without having to queue to see the clinician. To see how this model works, watch this video: watch this video.
Individual models not based at facilities (for example, community pick-up points, community pharmacies, private pharmacies, mobile services, home delivery)	Individuals collect their medication refill from a location outside the clinic. Many examples of this model exist, including mobile clinics that visit a specified location on specific dates, community pharmacies linked to the facility, and home delivery. To see how this model works, watch this video: watch this video.
Group models managed by healthcare workers (for example, adherence clubs, teen clubs)	Groups of 20-30 people meet at a set time in an agreed location that can be in or out of the health facility to collect their medication refill. The group is led by a nurse, counsellor, community health worker (CHW) or peer. There is time for peer support, and medication is pre-packed for quick collection. To see how this model works, watch this video: watch this video.
Group models managed by clients (for example, community medication groups, community adherence groups)	Groups of four to 10 people, who live near each other, meet in an agreed community location to collect their refill from a group member. The group nominates a group leader and, for each refill, selects one member to collect medication refills for the whole group. To see how this model works, watch this video: watch this video.

WHO Guidelines

Box 1 – Established on ART

WHO uses the following criteria for determining whether a person is established on ART:

- Receiving ART for at least six months
- No current illness, which does not include well-controlled chronic health conditions
- Good understanding of lifelong adherence: adequate adherence counselling provided
- Evidence of treatment success: at least one suppressed viral load result within the past six months (if viral load is not available: CD4 count >200 cells/mm^3 and CD4 count >350 cells/mm^3 for children 3-5 years old) or weight gain, absence of symptoms and concurrent infections). For children 3-5 years, CD4 cell count >350 cells/mm^3.

Why DSD for family planning?

Of the 1.9 billion women of reproductive age (15-49 years) globally, an estimated 874 million use a modern contraceptive method. However, 164 million women who want to delay or avoid pregnancy are not using any contraceptive method and are considered to have an unmet need for family planning (2). In 2024, unmet contraceptive need ranged from 14% in Asia and the Pacific to 19% in central, eastern, southern and western Africa [3].

Adolescent girls aged 15-19 years have particularly high unmet needs for contraception – 43% compared with 24% among all women of reproductive age. In low- and middle-income countries, adolescents have an estimated 21 million pregnancies each year, nearly half of which are unintended. Of these unintended pregnancies, 55% end in abortions, many of which are unsafe (4).

Applying a client-centred, DSD approach to family planning – built around the "When", "Where", "Who" and "What" building blocks of service delivery – can reduce the burden on existing clients while expanding access for those with unmet need. Offering flexible service delivery models means that women are better able to access care at convenient times and locations.

Long-acting contraceptive methods are particularly well suited to a DSD approach as they minimize the need for frequent interactions with the health system. For methods requiring ongoing commodities, offering longer scripts and longer refill durations also reduces visit frequency, lessens client burden, and helps address barriers to uptake and continuation.

A DSD approach is further enabled by such policy recommendations as the WHO guidance to provide up to a one-year supply (13 cycles) of oral contraceptives, depending on user preference and intended use, reducing the need for frequent clinical monitoring (5).

Family planning and contraceptive method options

According to WHO, "family planning allows people to attain their desired number of children, if any, and to determine the spacing of their pregnancies" (6).

Family planning services should be accessible to all women of childbearing age, including those living with HIV. Women, men and couples affected by HIV should be regularly and sensitively engaged – at each clinical interaction – about their reproductive intentions, including desires for future childbearing and pregnancy prevention. These discussions should be non-judgemental and client centred.

Comprehensive counselling on safer conception and pregnancy planning should be provided to clients who wish to become pregnant. A full range of contraceptive method options and counselling should be offered to those who choose to prevent pregnancy.

Contraceptive method selection should be guided by the duration of protection needed, relative effectiveness, clinical considerations, preferred route of administration, and individual preferences, including any required scheduling alignment with other health needs. Annex 1 provides an overview of contraceptive methods, including their duration and effectiveness.

According to WHO, the range of contraceptive methods that should be made available includes: long-acting reversible contraceptives (LARCs), such as implants and intrauterine devices (IUDs); short-acting injectable contraception (including self-injectables); combined and progestin-only oral contraceptive pills; and male and internal (female) condoms. In some settings, contraceptive rings and patches are also available. Referral should be offered to clients who are interested in permanent methods of contraception, such as female sterilization or vasectomy. WHO also recommends that all women and girls have access to emergency contraception through national family planning programmes.

WHO advises that women and girls living with HIV, as well as women and girls vulnerable to acquiring HIV, can generally use all available contraceptive methods safely and effectively (see Box 2). In addition, dual method use – condoms alongside another effective contraceptive method – should be encouraged to prevent both HIV and other sexually transmitted infections (STIs).

Find further guidance in *Family Planning: A Global Handbook for Providers* (2022 update), published by WHO and partners.

WHO Guidelines

Box 2: WHO guidance on women and girls living with HIV and contraceptive method (5)

All family planning methods, with the exception of nonoxynol-9 spermicides, are safe for all people at high risk of HIV, including both hormonal (either combined or progestin-only) and non-hormonal methods.

https://fphandbook.org/chapter-23-family-planning-adolescents-and-women-high-risk-hiv

Promoting self-care

WHO's definition of self-care is "the ability of individuals, families and communities to promote health, prevent disease, maintain health, and cope with illness and disability with or without the support of a health worker" (7). For certain health services, including family planning, actively including self-care interventions can be an innovative strategy to strengthen primary healthcare, improve universal health coverage (UHC) and help ensure continuity of health services during emergencies.

WHO recommends self-care interventions as a way to improve people's contraceptive options (Box 3). Self-care options for contraceptive care also diversify where contraceptives can be accessed and provide flexibility in the level of engagement with health services. Contraceptive self-care interventions include self-injectable contraception and oral contraception (when provided over-the-counter).

WHO Guidelines

Box 3: Select WHO recommendations and good practice statements related to self-care and family planning

Recommendations (7)

- Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age (Strong recommendation; moderate certainty evidence) (7, 8).
- Over-the-counter (OTC) oral contraceptive pills should be made available without a prescription for individuals using oral pills (Strong recommendation; very low certainty evidence) (7).
- Provide up to one year's supply of pills, depending on the woman's preference and anticipated use.
- Programmes must balance the desirability of giving women maximum access to pills with concerns regarding contraceptive supply and logistics.
- The resupply system should be flexible so that the woman can obtain pills easily in the amount and at the time she requires them.

Good practice statements (7)

- All self-care interventions for health must be accompanied by accurate, understandable and actionable information, in accessible formats and languages, about the intervention itself and how to link to relevant community- or facility-based healthcare services. Clients must have the opportunity to interact with a health worker or a trained peer supporter to support decisions around, and the use of, the intervention.
- The provision of self-care interventions for health should increase clients' options about when and how they seek healthcare, including offering flexibility in the choice of interventions and in the degree and manner of engagement with health services.

DSD for family planning

The building blocks of DSD and models for less-intensive follow up, as described above, can also be applied to the provision of family planning services.

When considering the building blocks for family planning services, contraceptive methods can be divided into two categories:

- **Contraceptive methods that, once started, do not require any further interaction with the health system** until pregnancy is desired, their duration of contraceptive effectiveness ends, or the user chooses to discontinue them (these are the LARCs – implants and IUDs). The non-reversible permanent methods also do not require further interaction with the health system.
- **Contraceptive methods that need regular, ongoing interaction with health services** for clinical review, rescripting of ongoing supplies or administration (these include contraceptive pills, patches, rings and injectables). When initiated, these methods are usually reviewed after one to three months. If the method is acceptable to the client, the preferred method can be scripted for a longer period with multi-month refills of pills, rings, patches and self-injectable units supplied. When requiring healthcare worker administration, community or fast-track administration could be provided.

Assessing policies for DSD for family planning

Before designing DSD for family planning, it is important to understand the relevant national policy for each of the building blocks. In some settings, the policies for task sharing, extended refills and decentralization for family planning services and/or contraceptive method provision may be more advanced than for ART delivery. Table 1 outlines some of the key policy questions that should be assessed ahead of developing DSD for family planning.

Table 1: Policy questions for each building block to support DSD for FP

Building block		Key questions
WHEN	Service frequency	• What is the frequency of clinical review? • What is the maximum prescription length for oral pills and injectables (healthcare worker-administered and self-injectables, rings and patches)? • What is the maximum refill duration for multi-month contraception methods?
WHERE	Service location	• Can primary care services insert implants and IUDs? Does this differ for hormonal IUDs if available? • Is out-of-facility delivery of pills, rings, patches and injectables (intramuscular or subcutaneous) allowed? • Can over-the-counter (OTC) oral pills be provided without a prescription, or is this limited to emergency contraception?
WHO	Service provider	• Who can prescribe each of the contraceptive methods? • Who can insert copper and hormonal IUDs and implants? • Can community health workers administer intramuscular contraceptive injectables? • Can community health workers provide subcutaneous contraceptive injectables? • Can clients self-inject subcutaneous contraceptive injectables? • Can CHWs or lay providers distribute oral/ring/patch contraceptive methods?
WHAT	Service package	• What contraceptive methods are offered? • Are condoms standardly offered with contraceptive methods for STI and HIV prevention? • Are there any specific service package requirements, for example, pregnancy testing?

Initial and continuation phases of DSD for family planning

The duration of protection from pregnancy required by the client will often guide the choice of contraception method. For those requiring longer-term contraception, LARC may be favoured. Some women may also choose a short-acting method that may continue for anywhere from a few months to several years.

Historically, family planning-related national policies have not separated the family planning clinical review and refill collection-only visits, requiring a clinical review at each refill collection. Such policies frequently require clinical review of short-acting contraception methods one to three months after method initiation. Unlike ART, there is no need for a definition of "established" on contraception, only the need to assess the client's acceptability and adherence. If the method is acceptable, the provision of the contraceptive continues with less frequent clinical visits and, for short-acting methods, the provision of multi-month refills continues (Table 2).

Family planning service clients should not be required to return to the facility for assessment of contraception method acceptability as this is unnecessarily burdensome for both women and the health system. At contraception method initiation or switch, providers already educate the client to return if the method is not suitable or the client experiences any issues with administration. This enables a longer scripting period from the start of a contraceptive method. The first script can provide a shortened refill length (for example, a three-month supply) to reduce the risk of waste if a woman decides to discontinue or switch method after trialling the method's appropriateness for her. Refills can then be collected using a fast-track community or facility DSD model without clinical review. At the annual clinical review, the second script could then extend the refill length. For women already on their preferred contraceptive method, the refill length should be as long as possible.

Table 2: Considerations for the initial and continuation phase of DSD for family planning

	Initial phase in DSD model of choice – first script		Continuation phase in DSD model of choice – second script onwards	
	Clinical assessment	Refill duration	Clinical assessment	Refill duration
Long-acting (IUD and implant)	Unless there are side effects or complications of insertion, no clinical follow up is required until pregnancy is wanted or method needs replacing			
Short-acting self-administered (pills, S/C self-injectable unit, rings, patches)	12 months after initiation Self-managed earlier return for clinical review if method is unsuitable or administration challenges	3 monthly	Annual	12 monthly (13 pill packs; 4 s/c self-injectable units; 13 rings)
Short-acting HCW-administered (IM injectable)		2-3 monthly with fast-track administration		2-3 monthly limited to fast track administration NB: Note that this method increases the intensity and/or frequency of visits and may be limited to facility-based DSD method options

The DSD building blocks for contraceptive method continuation

The building blocks will vary for different contraceptive methods (Table 3). For short-acting methods, the goal is to provide, where possible, sufficient commodities until the next clinical review (annually). If the supply chain is not able to dispense a one-year supply or there are limitations in terms of purchasing a one-year supply, a multi-month prescription should be completed with a shorter refill dispensed through a refill model without clinical review. Women could be offered refill collection through any of the four DSD refill models outlined on page 4.

For those using the intramuscular injectable, the most appropriate model would include availability of the cadre of healthcare worker at the location to administer the injection through a fast-track mechanism without a clinical review. This is most likely at a health facility, but could also be as part of mobile outreach to community locations. In some settings, community health workers may be able to administer the intramuscular injectable out of the facility, and in others, public sector partnerships with private pharmacies could be utilized as alternative locations for administration.

Table 3: Building blocks of DSD for family planning considering different contraceptive methods

	Short-acting methods: self-injected and contraceptive pills	Injectable (healthcare worker-administered)
WHEN	Supplies to provide one year of protection (e.g., 13 packs of pills; 4 x self-injectable units)	Fast-track administration Every 2-3 months depending on formulation
WHERE	Facility Out of facility	Facility Out of facility
WHO	Doctor (prescribe and distribute) Nurse (prescribe and distribute) CHW (distribute/administer) Peers (distribute/administer) Client (self-inject)	Doctor (prescribe and administer) Nurse (prescribe and administer) Trained CHW (prescribe and administer)

Case example:

Increasing contraceptive care through community access in Malawi

In Malawi, the family planning programme has been focused on increased access to modern contraceptive methods. As part of these efforts, the community cadres of health surveillance assistants (HSAs), community-based distribution agents (CBDAs) and community mobilizers have been trained to support demand creation, administration and distribution of specific contraceptive commodities. HSAs support demand creation for all methods and distribution of short-term methods; CBDAs distribute oral pills and subcutaneous self-injectable units; and community mobilizers create demand for different methods and support uptake of outreach services for tubal ligation and male sterilization (Table 4).

Table 4: Building blocks of Malawi's DSD for family planning models

Methods		IUD	Implant	Oral pills	Subcutaneous self-injectable	Intramuscular injectable
WHEN Service frequency	Clinical review	6-7 years	3-5 years	3-monthly	Annual	3-monthly
	Script length			3-monthly	Annual	3-monthly
	MMD			3-monthly* (3 packs) * 6-12 monthly if travelling	12-monthly (4 units)	3-monthly (1 unit)
WHERE Service location	In facility, in community or both	Facility FP services	Facility FP services Outreach clinics	Facility FP services Outreach clinics Community and home	FP services and outreach clinics Community and home	Facility services Outreach clinics
WHO Service provider	Cadre	FP nurse, clinicians, doctors, CMAs, CHNMs	FP and MNCH nurse, clinicians	Nurses, HSAs, CBDAs	Nurses, HSAs, CBDAs, client	Nurses, clinicians, HSAs
	Self-administered			Yes	Yes	No
WHAT Service package	Added or integrated			Integrated with other services	Client calendar Pregnancy self-test Call line	Integrated with other services

CBDA – Community-based distribution agent, CHNM – Community health nurse midwife, CMA – Community midwife assistant, HSA – Health surveillance assistant, FP – Family planning, MMD – multi-month dispensing, MNCH – Maternal and child health

DSD for family planning and integration with ART

To improve access to family planning, WHO recommends the integration of family planning services into HIV care settings (Box 4). Family planning services should be offered to all women living with HIV of childbearing age at each HIV clinical visit. Integration of FP and HIV services can occur across the cascade (for example, with the integration of HIV testing into family planning services at clinics). However, this supplement focuses on the integration of family planning and HIV treatment services.

WHO Guidelines

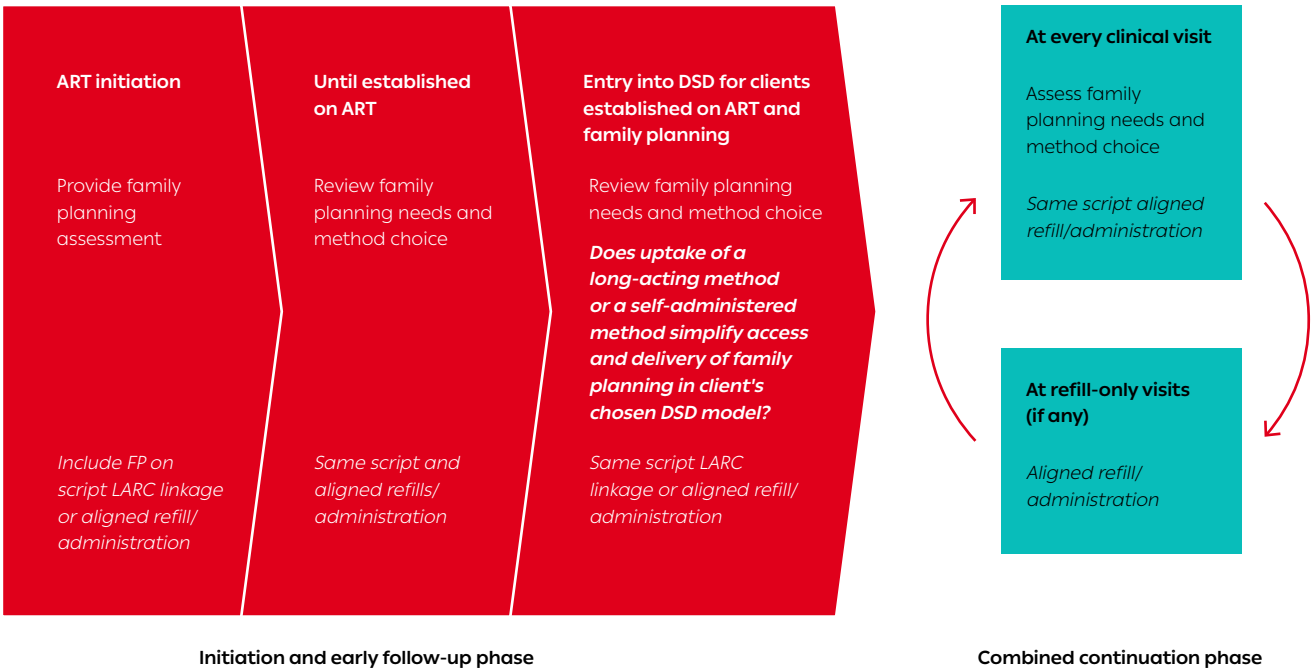
BOX 4: WHO recommendation on FP and HIV integration

Sexual and reproductive health services, including contraception, may be integrated within HIV services.

Source: WHO, Updated recommendations on service delivery for the treatment and care of people living with HIV, April 2021(1)

There are multiple opportunities for the integration of family planning and ART services (Figure 1).

Figure 1: Opportunities for family planning and ART integration



ART has two phases - initial and continuation - during which family planning needs and preferences should be assessed and integrated (Table 5). To be eligible for one of the four less-intensive differentiated service delivery (DSD) models in the continuation phase, clients must first be established on ART.

To support family planning integration, providers should assess and regularly review clients' family planning needs and preferences from the time ART is initiated. Many clients may already be using contraception, which will require clinical review and alignment of refills with ART visits.

For clients not using contraception—or using a method that increases the frequency or burden of visits—ART clinical review providers should assess contraceptive needs. This includes discussing available contraceptive methods and how they may affect visit frequency and service location. Some clients may choose to switch to a method that is easier to integrate with their ART care and reduces the need for separate or more frequent visits.

Ideally, providers within HIV clinics would be trained and equipped to deliver comprehensive family planning services, including assessment, counselling on available methods, and provision. However, this depends on sufficient training and capacity. Where capacity is limited, a brief family planning assessment can be conducted, and clients requiring a more detailed consultation can be actively referred, with follow-up at the next ART clinical visit.

Some services, such as implant or IUD insertion, may be less feasible to offer in ART clinics and may require scheduling at a separate family planning service or site.

Table 5: Initial and continuation phases for ART integrating contraceptive methods

	Initial phase	Continuation phase (through less-intensive DSD model)	
	ART clinical consultations	***Clinical visit***	***Refill visit***
HIV ART delivery	As per national guidelines (e.g., month 1, 3, 6)	Annual	3-6 months
Family planning services delivery	Offer contraception methods at each clinical visit	Annual: Offer or review FP needs and method choice	
Long-acting	Actively link to or insert LARC at clinical visit	NA	NA
Short-acting self-managed	Start/continue contraception method *(if starting self-injectable, demonstrate)* Align oral refills to ART supply For self-injection injectables, align appointments using injectables flexibilities (see Box 4); otherwise, adjust ART refill length	Annual script (12MMS)	6-12 MMD/2-4 units Align with ART refill collection date *(can skip an ART refill collection date if a longer contraception method supply than ART is provided)*
Short-acting intramuscular healthcare worker-administered injectable	Start/continue Align appointments using injectable flexibilities (see Box 4; otherwise, adjust ART refill length	Annual script (12MMS)	2-3 monthly according to method through fast-track option Align with ART refill collection date if both are 3 monthly *Consider location of less-intensive ART DSD model and align, e.g., facility-based individual/group if the injectable is only administered by healthcare worker at a health facility*

Integrating the service delivery building blocks for ART and contraceptive care—specifically clinical visits and medication refills—maximizes efficiencies for both clients and the health system (see Table 6). LARC methods are particularly well-suited to integration with less-intensive ART DSD models, as they do not require regular rescripting or refills.

For clients choosing short-acting, self-administered contraceptive methods, prescriptions should ideally be aligned with ART scripting and provided as multi-month refills, matching the longest possible ART refill period.

When supply chain limitations restrict the availability or duration of contraceptive refills, providers should still offer aligned multi-month prescriptions. In these cases, repeat refills can be made available through fast-track facility or community pick-up, without requiring a clinician visit. In some instances, it may even be possible to provide a longer supply of contraceptives than ART—for example, offering four units of a self-injectable method alongside a six-month ART supply. In such cases, there is no need to rescript the self-injectable method at every second ART clinical review.

Aligning self-managed contraceptive methods (e.g., oral pills or rings) with ART refills is generally straightforward. Aligning injectable contraception—whether self-injected or administered by a healthcare worker—can be more complex. However, WHO guidance on flexible injectable timing, which allows for early or delayed administration (see Box 5), can facilitate alignment.

If immediate alignment is not feasible, adjusting the duration of the first ART scripting or refill period may help bring future ART and contraceptive schedules into sync.

WHO Guidelines

Box 5: WHO Guidelines. Selected practice recommendations for contraceptive use (8)

The repeat injection of depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) can be given up to two weeks early. The repeat DMPA injection can be given up to four weeks late without requiring additional contraceptive protection. The repeat NET-EN injection can be given up to two weeks late without requiring additional contraceptive protection.

Table 6: Building blocks for FP and ART integration

Methods	Clinical visits	Refills visits (through one of the four less-intensive DSD models)
WHEN	Align ART and FP clinical review and script length	Align refill length and pick-up day for ART and contraception refills. If supply limitations do not support the same-length of multi-month refills for ART and the contraceptive method, additional refill pick-ups should be provided through the chosen refill model or fast-track administration mechanism.
WHERE	ART clinic (or PHC clinic or FP clinic)	ART clinic Out-of-facility location
WHO	Same HCW providing ART and FP clinical review	Same person distributing refills (e.g., nurse, CHW, peer)
WHAT	Clinical review for ART and FP as per national guidelines Scripting for ART and short-acting contraceptive methods, insertion/removal of LARC if chosen	Short-acting contraceptive method refills/administration ART refills

Case example:

Integration of contraceptive care within DSD for HIV treatment models in Lesotho

In Lesotho, women living with HIV are increasingly able to receive contraceptive care integrated within their HIV treatment, including through DSD models (see Table 7).

ART providers assess each woman's family planning needs and offer a range of contraceptive methods. If a LARC method such as an implant is chosen, the ART provider can insert it during the same visit. If the woman chooses an IUD, a referral to a family planning provider is made for insertion.

For women choosing oral contraceptives or self-injectable methods, contraceptive care is integrated into their annual ART clinical review. ART is scripted for 12 months, with medication refills collected every three or six months. Refill options include facility-based individual pick-up, community outreach services, automated dispensing units, or collection through the community ART group (CAG) model. Lesotho is currently scaling up 6-month multi-month dispensing (6MMD) as part of this model.

Due to supply chain constraints, it is not always possible to provide a full 12-month supply of oral pills or self-injectables at once. However, multi-month prescriptions are still given. At their annual clinical review, women receive three to six months of oral contraceptives or two units of self-injectables from their ART provider. Subsequent refills—three months of oral pills or one to two additional injectable units—can be collected through a facility fast-track system or from a community health worker (CHW) based in their village. In the capital city, oral contraceptive refills are also available through an automated dispensing unit.

Table 7: Building blocks of Lesotho's integration of contraceptive care within DSD models for HIV

		Combined refill-only collection				
ART DSD model	**Combined ART-FP clinical review**	**ART refill**	**LARC: IUD, implant**	**Oral pill refill only**	**Subcutaneous self-injectable**	**Intramuscular injectable**
Individual Facility-based	Annual	6-month refill	N/A	If only 3 months supply can be provided, the additional 3 months is collected either from fast-track collection at the facility or from community outreach or from CHW in village	2 units (6-months) *Collect further 2 units from CHW in village*	2-3 monthly at facility-based FP service or outreach FP service *with ART refill collection or combined ART and FP review scheduled on an administration date*
Individual Community outreach	Annual	6-month refill	N/A			
Community ART groups	Annual	3- or 6-month refill collected by CAG representative	N/A	3-month refill collected by CAG representative *Collect additional 3-month refill from CHW in village*		
Auto-dispensing unit	Annual	6-month refill	N/A	6-month refill	1-2 units *Collect further 1 unit from CHW in village*	

DSD for family planning and integration with PrEP

WHO has developed guidance on DSD for PrEP, which aligns with the DSD building blocks. This includes separation of clinical visits for review from PrEP-only refill visits.

- **WHEN**: Providing multi-month refills of PrEP,
- **WHERE**: Offering PrEP through out-of-facility distribution models,
- **WHO**: Utilizing lay providers to distribute PrEP refills, and
- **WHAT**: Integrating essential services such as HIV testing, STI screening, and other elements of PrEP management (9).

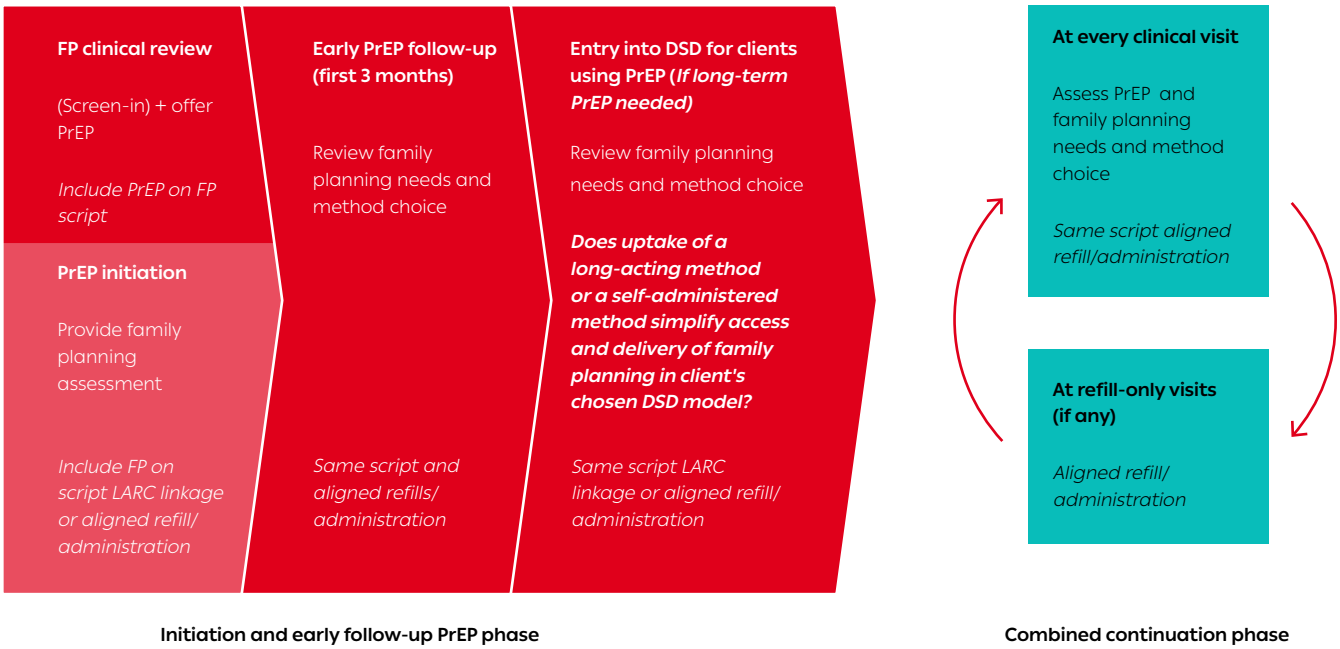
Women of childbearing age who require PrEP may also need access to contraception. Integrating FP and PrEP services can improve efficiency for clients and reduce the burden on health systems. PrEP can be incorporated into existing FP services, or FP services can be added at any location where PrEP is provided. Evidence increasingly shows higher PrEP uptake and continuation when PrEP is offered within FP services. Both services can also be delivered through other platforms such as antenatal and postnatal care. Opportunities for integration are described in Figure 2.

PrEP and contraceptive care are often required during overlapping—but not always simultaneous—periods of increased vulnerability to HIV acquisition and risk of unintended pregnancy. As such, women may start or stop PrEP and contraception at different times, depending on their needs and intentions throughout life.

There are now multiple method options available for both PrEP and contraception that should be routinely offered to clients. These include injectables—either healthcare worker-administered or self-injected—as well as oral formulations and rings. Self-injectable contraception is already widely available, and self-injectable PrEP may become available soon. In addition, clients should be offered LARCs, such as implants and IUDs.

Women may choose different methods for PrEP and contraception based on a range of factors. These include their current level of HIV vulnerability and pregnancy intentions, the efficacy and side effect profiles of the available methods, and personal preferences—particularly the feasibility of aligning methods to reduce the number of healthcare visits required.

Figure 2: Opportunities for FP and PrEP integration



PrEP can also be considered to have an early follow-up phase and a continuation phase (Table 8). The early phase includes an initiation visit, followed by a second visit to retest for HIV to rule out missed acute infection at initiation, review other test results and, assess satisfaction with the method chosen – making adjustments if needed. Once a client expresses an intention to continue PrEP use longer term, they enter the continuation phase. At this stage, clinical review visits may become less frequent, and multi-month PrEP refills can be provided.

If the duration of PrEP refills is shorter than the interval between clinical reviews, refill prescriptions should be aligned with clinical review schedule, and refill-only collections can be supported through any of the four less-intensive DSD models (see *Differentiated pre-exposure prophylaxis (PrEP) service delivery: Key considerations in developing policy guidance for differentiated PrEP service delivery*) (10).

To meet the HIV testing requirements during the continuation phase, clients can be given an HIV self-testing kit at their clinical review visit to use prior to collecting their next refill, or at the time of refill collection, with appropriate education. If a self-test returns a positive result, clients should be educated to return to the facility for confirmatory testing. Given increasing resource constraints, the frequency of HIV retesting during the continuation phase of PrEP may need to be limited to match the schedule of clinical reviews.

Table 8: Initial and continuation phases for PrEP integrating contraceptive methods

		Early follow up	Continuation	
		Clinical consultations	*Clinical visit*	*Refill visit+*
PrEP service delivery	PrEP oral	As per national guidelines, commonly month 1 and 4	6 monthly	3-6 monthly
	PrEP LA injectable*	Month 2	6 monthly	2-monthly HCW-administered injection
	PrEP vaginal ring	Month 1 and 3	6 monthly	3-6 monthly (3-6 vaginal rings)
FP service delivery	Long-acting FP	Actively link to or insert LARC at clinical visit	NA	NA
	Short-acting self-managed	Start or continue contraception method (if starting self-injectable, demonstrate)	Annual script (12MMS)	6-12 MMD/2-4 units Align with PrEP refill collection date
	Short-acting HCW-administered injectable	Start or continue IM method but use injectable flexibilities (see Box 5)	Annual script (12MMS)	2-3 monthly through fast track option

IM – intramuscular, LA – long-acting, LARC – long-acting revisable contraceptive, MMD – multi-month dispensing, MMS – multi-month scripting
+ Refills could be provided through any of the four less intensive DSD models

*As six-monthly lenacapavir becomes available for all FP clients, it will be possible to immediately provide six-monthly combined scripting and aligned administration/refill length.

As with ART and family planning, aligning the service delivery building blocks for PrEP and family planning provides maximum efficiency for the client and the health system (Table 9).

Figure 9: Building blocks of PrEP and family planning

Building block	Clinical visits	Refills-only visits (through one of the four less-intensive DSD models)
WHEN	Align PrEP and FP clinical review and script length *(Can provide 6-monthly for PrEP and 12-monthly for FP if contraceptive method only needs annual review)*	Align refill length and pick-up day for PrEP and contraception method refills *If limitations in supply will not support same-length multi-month refills of either PrEP or contraceptive method, additional refill pick-ups should be through the chosen refill model*
WHERE	Location where PrEP provided or FP clinic Facility or out of facility	Through chosen facility or out-of-facility model
WHO	Same HCW providing PrEP and FP clinical review	Same person distributing refills (oral pills or self-injection units) or administering intramuscular injectables Nurse Community health worker Peer
WHAT	Clinical review for PrEP and FP as per national guidelines HIV retesting (rapid or HIV self-test) for PrEP continuation Scripting for PrEP and FP short-acting options; insertion removal of LARC as indicated	Short-acting FP refills PrEP refills (HIV self-test)

Case example:

DSD for integrated PrEP and family planning services in Mozambique

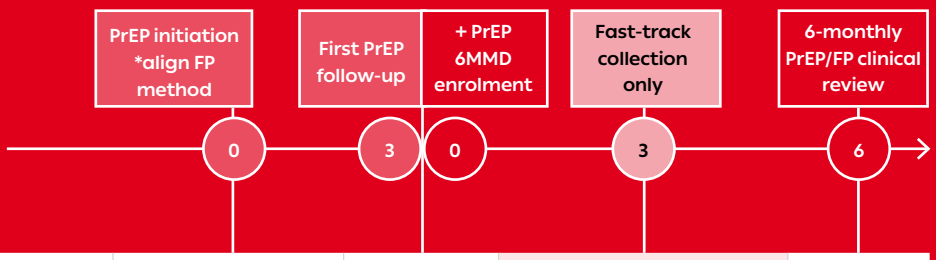
In Mozambique, a public sector demonstration project is integrating PrEP into existing facility-based family planning services (Figure 3). As part of the project, all FP providers will be trained to manage and deliver PrEP services.

FP clients are routinely assessed for HIV vulnerability and offered PrEP. Clients who choose to initiate PrEP receive a three-month supply at their first visit. At the three-month follow-up, those who test negative for HIV and decide to continue PrEP are transitioned to integrated FP and PrEP clinical reviews every six months. LARCs are proactively offered. For clients choosing short-acting methods, these are co-prescribed with PrEP for six months.

Clients typically receive either a six-month supply of PrEP and oral contraceptive pills, or two units of self-injectable subcutaneous contraception. When there is limited stock availability – whether for PrEP or oral contraceptives – a three-month supply is provided with a fast-track option in place for collecting the remaining three-month refill. In instances of limited available of self-injectable units, healthcare providers may alternate between administering an intramuscular injection during the clinical review and providing a subcutaneous unit for the client to self-administer at home.

HIV testing is conducted every six months at the clinical review visit. However, if a client prefers more frequent HIV testing (every three months), they are offered two self-care options: collecting an HIV self-test from a community health worker or visiting any facility for an HIV rapid test.

Figure 3: Overview of the demonstration project integrating 6-monthly contraception/ PrEP DSD model



Combined FP-PrEP clinical consultation and scripting	X	X		X
Prep refill	3MMD	6MMD (or 3MMD)	Fast collect 3MMD if stock shortages*	6MMD (or 3MMD)
HIV testing	Rapid test at facility	Rapid test at facility	Self-managed rapid test any health facility or HIVST in community (not required)	
LARC (IUD/implant)	Implant insertion by ART provider Co-ordinated referral for IUD insertion			
Injectable	1 unit (demonstrate if first time)	2 units*	self-inject	2 units*
Oral	3MMD	6MMD (or 3MMD)	fast collect 3MMD if stock shortages*	6MMD (or 3MMD)

* Oral contraception pills may be in short supply requiring fast track set-up and utilization
+ Can rotate intramuscular and sub-cutaneous with intra-muscular administered at clinical consult and sub-cutaneous dispensed for self-injection 3-months later if DMPA-SC shortage/saving

Conclusion

Differentiated service delivery for family planning and the integration of family planning into DSD for HIV treatment (ART) and PrEP focuses on providing person-centred care that reduces unnecessary burdens on both clients and the health system. This approach aims to maximize efficiency and improve overall service delivery.

Long-acting reversible contraceptives are the most effective contraceptive options and offer the additional advantage of requiring no follow up until replacement is needed or pregnancy intentions change. For clients using short-acting methods (whether self- or provider-administered) and requiring long-term contraception, one of the four less-intensive DSD models can be applied.

Integration of family planning with ART or PrEP into family planning services seeks to align clinical visits and medication refills in terms of timing, location and provider. Family planning needs should be routinely addressed at every ART or PrEP clinical visit. For clients established on ART or continuing PrEP for a longer term and who use short-acting contraceptive methods, refill visits can be separated from clinical consultations if necessary. Refills for both ART/PrEP and contraception should then be provided through one of the less-intensive DSD models.

The ultimate goal of applying DSD principles to family planning is to improve health outcomes by delivering person-centred, streamlined services – whether through standalone family planning platforms or integrated FP and ART or PrEP services.

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