

The potential efficiencies of DSD for family planning (FP)

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The future of differentiated HIV services: Making care easier and more efficient

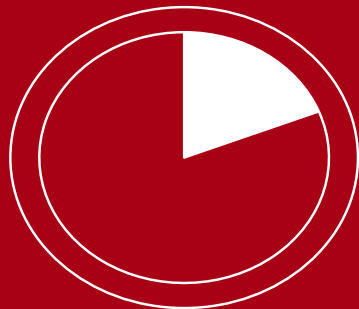
ICASA 2025

Background: Global contraceptive use and unmet need

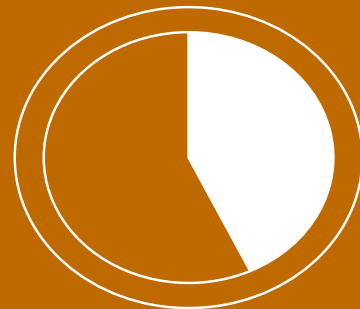


Globally 164 million women-unmet need for FP

46% women using modern contraception

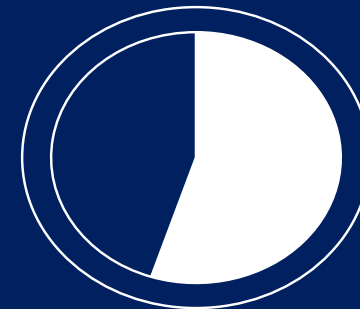


19% unmet contraceptive need in central, eastern, southern and western Africa



43% Unmet need among adolescent girls

Compared to 24% among all women of reproductive age



55% unintended pregnancies among adolescents end in abortions

Many abortions are unsafe

One-person, multiple health conditions and needs...

- DSD is not just for HIV, there are opportunities for it to be applied to any health service requiring ongoing care, including family planning
- With the current health system strain-limited HRH, commodity pressures, and clinic congestion, DSD to the rescue



WHO recommendation for integration of family planning with ART 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)

- FP and HIV services should be integrated **across the HIV cascade** from HIV testing to ART continuation
- Family planning services should be **offered to all** women living with HIV of childbearing age **at each HIV clinical visit**

Remember → contraception is ahead of ART/PrEP formulations

- 1. Long-acting formulations (LARC)** already exist with multiple methods: 3-10 years
- 2. Self-care methods** exist including self-injectable contraception (Sayana Press/DMPA-SC)
- 3. Long refills already recommended:** WHO recommends 12MMS and 12MMD



Family planning methods provide opportunities for FP DSD and integrated ART/FP DSD

Methods NOT requiring ongoing interaction (long-acting methods)

VS

Methods requiring ongoing interaction for commodity supply/administration (short-acting methods)

(until replacement or pregnancy intention changed)

1

IUDs
(copper/hormonal)

2

Implants

1

Self-administered: Oral pills/sub-cutaneous self-injectables (DMPA-SC)/ patches/rings

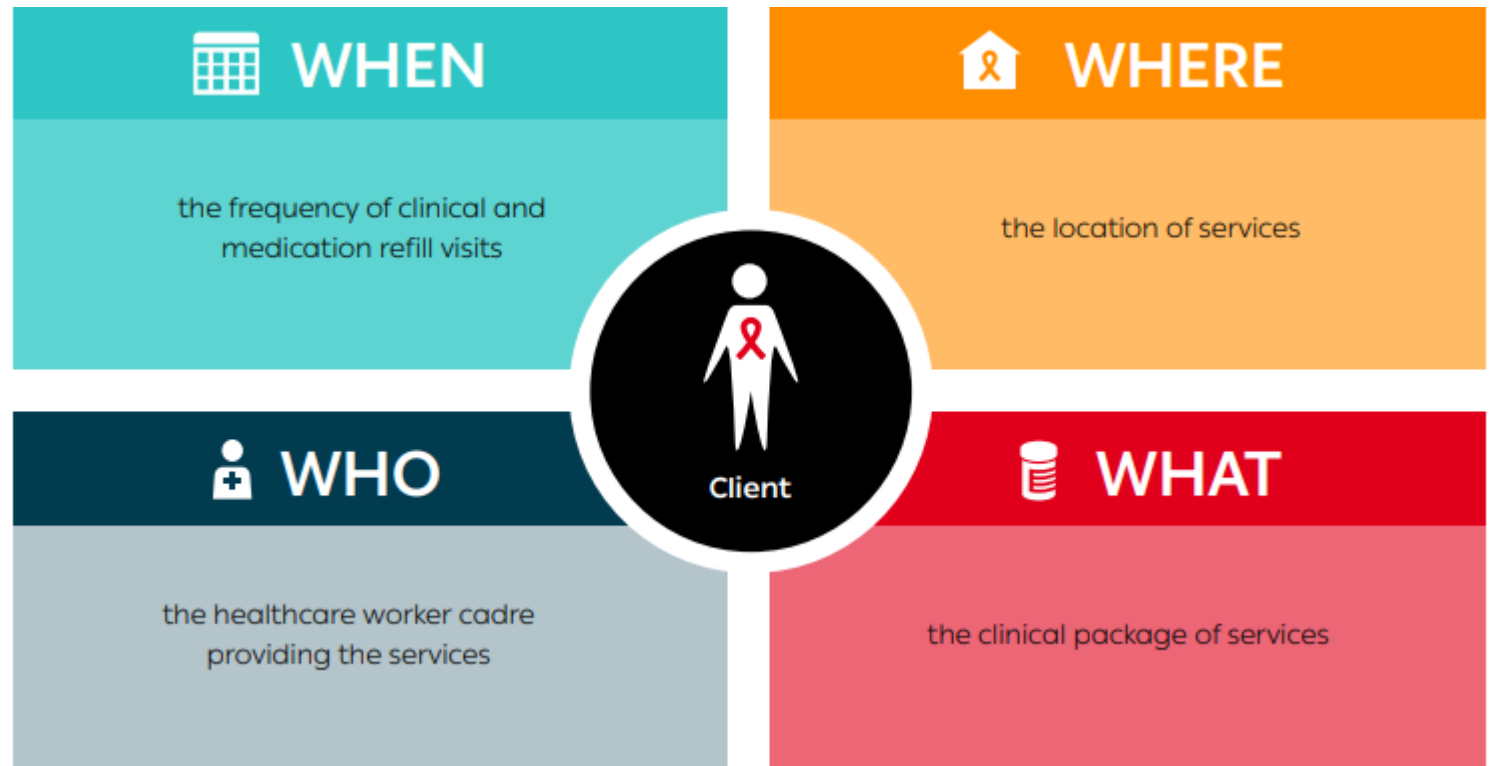
2

HCW-administered: Intra-muscular injectables (DMPA-IM or NET/EN)





Family planning services may have already adapted the building blocks of DSD, but are further adaptations needed?

To reduce intensity of service delivery burden:

- i. Possible to separate clinical consultation and refill collection visits
- i. Integrate FP/ART DSD building blocks



Policy change may be needed for EACH building block

Building block		Key questions
 WHEN	Service frequency	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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?

Building blocks for short-acting contraception 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	<ul style="list-style-type: none"> Doctor (prescribe and distribute) Nurse (prescribe and distribute) CHW (distribute/administer) Peers (distribute/administer) Client (self-inject) 	<ul style="list-style-type: none"> Doctor (prescribe and administer) Nurse (prescribe and administer) Trained CHW (prescribe and administer)

"WHEN": Spaced clinical consults and multi-month prescription possible, EVEN when stock only supports shorter refills

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

	Clinical assessment	Refill duration
Long-acting (IUD and implant)	no clinical follow up is required until pregnancy is wanted or method	
Short-acting self-administered (pills, S/C self-injectable unit, rings, patches)	Annual	12 monthly (13 pill packs; 4 s/c self-injectable units; 13 rings)
Short-acting HCW-administered (IM injectable)		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

Remember: Clinical review CAN be less frequent than refills/administration

Opportunities for ART and FP DSD integration

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	<p>Start/continue contraception method (<i>if starting self-injectable, demonstrate</i>)</p> <p>Align oral refills to ART supply</p> <p>For self-injection injectables, align appointments using injectables flexibilities (see Box 4); otherwise, adjust ART refill length</p>	Annual script (12MMS)	<p>6-12 MMD/2-4 units</p> <p>Align with ART refill collection date (<i>can skip an ART refill collection date if a longer contraception method supply than ART is provided</i>)</p>
Short-acting intramuscular healthcare worker-administered injectable	<p>Start/continue</p> <p>Align appointments using injectable flexibilities (see Box 4); otherwise, adjust ART refill length</p>	Annual script (12MMS)	<p>2-3 monthly according to method through fast-track option</p> <p>Align with ART refill collection date if both are 3 monthly</p> <p><i>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</i></p>

Four models of DSD for HIV treatment that can integrate family planning & contraception provision



GROUP MODELS

Teen clubs
Facilitated by a healthcare worker – lay provider or clinical

Community ART groups
Managed by the people living with HIV in the

GROUP MODELS MANAGED BY HEALTH-CARE WORKERS GROUP MODELS MANAGED BY CLIENTS



INDIVIDUAL MODELS

Fast-track
FACILITY-BASED INDIVIDUAL

Outreach points, CBOs, private pharmacies...
OUT-OF-FACILITY INDIVIDUAL

Efficiencies gained

	Recipient of care	Health system
WHEN	<ul style="list-style-type: none"> • Fewer clinical visits at the facility • Reduced time spent accessing services (less waiting/travel) • Increased flexibility to receive services at convenient locations and times 	<ul style="list-style-type: none"> • Decongests health facilities • Time freed for first-time FP users
WHERE	<ul style="list-style-type: none"> • Access outside traditional clinics (community models of care) • Closer-to-home access reduces travel burden 	<ul style="list-style-type: none"> • Shift of stable users to lower-intensity platforms • Optimizes facility space for other services • Expands service coverage without expanding infrastructure
WHO	<ul style="list-style-type: none"> • Task-sharing enables access through CHWs, pharmacists, and self-care (e.g., self-injectables) • Reduced dependency on specialists 	<ul style="list-style-type: none"> • Redistribution of tasks from clinicians to trained cadres and clients themselves • Improved efficiency of HRH use • Ability to focus skilled providers on complex cases



Key takeaways

ART-FP Integration

Enables ART-FP integration by aligning clinic visits, refills, and services

LARC Support

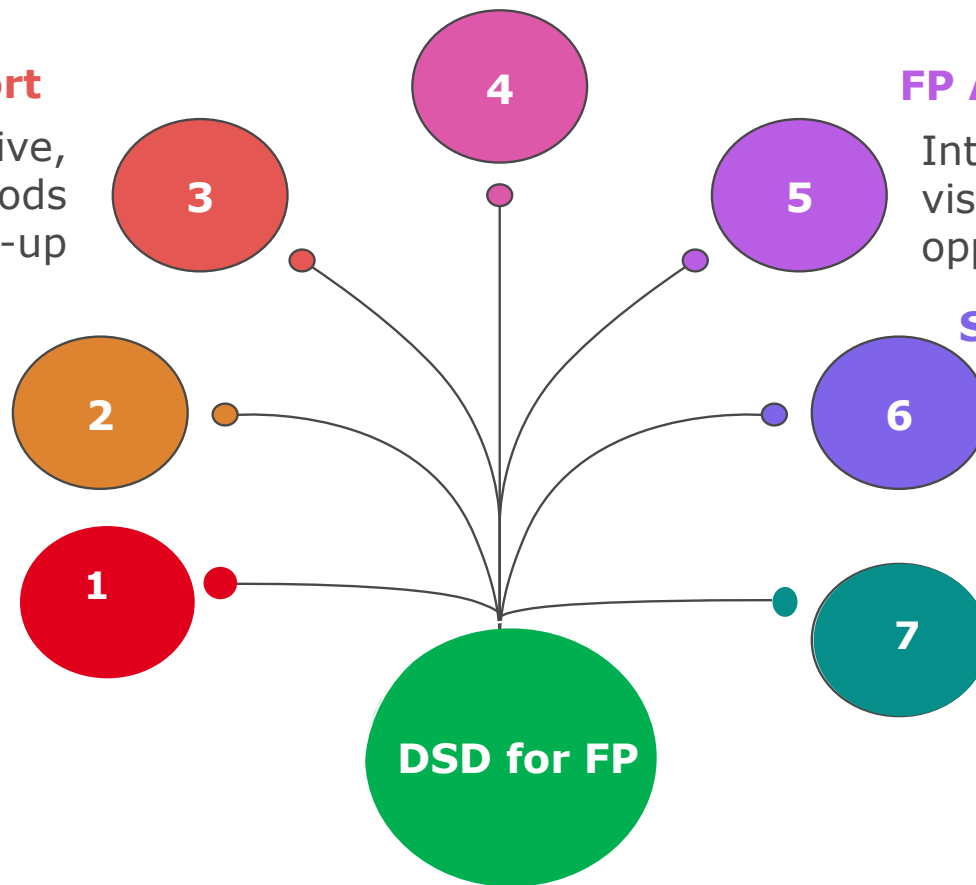
LARCs as highly effective, low-burden methods requiring minimal follow-up

Use of LIM

Uses LIM for clients on short-acting methods.

Reduced Burden

On RoC & health system



FP Addressed

Integrates FP into every ART visit to avoid missed opportunities.

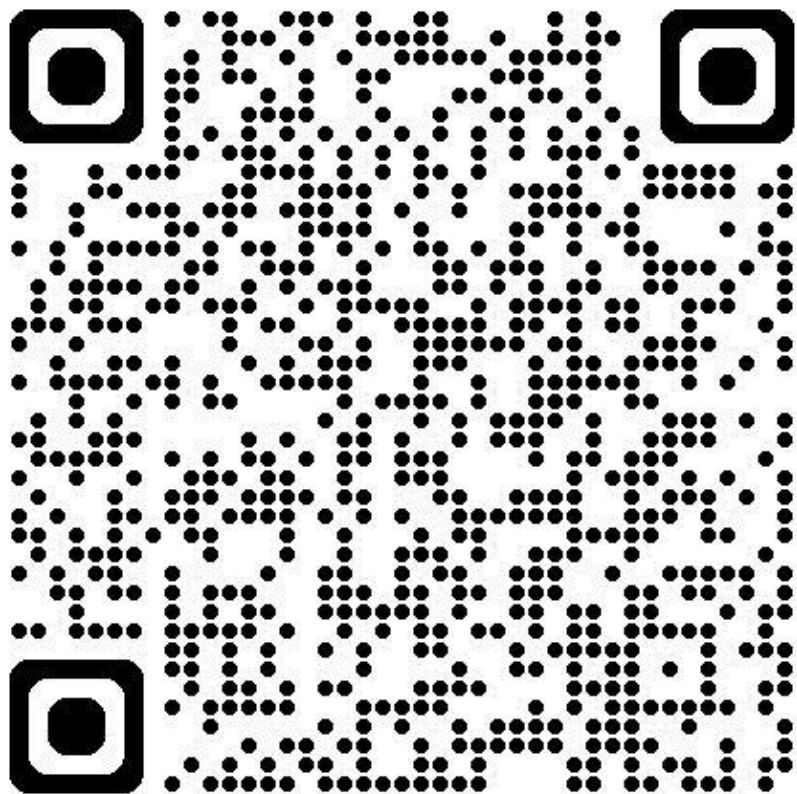
Service Efficiency

Streamlines delivery to improve efficiency and quality in standalone or integrated FP-ART services

Clinic reviews from refills

Separates reviews from refills, allowing ART and FP refills through less-intensive DSD models

New updated supplement



Differentiated service delivery for family planning services and contraceptive methods

Including opportunities for integration of ART and PrEP

