

LEVERAGING DIFFERENTIATED ART DELIVERY MODELS TO STRENGTHEN FAMILY PLANNING CARE

A supplement to *A Decision Framework for antiretroviral therapy delivery*

This supplement to *A Decision Framework for antiretroviral therapy delivery* outlines how models of differentiated antiretroviral therapy (ART) delivery can be leveraged towards strengthening family planning. The aim is to provide:

- An overview of differentiated service delivery (DSD)
- An overview of family planning (FP)
- Key principles for family planning in the context of differentiated ART delivery
- Guidance on how family planning could be integrated into differentiated ART delivery models using the DSD building blocks
- Case studies and examples of how family planning has been integrated into differentiated ART delivery models
- Take-home messages for leveraging differentiated ART delivery models to strengthen family planning care.

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

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. For clients on antiretroviral therapy (ART), ministries of health have scaled up four models of differentiated ART delivery. Further details of these models can be found in the published *A Decision Framework for antiretroviral therapy delivery*. The models are:

- Facility-based individual models, such as fast-track, where individuals collect their ART refills at the health facility without queuing or seeing a clinician.
- Out-of-facility individual models, where individuals collect their ART refills from mobile ART services, fixed community distribution points or community pharmacies.
- Healthcare worker-managed groups in facilities or communities, such as adherence clubs, ART refill support groups or teen clubs. These are 10-30 clients booked to collect their ART at the same time as a group, usually within a health facility. A nurse, lay worker or peer facilitates the group with the aim of providing education, support and distributing medication (often pre-packed).
- Client-managed groups, such as community ART groups (CAGs). These are usually groups of 4-12 clients who meet in the community. Each group nominates a group leader and one member to collect medication for the rest of the group.

ACRONYMS

ART	Antiretroviral therapy	IUD	Intrauterine device
CAGs	Community ART groups	LARC	Long-acting reversible contraception
DSD	Differentiated service delivery	STI	Sexually transmitted infection
FP	Family planning	WHO	World Health Organization

What is family planning and why is it important?

According to the World Health Organization (WHO), family planning is defined as “the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births” [1]. Family planning (FP) helps couples avoid unintended pregnancies, reduces the spread of sexually transmitted infections (STIs) and decreases morbidity and mortality related to unintended pregnancy [2,3]. It is achieved primarily through the use of contraception. All women and girls, including those living with HIV, should have access to voluntary, effective contraception as a health and human right [4–6]. For women and girls living with HIV, using effective contraception also reduces mother-to-child transmission of HIV by preventing unintended pregnancies and enabling the planning and safer conception of desired pregnancies [7–9].

Healthcare providers should encourage clients living with HIV to speak openly about their reproductive plans and desires and assist them to make well-informed decisions regarding pregnancy prevention or planning. HIV-affected women, men and couples should be asked regularly, in a non-judgemental and sensitive way, about their desires and plans for future childbearing and pregnancy prevention (this is called “provider-initiated discussions”). If clients would like to become pregnant, then comprehensive safer conception and pregnancy planning advice should be given. If they choose pregnancy prevention, they should be offered comprehensive counselling and provision of contraception.

To improve access to family planning, WHO recommends the integration of family planning services into HIV care settings (Box 1) [10]. This recommendation has been poorly and unevenly implemented. Ensuring easy access to highly effective long-acting reversible contraceptive (LARC) methods, such as implants and intrauterine devices (IUDs), has been particularly challenging.



BOX 1: WHO recommendation on FP/HIV integration

Sexually transmitted infection and family planning services can be integrated within HIV care settings.

Source: WHO. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection 2016 [10].

A quality-of-care approach to family planning, as presented in WHO’s 2017 *Quality of care in contraceptive information and services, based on human rights standards* [11], emphasizes the importance of putting the client and their experience at the centre of care. Key elements of high-quality care in family planning services are outlined in Box 2.

BOX 2: Key elements of high-quality care in family planning services

- Grounding in a human rights-based framework
- Respectful relationships between providers and clients
- Each client's autonomous choice among a wide range of contraceptive methods
- Client access to evidence-based information on the advantages and disadvantages of various contraceptive methods
- Client decision making without coercion or judgement
- Client privacy and confidentiality
- Technically competent health workers for counselling and provision of a wide range of contraceptive methods
- An appropriate constellation of services (including follow up and ongoing support) and contraceptive methods that are available in the same locality

Sources: WHO. *Consolidated guideline on sexual and reproductive health and rights of women living with HIV 2017* [4]; WHO. *Quality of care in contraceptive information and services, based on human rights standards: a checklist for health care providers 2017* [11]; WHO. *Ensuring human rights in the provision of contraceptive information and services 2014* [12].

Ensuring that a range of contraceptive methods are available

According to WHO, the range of contraceptive methods available should include LARCs (implants and IUDs), injectable contraception, combined and progestin-only oral contraceptive pills, male and female condoms, and emergency contraception. Referral for clients wanting a permanent method of contraception (that is, female sterilization or vasectomy) should also be available. In some settings, the contraceptive ring and patch may be available as well. WHO states that all women and girls should have access to emergency contraception through national family planning programmes [13]. Annex 1 provides details on contraceptive methods, including duration and level of effectiveness.

WHO advises that women and girls living with HIV can generally safely and effectively use all available contraceptive methods (Box 3) and should be encouraged to use dual methods, that is, use of condoms in addition to another effective method of contraception to also prevent transmission of HIV and other STIs. Guidance can be found in the WHO publications, *Providing contraceptive services in the context of HIV treatment programmes* (2019) [2] and *Medical eligibility criteria for contraceptive use, Fifth edition* (2015) [14].

While not necessarily the right method for all clients, LARCs, such as implants and IUDs, should be promoted. Box 4 outlines some of the medical and programmatic advantages of LARCs. LARCs are also the most cost-effective options [15].



BOX 3: WHO guidance on women and girls living with HIV and contraceptive methods

Women and girls living with HIV can, generally, safely and effectively use all available contraceptive methods.

Sources: World Health Organization. *Providing contraceptive services in the context of HIV treatment programmes. Implementation Tool 2019* [2], World Health Organization. *Medical eligibility criteria for contraceptive use, 5th ed. 2015* [14].



BOX 4: WHO guidance on LARCs

Long-acting reversible methods (implants and IUDs) are very effective because:

- Of the level of protection afforded by the method itself
- They can be used for a long time (5-10 years for IUDs and 3-5 years for implants)
- Once they are started, they require little or no action for continued use and do not require frequent resupply

Source: World Health Organization. *Providing contraceptive services in the context of HIV treatment programmes. Implementation Tool 2019*. [2]



Two categories of contraceptive methods

When thinking about how the different contraceptive methods may be integrated into differentiated ART delivery models, there are two categories of contraceptive methods that must be considered:

1. Those 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.
2. Those that need ongoing interaction with health services, ongoing supplies and/or medical intervention for continued use (these include condoms, contraceptive pills, patches, rings and injectables).

Unmet family planning need among women living with HIV

Despite the positive clinical and social impact of family planning, the unmet need for contraception remains high among women and girls living with HIV. Among women living with HIV in low- and middle-income countries, over half of the 1.5 million annual pregnancies are unintended [16–20]. Recent data from across the African region illustrates that a significant unmet contraceptive need remains among women living with HIV [20–22], with use of shorter-acting methods and condoms outweighing the use of more effective LARC methods and low levels of dual method use [23–25]. Unmet need for contraception is highest among the most vulnerable, including adolescent girls and young women, women and girls postpartum, and key populations, including female sex workers [26].

Why focus on family planning in differentiated ART delivery models?

People living with HIV have health needs beyond just HIV. Providing person-centred care means addressing other health needs, which may include treatment of other acute or chronic co-morbidities and the provision of family planning and other sexual and reproductive health services.

People living with HIV who visit health facilities every three to six months to collect their ART do not maximize the benefit of their differentiated ART delivery model if they need to return to the facility more frequently for management of these other medical needs, including family planning.

Differentiated ART delivery has been scaled up in many countries in recent years. Many people living with HIV are now seen by clinicians or visit health facilities every six or 12 months. Concurrently, there is renewed emphasis on ensuring that all women and girls living with HIV have access to high-quality family planning care as part of their HIV care and as an essential pillar in the prevention of mother-to-child transmission of HIV. The need for high-quality family planning care has been re-emphasized given the current scale up of dolutegravir-based ART [27,28].

However, family planning has not been systematically integrated within differentiated ART delivery models. Clients in differentiated ART delivery models should be supported to use the contraceptive method of their choice and, where ongoing commodities are required, be able to obtain these through their differentiated ART model.

KEY PRINCIPLES FOR INTEGRATION OF FAMILY PLANNING INTO DIFFERENTIATED ART DELIVERY

There are five key principles in strengthening family planning integration within differentiated ART delivery.

1. Engage women and girls living with HIV

Designing a service delivery model for family planning within a DSD model for ART should be done in consultation and collaboration with the service users. The goal should be to address clients' needs and ensure the provision of a quality service.

Involving women and girls living with HIV as active participants in developing, delivering and evaluating these services is important for programmes to build trust and deliver services that fully benefit individuals and communities.

2. Utilize DSD referral and follow up as an opportunity for continuity of family planning care

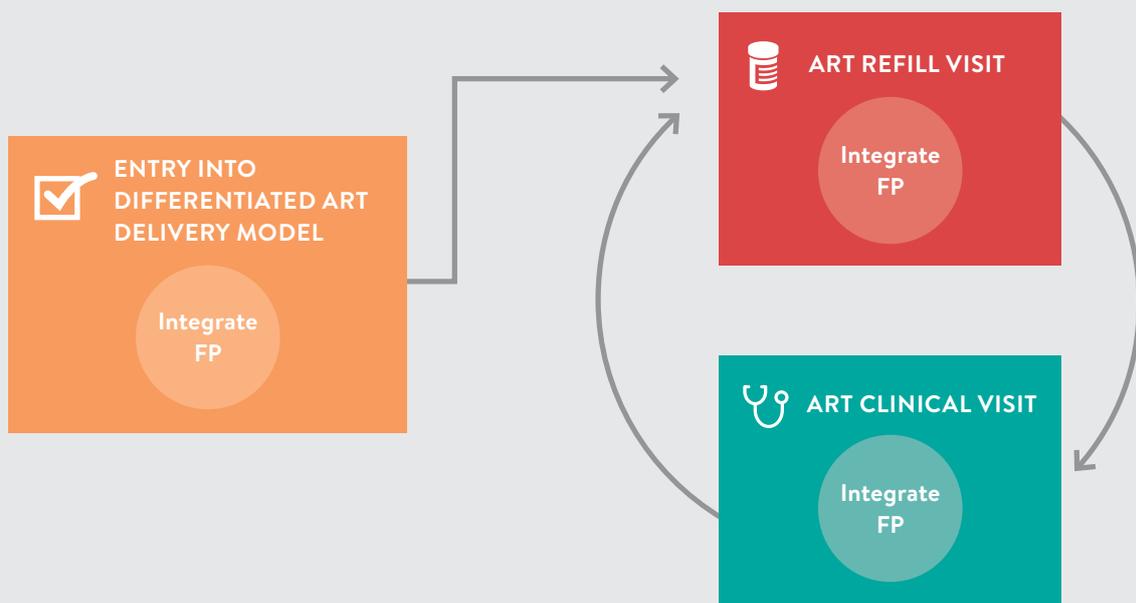
Differentiated ART delivery models should be leveraged to strengthen family planning care – and there are

components of this that should happen at entry into differentiated ART delivery models and during follow up.

At referral to differentiated ART delivery, a quality family planning consultation should be offered. As part of this consultation, both counselling and contraceptive commodities should be provided. Given that entry into most differentiated ART delivery models involves reducing the frequency of clinical consultations and health facility visits, there should be a discussion on contraceptive options and which option can best align with the client's needs and preferences, and HIV care. This discussion should be documented in an ongoing way at each follow-up clinical interaction (Figure 1).

At ART refill visits, clients should have the option to receive their contraceptive care with their ART. This should be provided in an integrated manner considering the building blocks of "When", "Where" and "Who" as discussed on pages 9–15.

Figure 1. Family planning care throughout differentiated service delivery of ART



3. Promote the use of long-acting reversible contraceptives among clients in differentiated ART delivery models

LARCs should be easily accessible and positively promoted for women and girls in DSD models. The contraceptive implant and the IUD – long-acting, fully-reversible contraceptive methods – are some of the

most effective contraceptive methods available. They are highly effective at preventing pregnancy and they provide contraception for an extended period, from three to 10 years, without requiring user action (that is, no follow-up visits to a clinic, no refills and no user adherence required) or interaction with the facility until the user wishes to become pregnant, the method has reached its expiry date and needs replacing or the user chooses to discontinue for another reason.



Case study 1: Discussing family planning, including LARCs, for women in differentiated ART delivery models, Lilongwe, Malawi

In Lilongwe, Malawi, LARC use was negligible among women living with HIV. In response, contraception services were integrated into the ART clinic, and HIV healthcare workers received training on delivery of all available contraceptive methods, including LARCs. Since the intervention was implemented, contraceptive uptake has substantially increased: 55% of clients are using the three-monthly injectable, 19% a copper IUD, 14% oral contraceptive pills and 12% a contraceptive implant.

The most common differentiated ART delivery model in Malawi is facility fast-track with clients receiving three- to six-month ART refills. To improve uptake of LARCs, all women have their contraceptive needs and preferences assessed at the time of referral to differentiated ART delivery.



4. Align contraceptive and ART resupplies in differentiated ART delivery models

Resupplies of contraception and ART should be aligned to benefit clients and health services (Box 5). The duration of contraception pill refills should be aligned with the

maximum duration of ART refill available (for example, three months, six months). WHO supports giving a one-year supply of contraceptive pills for continuing users. For injectable contraceptives, the reinjection schedule should be safely adapted to align with ART refills and minimize the number of facility visits.



BOX 5: WHO advice on pill refills and reinjection windows

WHO advises the following to help continuing users of combined oral contraceptive and progestin-only pills: “Give her more pill packs—a full year’s supply (13 packs), if possible.”

Further, “injections can be as much as 4 weeks late for DMPA or 2 weeks late for NET-EN” and still be effective. This leeway in the reinjection window may be helpful in initially aligning reinjection and ART refills when a client enters a DSD model.

Source: World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 edition) 2018 [30]

5. Integrate family planning and ART care in differentiated ART delivery models in facilities and communities

As much as possible, family planning and ART care should be provided at the same time (see “When”, page 10), in the same place (see “Where”, page 12) and, where appropriate and possible, by the same provider (see “Who”, page 14).

In facilities, this can be achieved through different approaches, including multi-skilled HIV and FP providers and a one-stop service within the ART clinic site offering HIV and family planning services under one roof [29]. A referral system for certain contraceptive methods, such as IUDs and sterilization, or for implant removals, may have to be in place.

Community-based distribution and task sharing, as well as provision directly to clients through methods such as the self-administered injectable should be implemented to facilitate services in out-of-facility and client-managed group DSD models.





Case study 2: Aligning the duration of injectable contraception and contraceptive pill with ART, Chiradzulu, Malawi

In Chiradzulu, Malawi, nurses facilitate teen clubs for adolescents living with HIV. Teen clubs meet every three months at the health facility, and participants receive group adherence counselling, peer support and three-monthly ART refills. LARCs are available at the facility, but 83% of those needing contraception currently use injectable contraception. For contraceptive methods requiring ongoing resupply (e.g., injectable and pill), three months of pills are provided or the three-monthly injection is given during the teen club visit. This alignment ensures uninterrupted supply of contraceptives and ART while minimizing visits to the health facility.



Case study 3: Integrating ART and FP provision in a community outreach model, Uganda

In Uganda, one of the DSD models offered is an outreach model. An outreach team attends a designated site every month and delivers ART, providing a three-month supply. Clients requiring resupply of oral contraceptive pills and injectable contraception receive these services at the same time as collecting their ART, with the duration of the contraceptive supplies aligned with their ART.

BUILDING BLOCKS OF FAMILY PLANNING INTEGRATION INTO DIFFERENTIATED ART DELIVERY

Differentiated ART delivery models are built by adapting the “building blocks” of “When” (service frequency and timing), “Where” (service location), “Who” (service provider; cadre of personnel delivering the service) and “What” (service package; what services are being delivered) (Figure 2). The “What” building block of family planning and DSD is the package of contraceptive commodities and

services described in the section, “What is family planning and why is it important?” (pages 2–4), and in Annex 1. The online Annex 2 provides a tool to assess local policies and facility-level implementation for each of the building blocks of service delivery related to family planning (<https://bit.ly/2zWWLFI>).

Figure 2: Integrating the building blocks of family planning into differentiated ART delivery





WHEN

Family planning care should be offered throughout the cycle of differentiated ART delivery

A high-quality family planning consultation, with access to a complete range of contraceptive methods, including LARC methods, such as implants and IUDs, should be offered routinely before women and girls living with HIV enter a differentiated ART delivery model and at subsequent clinical visits [4].

ART and family planning should be provided at the same appointment time

Family planning and ART should be provided at the same appointment time to provide client-centred services. A quality family planning discussion should be offered at entry into a DSD model and at each clinical visit. For continuity of family planning care, it is important to maintain routine

check in with all clients at clinical follow-up visits to assess contraceptive need and reproductive plans and to support continued contraceptive method use, switch or discontinuation, as needed.

ART and family planning resupplies should be aligned

For women choosing a contraceptive method requiring regular resupply, such as pills or injectables, **duration of contraceptive resupply should be aligned with the duration of ART refill.** For example, if six-monthly supplies of ART are given, six months or more of oral contraception should be provided. Reinjection visits and ART refills should be structured in such a way that they can coincide. For community models, assessment of contraceptive needs should be a routine part of the client's assessment at the individual drug pickup or community group meeting.



Example 1: Family planning integration in an individual facility model, Uganda

In Uganda, a facility-based fast-track differentiated ART delivery model is offered, among other models. Clients are seen for a clinical visit every six months and receive a three-monthly ART refill directly from the facility pharmacy in between visits. Contraceptive options offered to clients in this model are LARCs, injectables, oral contraceptive pills and condoms. Nearly all the healthcare workers in the ART clinic give family planning health education. Counselling on family planning is done at every clinical visit and is recorded on the client ART care card.

The majority of women use the three-monthly DMPA injectable. Injectable contraceptive users can get their reinjection when they visit the clinic to collect their ART through a family planning fast-track mechanism. For clients using pills, resupplies can be collected via the fast-track window at the same time, and duration of pill refill is aligned to the ART refill (that is, three months of pills are provided at a time).

Figure 3: Building blocks of family planning care in an individual facility-based model in Uganda

	IUD	Implant	Oral pills	Sub-cutaneous 3-monthly injectable	Intra-muscular 3-monthly injectable	Condoms
WHEN	At DSD entry by referral At DSD clinical visits At facility walk-in services in between visits	At DSD entry At DSD clinical visits At facility walk in services in between visits	At same clinical and refill visit as ART Every 3 months	Not yet available	At same clinical and refill visit as ART At walk-in service Every 3 months	At same clinical and refill visit as ART Every 3 months
WHERE	Primary care clinics Hospitals	Primary care clinics Hospitals	Primary care clinics Hospitals	Not yet available	Primary care clinics Hospitals	Primary care clinics Hospitals
WHO	IUD-trained doctor, midwife or nurse	Implant-trained doctor, midwife or nurse	FP-trained doctor, midwife, nurse, clinical officer, community health worker	Not yet available	FP-trained doctor, clinical officer, midwife, nurse, community health worker	Doctor, clinical officer, midwife, nurse, community health officer, client's independent collection
WHAT	IUD information, counselling, insertion/removal, management of side effects	Implant information, counselling, insertion/removal, management of side effects	Combined and progestin-only pills, information, counselling, dispensing of pills, management of side effects	Not yet available	Injectable information, counselling, giving of injection, management of side effects	Male and female; information, counselling, dispensing of condoms

WHERE

ART and family planning should be provided in the same location

Differentiated ART delivery models can facilitate the better integration of HIV and family planning care by **enabling the client to receive their family planning services at the same place as their ART**. DSD models can be delivered at the facility or in the community, and options for co-located family planning care should be provided in each setting.

At facility level, ideally, family planning services should be administered in the same place or near the location where group ART sessions are held, with the necessary privacy

provided. Likewise, clients in facility-based fast-track models should be able to collect their family planning commodities and their ART from the same pharmacy.

To facilitate provision of family planning services at the community level, issues of task sharing may have to be addressed (see the section, “Who”). Where ART is delivered through community outreach, family planning services may be delivered at the same location. Similarly, for community group models, provision of family planning through community distribution of commodities should be facilitated.

Example 2: Family planning integration in a client-led, community-based group model, Kenya

In Ndhiwa, Kenya, the community ART group (CAG) is one of the differentiated ART delivery models offered. Four to 12 people living with HIV form a group and meet in a community setting every three months. They nominate one group member to collect ART for the group, from the facility, every three months. Every six months, the group members attend together for their individual clinical visits.

When first implemented, clients had to make additional clinic visits for family planning and contraceptives. Family planning options in this setting include contraceptive implants, the three-monthly injectable and oral contraceptive pills. IUDs are available but are rarely taken up; the vast majority of women use the injectable.

To reduce clinic visits, the CAG members requested that resupplies for members needing reinjections or pills be dispensed when ART is collected. On the community CAG refill form used during the CAG meetings, members’ family planning use is part of the routine documentation. Any CAG member who requires reinjection or needs to collect oral contraception resupplies from the clinic is selected to collect ART for the group, and thus can receive their contraception at the same time. Duration of contraceptive pill refill is aligned with the ART refill (three monthly).



Figure 4: Building blocks of family planning care in a client-led, community-based group model in Kenya

	IUD	Implant	Oral pills	Sub-cutaneous 3-monthly injectable	Intra-muscular 3-monthly injectable*	Condoms
WHEN	Available but not taken up	At DSD entry At DSD clinical visits At facility walk in services in between visits if contraceptive need identified	Every 3 months	Not yet available	Every 3 months	Every 3 months
WHERE	Available but not taken up	At same facility as ART where transition to DSD initiated/ ART collected for CAG	Collect ART and FP script from same clinic room and collect from the same pharmacy	Not yet available	Injection given in same room as ART assessment; group member in need nominated to collect ART for others	Dispensed at facility to group member; distributed in community
WHO	Available but not taken up	Implant-trained doctor, clinical officer, midwife or nurse	FP-trained clinical officer, midwife or nurse provides script	Not yet available	FP-trained clinical officer, midwife or nurse	Client collection or dispensed at facility by midwife or nurse, lay cadre
WHAT	Available but not taken up	Implant information, counselling, insertion/ removal, management of side effects	Combined and progestin-only pills, information, counselling, script for pills, management of side effects	Not yet available	Injectable information, counselling, giving of injection, management of side effects	Male and female; information, counselling, dispensing of condoms

*In Kenya, only the three-monthly injectable is available.

The same healthcare worker should provide ART and family planning

Differentiated ART delivery models can strengthen the integration of HIV and family planning care by **ensuring that clients can receive their family planning commodities and their ART from the same healthcare worker**. Policy and training considerations for who can provide counselling, prescribe, dispense, administer or insert various contraceptive methods will be key to providing successful models of integrated family planning and ART.

Task sharing supports integration of ART and family planning

Expanding regulations around who can provide implants and IUDs may be needed in some settings where currently this is allowed only by nurse-midwives and doctors. Task sharing to enable community health workers or, where possible, lay workers or clients themselves to distribute oral contraceptives and administer injectables may enable faster delivery of services at facility level and allow provision of pills and injectables in community-based models. There are several examples of where such task sharing has been done successfully, increasing access to family planning [31–35].

Self-management of contraception supports ART and family planning integration

Increased availability of subcutaneous DMPA injectable (DMPA-SC) (a form of the three-monthly injectable that

can be self-injected by the user or injected by healthcare cadres, such as community health workers) may expand options for family planning service provision in DSD models and enhance women's self-management of their contraception [5,36,37]. This is supported by a new WHO recommendation (Box 6). Supporting women to self-manage their sexual and reproductive health and contraceptive needs is empowering and DMPA-SC can be more readily integrated into community-based models where clinical visits have been reduced to every six or 12 months. DMPA-SC is currently available in at least 20 Family Planning 2020 countries, many of which are scaling up differentiated ART delivery models [5,38].



BOX 6: WHO recommendation on self-injectable contraception

Self-administered injectable contraception should be made available as an additional approach to deliver injectable contraception for individuals of reproductive age.

Source: World Health Organization. Consolidated guideline on sexual and reproductive health and rights of women living with HIV 2017 [4]



Example 3: Family planning integration for postnatal women and girls through a healthcare worker-led group model (postnatal clubs), South Africa

In Khayelitsha, South Africa, postnatal clubs are run at a health facility for breastfeeding women and their HIV-exposed infants. Groups of three to 15 women and their babies attend at the same time and meet in a “club room” at the facility where they receive both their ART and contraception. In the first six months post delivery, the mothers, with their babies, meet monthly (with clinical follow up by a nurse-midwife). Thereafter, they meet every three months until 18 months after delivery.

ART refills are provided at the club setting, along with provision of FP and services for the exposed infants (such as prophylaxis and immunizations), all provided by the same nurse-midwife. Presently, most women in this model use injectable contraception. Both the two- and three-monthly injectables are available, and reinjections are aligned to ART refills. Few women use oral contraceptive pills, but for those who do, the duration of pills provided is aligned with the ART refill (up to three months). LARCs are available, but uptake is low.

Figure 5: Building blocks of family planning care in a healthcare worker-led group model for postnatal women and girls in South Africa

	IUD	Implant	Oral pills	Sub-cutaneous 3-monthly injectable	Intra-muscular 2- or 3-monthly injectable	Condoms
WHEN	Offered at week 18 or 22 postpartum; same day as club meeting	Offered at week 18 or 22 postpartum; same day as club meeting	Every club visit; same duration as ART refill monthly for first 6 months and then 3 monthly	Not yet available	Every club visit; aim to align with ART refill duration 3 monthly	Every club visit
WHERE	Separate clinic room to club	Separate clinic room to club	Club room	Not yet available	Separate clinic room to club	Club room
WHO	Club nurse	Club nurse	Club nurse	Not yet available	Club nurse	Club nurse Club facilitator
WHAT	IUD information, counselling, insertion/removal, management of side effects	Implant information, counselling, insertion/removal, management of side effects	Combined and progestin-only pills, information, counselling, script for pills, management of side effects	Not yet available	2- and 3-monthly injectable; injectable information, counselling, giving of injection, management of side effects	Male and female; information, counselling, dispensing of condoms



CONSIDERATIONS FOR SPECIFIC POPULATIONS

Adolescent girls

Adolescent girls living with HIV are eligible to use all the same methods of contraception as adult women and have the right to access the full range of contraceptive options, including long-acting reversible methods and emergency contraception [6]. Long-acting reversible contraceptive methods are safe and appropriate for adolescent girls, including nulliparous adolescent girls [14]. Adolescent girls, compared with adult women, often have poorer adherence and/or higher discontinuation rates when using short-acting methods and, therefore, LARC methods may be more convenient and effective [6,39]. One of the most common differentiated ART delivery models for adolescents is the teen club. Integration of family planning provision into teen clubs should be a priority to meet the sexual and reproductive health needs of this vulnerable group.

Older women

Women older than 40 years who are sexually active and want to avoid an unintended pregnancy should use

contraception until they reach menopause. Women in this population may be interested in long-acting reversible or permanent methods; however, contraceptive method choice from the range of options should be supported.

Breastfeeding women and girls

Postpartum women and girls are among those with the greatest unmet need for contraception [2]. There are some unique considerations for providing contraceptive services to women and girls during the postpartum period and while breastfeeding. See the WHO *Postpartum Family Planning Compendium* [40] and *Family Planning: A Global Handbook for Providers* [30] for more information. The postnatal clubs in Example 3 demonstrate how such integration has been implemented in South Africa.

CONCLUSION

Strengthening access to and use of contraception, including the highly effective, longer-acting methods, is a key strategy for improving health and well-being outcomes of people living with HIV and for preventing mother-to-child HIV transmission. Leveraging differentiated ART delivery models for women and girls living with HIV presents an opportunity to increase coverage and improve the quality of family planning care. Advocacy for this to happen must address investment in – and access to – the commodities, along with national policies to overcome policy barriers related to how family planning care is delivered. This should include assessment of policies and guidelines, greater task sharing and decentralization of family planning services in order to more effectively integrate family planning care into differentiated ART delivery models.

Using a rights-based, client-centred approach, all women and girls living with HIV in differentiated ART delivery models should be offered family planning counselling and information in an ongoing way, with a choice from the full range of contraceptive methods and easy access to the method of their choice. HIV and family planning policies, programmes and services should be aligned to enable this.

1. Engage women and girls living with HIV.
2. Utilize DSD referral and follow up as an opportunity for continuity of family planning care.
3. Promote the use of long-acting reversible contraceptives among clients in differentiated ART delivery models.
4. Align contraceptive and ART resupplies in differentiated ART delivery models.
5. Integrate family planning and ART care in differentiated ART delivery models in facilities and communities.



ANNEX 1: OVERVIEW OF CONTRACEPTIVE METHOD OPTIONS

Contraceptive methods that may be available in countries and programmes

LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS) AND PERMANENT METHODS OF CONTRACEPTION		
<p>Once in place, LARCs do not require any further interaction with the health system until pregnancy is desired, their duration of contraceptive effectiveness ends or the user wants to discontinue for another reason. The nonreversible permanent methods also do not require further interaction with the health system.</p>		
<p>Long-acting reversible contraceptives</p> <ul style="list-style-type: none"> • These methods provide very effective contraception for an extended period of time without requiring user action (i.e., no regular clinic visits, refills or remembering required). • These methods are fully reversible, meaning that future pregnancies are possible. • These methods do not have to be used long term. The user can, and has the right to, discontinue them at any time they choose. • LARCs are intrauterine devices (IUDs) and contraceptive implants. 		
	Duration of effectiveness?	How effective as commonly used*?
<p>Contraceptive implants (LNG and ETG implants)</p> <p>Small plastic rods, each about the size of a matchstick, that release a progestin. Inserted by specifically trained healthcare providers who place one or two rods under the skin on the inside of a woman's upper arm.</p>	3-5 years	Very effective
<p>Hormonal intrauterine device (LNG-IUD)</p> <p>Small, flexible, plastic frame, which releases a small amount of the progestin, levonorgestrel. Inserted by specifically trained healthcare providers into a woman's uterus through her vagina and cervix.</p>	3-5 years	Very effective
<p>Copper-bearing intrauterine device (Cu-IUD)</p> <p>Small, flexible, plastic frame with copper around it. Inserted by specifically trained healthcare providers into a woman's uterus through her vagina and cervix.</p>	5-10 years	Very effective
<p>Permanent methods of contraception</p> <ul style="list-style-type: none"> • These methods provide very effective contraception permanently. • These methods are not reversible. • Permanent methods are safe, suitable and appropriate for women and couples only if they want no further pregnancies, have received counselling on the irreversible nature of the methods, have decided on a permanent method in a voluntary way, and have given full, free and informed consent. 		
	Duration of effectiveness?	How effective as commonly used*?
<p>Male sterilization (vasectomy)</p> <p>Permanent surgical sterilization for men who do not want more children. The two tubes that carry sperm to the penis are cut or blocked through a small puncture or incision in the scrotum.</p>	Permanent	Very effective
<p>Female sterilization (tubal ligation)</p> <p>Permanent surgical sterilization for women who do not want more children. The two fallopian tubes that carry eggs from the ovaries to meet sperm are cut or blocked through a surgical procedure.</p>	Permanent	Very effective

OTHER REVERSIBLE METHODS (SHORTER-ACTING METHODS)		
<p>These methods need ongoing interaction with health services, ongoing medical supplies and/or medical interventions for continued use.</p> <ul style="list-style-type: none"> • These methods can provide effective contraception but require user action, such as regular clinic visits, remembering, correct and consistent use, and resupply of commodities. • These methods are reversible, meaning that future pregnancies are possible. • These methods can also be used long term for preventing pregnancy. 		
	Duration of effectiveness?	How effective as commonly used*?
<p>Monthly combined injectable contraceptive (CIC)</p> <p>This injection contains two hormones, a progestin and an oestrogen, and is given into the muscle every month.</p>	Injection every month	Effective
<p>Progestin-only injectables: 3-monthly depot medroxyprogesterone acetate (DMPA) injectable, intramuscular or subcutaneous (DMPA SC; Sayana Press); 2-monthly norethisterone enanthate (NET-EN) injectable, intramuscular.</p> <p>These injections, which contain a progestin hormone, are administered into the muscle. With a new formulation of DMPA SC, the injection is given just under the skin.</p>	Injection every 2 or 3 months	Effective
<p>Combined oral contraceptive (COC) pills</p> <p>Pills that contain low doses of two hormones, a progestin and an oestrogen.</p>	Take pill daily	Effective
<p>Progestin-only oral contraceptive pills (POP)</p> <p>Pills that contain very low doses of a progestin hormone.</p>	Take pill daily	Effective
<p>Contraceptive vaginal ring</p> <p>A flexible ring that a woman places in her vagina, which continuously releases two hormones, a progestin and an oestrogen. She leaves the ring in place for 3 weeks and then removes it for the fourth week.</p>	New ring needed every 4 weeks	Effective
<p>Contraceptive patch</p> <p>A small, thin square of flexible plastic worn on the body, which continuously releases two hormones, a progestin and an oestrogen. The woman puts on a new patch every week for 3 weeks and then no patch for the fourth week.</p>	New patch needed every week	Effective
<p>Condoms, male and female</p> <p>Sheaths that fit over a man's erect penis, usually made of latex. Sheaths with flexible rings at both ends that fit loosely inside a woman's vagina, made from various materials, such as latex and polyurethane. Male and female condoms help protect against sexually transmitted infections, as well as pregnancy.</p>	Must be used consistently and correctly with each sex act	Moderately effective to less effective
EMERGENCY CONTRACEPTION		
<p>Oral emergency contraceptive pills (ECPs)</p> <p>Sometimes called post-coital contraception, ECPs can help prevent pregnancy when taken up to 5 days after unprotected sex. Several options can be used as ECPs: dedicated EC products, progestin-only pills and combined oral contraceptives.</p>		
<p>Emergency Cu-IUD</p> <p>Highly effective as emergency contraception. Can provide ongoing long-term pregnancy protection if inserted for emergency contraception.</p>		

Source: adapted from WHO Family planning/contraception (2018) [30,41]

* "As commonly used" means how the method is used under real-life, day-to-day conditions experienced by average users (assuming occasional non-use and/or incorrect use).

REFERENCES

- 1 World Health Organization. Family Planning 2008. http://www.who.int/topics/family_planning/en/ (accessed April 20, 2020).
- 2 World Health Organization. Providing contraceptive services in the context of HIV treatment programmes. Implementation Tool 2019. <https://apps.who.int/iris/bitstream/handle/10665/325859/WHO-CDS-HIV-19.19-eng.pdf?ua=1> (accessed April 20, 2020).
- 3 Chola L, McGee S, Tugendhaft A, Buchmann E, Hofman K. Scaling Up Family Planning to Reduce Maternal and Child Mortality: The Potential Costs and Benefits of Modern Contraceptive Use in South Africa. *PLoS One* 2015;10:e0130077–e0130077.
- 4 World Health Organization. Consolidated guideline on sexual and reproductive health and rights of women living with HIV 2017. <https://apps.who.int/iris/bitstream/handle/10665/254885/9789241549998-eng.pdf> (accessed April 20, 2020).
- 5 World Health Organization. WHO consolidated guideline on self-care interventions for health: sexual and reproductive health and rights 2019. <https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf?ua=1> (accessed April 20, 2020).
- 6 World Health Organization. WHO recommendations on adolescent, sexual and reproductive health and rights. 2018. <https://apps.who.int/iris/bitstream/handle/10665/275374/9789241514606-eng.pdf> (accessed April 20, 2020).
- 7 Reynolds HW, Janowitz B, Wilcher R, Cates W. Contraception to prevent HIV-positive births: current contribution and potential cost savings in PEPFAR countries. *Sex Transm Infect* 2008;84 Suppl 2:i49–53.
- 8 Reynolds HW, Janowitz B, Homan R, Johnson L. The value of contraception to prevent perinatal HIV transmission. *Sex Transm Dis* 2006;33:350–6.
- 9 IATT M&E WG. Global Monitoring Framework and Strategy for the Global Plan towards elimination of new HIV infections among children by 2015 and keeping their mothers alive (EMTCT) 2012. http://srhivlinkages.org/wp-content/uploads/2013/04/global_plan_me_frame_en.pdf (accessed March 16, 2020).
- 10 WHO. Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infections. Recommendations for a Public Health Approach. 2016 n.d. http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf?ua=1 (accessed May 7, 2020).
- 11 World Health Organization. Quality of care in contraceptive information and services, based on human rights standards: a checklist for health care providers. 2017. <http://apps.who.int/iris/bitstream/10665/254826/1/9789241512091-eng.pdf?ua=1> (accessed May 4, 2020).
- 12 World Health Organization. Ensuring human rights in the provision of contraceptive information and services 2014. https://apps.who.int/iris/bitstream/handle/10665/102539/9789241506748_eng.pdf?sequence=1 (accessed April 20, 2020).
- 13 World Health Organization. Emergency contraception: factsheet 2018. <https://www.who.int/news-room/fact-sheets/detail/emergency-contraception> (accessed April 20, 2020).
- 14 World Health Organization. Medical eligibility criteria for contraceptive use. 5th ed. 2015. https://apps.who.int/iris/bitstream/handle/10665/181468/9789241549158_eng.pdf?sequence=9 (accessed April 20, 2020).
- 15 Clinton Health Access Initiative. Family Planning Market Report 2018. https://www.clintonhealthaccess.org/wp-content/uploads/2019/01/2018_CHAI_Family_Planning_Market_Report.pdf (accessed April 20, 2020).
- 16 Feyissa TR, Harris ML, Melka AS, Loxton D. Unintended Pregnancy in Women Living with HIV in Sub-Saharan Africa: A Systematic Review and Meta-analysis. *AIDS Behav* 2019;23:1431–51.
- 17 Adeniyi OV, Ajayi AI, Moyaki MG, Goon D Ter, Avramovic G, Lambert J. High rate of unplanned pregnancy in the context of integrated family planning and HIV care services in South Africa. *BMC Health Serv Res* 2018;18:140.
- 18 Sutton MY, Zhou W, Frazier EL. Unplanned pregnancies and contraceptive use among HIV- positive women in care. *PLoS One* 2018;13:e0197216.
- 19 O'Shea MS, Rosenberg NE, Tang JH, Mukuzunga C, Kaliti S, Mwale M, et al. Reproductive intentions and family planning practices of pregnant HIV-infected Malawian women on antiretroviral therapy. *AIDS Care* 2016;28:1027–1034.
- 20 Schwartz SR, Rees H, Mehta S, Venter WDF, Taha TE, Black V. High incidence of unplanned pregnancy after antiretroviral therapy initiation: findings from a prospective cohort study in South Africa. *PLoS One* 2012;7:e36039–e36039.
- 21 Sarnquist CC, Rahangdale L, Maldonado Y. Reproductive health and family planning needs among HIV-infected women in Sub-Saharan Africa. *Curr HIV Res* 2013;11:160–8.
- 22 Family Planning 2020. FP2020 Progress Report 2019. http://progress.familyplanning2020.org/sites/default/files/FP2020_2019Report_FINAL_110819.pdf (accessed April 20, 2020).
- 23 Mayondi GK, Wirth K, Morroni C, Moyo S, Ajibola G, Diseko M, et al. Unintended pregnancy, contraceptive use, and childbearing desires among HIV-infected and HIV-uninfected women in Botswana: a cross-sectional study. *BMC Public Health* 2016;16:44.
- 24 Antelman G, Medley A, Mbatia R, Pals S, Arthur G, Haberlen S, et al. Pregnancy desire and dual method contraceptive use among people living with HIV attending clinical care in Kenya, Namibia and Tanzania. *J Fam Plan Reprod Health Care* 2015;41:e1–e1.
- 25 Alene KA, Atalell KA. Contraceptive use and method preference among HIV-positive women in Amhara region, Ethiopia. *BMC Womens Health* 2018;18:97.
- 26 McCoy SI, Buzdugan R, Ralph LJ, Mushavi A, Mahomva A, Hakobyan A, et al. Unmet need for family planning, contraceptive failure, and unintended pregnancy among HIV-infected and HIV-uninfected women in Zimbabwe. *PLoS One* 2014;9:e105320–e105320.
- 27 Anam F, Chung C, Dilmitis S, Kenkem C, Matheson-Omond R, Moroz S, et al. Time to realise our sexual and reproductive health and rights. *Lancet Glob Heal* 2018;6:e1064–5.
- 28 Zash R, Makhema J, Shapiro RL. Neural-Tube Defects with Dolutegravir Treatment from the Time of Conception. *N Engl J Med* 2018;379:979–81.
- 29 Inter-Agency Working Group on SRH and HIV Linkages. SRHR and HIV Linkages: Navigating the work in progress 2017 2017. http://index.srhivlinkages.org/docs/IAWG_navigating-the-work-in-progress-2017.pdf (accessed May 8, 2020).
- 30 World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP) Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 edition) 2018. <http://apps.who.int/iris/bitstream/10665/260156/1/9780999203705-eng.pdf?ua=1> (accessed April 20, 2020).
- 31 Hoke TH, Wheeler SB, Lynd K, Green MS, Razafindravony BH, Rasamihajamanana E, et al. Community-based provision of injectable contraceptives in Madagascar: 'task shifting' to expand access to injectable contraceptives. *Health Policy Plan* 2011;27:52–9.
- 32 Bertrand JT, Makani PB, Hernandez J, Akilimali P, Mukengeshayi B, Babazadeh S, et al. Acceptability of the community-level provision of Sayana(R) Press by medical and nursing students in Kinshasa, Democratic Republic of the Congo. *Contraception* 2017;96:211–5.
- 33 Mwembo A, Emel R, Koba T, Sankoko JB, Ngay A, Gay R, et al. Acceptability of the distribution of DMPA-SC by community health workers among acceptors in the rural province of Lualaba in the Democratic Republic of the Congo: a pilot study. *Contraception* 2018;98:454–9.
- 34 Burke HM, Mueller MP, Packer C, Perry B, Bufumbo L, Mbengue D, et al. Provider acceptability of Sayana(R) Press: results from community health workers and clinic-based providers in Uganda and Senegal. *Contraception* 2014;89:368–73.
- 35 Burke HM, Mueller MP, Perry B, Packer C, Bufumbo L, Mbengue D, et al. Observational study of the acceptability of Sayana(R) Press among intramuscular DMPA users in Uganda and Senegal. *Contraception* 2014;89:361–7.
- 36 Kohn JE, Simons HR, Della Badia L, Draper E, Morfesis J, Talmont E, et al. Increased 1-year continuation of DMPA among women randomized to self-administration: results from a randomized controlled trial at Planned Parenthood. *Contraception* 2018;97:198–204.
- 37 Dragoman M V, Gaffield ME. The safety of subcutaneously administered depot medroxyprogesterone acetate (104 mg/0.65 mL): A systematic review. *Contraception* 2016;94:202–15.
- 38 Family Planning 2020. FP2020 Countries n.d. <http://www.familyplanning2020.org/countries> (accessed April 20, 2020).
- 39 Jaccard J, Levitz N. Counseling adolescents about contraception: towards the development of an evidence-based protocol for contraceptive counselors. *J Adolesc Health*. 2013;52(4 Suppl):S6–13.
- 40 World Health Organization. Postpartum Family Planning Compendium n.d. <http://srhr.org/postpartumfp> (accessed April 20, 2020).
- 41 World Health Organization. Family planning/Contraception 2018. <https://www.who.int/news-room/fact-sheets/detail/family-planning-contraception> (accessed April 20, 2020).