IMPLEMENTATION BRIEF

INTEGRATION OF HIV TESTING AND LINKAGE IN FAMILY PLANNING AND CONTRACEPTION SERVICES

OCTOBER 2021

World Health Organization

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ABBREVIATIONS

ART	antiretroviral therapy
FP	family planning
HIVST	HIV self-testing
HTS	HIV testing services
ICPA	Independent Community Pharmacy Association
IPPF	International Planned Parenthood Federation
NDOH	National Department of Health
PDSA	plan-do-study-act
PIN	personal identification number
PITC	provider-initiated testing and counselling
PrEP	pre-exposure prophylaxis
SRHR	sexual and reproductive health and rights
STAR	HIV Self-Testing Africa (STAR) Initiative
STI	sexually transmitted infection
UHC	universal health coverage
URL	uniform resource locator
WHO	World Health Organization

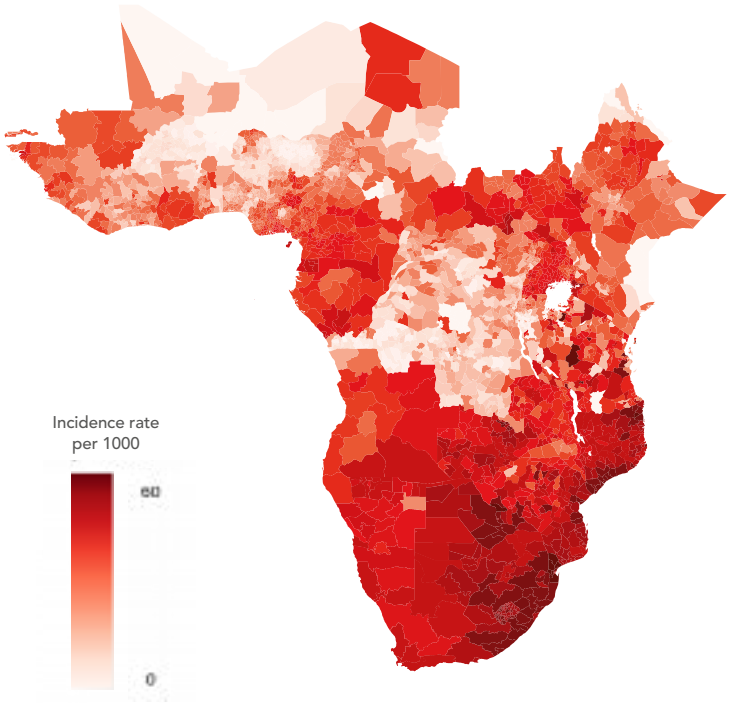
1. BACKGROUND AND OBJECTIVES

1.1. BACKGROUND

In parts of east and southern Africa, approximately 60% of new HIV infections are among women[1] and girls of all ages. In this region adolescent girls and young women (ages 15–24) account for one quarter of new infections, even though they constitute only 10% of the population and are three times more likely to acquire HIV infection than male peers their own age, *(1, 2)* (Fig. 1). At the same time, as many as one quarter of adolescent girls and young women in sub-Saharan Africa use modern contraception, and contraceptive prevalence is even higher in high HIV burden countries such as Lesotho (59.2%), Zimbabwe (50.7%) and Kenya (36.8%) *(3)*. While family planning (FP) service coverage needs to expand to reduce unmet need, current FP service coverage in high HIV burden countries suggests that FP services may be an important venue for reaching adolescent girls and young women with HIV testing and linkages to prevention and treatment for those at high ongoing risk.

Concrete action is required, particularly in these regions, to expand coverage of services for FP, HIV testing and linkage to HIV prevention and treatment for women and adolescent girls. Where HIV burden is high, family planning clients should be routinely offered HIV testing and HIV prevention options in addition to a choice of contraceptive methods (Appendix 1) *(4)*. Integrated FP and HIV testing services (HTS) can be implemented through a variety of provider-delivered and self-testing modalities. In particular, HIV self-testing (HIVST) is emerging as a convenient, effective and feasible way to integrate HIV testing into FP services in health facilities, pharmacies and communities.

Fig. 1. HIV incidence among adolescent girls and young women ages 15 to 24 years, subnational levels sub-Saharan Africa, 2019



Source: UNAIDS epidemiological estimates, 2020.
Note: HIV incidence estimated as new HIV infections per 1000 person-years at risk. Countries: For selected countries in sub-Saharan Africa that had the data required to produce subnational HIV estimates.

A growing emphasis on universal health coverage (UHC) enhances opportunities to integrate FP services and HTS (Box 1).

Box 1. Universal health coverage framework: opportunities for integration in FPs

Universal health coverage (UHC) is an essential framework to promote healthy lives and well-being for all people (Sustainable Development Goal 3). As countries define their UHC policies and programmes, there is a unique opportunity to ensure that UHC efforts deliver person-centred care and include interventions for sexual and reproductive health and rights (SRHR) that are grounded in evidence and based on principles of gender equality and equity of access. UHC and person-centred models can be complementary and emphasize integration, coordination, equity in access, care without discrimination or coercion, choice and being treated with dignity and respect. Improving the health of women and adolescents, including their SRHR, is at the centre of UHC's broad health and development goals and critical to their achievement.

As programmes co-deliver HTS and FP within UHC platforms, there are opportunities to:

- expand FP service packages to encompass FP, HIV testing, HIV prevention including pre-exposure prophylaxis (PrEP), referral to HIV treatment, sexually transmitted infection (STI) screening and treatment and services for gender-based violence;
- tailor service packages to better serve priority populations, including adolescent girls, young women and sex workers;
- deliver integrated HIV services within FP services in areas of high HIV incidence and prevalence, where they are most needed.

[1] All individuals have the right to equality and non-discrimination in sexual and reproductive health care. In this implementation brief, we recognize that most of the available evidence on family planning services is based on study populations of cisgender women, and we also recognize that cisgender women, transgender men, non-binary, gender fluid and intersex individuals born with a female reproductive system have the right to access family planning services. However, to be concise and facilitate readability, we use the term "women" to refer to all gender diverse people needing family planning and contraceptive services. Sexual and reproductive health service providers, family planning and HIV services must consider the needs of – and provide equal care to – all individuals independently of gender identity or its expression.

1.2. OBJECTIVES AND INTENDED AUDIENCE

This implementation brief addresses integration of HTS into FP services (see Box 2 for definitions). It is intended as a practical resource for national health programmes seeking to introduce or scale up HIV testing and linkage to HIV prevention, STI, and antiretroviral therapy (ART) services in FP. The World Health Organization (WHO) publication *Providing contraceptive services in the context of HIV treatment programmes (5)* describes considerations for delivering family planning to women living with HIV within HIV services. This and other useful resources are presented in Appendix 2. This document highlights emerging good practices and country experiences of integrated HIV prevention and testing services within FP and advocates for increased linkage for FP clients to HIV services according to their needs. It also brings together information on models of integration of HIV testing into FP services, programme examples from east and southern Africa and guidance on the implementation monitoring process.

Box 2. Key definitions

Family planning

Family planning (FP) enables individuals and couples to plan for and attain their desired number of children and to space and time births, achieved through use of contraceptive methods. The term "FP services" encompasses all services that deliver contraceptives and infertility treatment, including contraception for adolescent girls and young women.

The terms family planning and contraception are often used interchangeably. In this brief we use the term family planning, which is frequently used in eastern and southern Africa, where implementation of integrated FP and HIV testing services is most urgent. However, many women, particularly young women and adolescent girls, come to FP services for contraception to prevent an immediate pregnancy and not to plan a family.

HIV testing services

The term HIV testing services (HTS) encompasses a range of services that should be provided together with HIV testing. These include brief pre-test information; post-test counselling; voluntary provider-assisted referral (index testing); linkage to appropriate HIV prevention, care and treatment services and other clinical and support services; and coordination with laboratory services to support quality assurance. HTS may be delivered by providers, through self-testing and through partner-delivered approaches in health facilities and community settings.

HIV self-testing

HIV self-testing (HIVST) is a testing modality where a person collects their own specimen (oral fluid or blood) and then performs an HIV test and interprets the result, often in a private setting, either alone or with someone they trust.

1.3. CONTRACEPTIVE CHOICES FOR WOMEN AT HIGH RISK OF HIV

All contraceptive methods, with the exception of spermicides containing nonoxynol-9,[1] are safe for people at high risk of HIV acquisition. This includes both hormonal methods (combined estrogen and progestogen or progestogen-only) and nonhormonal methods. WHO's 2019 publication, *Contraceptive eligibility for women at high risk of HIV (6)*, presents updated and comprehensive considerations, clarifications and evidence. WHO recommends that, in high HIV burden settings, testing for HIV be made available for all women at FP services *(4, 6, 7)*. Integrating HIV testing into FP services presents an opportunity to reach both women with undiagnosed HIV and link them to ART and to link women at high risk of HIV to prevention services and options (Box 3).

[1] Repeated and high-dose use of nonoxynol-9 spermicide has been found to be associated with increased risk of genital lesions, which may increase the risk of acquiring HIV (see *Family planning: a global handbook for providers* (2018 edition), Chapter 16, Question 3, p. 286). For this reason, the MEC category for spermicides and diaphragms is Category 4 (that is, "Method not to be used") for women who are at high risk of acquiring HIV (see *Family planning: a global handbook for providers*, Appendix D: Medical Eligibility Criteria for Contraceptive Use, p. 398).

Box 3. Why integrate sexual and reproductive health services and HIV services?

A sharper focus on linkage and integration of sexual and reproductive health and rights (SRHR) and services, on one hand, and HIV services, on the other, supports joint achievement of two crucial health outcomes. Research shows that SRHR and HIV linkages result in:

- higher HIV testing coverage
- more consistent condom use
- improved quality of care
- better use of scarce human resources for health
- reduced HIV-related stigma and discrimination
- improved coverage, access to and uptake of both SRH and HIV services for at risk, vulnerable and key populations, including people living with HIV.

SRHR/HIV linkages offer bidirectional synergies in policy, programmes and service delivery that support the SRH needs and rights of all people, including people living with HIV, within a framework of gender equality and human rights.

SRHR/HIV integration is a subset of SRH/HIV linkages that take place at the service delivery level and join operational programmes to ensure effective outcomes through multiple modalities (multi-tasked providers, referral, both services under one roof, etc.).

Source: Adapted from https://www.who.int/reproductivehealth/topics/linkages/srhr-hiv/en/

1.4. HIV TESTING SERVICES

HTS comprises a package of diagnostic, support and linkage services. The *WHO Consolidated guidelines on HIV testing services*, 2019 *(4)*, provides comprehensive information and recommendations on how programmes can identify and offer a strategic mix of differentiated facility- and community-based HTS options. In high HIV burden settings, WHO recommends routine-offer of HIV testing to clients in clinical services (also known as provider-initiated testing and counselling (PITC) *(4)*. This approach, alongside the scaling up of HIVST and lay-provider testing, has increased testing coverage *(8–10)*. HIV testing is also frequently offered in non-clinical settings in communities, such as workplaces, bars, clubs, pharmacies and faith communities, where it is delivered by trained professional health or lay providers, or though peers and vending machines that distribute HIVST kits.

2. MODELS FOR INTEGRATING HTS INTO FP SERVICES

FP–HTS integration presents the opportunity to deliver services, education and counselling for women of reproductive age through primary health care platforms and providers and in health facilities, communities and retail settings. It may be implemented as a combined package in the same room with the same provider (one-stop-shop approach) or through referrals between providers within a facility (supermarket approach) or at different facilities. FP–HTS also can be delivered virtually through online platforms that connect users to health facilities or pharmacies or that deliver self-care options by mail. While the objectives may be similar for each type of integration, the approaches and outcomes may be different.

A range of testing modalities and approaches can be used to integrate HTS into FP services (Fig. 2). Integrated FP and HTS service packages involve clinic staff or lay providers sharing pre- and post-test information, administering and interpreting rapid tests or distributing HIVST kits to clients and their partners, and linking people to prevention or treatment as appropriate to their test results. Practical approaches for integrating HTS into FP services are emerging. This section presents five short examples of programmes that are delivering contraception, HIV testing and other services in an integrated manner (Boxes 4–8). While each service may not be comprehensive, together they showcase a range of real-world integration models that are evolving and adapting to better serve women and girls.

Fig. 2. Models for integrated family planning and HIV testing

Health facility-based FP and HIV testing

In health facilities HTS can be offered routinely to FP clients through provider-delivered or self-testing options.

HIVST kits can be offered in waiting rooms for FP clients to test on-site or take home. Clients who use HIVST on-site may discuss results as well as prevention, diagnosis, treatment, partner services and linkage options with their FP provider. Clients may take HIVST kits home to share with partners (see also secondary distribution).

Provider-delivered HIV tests are offered to FP clients by providers during FP consultations. Clients who are tested for HIV by an FP provider on-site may discuss results, as well as prevention, diagnosis, treatment, partner services and linkage options.

See Boxes 4, 5 and 6 for implementation examples.

Community-based FP and HIV testing

Community-based FP and HTS can be delivered through provider-delivered or HIVST options. Where FP outreach and community-based HIV testing services are already underway in parallel, partnerships between programmes to co-deliver FP and HIV testing could improve efficiency and optimize resource use. Regardless of testing modality, linkage to prevention, treatment and partner services can be offered to all clients.

See Boxes 5 and 8 for implementation examples.

Retail-based FP and HIVST distribution

HIVST kits can be distributed by pharmacists or in vending machines to clients who are picking up contraception. Women receiving HIVST kits can be offered information and support through virtual interventions including helplines, chat-bots and linkage services.

See Boxes 7 and 8 for implementation examples.

Virtual interventions to support access to FP and HIV testing

Virtual interventions including websites, apps, chat-bots and social networks that can be used to:

- link users to facility-based services for FP and HIVST
- link users to community or retail-based FP services and HIVST
- deliver informative and motivational messages and linkage support
- order mail delivery of HIVST or self-sampling kits.

See Box 7 for implementation example.

Secondary distribution: FP clients can pick up HIVST kits to share with partners

At health-facility and in community-based settings, FP clients can receive HIVST kits to share with partners. Information, support and linkages can be delivered through virtual interventions including helplines and chat-bots.

See Box 4 for implementation example.

2.1. FACILITY- AND COMMUNITY-BASED DELIVERY OF FP AND HTS, INCLUDING HIVST

HIVST is a process in which people collect their own specimens (oral fluid or blood), perform a simple rapid HIV test and interpret their results *(11)*. HIVST has emerged as an important confidential and convenient testing option for people who would not otherwise test as well as those who find this self-care option more convenient *(4)*. Both facility- and community-based approaches can be used to distribute HIVST kits. Further, clients can take kits and give them to sex or drug-injecting partners and to social contacts of members of key populations.[1] When HIVST kits are distributed in clinical settings, the client can perform the test in a designated private space on-site while waiting to be seen by a health care worker and then have the opportunity to discuss the results and receive further testing if needed. Alternatively, clients and partners can take HIVST tests at home or elsewhere outside the health facility. FP programmes in Zimbabwe (Box 4) and Uganda (Box 5) have integrated PITC with both HIVST and provider-delivered testing, and in South Africa public primary care clinics that offer FP services have started distributing HIVST kits (Box 6).

Box 4. Integrated contraception, HIV testing and PrEP in Zimbabwe family planning clinics

In 2019 clinics in the Zimbabwe National Family Planning Council (ZNFPC) network offered clients HTS in the same facility as FP and STI management, but separately and by different providers. In the following year, the Government of Zimbabwe began to fully integrate FP/contraception, STI management and HIV services, including testing (provider-administered and HIVST) and pre-exposure prophylaxis (PrEP) at participating clinics. To develop the new model, the Ministry of Health and Child Care (MOHCC) and WHO formed a multi-agency team. The team of decision-makers, managers and health care workers visited FP clinics to review staffing, client flow and service delivery data and then developed and introduced a modified service delivery protocol.

FP staff were trained to counsel and link FP clients receiving HIVST kits to appropriate services. The approach was pilot-tested in October 2020. In one site, Spillhaus clinic in Harare, HIV testing uptake among FP clients increased from less than 0.5% of clients to 64% during the first quarter of implementation. Clients were offered provider-administered HIV testing or HIVST kits to take home for themselves and their partners. Of the FP clients who accepted HIV testing during the implementation period, one quarter of clients who tested for HIV chose HIVST. The project demonstrated improved service uptake and client satisfaction by having all their SRHR services provided by the same cadre of health workers. The approach is now being scaled up nationally.

Source: Zimbabwe Ministry of Health and Child Care and ZNFPC
Funding: WHO and Children Investment Fund Foundation

Box 5. Integrated community- and facility-based contraception and HIV services for sex workers, migrants and young people in Uganda

The Moon Light Star Clinic delivers integrated HIV and contraceptive services to an urban population that includes sex workers, migrants and young people in Bwaise, a neighbourhood in Kampala. Reproductive Health Uganda (RHU), an affiliate of the International Planned Parenthood Federation (IPPF), introduced this evening outreach services to coincide with the working hours of clinic clients. Trained peer educators and community-based lay providers work together with RHU nurses to deliver integrated FP/contraception, STI management, cervical cancer screening and HIV testing services and to facilitate linkage to antiretroviral treatment and pre-exposure prophylaxis (PrEP). A peer-network referral generates demand for services.

During each visit, clients are offered a range of contraceptives, STI management and cervical cancer screening, which serve as entry points to raise awareness and promote the routine offer of provider-administered HIV testing and information about PrEP. In 2019 the Bwaise clinic delivered integrated community- and facility-based services to 218 197 clients; with contraception delivered to 35 177 clients and HIV testing provided to 61 302 clients.

The strength of the clinic is rooted in the collaboration and engagement of the community, including sex workers, to generate demand for and improve the quality of services. Activities aimed at building and maintaining service quality are prioritized. These include monthly meetings for clinic staff and administrators with peer educators to discuss performance, emerging issues, challenges and success stories and partnering with public health institutions and community-based organizations.

Source: Reproductive Health Uganda
Funding for RHU's HIV testing: International Planned Parenthood Federation (IPPF), Danish International Development Agency (DANIDA), Rutgers, and Danish Family Planning Association

[1] Key populations include men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people.

Box 6. Facility-based distribution of HIVST at primary health care clinics in South Africa

Despite major efforts to increase PITC services in South Africa, not all those eligible take advantage of testing services. Multiple factors limit PITC: insufficient staffing, constraints on health workers' time, busy and overcrowded clinics, stigma and discrimination and limited preparedness of clients to accept facility-based HIV testing. To provide a more accessible option, the South Africa National Department of Health, with support from the HIV Self-Testing Africa (STAR) Initiative, has integrated HIVST into public-sector health facilities, providing on-site HIV self-testing options to clients attending outpatient primary care services, which also offer family planning and other SRH services.

Clients, including, adolescent girls and young women, ages 15–24 years, can receive contraception and other SRH services and medical abortion services at no cost at public-sector health facilities. In Ekurhuleni, East Rand region of Gauteng, where HIVST was introduced in 2019, these clients constituted an estimated 35% of female outpatients and about 25% of all outpatients who were offered HIVST. Offering HIVST when these women were seeking FP and SRH services provided opportunities to increase HIV testing coverage in a group with high HIV incidence. An estimated 10% of those reached had never tested before for HIV.

To maintain HIV testing services, integration of HIVST was accelerated during the COVID-19 lockdown in March–May 2020. In this public sector model, family planning clients are offered the opportunity to self-test for HIV on-site, using either an oral fluid test or a finger prick test. Private booths, tents and counters are set up for clients to test themselves while waiting for their appointments with doctors or nurses, and people can also take self-test kits home for use off-site. Clients with reactive HIVST results receive HIV testing according to the South Africa testing algorithm and are referred for ART initiation at the same facility.

Pre and post data from selected facilities in Ekurhuleni show that HIV testing coverage among eligible clients increased from 20% to over 70%. Introduction of HIVST increased the numbers of eligible clients who received testing for HIV, and the number of HIV-positive cases identified increased by 30%.

Source: PSI/STAR
Funding: Unitaid

2.2. VIRTUAL INTERVENTIONS TO SUPPORT LINKAGE TO CONTRACEPTION AND HIV TESTING

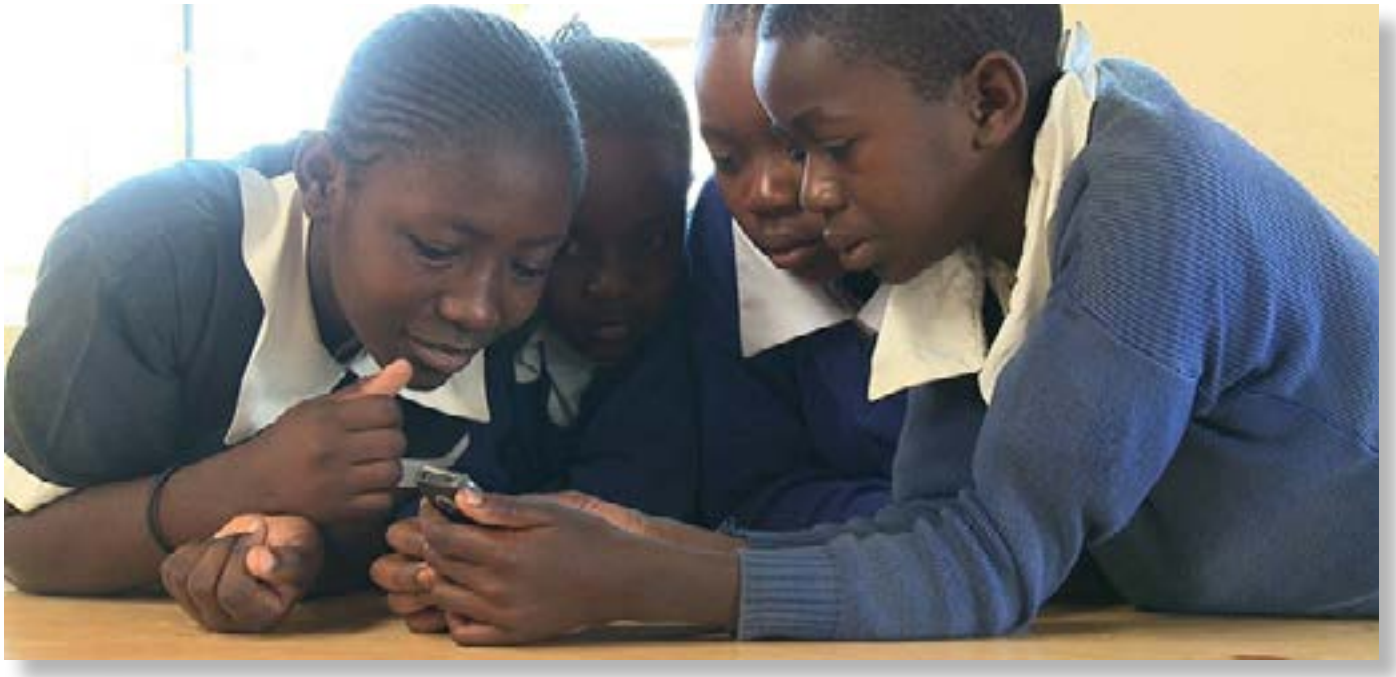
Virtual tools such as smartphone apps and websites may be used to connect users to contraceptives and HIVST, especially among populations not adequately reached by existing services, such as adolescent girls and young women, or as part of focused outreach to members of key populations. Many HIVST service delivery models are feasible; online ordering, mail delivery and facility-based distribution are all demonstrated delivery mechanisms *(8)*. When multiple types of services are offered virtually, delivery of those services may not necessarily be integrated. Instead, people can receive health information and then be linked to contraception and HIV testing options of their choice. In Kenya Triggerise, a nongovernmental organization, launched such an app-based approach to deliver contraception and HTS to adolescent girls in urban settings (Box 7).

Box 7. Integrating HIVST into digital platform for delivering contraception to adolescent girls in Kenya

In Their Hands is a programme that delivers quality-assured information on contraception and HIV testing and links people to services in Kenya through a mobile phone app called Tiko. The programme, developed by Triggerise, connects adolescent girls and women with health service providers, community mobilizers and local pharmacies. Users can choose contraception and HIV testing services offered by a network of subsidized private-sector providers including pharmacies. After receiving services, users can rate the services and provide anonymous feedback to providers. Since 2017 over 400 000 adolescents have joined the platform and accessed more than 250 000 sexual and reproductive health and HIV services.

HIVST was incorporated into the In Their Hands package in April 2019, enabling Tiko users to obtain free HIVST kits as well as a range of contraceptives, including long-acting methods. In line with Kenya HIVST guidelines, women of 18 and 19 years of age can pick up HIVST kits at pharmacies, while those under age 18 are linked to clinics for testing supported by a provider. Clients with reactive self-test results are linked to a clinic that provides comprehensive HIV testing, treatment and support services. Clients with nonreactive self-test results and clients who access only FP services receive HIV prevention information. In total 32 206 girls obtained HIVST through the Tiko platform between 1 April 2019 and 31 January 2021. Of these, 77% also took up a contraceptive method. Most who took both HIVST and a contraceptive chose oral contraceptives (10 003), followed by implants (8379) and injectables (4112). The majority of girls – 78% – took both HIVST and contraceptives on the same day, while 22% took HIVST on one visit, followed by contraception on a later visit.

Source: Triggerise (https://triggerise.org/)
Funding: CIFF and the Netherlands Ministry of Foreign Affairs (MIMBUZA)



2.3. PRIVATE-SECTOR DISTRIBUTION OF CONTRACEPTION AND HIVST

Experience shows that people find many different HIVST service delivery models suitable. Many of these approaches can involve community-based and private-sector distribution – for example, from pharmacies, vending machines, pick-up from a local shop, peer-based distribution, community-based distribution and online ordering with mail delivery *(8)*. In South Africa the National Department of Health, with support from the STAR Initiative, has launched community pharmacy-based distribution of free HIVST kits and condoms, with a focus on delivering test kits to clients seeking contraception and emergency contraception (Box 8).

Box 8. HIVST kit distribution to young women seeking contraception and emergency contraception at community pharmacies in South Africa

In South Africa community pharmacies are readily accessible in both urban and rural areas. Many people obtain medicines, information about medication and counselling on medical care at these pharmacies. In fact, during COVID-19 business closures, pharmacies, along with grocery shops, offered the only opportunity to buy essential items, masks, condoms and other contraceptives.

In 2019 the Self-Testing Africa Initiative (STAR), in collaboration with the National Department of Health (NDOH) and the Independent Community Pharmacy Association (ICPA), introduced distribution of free HIVST kits over-the-counter to pharmacy clients at 10 pharmacies in Gauteng Province. This initiative was then scaled up to 100 pharmacies across all nine South African provinces in April 2020, during the COVID-19 pandemic. The implementation team identified pharmacies in HIV hot spot areas to reach high-risk populations, including adolescent girls and young women in transactional relationships.

Pharmacists were trained to promote HIVST kits and demonstrate their use. HIVST kits are promoted to clients obtaining contraceptives, including condoms, lubricants and emergency contraceptives, and STI treatment. They explain how to conduct the self-test and how to link to post-test support, including confirmatory HIV testing, treatment and prevention services, through an interactive digital chatbot accessible via WhatsApp or through referral information on a printed card. Also, they collect contact details for voluntary follow-up by community-based organizations.

The pharmacies distributed some 110 200 HIVST kits between January 2019 and June 2020, with distribution increasing since the COVID-19 business closures started in April 2020. Just under 10% of the HIVST kits were distributed to women ages 15–24 years, and about 30% were distributed to women ages 25–49 years.
To further increase convenience and access to HIVST, pharmacies are currently testing vending machines where contraception is available that are placed in pharmacies at hotspots and in areas of high foot traffic. Clients obtain unique and anonymous personal identification numbers (PIN) through a Uniform Resource Locator (URL). Entering the PIN code into the vending machine yields a free HIVST kit. Clients who choose to be followed up are contacted through the chatbot, which will guide them through the self-testing process and provide referral and linkage to post-test services including support, PrEP and ART.

© PSI

Source: PSI/STAR
Funding: Unitaid

3. IMPLEMENTATION CONSIDERATIONS

3.1. BUILD A COALITION OF FAMILY PLANNING AND HIV PARTNERS

Often, different departments in the ministry of health oversee hand FP services. As was often done to support integration of HIV testing and FP education into antenatal care services, a cross-area working group needs to be established to design and support delivery of integrated HTS and FP services. Buy-in from all relevant departments is critical. A first step is facilitating collaboration between the responsible staff. This collaboration is needed to jointly consider logistics, personnel, supply chain and other issues and to understand and resolve concerns, barriers and issues regarding HIV testing in FP services.

It is important to recognize that the goals for FP services and of FP providers are primarily to increase access to and coverage of contraceptive services. Adding or integrating HIV elements, where the epidemiology warrants, may be initially perceived as a distraction or not feasible in terms of staffing and resources. Although it is important to foster collaboration between FP and HIV partners, ultimately leadership and buy-in will be needed from FP providers – in the same way that the successful integration of HIV services into antenatal care was successfully achieved because it was led by those responsible for antenatal services.

3.2. ASSESS EXISTING SERVICE PROVISION TO IDENTIFY OPPORTUNITIES FOR INTEGRATION AND DEVELOP NEW OPERATIONAL MODELS

All programmes can build on existing FP essential service packages and programme partnerships to develop improved integrated packages that deliver health information, contraception and HIV services. FP services can start by integrating HIV testing in ways that complement existing FP delivery approaches and link to existing local resources, including HIV partner services, ART for those who test positive and PrEP for those who test negative. In many contexts, including where staff and/or health infrastructure are limited, distribution of HIVST kits may be the most feasible option and the quickest to implement. Where staffing and systems allow, provider-delivered testing may be introduced alongside HIVST options. Whatever the modality, a package of services that delivers information, diagnosis and linkage can be developed and delivered that enables women and girls at high risk for HIV to receive HIV testing at the same time as contraception and be linked to HIV prevention or treatment services.

Successful implementation starts with careful preparation involving a coalition of family planning and HIV testing, prevention and treatment stakeholders. This coalition needs to include diverse representatives and contributors from across ministerial, technical, implementing and FP/contraception clients, including adolescents and members of key populations and their organizations, and community-based partners. This team should undertake a baseline assessment to identify:

- geographic areas and populations to prioritize for introduction of integrated testing services
- available resources in FP and HIV programme budgets, including existing or supplementary funding and health commodities
- availability and competency of health staff
- health infrastructure
- client linkage pathways
- community-based and peer networks to support linkage and demand generation
- professional development and training opportunities
- additional technical, implementing and community partners
- strategic information available from monitoring and surveillance systems and surveys.

The team can review and map available information on prevalence and incidence of HIV and STIs, including information on related risk factors and unintended pregnancies in their service delivery area, as this may vary greatly from country to country and location to location. Localized assessments would inform the contraceptive services needed in combination with HIV and STI prevention, treatment and care *(12)*. Representation of clients, including adolescent girls and women from key populations, will be critical in informing and complementing the data available.

When designing approaches for integration, programmes must consider the existing health system, the capacity of providers to deliver a comprehensive package of HTS and the needs of the clients. Stakeholders should carefully review the results of the baseline assessment to determine which models of HTS/FP integration are most appropriate for which types

of facilities and what technical and financial inputs are needed to support implementation. Facilities that already have FP and HTS services on-site but in different clinics or rooms and offered by different providers can review and consider adapting models of integration between services to improve linkage and coverage in line with programme objectives. Facilities that do not offer HTS on-site will need to plan for training, staff support and linkage with external facilities and community-based support organizations. Programme managers can revise essential service packages, training materials, monitoring and evaluation tools and communication materials to support the introduction of integration models. Where FP clinics are short-staffed, HIV programmes may strategically network trained post-test counsellors and providers from partner services to fill gaps. With an eye toward mutual programmatic benefit, financial resources, testing commodities and existing human resources from HIV programmes can be identified and leveraged to support the introduction and implementation of integrated activities into FP.

Launch of integrated service delivery should quickly follow the assessment and programme planning process. Programmes may experience challenges when embarking on integrating HTS into FP services. A landscape analysis of offering HIV testing in FP services found that some of the challenges and initial concerns shared by FP providers and clients are: lack of adequate clinic space, longer wait time due to additional services being offered, lack of trained testing providers and short supply of test kits *(13)*. Despite initial concerns many programme managers expressed confidence that integrated FP–HTS services were feasible to deliver, challenges could be overcome with support and that clients preferred and appreciated co-delivered services *(13)*.

3.3. DELIVER TARGETED PRE- AND POST-TEST SERVICES AND INFORMATION

Before and after HIV testing, people need information about HIV testing, prevention options and the benefits of treatment. Various channels and tools can be used to generate demand for HTS, deliver messages, information and counselling, including trained peer providers, videos, social media and dedicated mobile phone applications. FP services that integrate HTS can leverage these tools to ensure that clients receive pre- and post-test information. FP and HTS clinics may form networks to share tasks related to provision of information, HIV testing and post-test counselling and support, particularly for clients who test positive and need to be offered voluntary partner services.

GENERATE DEMAND FOR HTS

Generating demand for FP and HIV testing can increase service uptake, deliver information to and engage women and girls in need of FP–HTS services and may be a valuable tool for mitigating stigma and discrimination. A wide range of demand creation strategies have been rigorously tested to assess their impact on HIV testing uptake and the proportion of people diagnosed with HIV. Evidence-based platforms for delivering demand creation include peer-led approaches and virtual interventions. Approaches that have shown evidence of increasing demand for HIV testing include: advertisement of specific HTS attributes, brief key messages and counselling by providers (less than 15 minutes). messages related to risk reduction and economic empowerment, and motivational messages. FP and HIV services can work in collaboration with organizations that deliver other community-based services to design and adapt demand generation approaches according to the setting, focus population and available resources.

PRE-TEST INFORMATION

Provision of information before testing can be brief and provided to women and girls through digital communication, including videos, mobile phone chat-bots or other smart phone applications, or in person in a group session in a clinic waiting room or community outreach meeting. Lay and peer providers can deliver pre- and post-test information. WHO does not recommend individual pre-test counselling, however, all women and girls should have the opportunity to ask questions in a private setting if they request it. Family planning for adolescents and women at high risk for HIV *(7)*, a newly updated chapter of Family planning: a global handbook for providers, is a useful resource for family planning providers and includes simple counselling messages that can be used by providers as they engage clients (https://www.who.int/publications-detail-redirect/family-planning-for-adolescents-and-women-at-high-risk-for-hiv).

POST-TEST INFORMATION

All provider-delivered HIV testing must be accompanied by appropriate post-test counselling. Health staff and lay providers can present concise information to support clients, share important health messages and link people to necessary services appropriate to their test results and situations. Post-test counselling can be provided in many ways, such as one-on-one or with couples and partners, in health facilities or community settings. The Consolidated guidelines on HIV testing services and Family planning for adolescents and women at high risk for HIV *(7)* present key information messages.

All post-test messages need to emphasize the availability of contraceptive choices and the benefits of ART and PrEP. Important information for all clients is that people taking ART who are virally suppressed cannot transmit HIV to their partners.

Referral cards, peer navigators, hotlines and online support tools should be adapted or developed according to local context and used to deliver post-test messages.

Many women who seek FP/contraception in high HIV-burden settings will test negative for HIV but may still be at high ongoing risk. These HIV-negative women need information and encouragement to take up comprehensive FP and HIV prevention services, including PrEP and condoms. They need to learn what effective prevention options are available for men and women.

Women who test positive and are living with HIV need information on the health and prevention benefits of antiretrovirals and the offer of immediate ART, reduced ART side effects, follow-up visits for treatment, voluntary services that support disclosure to partners (voluntary provider-assisted referral) and comprehensive support services *(4)*. FP clinics may choose to refer clients with positive HIV test results to existing provider-assisted referral services that are operated in the same facility, in neighbouring health facilities or in community-based HTS.

LINKAGE

Linkage to prevention, partner services and provider-assisted referral, as well as treatment and care following HIV testing in FP, is a key responsibility of testing providers and programmes and essential for programmatic impact. Barriers to linkage to prevention and treatment include transportation costs, distance to facilities, stigma, fear of disclosure of HIV status or sexual activity, staff shortages and long wait times, as well as policy and legal barriers, especially for adolescents and members of key populations.

New and existing linkage services can support FP clinic staff to connect FP clients to HIV prevention and treatment services offered within and outside their clinics. Facility- and community-based HTS counsellors, partner service providers, peer navigators and community organizations can work in a coordinated way with FP services to support linkage across separate facilities. After testing and provision of post-test information, FP clinic staff can provide free male and female condoms and link women and girls to prevention, treatment and support according to their test results:

- **Clients with negative results** following provider-administered and HIVST need to be linked to HIV prevention services, including PrEP (Box 9). Nonreactive HIVST results should be considered negative, with no need for immediate further testing.

Box 9. PrEP

PrEP is an effective HIV prevention option. WHO recommends offering PrEP to anyone at substantial HIV risk, defined as being in a population that has an incidence of greater than 3 per 100 person-years. Overall, incidence in the ECHO trial in eastern and southern Africa was 4.2 per 100 person-years *(6)*. Currently, PrEP is not generally available to women at family planning clinics. However, there are sites that have begun exploring the feasibility of offering PrEP at family planning clinics. There is a strong need to increase access to PrEP for women at high risk of HIV infection, in particular in locations with high HIV incidence, as well as in sites that serve key populations.

- **Clients with positive results** after testing with a provider need to be offered referral and linkage to ART services as well as partner services, including voluntary provider-assisted referral (index case testing) to support HIV testing and support for partners and biological children (Box 10). FP clinics may use referral or linkage approaches to deliver partner services for clients.

  A variety of interventions have demonstrated benefits in improving linkage to care following an HIV diagnosis. WHO's recommendations for linkage include:
  - streamlined interventions to reduce time between diagnosis and engagement in care, including 1) enhanced linkage with case management, 2) support for HIV disclosure, 3) patient tracing, 4) staff training to provide multiple services and 5) streamlined and co-located services (*moderate-quality evidence*);
  - peer support and navigation approaches for linkage (*moderate quality evidence*).

- Clients with reactive HIVST results need to be linked to a trained testing provider for confirmatory testing and diagnosis. When an HIVST result is reactive (positive), the person needs further testing, beginning with the first test in the national testing algorithm.

  Providers distributing HIVST kits or following up with self-testers need to refer clients who disclose that they had a reactive self-test result for further testing, as well as ART or prevention services as needed (an HIV testing site, ART clinic,

Box 10. WHO recommendations and good practice statements on provider-assisted referral

WHO recommendations

Provider-assisted referral should be offered to all people with HIV as part of a voluntary comprehensive package of testing, care and prevention (*strong recommendation, moderate-quality evidence*).

Couples and partners should be offered voluntary HIV testing services with support for mutual disclosure (*strong recommendation, low-quality evidence*).

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence. If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so (*strong recommendation, indirect evidence*).

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care (*strong recommendation, indirect evidence*).

WHO good practice statements

Extending provider-assisted referral to the biological children of people with HIV may also be considered as part of a voluntary provider referral package.

Mandatory or coercive testing is never warranted. In consultation with the client, the provider should assess the risk of harm, the most appropriate approach for couple and partner testing, including more supportive options such as provider assistance, and situations that make couple or partner testing inadvisable.

Source: Consolidated guidelines on HIV testing services, 2019 *(4)*

laboratory or site serving members of a key population). These providers should encourage clients with a reactive test to go as soon as possible to such a facility for additional testing and diagnosis. Community outreach using a test for triage or supporting self-testing must make every effort to prevent loss to follow-up along the care cascade, from further testing through to diagnosis and linkage to ART, HIV prevention and other health services. They must also make sure that clients understand that a single reactive test always needs confirmation and that it does not mean an HIV-positive diagnosis.

- **Clients with non-reactive HIVST results** are considered to be HIV-negative. Counselling messages for clients with HIV-negative results are described in the clients with HIV-negative results portion of section 3.3 of this brief.

3.4. CONSIDERATIONS FOR PEOPLE AT HIGH RISK OF HIV ACQUISITION

Efforts to deliver and expand HIV testing, including through its integration with FP services, should prioritize the individuals most affected by and at high ongoing risk of HIV, including those with specific personal or structural vulnerabilities. Clients of SRHR services who face the highest HIV risk are sex workers, women who inject drugs and adolescent girls and young women (Box 11). Pregnant and postpartum women are also at elevated risk of HIV acquisition.

Box 11. Populations at high risk of HIV

While risk varies by local context and individual circumstances, the following are examples of women who are at high risk of HIV infection:

- young women (15–24 years) in sub-Saharan Africa
- young women who sell sex
- female sex workers
- women who inject drugs
- HIV-negative women with a partner living with HIV
- women who have experienced sexual violence
- transgender men (female-to-male) with childbearing reproductive organs.

SPECIAL CONSIDERATIONS FOR SEX WORKERS

Key populations, which include sex workers, are those at high ongoing risk of HIV regardless of setting. Access to contraception and to HIV testing, prevention, treatment and care is inadequate for key populations everywhere. Countries should prioritize integrated and acceptable contraception and HIV services for sex workers and reduce barriers to access. A recent study found that most sex workers were aware of a range of contraceptive options, but they faced barriers to access ranging from male partners' or clients' opposition, concerns about side effects and health system factors such as limited accessibility and clinic environments hostile to sex workers *(14)*. The experience of care, such as the way that providers treat sex workers, the availability of contraceptive methods and clinic schedules were important considerations for sex workers. Recognizing potential barriers and adapting services could improve access to and utilization of services. Provision of integrated HTS and FP services through sex worker-focused service delivery venues, such as drop-in centers, key population-led clinics and competent community-based organizations, may be preferable to female sex workers and mitigate access barriers *(15)*.

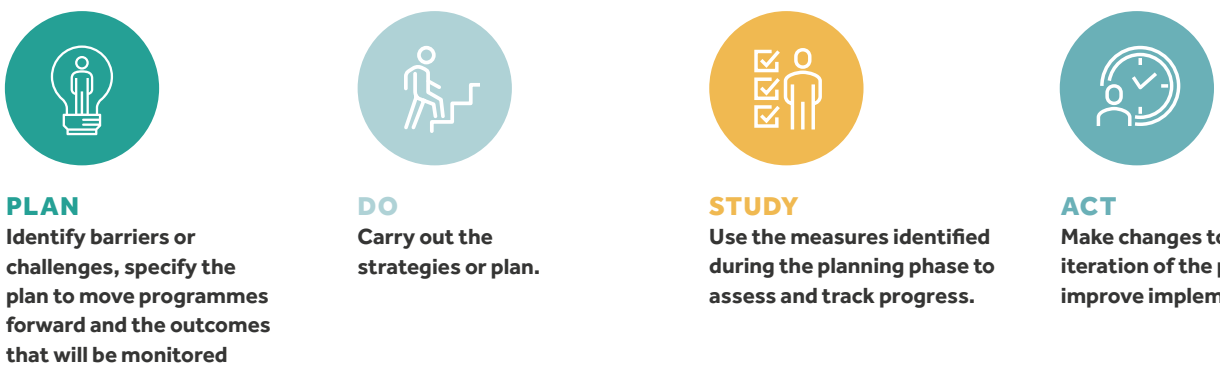
SPECIAL CONSIDERATIONS FOR ADOLESCENT GIRLS AND YOUNG WOMEN

Adolescent girls and young women remain especially vulnerable to HIV in high burden settings in east and southern Africa. Despite their risks, adolescents and young people are less likely to test for HIV than adults and are also less likely to obtain and use contraception. Age of consent policies may limit both contraception and HIV testing access for adolescents. They need to be reviewed, revised and harmonized to support adolescents' access to contraception, HIV testing and prevention. Programmes should prioritize focused, adolescent-friendly approaches to reach adolescents and young people, particularly those from key population groups. Principles of equitable service delivery and the right of access to health services and unbiased information call for structural changes that empower and enable adolescents to freely access their contraceptive and HIV prevention methods of choice as well as HIV testing and the mode of testing they prefer, including the option of HIVST *(16–18)*.

3.5. STRATEGIES AND RESOURCES FOR LAUNCHING, MONITORING AND IMPROVING QUALITY

Implementation of WHO guidance in a national programme is a complex, multidisciplinary and multi-stakeholder process that is best pursued in a systematic and evidence-based manner. FP clients, adolescent girls and young women and people from priority populations should be included. To structure this process, programmes can adopt a quality improvement approach rooted in the Plan-Do-Study-Act (PDSA) cycle. The *Implementation guide for the Medical eligibility criteria for contraceptive use and Selected practice recommendations for contraceptive use guidelines (19)* presents this rapid-cycle problem-solving method. An accompanying resource, the Toolkit for the implementation guide for the *Medical eligibility criteria for contraceptive use and Selected practice recommendations for contraceptive use guidelines (20, 21)* provides practical tools, including a PDSA framework (Fig. 3), that programme managers can use when introducing new integrated models for delivery of FP services and HTS . Regardless of approach, regular communication, feedback and data review with health administrators and providers (FP and HTS) who are tasked with implementing and supporting new models of care as well as programme managers and clients is essential.

Fig. 3. The PDSA process



Source: Implementation guide for the Medical eligibility criteria for contraceptive use and Selected practice recommendations for contraceptive use guidelines *(19)*

Programmes are encouraged to "learn by doing", an approach in which they continuously monitor implementation and adapt it in response to data and experience. Programmes can monitor and improve quality among newly integrated services through:

- routine collection, review and analysis of monitoring data on service delivery and linkage
- routine or periodic collection of client experience of care
- supportive supervision, mentoring and meetings for exchange among FP and HIV providers
- partnerships of community support organizations with local health administrators and clinics, which are an important practical approaches to improving the quality of newly integrated services.

Opportunities to further expand the package of services should be considered according to context. Integration and linkage with PrEP, condoms and lubricants, STI management and cervical cancer screening and treatment are among those that might be prioritized.

4. MONITORING INTEGRATED HTS AND FP SERVICES

It is important to make monitoring of HTS in FP programmes as simple as possible so as not to overburden FP services. Programmes collect information for three primary purposes: patient monitoring, programme management and programme monitoring. Programmes undertaking expansion of integrated FP and HTS services may need to review and modify existing service delivery materials. These include client cards, registers and reports to facilitate routine monitoring of integrated HTS and FP services and linkage to follow-on services, if this is something they want to monitor.

Documenting an individual's contraceptive method choice and access, HIV testing history and HIV status on her client card will allow providers to know her contraceptive history and when to offer HIV testing to clients and potentially to partners. In some settings noting information on ART and PrEP (current use and/or referral to services) may be considered.

Aggregating data on clients' uptake of contraceptive methods, offer of HIV testing, HIV test positivity and linkage can help programmes better understand and strengthen service delivery. As national programmes introduce and expand HTS in FP, they can prioritize reporting and monitoring that captures basic information on the proportion of FP clients who are offered HTS and the proportion of them that receive testing.

HIV programmes often emphasize detailed programme and patient-level monitoring. As integrated HTS and FP service monitoring approaches are developed, they need to be tailored to and appropriate for the FP context. Table 1 presents a list of possible monitoring indicators that could be considered, drawn from global guidance *(11, 22, 23)*.

Table 1. Possible indictors to consider for monitoring integrated HTS and family planning services

Indicator	Indicator reference information
New users of modern contraceptive methods: the number of women of reproductive age (or their partners) initiating use of a modern contraceptive method	Measuring family planning service delivery: an assessment of selected indicators across implementing partners *(23)*
Continuing users of contraception: the number of clients returning to a facility for contraceptive methods	Measuring family planning service delivery: an assessment of selected indicators across implementing partners *(23)*
Number of visits: the number of visits at which FP clients receive contraceptive services	Measuring family planning service delivery: an assessment of selected indicators across implementing partners *(23)*
HTS testing volume and positivity: the number of HIV tests conducted in FP (testing volume) and the percentage of HIV-positive results returned to people (positivity)[a]	TL.2. HTS testing volume and positivity (Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management) *(11)*
HTS index testing and partner notification: the number of people who were identified and tested using index testing services and received their results	TL.4. HTS index testing and partner notification (Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management) *(11)*
Linkage to ART: Number and percentage of people newly diagnosed with HIV initiated on ART	TL.3. Linkage to ART (Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management) *(11)*
Number of individual HIVST kits distributed	TL.5. Number of individual HIVST kits distributed (Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management) *(11)*
Adolescent girls and young women HIV/SRH integration: the number and percentage of adolescent girls and young women seeking contraception/family planning who received an HIV test[b]	GW.1 Adolescent girls and young women HIV/SRH integration (Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management) *(11)*
PrEP uptake: the percentage of eligible people who initiated PrEP during the reporting period	PR.3. PrEP uptake (Consolidated HIV strategic information guidelines: driving impact through programme monitoring and management) *(11, 22)*

[a] Programmes may gain insight into implementation by disaggregation of the *HTS testing volume and positivity: the number of HIV tests conducted (testing volume) and the percentage of HIV-positive results returned to people (positivity)* indicator into the following three metrics: number and percent of clients offered HIV testing, number and percent of clients accepting HIV test, and number and percent of clients testing HIV positive.

[b] Programmes may gain insight into implementation by disaggregation of *this* indicator into the following three metrics: number and percent of adolescent clients offered HIV testing, number and percent of adolescent clients accepting HIV test, and number and percent of adolescent clients testing HIV positive.

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ANNEX 1.

SUGGESTED APPROACHES TO INTEGRATING HIV INTO CONTRACEPTIVE SERVICES, BY HIV PREVALENCE

General approach to integrating HIV services into contraceptive services		HIV prevalence among adult women*			
		Low (<1%)	**Medium (1–5%)**	**High (5–20%)**	**Extremely high (>20%)**
		Likely only a few changes needed; key population focus Mix of referral & on-site integration	Part of SRHR–HIV programme development Mix of referral & on-site integration	Rapid action (change operating procedures) On-site integration where possible	Immediate action (executive orders, change operating procedures) Immediate on-site integration
Offer as part of contraceptive service delivery	Male and female condoms and lubricant	**YES**	**YES**	**YES**	**YES**
	Condom promotion & skills building	**YES** Focused offer	**YES** Routine offer	**YES** Routine offer	**YES** Routine offer
	HIV prevention & risk reduction counselling	**YES** Focused offer	**YES** Routine offer	**YES** Routine offer	**YES** Routine offer
	HIV testing services (including self-testing) + ART	**YES** Focused offer	**YES** Focused offer	**YES** Routine offer	**YES** Routine offer
	STI diagnosis & treatment of asymptomatic women (including partner STI services)	**Focus on key populations**	**Focus on key populations**	**YES** Focused offer (routine offer if high STI prevalence)	**YES** Routine offer
	STI diagnosis & treatment of symptomatic women (including partner STI services)	**YES**	**YES**	**YES**	**YES**
	Partner HIV testing (for example, invitation letter + self-test) + ART	Referrals for partners of HIV-positive women	Referrals for partners of HIV-positive women	**YES** Routine offer	**YES** Routine offer
	Community outreach for HIV prevention for women using contraception and their partners	**Focus on key populations**	**Focus on key populations**	**YES** Focused outreach	**YES** Expanded outreach
	Pre-exposure prophylaxis	**NO** (but referrals for women at higher risk)	**NO** (but referrals for women at higher risk)	**YES** Focused offer	**YES** Routine offer
Prioritize complementary services and focus by population/location and scale up	Primary HIV prevention (the five pillars of prevention)	Key populations (full package**)	Key populations (full package**), condoms	Young women & male partners, key populations, condoms, VMMC, PrEP	Young women & male partners, key populations, condoms, VMMC, PrEP
	Expand contraceptive choices for women, including young women and women from key populations	Range of short-term and long-term contraceptive methods, counselling on advantages and disadvantages of different methods to support informed choices			
	Other health services	HIV/STI testing and treatment, full package of SRHR – including adolescent/youth-friendly services, mental health, gender-based violence prevention and support, comprehensive sexuality education, women's empowerment.			

Focused offer: service available and known to women; active offer made to women from key populations or with an HIV-positive partner
Routine offer: service offered to all women and provided with informed choice and consent
* Examples of areas by HIV prevalence
Low prevalence (<1%): most of Asia–Pacific, the Americas, Europe, Middle East and North Africa, parts of West Africa
Medium prevalence (1–5%): other parts of East, Central and West Africa, a very few small locations in the Caribbean, Asia, Eastern Europe
High prevalence (5–20%): parts of Kenya, Malawi, Mozambique, Namibia, South Africa, Uganda, United Republic of Tanzania, Zambia, Zimbabwe, few other locations in Africa
Extremely high prevalence (>20%): Botswana, Eswatini, Lesotho, several parts of South Africa, southern Mozambique, northern Namibia, southern Zimbabwe
** Essential health-sector interventions in the full package of services for key populations consist of:
1. HIV prevention
2. Harm reductions interventions for substance use
3. HIV testing and counselling
4. HIV treatment and care
5. Prevention and management of coinfections and comorbidities
6. Sexual and reproductive health.

Adapted from *Actions for improved clinical and prevention services and choices: preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence (24).*

ANNEX 2.

RESOURCES RELEVANT TO INTEGRATING HIV TESTING IN FAMILY PLANNING SERVICES

- A landscape analysis of offering HIV testing services within family planning service delivery. Frontiers in Reproductive Health; 2020. https://www.frontiersin.org/articles/10.3389/frph.2021.657728/full
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