

Integration of HIV prevention and sexual and reproductive health services in Kenya

**HIV Prevention
Market Manager**

Accelerating Product Introduction
Informing Product Development
Reducing Time to Impact



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Outline

1. **Background**
2. **Methods**
3. **Findings**
4. **Conclusions/Recommendations**

Background

Options in delivery channels can help meet the HIV prevention and family planning (FP) needs of AGYW

Maternal Child Health (MCH) and FP Clinics *(Public + Private)*

Meet AGYW where they are already receiving FP and other services

Leverage providers' time, sync HIV/FP prescriptions

Especially helpful for post-partum women at risk of HIV & unintended pregnancy

HIV Clinics *(Public + Private)*

Facilities already have human resources and infrastructure for PrEP, and can add on FP services

PrEP stigma due to marketing focused on MSM & FSW may be a barrier, especially for AGYW

Many HIV providers trained in FP services already

Pharmacies *(Private)*

Discreet and convenient for some FP services but PrEP is more expensive and not offered without a prescription

Clinic Dispensaries *(Public)*

Convenient and affordable but frequent stock-outs and can worsen provider workload

Community-Based Delivery *(Public)*

Mobile PrEP delivery has proven effective, especially for AGYW

De-medicalization of PrEP and certain contraceptives (pills, injectables, ring, etc.) can provide options for community-based prevention delivery for PrEP & FP

Defining *HIV/SRH integration and youth-friendly service delivery*



HIV/SRH linkages

Bidirectional synergies in policy, programs and service delivery that meet comprehensive SRH and HIV needs.



HIV/SRH integration

A subset of HIV/SRH linkages at the service delivery level joining operational programs to ensure access to SRH and HIV services through multiple modalities (e.g. through referral or “one-stop shop” services under one roof).



Youth-friendly (YF) services

Provision of accessible, acceptable, appropriate, effective and equitable services for adolescents and young people, by providers who are trained to be sensitive to and non-judgmental about their young clients' needs.

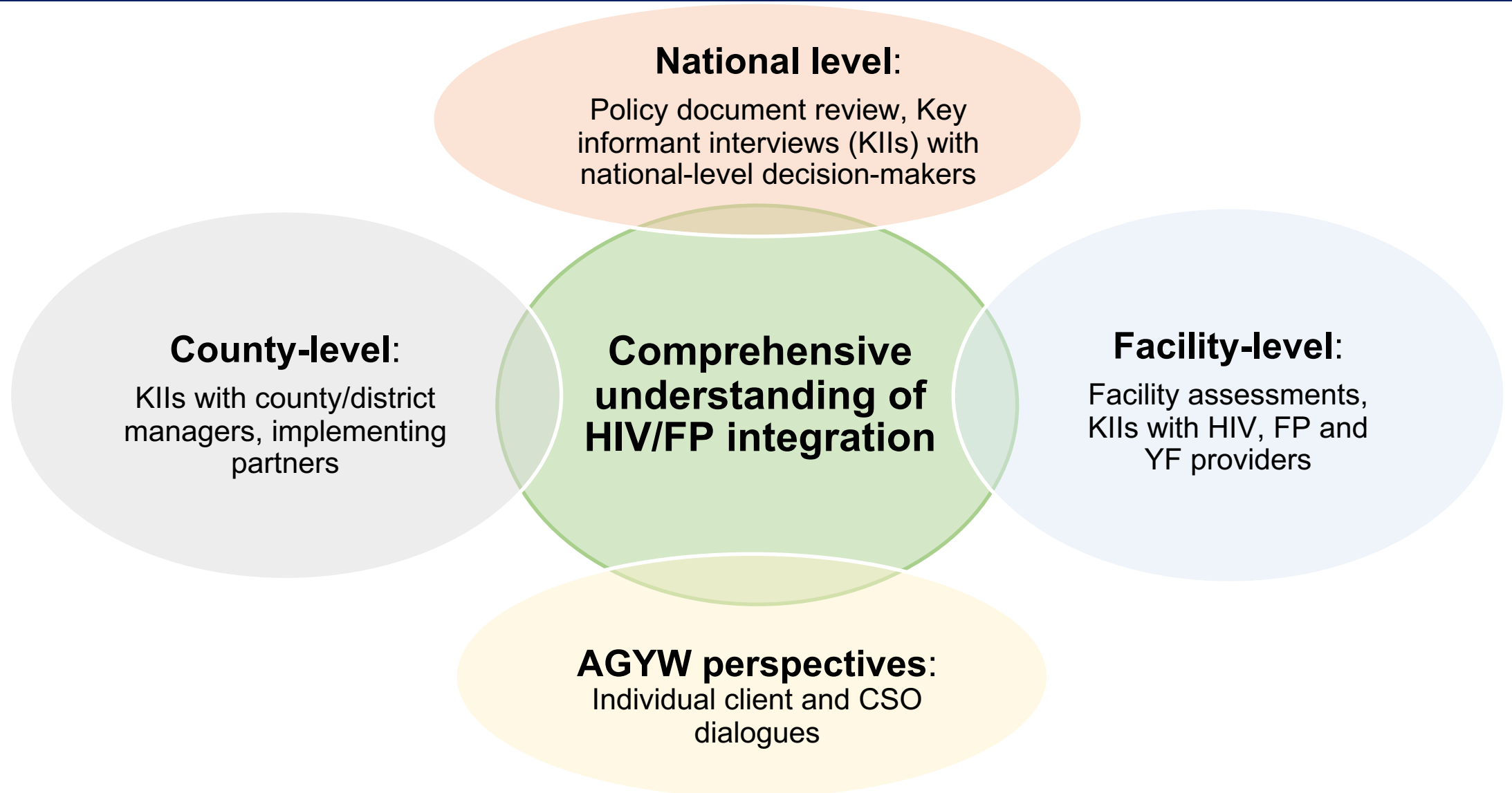


Key Takeaways: Overarching environment

- The policy environment shows evidence of political will for integration; however, up-to-date practical operational plans, tools and training materials on how to “do integration” are lacking.
- Comprehensive HIV Care Clinics (CCCs) and DREAMS safe spaces are the primary delivery channels of PrEP for AGYW.
- PMTCT offers a successful example of integrating of HIV services into MCH as we explore HIV/SRH integration in the context of oral PrEP.

Methods

In-country engagement at multiple levels to achieve comprehensive understanding of HIV/FP integration



Types of activities conducted



Policy level

- Policy review
- KIIs with 2 national level policymakers in leadership within HIV and RH/FP departments at the MOH



MOH Coordinators

- KIIs with 12 county-level MOH officials: 6 RH Coordinators and 6 County AIDS and STI Coordinators (CASCOs)
- KIIs with 3 implementing partners and 1 donor



Facility level

- Facility assessments at 10 sites: 9 public, 1 private; 2 youth-friendly; 5 rural, 5 urban (categories not mutually exclusive)
- KIIs with 23 providers working in HIV/RH/MCH departments



AGYW perspectives

- 2 dialogues with AGYW in Nairobi, one among AGYW living with HIV

Facility assessments and KIIs with providers

Location		County-level managers		Facility levels and types			Providers		
Region	County	CASCO	RH Coordinator	Facility	Facility level/type	Facility assessment	HIV	FP/SRH	YF
Nairobi	Nairobi	X	X	Kibera DO	Public -Tier 2	X	X	X	
Nairobi	Nairobi			Casino Special Treatment Centre	Public -Tier 3	X	X	X	
Central	Kiambu	X	X	Thika County Hospital	Public -Tier 3	X	X	X	
Coastal	Mombasa	X	X	Bomu Health Centre	Public -Tier 2	X	X	X	X
Coastal	Mombasa			Jomvu Model Health Centre	Public -Tier 2	X	X	X	
Eastern	Machakos	X	X	Athi River Health Centre	Public -Tier 2	X	X	X	
Nyanza	Kisumu	X	X	Maseno Mission Hospital	Public -Tier 3+	X	X	X	X
Nyanza	Kisumu			Bodi Health Centre	Public -Tier 2	X	X	X	X
Western	Kakamega	X	X	Manyala sub-County Hospital	Public -Tier 3+	X	X	X	
Western	Kakamega			Kilingi Health Centre	Public -Tier 2	X	X	X	

Tier 1: Community health services, such as demand creation activities and VHW visits, that identify cases that need to be managed at higher levels of care.

Tier 2: Primary care services, including dispensaries, health centers and maternity homes for both public and private providers.

Tier 3: County referral services, including hospitals operating in and managed by a given county for both public and private facilities.

Tier 4: National referral services, such as facilities that provide highly specialized services and all tertiary referral facilities.

Data gathered in facility assessments

Infrastructure, staffing and equipment	HIV Services	FP/SRH Services	Youth Friendly Services
Facility level and size	Types of HIV/SRH services offered and hours/days when offered	Specific FP methods offered and hours/days when offered	Types and hours of services offered
Number and cadres of staff (across HIV, SRH and YF service delivery areas)	Whether and how FP/SRH services are integrated	Whether and how HIV services are integrated	Whether and how HIV and FP services are integrated
General infrastructure and equipment	Reported stockouts of commodities and drugs	Reported stock outs of FP methods	YF training provided
	Accommodations made for youth, especially AGYW	Accommodations made for youth, especially AGYW	Reported stockouts of commodities, FP or PrEP/ARVs

MOH officials, Implementing Partners/Donors and Dialogues

Ministry of Health Officials - National level

- Head NASCOP
- Head Reproductive Health Unit

Implementing Partners

- Jilinde/Jhpiego
- Clinton Health Access Initiative (CHAI)
- LVCT Health

AGYW Dialogues

- AGYW living with HIV
- AGYW PrEP users

Topics covered in interviews and dialogues

Topics	MOH officials	Providers	Implementing partners	AGYW/CSOs
Integrated Service delivery	National: Current policies that address HIV/FP integration County/district: Need for operational guidance/tools	Status of integration at facility-level – where, how and when?	Innovative models of integration for AGYW – what has been done, what has worked, what are the challenges?	Experiences accessing HIV/SRH services – the good, the bad and the ugly
Strategies for promoting integration	National: Direct guidance/circulars, job aids, training County/district: Enhanced coordination, integrated site supervision	Accompanied referral vs. one room/one provider, training and supportive supervision needs	Types of YF and integrated services offered through safe spaces and youth specific clinics, AGYW specific outreach and PrEP champions, service delivery through pharmacies	Ideal delivery points, venues, providers and level of integration for the SRH and HIV services to AGYW
Multi-purpose prevention technologies (MPTs)	Issues related to registration of new products/devices, supply chain, and HCW training needs	At what service delivery points would MPTs be offered? Perceptions of how this would promote access among clients	At what service delivery points would MPTs be offered?	Attitudes about MPTs, ideal points of delivery, potential issues with access and use.
Prevention Champions	Investing in prevention/ integration champions – what is needed?	What characteristics do champions share? Are they providers, peers? What are the training needs?	What can be done to provide current PrEP champions with skills to promote FP?	Not assessed.

Findings

Facility Assessments

Service delivery* by facility type

Facility type	FP	HTS	PrEP	YF**	Specifics	Youth friendliness	Type of integration
Tier 2/Primary Low-volume (n=6)	6	6	6	3	Services typically offered by same provider in same room, including PrEP.	YF service delivery typically provided within CCCs for PrEP (but not within FP) - highly dependent on partner support. Facilities with no YF services in-house referred to nearby youth clinics, safe spaces.	“One-stop-shop” all services provided by same provider in same room, but not particularly YF.
Tier 3/Secondary High-volume (n=4)	4	4	4	3	HIV and FP services typically offered in separate rooms/areas. PrEP offered through CCCs.		Internal and accompanied referral and fast-track between FP and CCCs. 2 CCCs provided FP services within their area.
Youth friendly area or centre (n=3)	3	3	3	3	Youth wing or centre, designed specifically to address the needs of young people offering FP, HIV services and PrEP, with a particular focus on services being YF.	Partner-supported or NGO-run youth centers have high level of youth friendly capacity, including trained providers, confidential spaces, fully integrated services.	“One-stop-shop” fully integrated services for AGYW; same provider, same room/service delivery area.
Private (NGO, Mission) (n=1)	1	1	1	1	Depends on level of facility – mirrors levels described above. Private sector facilities are typically well-resourced compared to public sector, sometimes with user fees, and level of YF service delivery depends on partners’ support.		



Key Takeaways: Comparative analysis by facility type

Most facilities offered FP and HIV services, including PrEP. Levels of integration and youth friendliness varied by facility type and level of external (e.g. PEPFAR implementing partner) support.

- **Tier 2/Primary:** Low-volume facilities in which all services are typically provided by the same provider in same room; however, these services are not necessarily YF.
- **Tier 3+/Secondary and Tertiary:** High-volume facilities with well-trained specialized staff. HIV services (including PrEP) and FP are typically delivered in separate areas. CCCs often integrate FP, but FP units are not implementing PrEP. Integration within FP is achieved primarily through accompanied referral.
- **Pilot FP integration and youth friendly sites:** These facilities provide the strongest examples of comprehensive, intentionally integrated, YF service delivery. These sites are also highly supported by partners and external donors.

*Across sites, provider capacity and YF service delivery are **highly dependent on implementing partner support**, which equips them with additional resources and incentivizes achieving AGYW-focused targets.*

Key Informant Interviews

Government perspectives on integration – Common themes

- Siloed service delivery emerged to address the HIV crisis, leading to vertical, externally funded programs with demanding targets. HIV is better-resourced than FP/MCH.
- Most HIV funding follows external donor priorities, leaving little room for providers, champions, etc. to address issues of SRH or family planning.
- HIV providers are trained through pre-service education in SRH/FP, but SRH/FP providers lack similar training in HIV.

*“There is a tendency at facility level to look at HIV services as quite involving. As such, **there is a tendency to push and refer, rather than to embrace integration.** At the same time, in CCCs we are already overwhelmed and yet we are asked to do family planning.”*

-CASCO

Government perspectives on integration – Differences by stakeholder

MOH officials

- Opportunities exist to leverage/update national policies and develop operational guidance, targets and tools to drive integration and YF service delivery centrally – would need “buy-in” from highest level. This could help “push back” against siloed programs.

CASCOS

- AGYW fear pregnancy over HIV; FP providers are untapped point-of-entry for HIV prevention promotion, and need training to feel equipped to incorporate HIV services.
- Adolescent/youth-friendly programs supported by external donors have powerful potential to foster integration through leveraging incoming resources to address the HIV/SRH needs of young people.

County RH Coordinators

- Engaging County Directors to foster collaboration between CASCOS and RH Coordinators could be an effective strategy to promote necessary coordination.
- Successful integration of PMTCT with MCH was supported by investments in human resources (e.g. training, task shifting and hiring additional staff) – similar investments are needed for integrating PrEP into FP and MCH service delivery areas.



Key Takeaways: MOH perspectives

The MOH management structure has a critical role to play in fostering integration, from national through county to facility-level.

- National-level priority-setting for the integration of PrEP into FP/SRH programs could help leverage well-resourced donor-funded PrEP programs to:
 - Support the required human resources (HR) required for the integration of PrEP (and future HIV prevention products) into FP programs – following the example of PMTCT
 - Invest in expanding YF service delivery within the public sector (in addition to stand-alone safe spaces or drop-in centers)
- Operational directives from the highest level within the MOH has high potential to catalyze integration through county-level coordination, integrated supportive supervision, and practical guidance for greater integration at facility-level.

Provider perspectives on integration

HIV Providers

- Externally-funded HIV programs have sometimes led to less integration, with targets for HIV to to the exclusion of other services. CCC providers were wary to take on additional duties without more HR investments.
- M&E tools are not integrated; sharing and/or having HIV registers in the FP area and vice-versa helps facilitate required documentation.
- Whole site training (e.g. sensitizing watchmen, reception, cleaners on where to access HTS, FP, PrEP) was widely perceived as a successful intervention promoting greater access.

FP Providers

- Integration happens naturally in lower-level facilities (e.g. Tier 2/Primary) because all services are provided by the same providers in the same rooms.
- Many MCH/FP providers stated they would need more training to feel confident in providing HIV/PrEP services beyond PMTCT. Training and supervision were underscored as the greatest need for FP providers to provide HIV services.
- Highly trained FP nurses in the public sector are often transferred to facilities in need of improving service delivery, which can be a barrier to integration.



Key Takeaways: Provider perspectives

- **Training, supervision and the need for additional investments in human resources** were underscored as the most important investments required to promote integration of PrEP into FP/SRH service delivery areas. “With the training and additional staff, we can do it.”
- While externally-funded HIV programs have sometimes led to less integration (due to demanding HIV targets), these additional resources have also been **leveraged to support training for providers, peer educators and PrEP champions to also promote FP, and/or to hire additional staff within CCCs** to provide FP/SRH services.
- Given that M&E tools are not integrated, **sharing and/or having HIV registers in the FP area and vice-versa** helps facilitate required documentation.

Implementing Partners (IPs): Experiences with Service Delivery

Implementing Partners

- Reiteration that vertical funding can be a barrier to integration, but also that external funds bring opportunities to expand integrated service delivery.
- A major challenge to building capacity is that HCWs are often transferred from facility to facility – IPs have to constantly re-train.
- NGO-supported sites have great potential because once these facilities are capacitated, they have the resources to scale up integration. Coordination of IPs to align with national priorities is key.
- Requiring reporting of PrEP within SRH/FP services areas is a necessary step towards integration: *“If it is not reportable, then it is (perceived by providers to be) unimportant.”*

*“Our concern is that we have spent a lot to train a staff may be for a whole week then **within a month the staff is referred to another department altogether.**”*
-Implementing Partner, Nairobi



Key Takeaways: Innovations in service delivery


Current Innovations

- **NGO-supported “Safe Spaces”** offer comprehensive, integrated, YF “one-stop-shop” services – exclusively accessed by AGYW in 4 DREAMS counties (Nairobi, Homabay, Kisumu and Siaya). Considered “gold standard” SD model for AGYW.
- **“Prevention corners”** in public sector CCCs have helped mitigate stigma associated with HIV, provide privacy, and YF prevention services for AGYW – could be more sustainable than stand-alone safe spaces.
- At high-volume sites, **“whole site training”** (e.g. sensitizing watchmen, receptionists, cleaners, etc. on where to access HTS, FP, and PrEP) is a low-cost intervention to promote access.
- LVCT Health is piloting the [PrEP Communications accelerator](#) to develop demand creation for PrEP among AGYW and an [HIV Prevention Ambassador Training Package](#) for AGYW in Kiambu county.

Potential/Future Innovations

- Five combination prevention pilot sites to be implemented in early 2020 (in Mombasa, Nairobi, Nakuru, Homabay and Kisumu Counties), offering:
 - HTS, HIV prevention services including PrEP and STI screening and treatment, family planning and other sexual and reproductive health services (e.g. cervical cancer screening)
- Private providers and hospitals – Profit-oriented providers/facilities can use income generated through service delivery to scale PrEP
- Pharmacies – Screening for and delivering PrEP through pharmacies linked to facilities for clinical assessments

Youth Friendly and Integration Continuum for AGYW

Level 1 No accommodation	Level 2 Referral out to youth center or DREAMS safe space	Level 3 Trained providers and spaces within CCC offering FP or accompanied referral for FP	Level 4 YF wing or area highly capacitated to serve youth	Level 5 Stand alone youth drop-in center or safe space designed specifically to serve young people
				
<p>No special accommodation is made to provide YF services. Integration is generally through internal referral, but without accompanying or fast-tracking AGYW.</p>	<p>AGYW are referred to nearby youth, drop-in centers or DREAMS safe spaces. However, referrals are not accompanied or specifically tracked.</p>	<p>Often with external partner supported PrEP provision, HIV providers are trained in YF service delivery, hired to attend specifically to youth, and a room or set of rooms are assigned to attend to youth privately. Often FP services are offered within CCCs (but HIV services are not necessarily offered within FP/MCH areas). AGYW referred are accompanied and fast-tracked.</p>	<p>These wings/areas offer fully integrated services, by youth friendly providers, in private spaces for young people. Wrap-around services (e.g. counseling, recreation) are typically provided. AGYW get all SRH and FP needs met within the YF wing. Any required referrals for higher level care are accompanied and fast-tracked.</p>	<p>These are spaces designed specifically to meet the needs of young people as stand-alone facilities that serve only youth. Services tend to be fully integrated – “one-stop-shop” – with comprehensive wrap-around services. Any required referrals for higher level care are accompanied, fast-tracked and followed-up.</p>
Where facilities in the assessment fell along the continuum				
Kilingili Tier 2	Arthi River Tier 3+, Jomvu Tier 2, Bodi Tier 2	Manyala Tier 2, Casino Tier 2, Kibera Tier 2, Maseno Mission Tier 3	Bomu Health Centre Tier 3 (NGO clinic); Thika Tier 3	PEPFAR-funded Safe Spaces

Case studies: Integration through YF Service Delivery

Level 2 - Bodi Health Centre: Referral to nearby Safe Space

- AGYW in need of PrEP and FP services are referred to nearby PEPFAR- supported Safe Space

Level 3- Maseno Mission Hospital: Special YF days/times

- YF PrEP services are offered every 2nd Tuesday of the month
- Support groups for young people on PrEP
- No specific support for FP services

Level 4 - Bomu Hospital: Comprehensive YF Wing

- YF PrEP and FP services located in a separate area within NGO-supported facility for children (2-14) and youth (aged 15-30) only
- Staffing:
 - 1 clinical officer, 2 registered nurses trained to delivery YF services
 - 2 peer counselors
 - Outreach team in conjunction with MCH department
- Space provides: TV, sports clubs, day care for toddlers, a bed for young clients to nap on during their visit
- Services provided: HTS, PrEP, HIV care and treatment, and accompanied referrals to FP

Level 4 - Thika Hospital: Separate YF room

- YF PrEP and FP services located within a separate room located within the public-sector CCC supported by a PEPFAR IP
- Staffing:
 - 1 provider among the clinical officers, registered nurses and counselors rotate serving youth clients in the YF room
 - 2 Peer PrEP champions
- Space provides: private clinical room but public waiting area
- Services provided: HTS, PrEP, HIV care and treatment, FP, individualized counseling and PrEP education.



Key Takeaways: Integration and YF service delivery for AGYW

- Integration and youth friendly services seem to move in a continuum – the more youth friendly a clinic the more integrated it tends to be
- Lower-level public sector sites (e.g. Tier 2/Primary level sites) tend to fall on the left side of the continuum (less YF and integrated service delivery), with Tier 3+ offering YF and integrated services through CCCs, but not FP/SRH areas.
- Facilities with YF wings/areas or stand-alone clinics/safe spaces fall on the right side of the continuum (greater YF and integrated service delivery) – these tend to be NGO-funded or supported sites as they require investments in training and staffing.

AGYW/CSO dialogues

AGYW and CSO dialogues: Experiences of access

- Fear of stigma from the community and HCW attitudes are major barriers to access, especially if AGYW are engaging in or suspected to be engaging in sex work.
- In lower-level public sector facilities, provider capacity to insert implants is limited – clients are often asked to come back on a date when an experienced provider is available. This creates delays and leads to a lack of confidence in health providers.
- Not all providers are able to give FP and HIV services at the same time. After one service is done in family planning, a client is asked to come back another day to access HIV services.

“Once the community spots you going behind the building [to the health facility], anyone can guess what you are there for.”

-CSO dialogue



Key Takeaways: AGYW want Choice, Access, Respect, Privacy

**“Choice,”
integrated and
differentiated care**

“Sometimes when you go you are told to come another time as the FP method you want is out of stock. One time I was told to come back when a certain doctor would be available since he was the only one who would provide a certain FP service. I felt so discouraged I had to take the only method available; ‘the pills.’”- AGYW living with HIV, Nairobi

**Access to services
that meet their
needs, when they
need them**

“Sometimes when one goes they are told to come another time since the FP method they want is out of stock. One time I was told to come back when a certain doctor would be available since he was the only one who would provide a certain FP service. I felt so discouraged.” -AGYW aged 16-24, Nairobi

**Respect and non-
judgmental care**

“ I once went to a public health facility for FP services. The moment the health service provider found out I was living with HIV, she made sure I felt uncomfortable. I immediately became a promiscuous woman. ... She would loosely mention it to her colleagues, and this made me feel so attacked and vulnerable.” -AGYW aged 16-24, Nairobi

**Privacy and
Confidentiality**

“Service providers share your diagnosis in public and point to you where you are supposed to go. ... In most cases, people are divided according to what brought them there and this is not done in private e.g. ‘those with HIV come on this side!’. [I]n order to avoid such humiliation, AGYW prefer to go to outside [of their locality].” -AGYW aged 16-24, Nairobi



Key Takeaway: What makes a facility youth-friendly?

- Staff are trained to be sensitive to needs of young people, e.g. to provide **choice, access, respect and privacy**. Providers don't need to be young per se, but “young at heart.”
- Privacy is provided through separate rooms/waiting areas, where AGYW won't run into relatives or community members who will wonder why they are there.
- Providers are non-judgmental; they respect the choices AGYW make.
- All HIV and FP services are available, for free, ideally under one roof, at the same time.



Key Takeaways: Common themes around MPTs





- Interviewees were largely unfamiliar with MPTs (except some IP/donors). Once described, there was a lot of enthusiasm for a dual-protection product that could foster integration without increasing workload, and that could prevent HIV, but be masked as FP.
- Varied responses regarding preferred type of product (e.g. pill vs injectable vs. implant vs. ring). The strong sentiment was that there needs to be a variety to meet the diverse preferences of AGYW.
- Some concerns were raised about a dual product potentially enticing AGYW off of long-term effective methods of FP, and about how to manage and ‘untangle’ side-effects when two products are mixed together.

Integration Champions

Perspectives on Champions: Common themes





- When asked, “What is a Prevention Champion” most respondents identified **peer educators**, such as PrEP Champions being employed to create demand for PrEP, or **celebrities that NGOs invest in** to promote services (e.g. VMMC) or products (e.g. condoms).
- It was clear that opportunities exist to identify and invest in champions across all levels of the health care system to serve as “integration champions” although that is not a current practice.
- Integration champions would serve to catalyze the integration of HIV prevention into FP/SRH service delivery, in particular for AGYW.

The potential for Identifying & promoting integration champions

	Level	Champion Action	Characteristics
	Policy level	Spearhead integration policy and operational guidelines	<ul style="list-style-type: none">• Visionary, strategic, leader• Passionate about integration• Able to engage across stakeholder groups
	MOH Coordination at county/district level	Promote integrated coordination between FP/RH coordinators and HIV managers/CASCOs	<ul style="list-style-type: none">• Collaborative, passionate about integration, interested to work across siloed programs• Able to promote and cascade down national integration guidelines
	Facility level	Acting as “change managers” to promote integration at facility-level	<ul style="list-style-type: none">• Passionate about providing quality services• Seen as leader among peer HCWs• Able to think and operate at systems level and garner support and enthusiasm by peers
	Community level	PrEP champions attached to CCCs trained in FP to counsel, refer and promote uptake of FP	<ul style="list-style-type: none">• Empathetic, curious, and knowledgeable• PrEP and FP user, able to serve as a role model



Key Takeaways: Actions needed by Champions

	Level	Actions needed
	Policy level	<ul style="list-style-type: none">• Develop national guidelines/circulars on HIV/FP integration including facility-level targets, operational plans, training materials and job aids for what is required at county, facility and community level• Create integrated M&E tools
	MOH Coordinators	<ul style="list-style-type: none">• Integrated annual workplans developed by CASCOs and RH coordinators• Joint supervisory visits to facilities by county/district managers• Joint training and on-the-job-training for HIV and SRH/FP providers
	Facility level	<ul style="list-style-type: none">• Promote integration (based on national-level guidance and operation plan) at facility-level• Facilitate facility-level meetings to problem-solve around and promote integration
	Community level	<ul style="list-style-type: none">• PrEP champions to promote and provide FP education and counseling alongside PrEP

Conclusions and Recommendations

Conclusion #1: Integration of HIV/FP must start at the highest level with national-level guidance, cascading down through county/district level management to facilities

- Kenya has policies that address HIV/FP integration in various ways, pointing to strong political will and intention. What is lacking is the direct mandate to do it, and up-to-date operational guidelines that tell county/district-level and facility managers and providers **how** to do it.
- Governments could provide a circular with operational guidance, creating integrated work plans at district/county level between HIV and RH managers, integrated site supervision at facilities, and provider training when gaps are identified.
- Update M&E tools/registers, or guidance provided on how to use them, to account for integrated services.
- Leverage utilization data to select interventions based on evidence.

Conclusion #2: Operationalize the promotion of HIV/FP integration by capitalizing on what is working and by differentiating action by level and type of facility, using YF facilities as learning sites to capacitate the public sector

Tier 2 / Primary	Capitalize on inherently integrated service delivery by equipping all staff to provide youth friendly FP and HIV services, including PrEP. Ensure that all services are available at all times.
Tier 3 / Secondary and beyond	Capacitate HIV providers to identify potential FP clients, provide contraceptive counseling and make accompanied referrals. Capacitate SRH/FP providers to offer YF HIV testing, PrEP education and counseling, and accompanied referrals for AGYW in need of PrEP. Use whole site training approaches.
Family planning clinics	Ensure that FP providers and facilities are equipped to deliver HTS, PrEP education, counseling, and accompanied referrals. Ideally provide PrEP in-house with FP services.
Youth safe spaces and clinics	Leverage YF facilities to serve as learning sites to capacitate public health facilities through exchanges, by allowing attachments, and by providing mentoring and on the job training to public sector facilities.

Conclusion #3: AGYW want choices and options in terms of:

- FP and HIV prevention products that suit their needs at different times in their lives - including MPTs once they are available.
- Availability of services and products at times that are suited to their needs (e.g. after school, on Saturdays) and not only on certain days or at certain times.
- Being able to access non-judgmental services, in private spaces by providers who respect their confidentiality. Of critical importance are: **Choice, Access, Respect and Privacy.**

Conclusion #4: Youth-Friendly service delivery is the gold standard

- Integration and YF service delivery move together – the more youth-friendly the service, the greater the integration, and vice versa.
- Uptake is higher among more highly integrated and youth-friendly facilities.
- Integration can be effectively achieved through accompanied referral and fast-tracking of AGYW when “one room, one provider” is not an option.

Conclusion #5: Investing in champions across the health care system will catalyze integration

- **Champions at national level** required to define, develop and ensure the implementation of policy and operational plans (Conclusion #1)
- **Champions at county/district level** required to integrate annual workplans developed by CASCOS and RH coordinators together; conduct joint supervisory visits to facilities; joint training and on-the-job-training for HIV and SRH/FP providers
- **Champions at facility level** required to capacitate providers; institute accompanied referral; establish YF spaces
- **Champions at community level** required to take up and promote integration, e.g. PrEP champions can also promote FP services

Conclusion #6: There is great enthusiasm and potential for MPTs to...

- Offer opportunities for integration without additional burden on staff and facilities
- Provide HIV prevention “disguised” as a FP product
- However, it will be important to prepare carefully in terms of planning for where the product should “live” (in HIV, FP or both service delivery areas), training providers on delivery and how and to whom to market the product

Actionable Recommendations: MOH/Government

- **National level:** Develop and release a circular providing directives and concrete operational guidance that addresses integration at district/county-level and service delivery (supported by tools described in the previous slide)
 - Develop integrated training curriculum refresher as an online course
 - Invest in integration champions at different levels
 - Engage the new manager for integration as a potential champion to promote and lead this process
 - Integrate or revised M&E tools to allow for documentation of HIV/PrEP service delivery in FP and vice versa
- **County/District level:** Develop integrated workplans reflecting HIV and RH coordination on training, supportive supervision, review meetings (e.g for PMTCT, PrEP) and youth-friendly service delivery.

Actionable Recommendations: Facilities

- Implement and expand **solutions that are working**: HCWs capacitated to provide YF HIV and FP services; accompanied referral and fast-tracking young people; youth-friendly centers/areas when space and resources allow
- Ensuring that **IEC materials** for both FP and HIV are available
- Sharing and/or having **HIV registers** in FP area and vice-versa, including at pharmacy-level, to facilitate documentation
- **Whole site training**: Sensitizing watchmen, reception, cleaners on where you can access HTS, FP and PrEP, etc.

Next Steps

- **Brainstorm at dissemination meeting**

- Share findings at high-level meeting convened by MOH
- Identify potential solutions and actions to address integration at national and sub-national levels
- Commit to policy and programmatic solutions identified, such as the development of a circular or updated guidance that promotes operationalized integration from national down to facility-level

- **Implement commitments**

- Pilot integration approaches as recommended in select counties/districts