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

HIV Prevention Market Manager

Accelerating Product Introduction
Informing Product Development
Reducing Time to Impact

AVAC
Global Advocacy for HIV Prevention

CLINTON HEALTH ACCESS INITIATIVE

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Outline

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Background

Rationale: To promote uptake of HIV prevention services through a better understanding of HIV/SRH integration in Zimbabwe.

As part of a larger body of work focused on expanded and alternative delivery mechanisms to promote the uptake of HIV prevention services, the HIV Prevention Market Manager (PMM) collaborated with the Zimbabwe Ministry of Health and Child Care (MOHCC) to conduct **a rapid assessment** to:

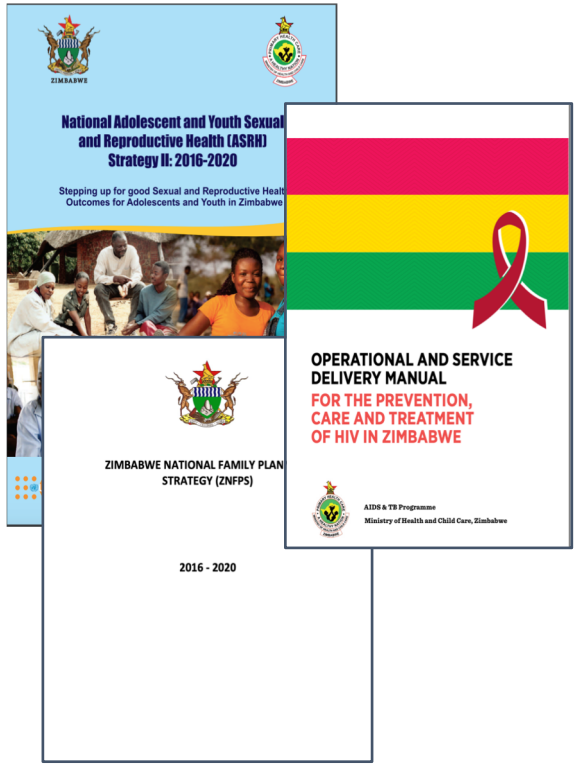
- Better understand the potential for **integration of PrEP and other biomedical prevention and family planning (FP) products** at facilities serving AGYW as one approach to improving access to and uptake of these methods by AGYW.
- Identify **characteristics and the training needs of "integration champions"** for engagement at different levels of the health care system, and at various points of entry at health care facilities, to inform policies and training approaches.

Specific objectives of the assessment

To provide **specific, actionable recommendations on HIV prevention and FP service integration** so that:

- **MOHCC and Implementers** can optimize integrated delivery of oral PrEP and next-generation HIV prevention (and potentially multi-purpose prevention) products, particularly for AGYW.
- **Providers** can be capacitated to provide integrated, youth-friendly (YF) services and better tailor messages for end users of HIV prevention and FP services and products.
- **Developers** can better plan for later-stage development towards rollout of next-generation HIV prevention (and potentially multi-purpose prevention) products.
- **Funders** can make informed funding decisions about investing in expanded service delivery for AGYW, and about the development of next-generation HIV prevention (and potentially multi-purpose prevention) products.

Policy environment shows strong will for HIV/SRH integration; however, policy updates are needed to guide PrEP integration and expand YF service delivery.



Key policies are currently being updated (process on hold due to COVID-19). Existing policies lack guidance on PrEP, or specifics on how to operationalize PrEP/FP integration at facility-level.

- National Health Strategy for Zimbabwe, 2016-2020 (currently being updated)
- National Health Strategy for HIV (current being updated)
- Zimbabwe National Family Planning Strategy (ZNFPS), 2016-2020
- National Adolescent and Youth Sexual and Reproductive Health (ASRH) Strategy II: 2016-2020

Policies need to address the integration of PrEP within FP/SRH services, and to allow for the delivery of PrEP for adolescents <18 years per actual practice on the ground (currently policies allow for PrEP delivery among 18+ only).

Coordination on integration is also a strength, but there is a need to expand access to PrEP outside of HIV service delivery.

- The Department of AIDS and TB, Department of Family Health and the Zimbabwe National Family Planning Council (ZNFPC) are three national bodies overseeing HIV prevention and treatment, and SRH services including FP.
- Program-specific (e.g. PrEP) technical working groups are integrated, as are the Prevention Partnership and Adolescent Reproductive and Sexual Health Partnership Forums (convened by MOH to coordinate program implementation).
- As a general rule, FP is well-integrated into primary and HIV services – offered through standalone ZNFPC, family health and HIV/OI clinics.

Opportunistic Infection (OI, or HIV treatment) clinics are the primary delivery channels for PrEP, which is not available through SRH services except for a limited number of pilot FP sites and youth facilities. **There is a critical need to expand access.**

AGYW comprise 35% of new HIV infections, demonstrating a need to improve HIV prevention efforts for this group.

People living with HIV (all ages) = +/- 1.3 M

Adults living with HIV (15+) = 1,200,000

Children/youth living with HIV (0-14) = 84,000

HIV Prevalence = 12.7%
Female = 15.4%
Male = 10%

Adolescents & youth make up 48% of all new infections

AGYW make up 35% of all new HIV infections

Number of New HIV Infections: All

All ages = 38,000

Adults (15+) = 33,000

Children (0-14) = 4,800

New Infections: Adolescents and Young Adults

Adolescents 10-14 years
New infections = 4,800

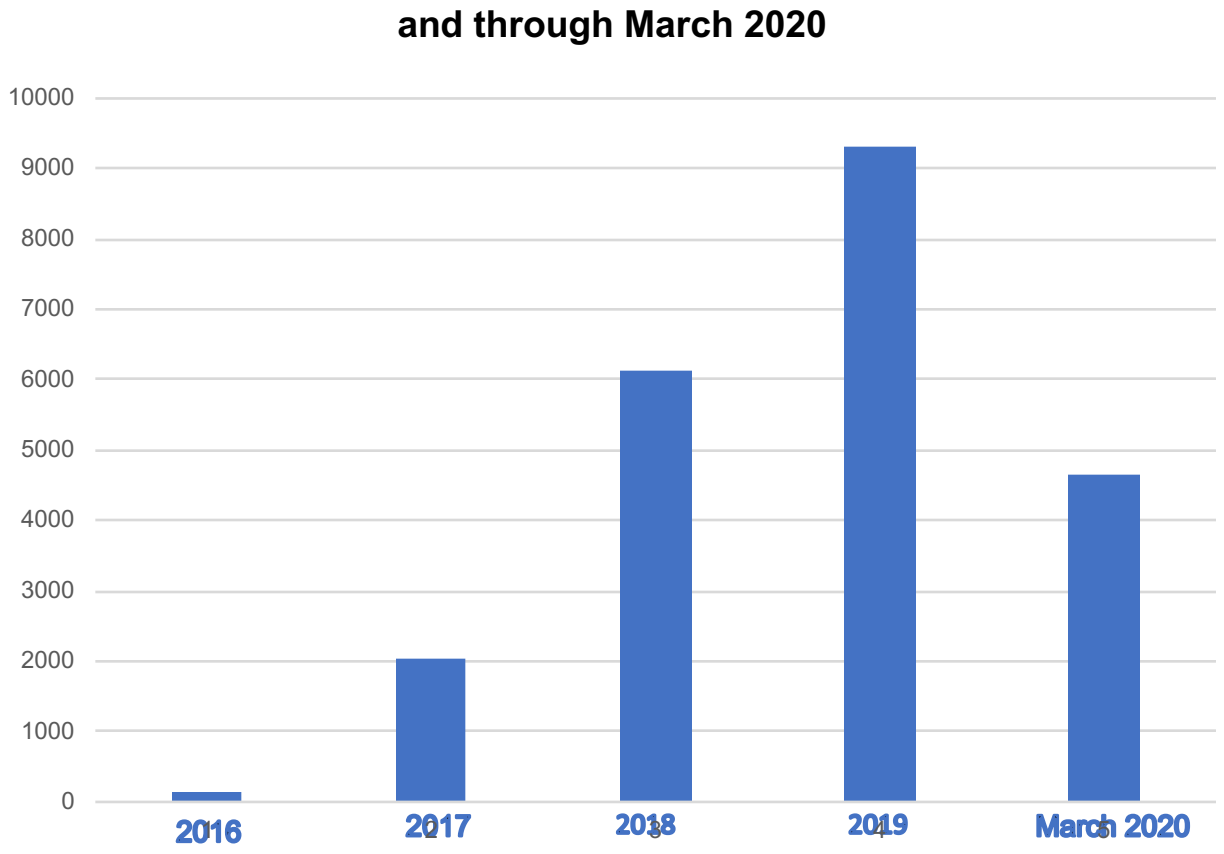
Young Adults 15-24 years
New infections = 13,000

AGYW 10-24 years
New infections = 13,300

Source: UNAIDS, 2019 http://aidsinfo.unaids.org/

As oral PrEP goes to scale, AGYW make up 30% of new initiations.

- 17,588 cumulative PrEP initiations as of Q1 2020 (AVAC, Global PrEP Tracker, Q1 2020).
- AGYW make up 30% of initiations so far in 2020 (1406/4649).
- National PrEP guidelines and a 3-year implementation plan for scale-up of PrEP guide implementation
- PEPFAR COP targets for 2020 call for over 38,000 initiations

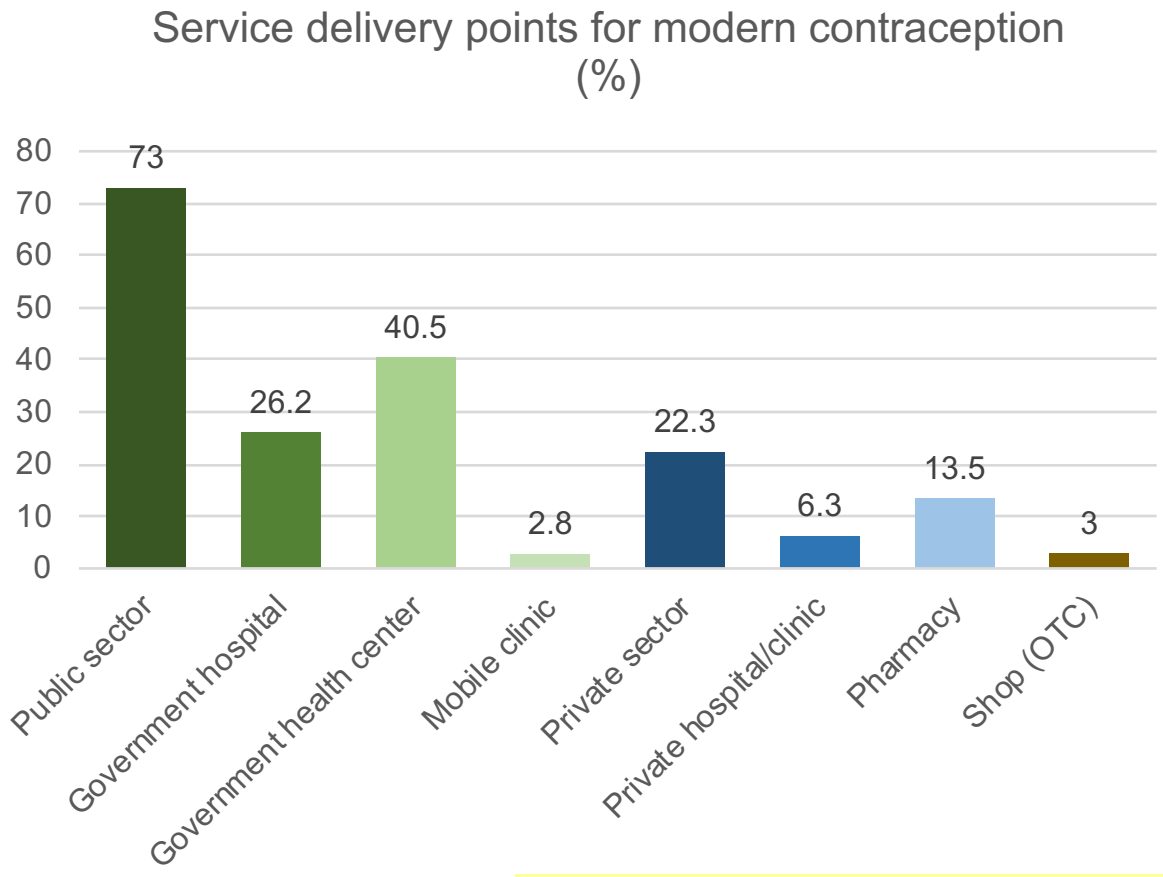


Source: Zimbabwe MOHCC, 2020

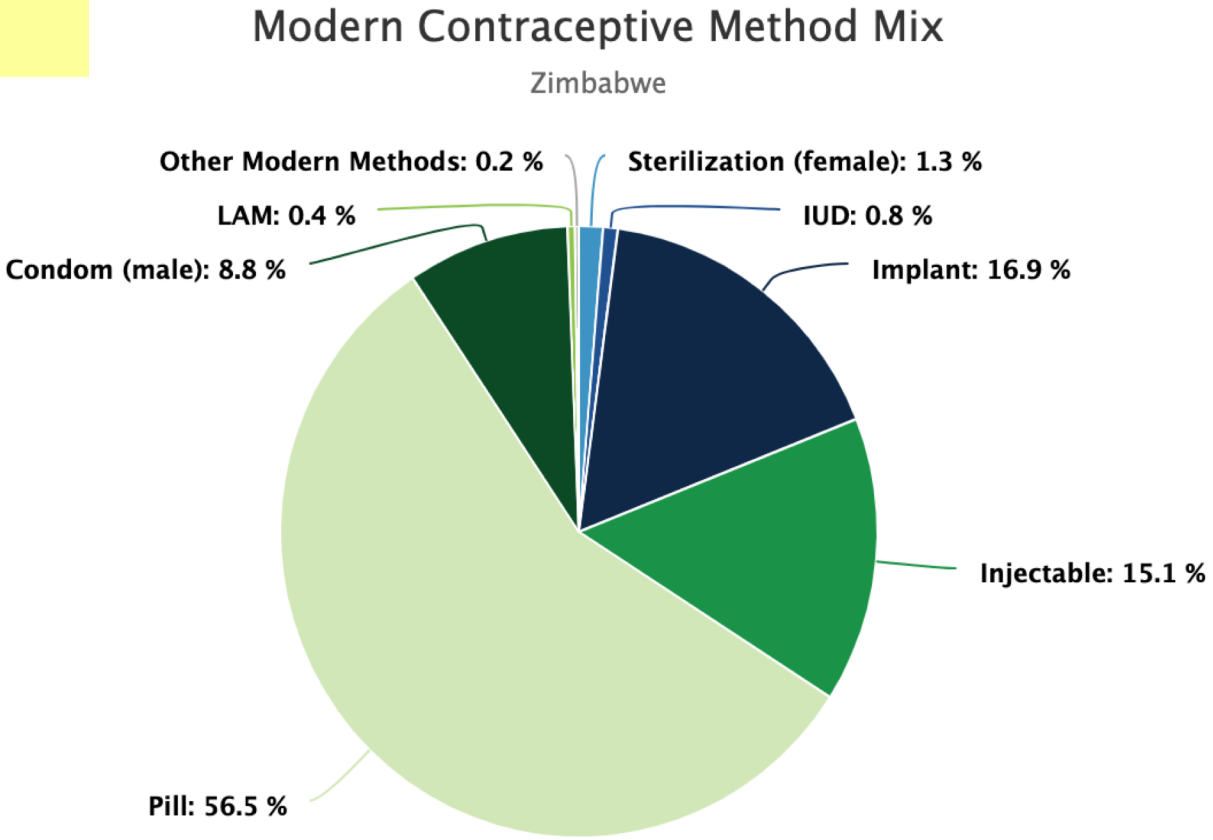
As PrEP continues to go to scale in Zimbabwe, increasing and ensuring access to and creating demand for PrEP for AGYW is a key national priority.

While modern contraception use is widespread, unmet need for FP is 40% among AGYW aged 15-19.

Unmet need for family planning is 40% among AGYW ages 15-19, compared to 17% for those ages 20-24.



Source: Zimbabwe 2015 DHS



Source: FP2020, *citing* Zimbabwe 2015 DHS

Gov't hospitals & health centers are primary delivery points of FP for AGYW.

Successful examples programmatic integration can help guide PrEP integration into MNCH and SRH service delivery.

PMTCT services:

- Major focus on Prong #1 – preventing unwanted pregnancy
- 56K+ pregnant women received PMTCT in 2018, a 94% coverage rate. Mother-to-child transmission rate: 7.6%

VMMC:

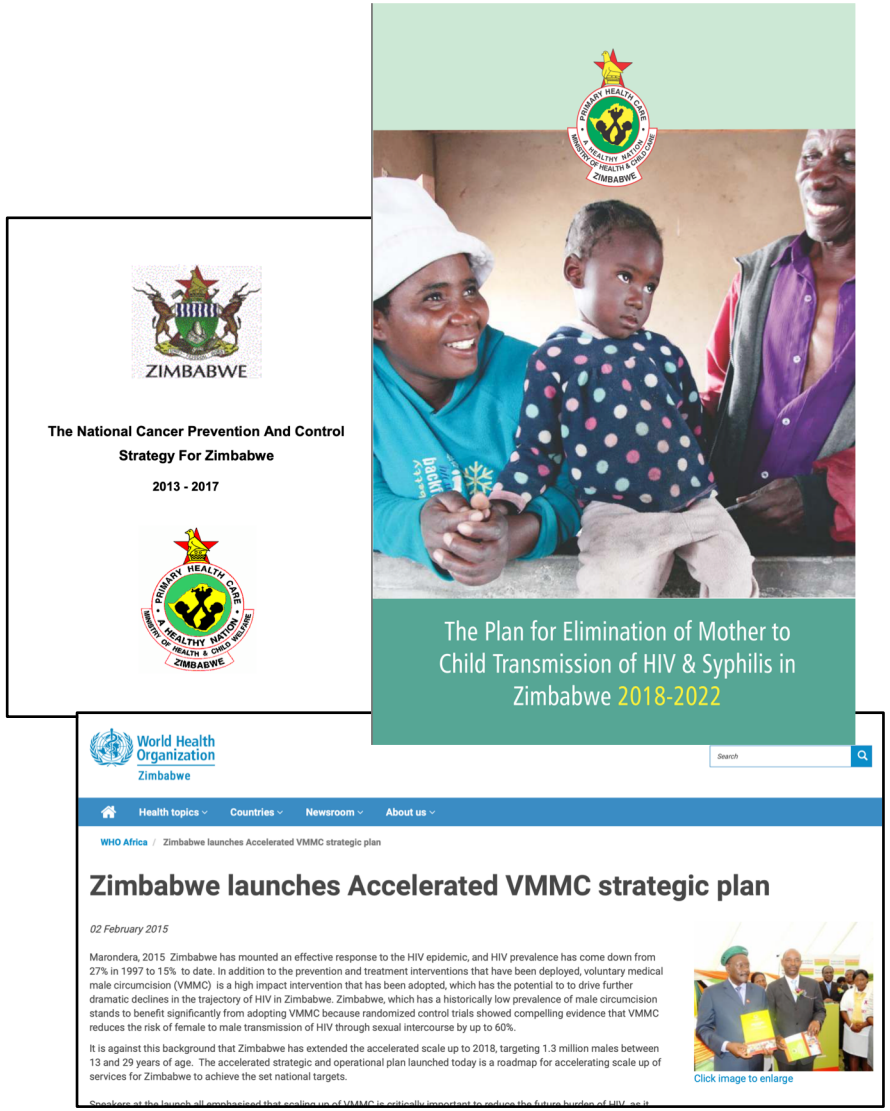
- National strategy for VMMC scale up, with over 326K procedures performed in 2018
- Mainstreamed into outpatient, with high public awareness

Cervical Cancer Screening:

- National strategy for cervical cancer screening among women living with HIV using visual inspection using acetic acid
- Over 20,000 women screened annually

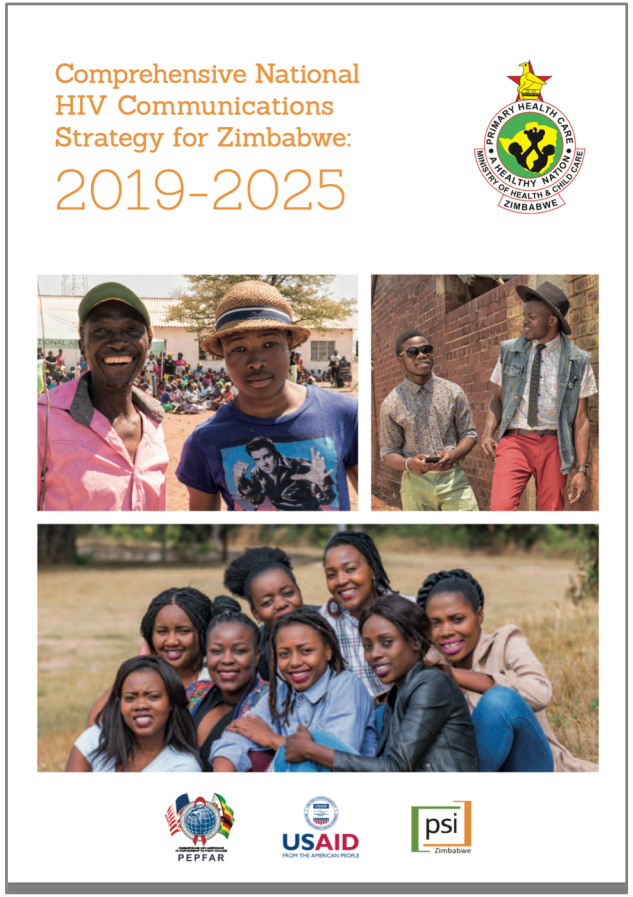
Sexual Gender Based Violence (SGBV) Clinics:

- Supported by UNFPA with Global Fund resources, providing PEP, FP, counseling and YF services, **but not PrEP**, in 7 districts
- No plans for extending funding beyond 2020



A Comprehensive HIV Communications Strategy exists, but it is not fully implemented due to limited funds, contributing to low PrEP awareness.

- The Comprehensive National HIV Communications Strategy for Zimbabwe (2019-2025) is the guiding framework for integrated HIV communications interventions and activities, including for PrEP.
- The strategy seeks to generate demand for sustainable uptake of HIV prevention, care and treatment services; encourage integrated communications and programme linkages; and influence positive social and cultural norms surrounding HIV and SRH.



Funds are limited to fully implement this strategy, contributing to low public awareness about and demand for oral PrEP.

Mainstreaming of YF service delivery is a national priority, though limited resources constrain effective implementation.

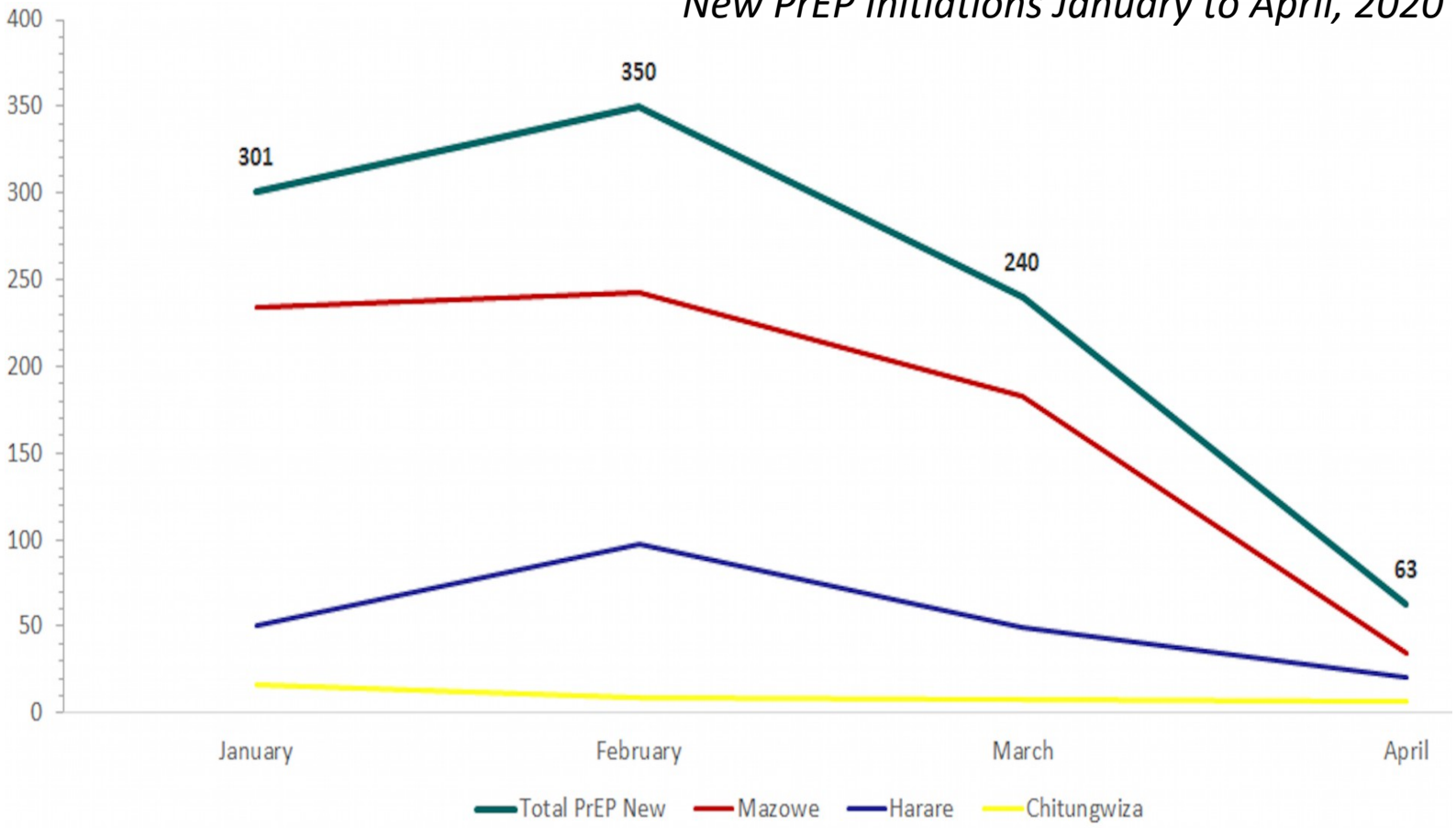
- Zimbabwe has adapted the Global Standards for Quality Health-Care Services for Adolescents (WHO, 2015), and has comitted to meeting 8 standards of YF service delivery:
  - Adolescents' health literacy
  - Community support
  - Appropriate package of services
  - Providers' competencies
  - Facility characteristics – operating hours and a welcoming environment
  - Equity and non-discrimination
  - Data and quality improvement
  - Adolescents' participation

Within the context of limited resources, the **ability to fully deliver on these standards is challenging**.

The COVID-19 crisis threatens all areas of health care, including HIV/SRH services.

- Monthly **HIV testing** declined from 65K in Q1 2020 to only 19K in April 2020, post lockdown.
- The average number of **VMMC procedures** conducted per week has declined from over 5,000 before the lockdown to only 200 during the lockdown.
- **PrEP initiations** are down by up to 78%, especially among AGYW and key populations.
- **ANC visits** post-lockdown have declined by nearly 20% compared to Q1 2019.

New PrEP Initiations January to April, 2020

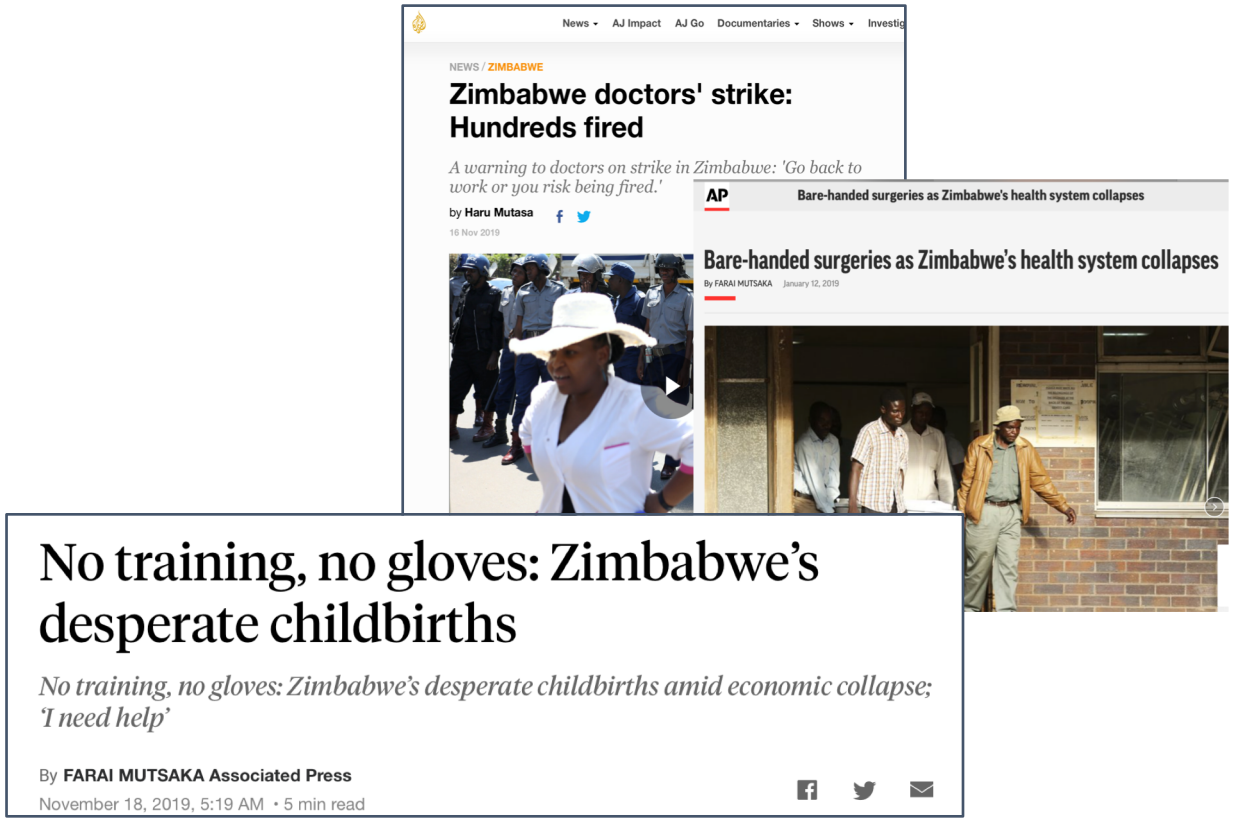


Source: Rapid assessment of HIV services within the context of COVID-19, May 2020

Ongoing economic crisis demands efficiencies in health care delivery through integration.

Current economic crisis in Zimbabwe is affecting quality of health service delivery overall.

- Doctor and other health care worker (HCW) strikes
- Stock-outs of drugs and commodities
- Fuel shortages for emergency and specimen transport
- HCW shortages and staff morale



While promoting HIV/FP integration within the context of an overarching health care crisis poses challenges, the **need for efficiencies in health care delivery for AGYW** are arguably more urgent than ever.

Key Takeaways: Overarching environment

- Current updating of existing policies show **strong political will for integration**; however, there is a **critical need to expand access to PrEP** and to provide practical operational plans, on how to "do integration".
- Funding for standalone SGBV and YF sites is ending, and MOHCC is shifting to **mainstreaming YF services**. Resources are limited to ensure HCWs are fully capacitated and that conditions at facilities meet the needs of adolescents and young people.
- **PMTCT, VMMC and VIAC offer recent examples of successful programmatic integration** as we explore HIV prevention and SRH integration in the context of oral PrEP.
- PrEP delivery is going to scale in the midst of an economic and health care (and now COVID-19) crisis; the **need for efficiencies in health care delivery** through integration are arguably more urgent than ever.

Methods

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

National level:

- Policy review
- KIIs with 5 national level policymakers in leadership within HIV and family health departments at the MOH and at ZNFPC

Provincial and District-level:

- KIIs with 4 provincial HIV focal persons
- KIIs with 4 provincial RH focal persons
- KIIs with 2 district nursing officers
- KIIs with 2 implementing partners and 1 donor

Facility-level:

- Facility assessments at 10 sites: 8 public, 2 private; 2 youth-friendly; 6 rural, 4 urban (*categories not mutually exclusive*)
- KIIs with 14 providers working in HIV/RH/MCH departments

AGYW perspectives:

- 4 dialogues with AGYW in Harare and Epworth

10 facility assessments, 24 KIIs with providers and provincial and district managers, and AGYW dialogues informed the assessment.

Location		**Provincial-level managers**		**District-level managers**	**Facility levels and types**			**Providers**		
Province	District	HIV focal person	RH focal person		Facility	Facility level/type	Facility assessment	HIV	FP/SRH	YF
Harare	Harare				CitiMed Hospital Chitungwiza	Private – Secondary	X	X	X	
Harare	Harare				SHAZ! HUB at CitiMed	Private – YF NGO	X			X
Harare	Harare				ZNFPC 5th Ave Clinic	Public – YF ZNFPC	X			X
Harare	Harare				Spilhaus Family Planning Clinic	Public – Secondary ZNFPC	X		X	
Manicaland	Makoni	X	X		Nyazura Clinic	Public – Primary	X	X		
Manicaland	Rusape				Rusape General Hospital	Public – Secondary	X	X	X	
Matabeleland	Bulawayo				UBH - youth friendly services wing	Public – Tertiary	X	X		X
Midlands	Gweru	X	X		Gweru Provincial Hospital	Public – Tertiary	X	X	X	
Mashonaland Central	Shamva	X	X	X	Chishapa rural clinic	Public – Primary	X	X		
Mashonaland West	Hurungwe	X	X	X	Mwami rural Health facility	Public – Primary	X	X		

Findings

Service delivery* by facility type

Facility type	FP	HTS	PrEP	YF	Specifics	Youth friendliness	Type of integration
Primary **Low-volume** (n=3)	3	3	3	0	Services offered by same provider in same room, including PrEP.	No YF services available in-house, but AGYW referred to a nearby sexual gender-based violence (SGBV) clinic.	"Supermarket Approach": all services provided by same provider in same room, but not YF.
Secondary/ Tertiary **High-volume** (n=5)	5	5	5	3	HIV and FP services typically offered in separate rooms/areas. PrEP offered through OI clinics.	3 out of 4 facilities provided YF services in-house through a YF wing or area. No accommodation in the 4th rural-based facility.	Internal and accompanied referral made between FP and OI clinics. FP services provided within OI clinics.
Youth friendly area or centre (n=3)	3	3	1	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.	Supermarket Approach offers fully integrated services for AGYW; same provider, same room/service delivery area.
Private (n=2)	2	2	2	2	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 mission or partners' support.		

**Note: categories are not mutually exclusive*

Key Takeaways: Comparative analysis by facility type

General awareness of the need for integration by facility staff, typically referred to as the "supermarket approach". Application of this approach differs by facility type and availability of trained cadres.

- **Primary**: Low-volume facilities; all services are typically provided by the same provider in same room. Could be strengthened by specific guidelines and greater availability of higher-level and YF services.
- **Secondary and Tertiary**: High-volume facilities with well-trained specialized staff. HIV services (including PrEP) and FP are typically delivered in separate areas. OI clinics often integrate FP, but FP units are not implementing PrEP. Integration within FP is achieved primarily through referral, ideally through accompanied referral especially for AGYW, but staff capacity and high workloads limit consistent implementation of this practice.
- **Pilot FP integration and YF sites**: Strongest examples of comprehensive, intentionally integrated, YF service delivery. These sites are also highly supported by partners and external donors. However, PrEP is still not widely available to AGYW, even in pilot sites.

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.

Government perspectives on integration

MOH Officials

- Funding streams and implementing partner (IP) priorities are a barrier to integration – HIV is better funded than SRH.
- Awareness of PrEP is low among providers and communities.
- There is a need to expand PrEP beyond the OI clinics, within FP areas and ZNFPC facilities.
- There is a national priority to mainstream YF service delivery to address adolescent needs.

Provincial HIV Focal Persons

- Lack of documentation of existing integration efforts
- Externally (donor) funded programs that incentivize HIV providers to deliver FP can create tension, with public sector staff not receiving incentives to do the same job. This can demotivate staff.

Provincial RH Focal Persons

- There are fewer RH trainings and fewer providers selected to attend these trainings compared to HIV.
- HIV service delivery is more robustly funded than FP/SRH.
- Lack of incentives in FP/SRH (compared to HIV programs) demotivates staff.

Awareness of PrEP among SRH and some HIV providers is low; **integration sometimes thwarted by stock-outs** (in particular implants); and **HCWs not fully capacitated to provide all FP and HIV services**, including YF services for AGYW.

Key Takeaways: Consensus on need to offer PrEP within FP/SRH services; vertically-funded programs hinder integration.

National policies and structures exist to foster integration, but donor-driven vertically funded programs pose barriers, and operational guidance, consistent supply chains, and HCW capacity (e.g. to insert implants and administer PrEP) is lacking.

- **National-level priority-setting** for the integration of PrEP into FP/SRH programs could potentially push well-resourced donor-funded PrEP programs to:
  - **Ensure national integration targets** are agreed, that donors must get in line to support
  - **Invest in PrEP awareness-raising** for providers and communities, esp. key populations and AGYW
  - **Support human resources** required for the integration of PrEP (and future HIV prevention products) into FP programs – following the example of PMTCT and VIAC.
- **Operationalize national priorities** to mainstream YF service delivery by fully training and capacitating providers across all levels of the health care system to provide comprehensive YF services.
- **Mandates focused on cascading** could ensure **training** of one HCW is shared (e.g. training of trainers)
- **M&E systems** need to be revised or strengthened to capture integration, and to ensure documentation of HIV services (including PrEP) being delivered in SRH service areas and vice versa.

Provider perspectives on integration

HIV Providers

- PrEP is being offered within OI clinics; most of these offer YF services or referrals to SGBV clinics. PrEP should be made available outside OI clinics (e.g. in ANC) – clients are being lost.
- M&E tools are not integrated; sharing and/or having HIV registers in the FP area and vice-versa, and within pharmacies, helps facilitate required documentation.

FP Providers

- Awareness of PrEP is low, and PrEP is not integrated in SRH services at all – HIV testing is not followed up with risk assessment or PrEP referrals for high-risk clients who test negative.
- Training (in HIV and YF service delivery) is required to ensure adequate staff to provide HTS, long-acting contraception (e.g. implants) and eventually PrEP in a manner acceptable to AGYW. Currently: they offer what they know.

YF Providers

- One room, one (YF) provider is best model to reach youth. Need PrEP available in SGBV and youth centers.
- AGYW with children are not treated as youth, referred to general primary care.
- Often YF services offered certain days or hours – should be available at all times.
- By policy, services should be free for youth, but with shortages, AGYW forced to pay for products they cannot afford.
- Critical aspect of YF service delivery is respect, which opens up opportunities to deliver HIV/ SRH services, even if youth come for other services.

Key Takeaways: Training is the most critical need for expanding integration, and the delivery of PrEP and YF services.

- **Integration is happening in important ways in both HIV and FP/SRH service areas.** HTS is routinely offered in SRH/FP spaces; FP and other SRH services are routinely offered in OI clinics – except for PrEP. There needs to be a national mandate to integrate PrEP into FP and ANC, and YF services areas (that donors get behind and support).
- **Supply chain and stockout issues need to be addressed,** in particular for implants and other products dependent on external procurement.
- **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, and to ensure YF service delivery.
- 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.

"If we are providing PrEP as a hospital but they have to go to OI to get, it becomes a barrier. You tell them please go to OI, and you give them directions, then you call OI to check if the client has arrived; they don't get there".
YF Provider, Bulawayo

AGYW and CSO perspectives on integration

- **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. Creates delays and 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 FP, a client is asked to come back to access HIV services.

"If you go to (the clinic) they only offer certain services at certain times, in fact they have a timetable. So if you don't know it you will miss it. ***If you come in the afternoon most times they will tell you they are done for the day and you have to come back the next day.***"
CSO dialogue, SHAZ! HUB

Access to services for AGYW in rural communities

- **Stockouts are common** – even male condoms are reported to be in short supply. When FP methods are out of stock, AGYW will "buy from the street" or HCWs will demand bribes.
- **FP is more readily available** than HIV services. PrEP is non-existent (except through DREAMS). HTS limited to PMTCT.
- **Religious and cultural beliefs remain a significant barrier**, including the belief that no girl should have sex before marriage. Virginity tests may be performed. Followers of certain religious sects are forbidden to seek modern medicine, including FP.
- The concept of youth friendly clinics is "unheard of."
- **Village Health Workers (VHWs) and outreach can be key**, with VHWs discretely supplying FP methods.

"If you want pills you pay one US dollar for two packets to the nurse. Otherwise they will just say there is none available. ***Most of us cannot afford that so we end getting those from the market*** *at five Zim dollars, which is slightly cheaper."*
CSO Dialogue, Katswe Sisterhood, Zimbabwe

"The girls and women show real fear when you mention clinics and FP. They believe the religious leaders can tell that one went to the clinic through the holy spirit. ***You will even be forbidden from taking part in church activities just for going to a clinic****."*
CSO dialogue, RNCYP

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

Choice, integrated and differentiated care

"At the end it has to be about choice so that an AGYW is able to access what works best for her…Adolescents are actually not a homogenous group; remember some of them are married. Some are out school and others are in high school, etc. So their choices and preferences are very different." CSO dialogue, RHRN

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

"Sometimes one pays 25 dollars user fees to be able to get to the clinic, only to be told that the particular service they need is not available. They are referred to another centre where they again need to pay 25 to access the clinic. After that they also need to buy the medication…Ideally all services should be free and in one place." CSO Dialogue, RNCYP

Respect and non-judgmental care

"Here (at a youth drop-in centre) I'm treated well. The staff is friendly and I meet other young people my age. I'm on PrEP and no one asks me why I need PrEP, like what have I done that warrants you taking PrEP." AGYW 16-24, SHAZ! HUB

Privacy and Confidentiality

"I prefer somewhere private so that one cannot guess what service I am there for. Unlike at (regular health) clinics where one can tell that you are now going for HIV testing which means you are having unprotected sex." AGYW 16-24, SHAZ! HUB

Youth Friendly and Integration Continuum for AGYW

Level 1 No accommodation	Level 2 Referral out to youth center	Level 3 Mainstreaming: trained providers and spaces within OI clinics offering FP or accompanied referral for FP; FP areas offering HIV services or accompanied referral.	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
Intensity of Youth Friendly Service Provision				
No special accommodation is made to provide YF services. Integration is generally through internal referral, but without accompanying or fast- tracking AGYW.	AGYW are referred to SGBV clinics or standalone NGO sites. However, referrals are not accompanied or specifically tracked.	Public sector HCWs are trained to to attend to youth privately. Accommodations may be made to address the needs of adolescents – e.g. separate hours, certain days of the week or month. HIV/SRH services are integrated, with referrals made to OI clnics on site for ART and PrEP. Ideally, AGYW referred are accompanied and fast-tracked.	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.	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.
Where facilities in the assessment fell along the continuum				
	Nyazura Primary, Chishapa Primary, Mwami rural health centre	Rusape General Hospital	CitiMed Secondary, Gweru Provincial. Spilhause Family Planning Clinic	SHAZ! HUB, ZNFPC 5th Ave Clinic, UBH youth friendly services wing

Stand alone vs mainstreamed YF services: Stand alone facilities offer more of what youth want, but mainstreaming is more feasible.

Stand alone YF service delivery (partner supported)

- Separate buildings, or spaces within larger facilities
- Typical Staffing:
  - YF coordinator
  - Nurses/midwives trained in comprehensive YF services
  - Peer counselors/educators and CATS
- Space: strictly youth environment; private waiting areas and consultation rooms; often includes computers, wifi, TV, life skills education and other recreational opportunities.
- Services offered: Comprehensive SRH and HIV services, however not typically offering PrEP.

Model offers youth private, confidential and tailored services, but may be too expensive for widespread scale-up. Peer support for PrEP highly effective.

Ideally, PrEP and ART would be provided in-house.

Examples: SGBV clinics, SHAZ!, UBH YF centre, and 5th Ave ZNFPC

Mainstreamed YF service delivery (MOHCC Policy)

- Providers at all levels are capacitated through training, supervision and mentorship to provide YF services
- Typical Staffing:
  - Sub-set of providers in every service delivery area trained in YF service delivery
  - Possibly peer counselors/educators and CATS (with Partner supported sites)
- Space: Youth access services in main facility areas, including waiting areas. Sometimes YF services are offered during certain days or times.
- Services offered: Comprehensive SRH and HIV services. Referrals to OI clinics for ART and PrEP.

Model less expensive than stand-alone clinics, theoretically offers YF services at all service points; but capacity is limited.

Ideally, PrEP and ART would be provided in MCH/FP areas (e.g. not just in OI clinics).

Examples: Rusape General, Chishapa Clinic, Nyazura Clinic

Key Takeaways: IP innovations and pilots offer integrated YF services and PrEP, but these are not accessible to most.

Implementing Partner Innovations

- **New Start Centers** (PSI) offer integrated HIV/SRH services including FP, HTS, HIV treatment and PrEP.
- Two **ZNFPC/PrEP pilot sites** (CHAI) in Harare. Recommendations made to offer PrEP in all ZNFPC sites; however, this has not yet been enacted due to limited resources to support training and capacity building.
- **UNFPA linkages program**, and integrated Sexual Gender-Based Violence (SGBV) facilities, including YFHIV/SRT services in 7 districts (but not PrEP).
- **Youth/AGYW-specific services**
  - Shaping the Health of Adolescents in Zimbabwe (SHAZ! HUB) – offering comprehensive HIV and SRH services, including PrEP, to over 1,000 AGYW per year.
  - 5th Ave. and Magunje ZNFPC clinics offering youth-friendly FP services, and in Magunje PrEP services.
  - DREAMS offering laying of interventions, including FP through UMHULI in Chipinge, Makoni and Bulawayo, including **DREAMS HIV prevention ambassadors**.
- PZAT piloting **PrEP Communications accelerator** to create demand for PrEP among AGYW.

Key Takeaways: mainstreaming YF services will require investments in training and service delivery modalities to fully meet the needs of AGYW.

Further investments in staff training:

- On youth friendly service delivery to **ALL** health care workers (not just one or two per site)
- To offer **ALL** SRH and HIV services, including **long acting contraception (e.g. implants) and PrEP**
- Job aids and tools that highlight **respect, privacy and confidentiality**

Creating spaces for young people:

- **Separate clinic times** for youth to better fit their schedules (after 5pm, during weekends and school holidays)
- **Specific accommodations** for youth to ensure privacy and confidentiality

Champions (individuals trained in specific service delivery specialties) can be utilized to promote integration.

- Opportunities to **identify and invest in "integration champions"** across the health system
- **Incentives (e.g. payment, t-shirts, airtime) are highly motivating to champions**, and when feasible can be used to help ensure training is put to use.

Level	Actions needed
 **Policy level**	• 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**	• Integrated annual workplans developed by HIV and RH focal persons • Joint supervisory visits to facilities by district managers • Joint training and on-the-job-training for HIV and SRH/FP providers
 **Facility level**	• 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**	• PrEP champions to promote and provide FP education and counseling alongside PrEP • Provide incentives to motivate champions to deliver on targets

Conclusions and Recommendations

Conclusion #1: Zimbabwe has policies that address HIV/FP integration, but national health and HIV strategies must be **updated to guide integration of PrEP within FP and SRH services**, including operational guidelines on ***how*** to do it.

- The National Health Strategy should address the need for high-level integration of HIV/SRH and MNCH services.
    - The HIV Health Sector Strategy should address the need for PrEP to be made available in FP and SRH services – with specific indicators and targets (similar to those that currently exist for HIV/TB and HIV/MNCH).
    - National plans should address targets for integration and PrEP delivery.
    - HCWs, and provincial and district managers, need operational guidance and investments in training to capacitate HIV testers and SRH HCWs to conduct education about and screening for PrEP, and ideally PrEP delivery.
- 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: Donor-funded priorities tend to invest in vertical programs, effectively hindering national efforts to integrate and invest in the delivery of PrEP within FP and family health programs.

- Donors in support of Zimbabwe's health and HIV strategies should invest in priorities and targets outlined by the national programs, including those that focus on integration.

- Support from donors investing in Zimbabwe's HIV and PrEP programs should include funds for training and building HCW capacities to delivery PrEP, not just within OI clinics, but also within FP and SRH services, including ZNFPC facilities.

- Donor targets should align on and support MOHCC's integration and PrEP targets.

Conclusion #3: As government moves toward mainstreaming YF service delivery, there is a critical need to ensure access to HIV/SRH service among AGYW across different types of facilities.

AGYW need:

- access to non-judgmental providers who respect their need for: **Choice, Access, Respect and Privacy.**
- Fully stocked facilities and trained HCWs to provide **all** FP and HIV prevention services, e.g. **including implants and PrEP.**
- YF services available at times that work for young people (e.g. after school and during weekends), and through days of the week or month set aside for youth only.

Primary	Capitalize on inherently integrated facilities by equipping all HCWs to offer YF FP/HIV services, including implants and PrEP.
Secondary and beyond	Capacitate SRH/FP providers to offer YF PrEP education and counseling, accompanied referrals to OI clinics, and ideally the delivery of PrEP.
Family planning clinics	Ensure that FP providers are equipped to deliver 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. Ensure access to PrEP.

Conclusion #4: Implementing the Comprehensive National HIV Communications Strategy can drive demand

- The HIV Communications Strategy can guide a national effort to sensitize HCWs and the general public about HIV prevention, including PrEP.

- It is critical to secure funding and begin implementing aspects of the strategy to promote demand creation for PrEP at the community level, and to raise awareness about HIV prevention and PrEP across all levels of the health care system.

Actionable Recommendations: MOH/Government

National Level

- Ensure updates to the national health and HIV strategies provide concrete targets and operational guidance for integrating PrEP within FP, MNCH and YF services:
  - Develop integrated training curriculum on PrEP, as an online course and within existing training modules used with FP/MCH providers to educate about and screen for PrEP.
  - Strengthen district mentoring teams to ensure they are able to mentor on PrEP.
- Create a costed implementation plans for the mainstreaming of YF service delivery, and the HIV communications strategy - use these to mobilize resources
- Revise M&E tools to allow for documentation of integrated HIV/PrEP service delivery

Provincial level: Oversee integration efforts at district-level

District level: Develop integrated workplans reflecting PrEP introduction in ANC/SRH, and HIV/RH coordination on training, supportive supervision, review meetings and YF service delivery mainstreaming. Oversight from district managers critical to train and support HCWs to fully realize integrated YF service delivery, monitor implementation and address gaps.

Actionable Recommendations: Facilities

- Ensure HCWs are **capacitated in YF and PrEP** service delivery
- Implement a system for **cascading training** when one HCW is trained in YF service delivery, and/or products (e.g. PrEP and Implants), to all HCWs on site
- Ensure that **IEC materials** for both FP and HIV are available throughout facilities – focus on educating HCWs and promoting PrEP (as has been done for VIAC and VMMC)
- Share and/or have **HIV registers** in FP area and vice-versa, including at pharmacy-level, to facilitate documentation

Actionable Recommendations: Donors

- Invest in and align with priorities and targets outlined by the national programs, including those that focus on integration and the delivery of PrEP in FP/SRH service delivery points.

- Support training and building HCW capacities to delivery PrEP, not just within OI clinics, but also within FP and SRH services.

Next Steps

- Share and discuss findings and next steps with with MOHCC leadership: AIDS and TB, Family Health, ZNFPC and the National Integration Coordinator (June 2020)

- Present findings through upcoming virtual Prevention Partners Forum in June 2020

- Potentially establish a national working group to carry forward priorities identified/commitments made through dissemination efforts.

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