

OPTIONS

Integrated Service Delivery

Findings on integration of oral PrEP into family planning services for adolescent girls and young women in sub-Saharan Africa

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About the analysis

- This analysis builds on the product introduction framework developed by OPTIONS to support national rollout and scale-up of oral pre-exposure prophylaxis (PrEP).
- It introduces an adapted framework to identify enabling factors for service integration.
- While integration across all HIV and sexual and reproductive health (SRH) services is important for women, this analysis focuses on integration of oral PrEP provision into family planning (FP) services.
- This framework is intended to support planning for delivery of oral PrEP, the dapivirine ring, and future multipurpose technologies in FP settings, particularly to expand reach to adolescent girls and young women (AGYW).
- The framework was developed based on insights from 7 countries: South Africa, Kenya, and Zimbabwe (OPTIONS focus countries) and Malawi, Lesotho, Uganda, and Zambia (other countries at varying stages of PrEP rollout and PrEP–HIV integration).
- Development of this analysis reflects the knowledge, input, and previous work of many country experts and partners, including interviews and input from ~30 key country experts and program leaders.
- Additional detail on sources and a list of interviewees who informed this analysis are in the appendix.



Glossary

AGYW	Adolescent Girls and Young Women
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Treatment
BCC	Behavior Change Communication
CHW	Community Health Worker
CIP	Costed Implementation Plan
FP	Family Planning
HMIS	Health Management Information Systems
HSA	Health Surveillance Assistant
HTS	HIV Testing Services
IEC	Information, Education, and Communication
IPV	Intimate Partner Violence
IUD	Intrauterine Device
LARC	Long-Acting Reversible Contraception (e.g., IUDs, implants)
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
NGO	Non-Governmental Organization
PHC	Primary Health Clinic
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
PrEP	Pre-Exposure Prophylaxis

SBCC	Social and Behavior Change Communication
SOP	Standard Operating Procedure
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TWG	Technical Working Group
YFHS	Youth-Friendly Health Services

Key Findings on the Current State of Integration

Detailed Findings on the Current State of Integration

Appendix: Detail by Country



Context

- **Integration between HIV and family planning (FP) services**, especially for AGYW, is a renewed area of focus for national policymakers, donors, and implementers. This interest is driven by two factors:
 - Recent findings from **PrEP implementation studies and the Evidence for Contraceptive Options and HIV Outcomes (ECHO) trial**, which highlight that general population women receiving FP services demonstrate high levels of HIV incidence and need HIV prevention, screening, and treatment in addition to FP.
 - Scale-up of **Oral PrEP** (and, in the future, the dapivirine ring and multipurpose prevention technologies), which may more effectively reach target populations, especially AGYW, in FP settings where they already receive preventive health services.
- However, experience demonstrates that **integration is challenging**. Although clients are interested in receiving integrated services, difficulties in implementation have resulted in mixed outcomes.
- Challenges arise because integration may require a **systems approach** and cannot be handled at the service delivery point alone. A number of cross-cutting factors, including policy, supply chain, provider training and mentorship, demand creation, and monitoring and reporting, need to be in place to effectively support integrated service delivery.
- To-date, **implementation of integrated services** has been largely pursued in small programs run by nongovernmental organizations (NGOs) with specific integration mandates or in settings designed to be “adolescent friendly.” No country included in this analysis has fully integrated HIV and FP services across public health settings, although some (e.g., Kenya, Uganda, and Zambia) are making progress.



Integration needs to be grounded in the reality of PrEP and FP delivery

Differences and similarities in PrEP and FP services

	Demand	Initiation of services	Follow-up
Specific to Family Planning	<ul style="list-style-type: none">• Greater demand for services and more knowledge of available method choices among target populations compared to PrEP• FP services can be accessed in local or community-based settings or pharmacies	<ul style="list-style-type: none">• Range of providers offer multiple FP methods and services relatively quickly:<ul style="list-style-type: none">○ Doctors, nurses, pharmacists, and community health workers (CHWs) serve as FP providers○ Common methods (e.g., injection, pill) can be provided without risk screening or testing, with minimal counseling○ Long-acting reversible contraceptive methods (LARCs) require procedures, but self-care options are also available	<ul style="list-style-type: none">• Different methods have different typical clinic visit schedules:<ul style="list-style-type: none">○ Pill and injection: 2-3 month schedules○ LARCs: 1-, 3-, 5-, or (for intrauterine devices [IUDs]) 10-year schedule• Providers discuss follow-up but do not emphasize or monitor continuation to avoid “coercing” clients
Specific to Oral PrEP	<ul style="list-style-type: none">• Lower levels of urgency around HIV risk and less knowledge of PrEP among target populations than for FP – clinicians are required to provide more information• PrEP access primarily in clinical HIV settings	<ul style="list-style-type: none">• Initiating PrEP requires clinicians and laboratory access:<ul style="list-style-type: none">○ Testing and screening procedures required depend on the country (e.g., HIV risk screening, HIV testing and counseling, PrEP eligibility screening, PrEP counseling, and creatinine clearance testing)○ Most country guidelines require doctors or nurses with PrEP training to deliver PrEP; support staff can complement with HIV testing and counseling	<ul style="list-style-type: none">• PrEP typically requires monthly visits at first, transitioning to a quarterly visit schedule<ul style="list-style-type: none">○ Visits are required for HIV tests, PrEP refills, and creatinine clearance testing in some countries• Effective use is a top priority<ul style="list-style-type: none">○ Providers emphasize adherence and continuation for effective prevention
Shared Aspects	<ul style="list-style-type: none">✓ Demand is driven/hindered by similar individual and systems factors (e.g., knowledge of risks, agency, stigma, community acceptance, partner dynamics)	<ul style="list-style-type: none">✓ FP and PrEP require counseling on method choice and side effects, especially at initiation✓ Judgment-free service delivery is critical, especially for AGYW✓ Differentiated service delivery facilitates uptake	<ul style="list-style-type: none">✓ Follow-up in most countries for common FP methods and PrEP is aligned to a 2- to 3-month schedule (e.g., for the pill or injectable contraceptives)

Integrated FP and PrEP services look different across contexts

Integration examples



Example 1: One provider provides a range of FP and HIV services

- In the **high-volume, Tier I, or central hospitals** or NGO-run programs where PrEP is most often available, this entails supporting HIV or FP providers to transition to integrated service delivery, with integrated training, job aids, risk screening and counseling, and monitoring, while leveraging task-shifting and other methods to lessen the burden on providers. This model is not frequently seen in practice.
- In **low-volume clinics, at the district or community level**, clinicians typically cover a broad range of healthcare services, including HIV testing and FP. Currently, the ability to add PrEP services is limited due to low access to laboratories for testing, especially if creatinine tests are required.

In **Zambia**, the JSI Discover Health project* has been integrated from the start, with each provider delivering HIV, HTS, and FP services in one visit. In **Zimbabwe**, primary providers in small clinics offer integrated services across FP and antiretroviral therapy (ART). They do not currently offer PrEP, which is available in central and district hospitals.



Example 2: One facility provides a range of FP and HIV services with strong referral mechanisms

A more common model of integrated service delivery at larger health facilities is when specialized service providers continue to provide separate HIV or FP services (e.g., a PrEP provider is “embedded” in FP services or facilities offer multiple services), but investments are made to support effective referrals (e.g., FP providers conduct HIV risk-screening, lay counselors support counseling, counselor-accompanied referrals, and/or fast-track mechanisms).

In **Kenya**, designated “youth-friendly wings” provide FP, HTS, and PrEP services, with counselors available to facilitate accompanied, “fast-track” referrals between services.



Example 3: Separate but co-located FP and HIV services are offered simultaneously

A good first step is to ensure services are offered in the same place at the same time (e.g., at the same facility and/or coordinated community-based programs); however, experience suggests this model requires strong referrals and/or fast-track mechanisms to effectively support clients to take up multiple services, even when services are offered simultaneously.

In **Lesotho**, community-based programs run by Jhpiego (HIV prevention/PrEP) and PSI (FP) co-located but found low uptake of services due to wait times to transition between services.



For all models, the full system needs to align to support sustained integration at scale

For PrEP and FP services to be integrated at the provider, facility, or community program level, other elements of the system need to support alignment.








PLANS & POLICIES	RESOURCE MANAGEMENT	SERVICE DELIVERY	PrEP USE	MONITORING & REPORTING
National and subnational policy provides a mandate to catalyze integration, and dedicated resources support policy implementation.	Procurement and supply chain systems are aligned to ensure FP facilities and programs are able to access, store, and manage PrEP stocks.	Healthcare workers are motivated to provide integrated services and receive training, supportive supervision, and mentorship to sustain high-quality, efficient delivery of PrEP in FP settings.	Clients understand their HIV risk and options, feel comfortable receiving PrEP in FP settings, and are able to safely and effectively use FP and PrEP simultaneously.	Follow-up and monitoring/reporting systems are aligned to enable efficiency for clients and healthcare providers.

Other critical factors that underpin provision of integrated PrEP and FP services for women and AGYW are: health system resources to effectively manage integrated services, cooperation between implementing partners, community acceptance, judgment-free service provision from healthcare providers, and consideration of partner dynamics, including risk of intimate partner violence (IPV).



17 elements support integration of PrEP into family planning services

PrEP–Family Planning Integration Framework

PLANS & POLICIES 	RESOURCE MANAGEMENT 	SERVICE DELIVERY 	PrEP USE 	MONITORING & REPORTING 
<p>Integration plans National PrEP plan includes FP sites as PrEP delivery channels, supported by broader prioritization of HIV–FP integration in national HIV, FP, and/or SRH plans.</p>	<p>Financing Financing for HIV prevention, and oral PrEP specifically, is available to be used in FP settings to support integration.</p>	<p>Risk screening & HIV testing FP providers and/or counselors regularly provide risk screening, HIV tests, and referrals to HIV services for FP clients in accordance with guidelines and/or standard operating procedures (SOPs).</p>	<p>Demand creation National/local communications promote comprehensive prevention (e.g., HIV and FP) and PrEP availability in FP sites.</p>	<p>Registers & forms FP sites have combined registers and forms (e.g., lab forms) for HIV prevention, PrEP, HTS, and FP.</p>
<p>Coordination bodies & champions National and subnational policymakers actively support FP–HIV prevention integration, either as part of a coordinating body (e.g., technical working group [TWG]) or as individual champions.</p>	<p>Procurement HIV and FP procurement are centralized and coordinated so that PrEP can be easily procured in FP facilities and programs.</p>	<p>Provider training PrEP training is widely available to FP providers (e.g., FP providers are invited and able to attend training, and training time is not prohibitive).</p>	<p>Client information Integrated materials on PrEP and FP are available in FP and HIV settings to support uptake and continuation (e.g., covering side effects).</p>	<p>Facility monitoring & reporting FP monitoring & reporting systems are able to capture indicators and data on HIV testing, PrEP eligibility, PrEP initiation, and PrEP use alongside reporting on FP services.</p>
<p>Guidelines for differentiated delivery Guidelines enable PrEP delivery across FP sites by allowing non-HIV providers to offer PrEP, not requiring creatinine clearance testing, and allowing multi-month prescriptions for PrEP.</p>	<p>Supply chain management FP sites have effective mechanisms for forecasting demand, avoiding stock-outs, and managing PrEP stores.</p>	<p>Ongoing mentorship/supervision Regular mentorship/supervision exists for integrated service providers (e.g., by cross-cutting teams at county or district level).</p>	<p>PrEP refills PrEP users can get quarterly refills aligned with FP visits at FP sites, and vice versa.</p>	
<p>Eligibility criteria PrEP is available for general population women and AGYW, in alignment with FP eligibility.</p>		<p>Support staff capacity Support staff (e.g., lay counselors, navigators, peer educators, mentors, CHWs) enable provider task-shifting to support integrated service delivery.</p>	<p>Effective use FP providers and support staff are able to support and counsel PrEP clients on adherence and continuation.</p>	



Consistent patterns emerge across the 7 countries in this analysis

Summary of key findings



PLANS & POLICIES

Integration Enablers

- Many policymakers have renewed interest in service integration.
- National plans often cite service integration as a priority for the health system.
- Most countries do not require creatine testing.

Integration Barriers

- While plans cite integration, that often does not translate to widespread implementation because integration is not a core responsibility for any actor (e.g., no TWG, no local-level support) and dedicated resources to roll out integrated processes/systems are limited.



RESOURCE MANAGEMENT

- Many countries have centralized procurement systems that support HIV and FP programs.
- HIV programs are well-resourced and have the potential to support integrated service delivery.

- Many FP programs operate at/over capacity; integrating PrEP into FP without additional resources risks reducing the quality of both services.
- In some settings, both HIV and FP programs experience regular commodity stock-outs, which can hinder integration efforts.



SERVICE DELIVERY

- Lay counselors, peer educators, expert clients, or navigators provide additional capacity for testing, counseling, and referrals to support integrated service delivery and alleviate provider burden.
- HIV self-tests can alleviate the additional burden on FP providers and streamline the client experience.

- Many FP providers are not trained to provide HIV services, including PrEP.
- HIV risk screening, testing, and counseling (e.g., risk assessment, discussion of sexual partners) is not a regular practice in FP services.
- Provider attitudes toward PrEP provision, especially for AGYW, will be a challenge for integrated services — as they are for independent services.
- Providers in smaller clinics already provide integrated services, but many have not yet been trained in PrEP provision.



PrEP USE

- Demand creation barriers are similar across FP and HIV prevention (e.g., stigma, partner dynamics).
- Visit schedules for PrEP and FP are aligned for the most common FP methods (e.g., quarterly).

- There are few examples of integrated demand creation.
- Integration could exacerbate challenges of stigma — efforts to improve acceptance of HIV prevention/PrEP are critical.
- HIV prevention and FP take different approaches to supporting follow-up.



MONITORING & REPORTING

- Monitoring and reporting systems are often siloed, with different registers for different services that are not always available across services.



Plans & policies key interview findings



PLANS & POLICIES

Integration plans

National PrEP plan includes FP sites as PrEP delivery channels, supported by broader prioritization of HIV–FP integration in national HIV, FP, and/or SRH plans.

*“In Kenya, there was widespread acknowledgement that the policy environment is conducive to HIV/SRH integration, although a lot of it **needs to be updated to include PrEP specifically.**” — Kenya*

*“The national PrEP implementation plan mentions integration, and it’s in the framework that PrEP should be offered within every service delivery point in a facility — including adolescent clinics, SRH, outpatient, and antenatal care (ANC). But in practice, it’s not really happening — some of it is resources and in part it was the early focus on PrEP for serodiscordant couples. **It’s in the guidelines but not reinforced on a practical level.**” — Lesotho*

Coordination bodies & champions

National and subnational policymakers actively support FP–HIV prevention integration, either as part of a coordinating body (e.g., TWG) or as individual champions.

*“A missing link is that integration is being discussed at national level, but **who really champions integration?** There is no unit — no one is really in charge of integration.” — Malawi*

*“There is good understanding at the national level, but there is a **disconnect at the district or facility level.**” — Lesotho*

*“The **county-level technical working groups are critical.** They will forecast for commodities, which now needs to happen collaboratively, conduct joint data reviews to look at how well PrEP uptake is among family planning clients, supervise integration of services, etc. That structure is critical to any of this going forward.” — Kenya*

Differentiated care guidelines

Guidelines enable PrEP delivery across FP sites by allowing non-HIV providers to offer PrEP, not requiring creatinine clearance testing, and allowing multi-month prescriptions for PrEP.

*“When integrating into FP services, they’ve already started exploring **different levels of the healthcare system.** With PrEP, you need to hook into those systems. What can a community health worker do?” — Global*

*“For PrEP, at this point, we expect it would be offered in central and district hospitals. Because of the **requirement of the creatinine clearance test** at initiation, 6 months, and 1 year – those labs are only at those facilities.” — Malawi*

*“Our public health facilities are very crowded. Without **multi-month scripting** for PrEP and FP, I’m not sure how to manage it.” — Zambia*

Eligibility criteria

PrEP is available for general-population women and AGYW, in alignment with FP eligibility.

*“This really emphasizes the **importance of not having PrEP be for certain populations.** PrEP is for people who feel they need it, and that will be important at FP settings. PrEP will need to be de-stigmatized for the general population.” — Global*

*“We are now looking at PrEP in FP settings because of our **focus on AGYW.**” — Uganda*



Resource management key interview findings

RESOURCE MANAGEMENT



Financing

Financing for HIV prevention, and oral PrEP specifically, is available to be used in FP settings to support integration.

*“Funding can be a real challenge depending on the donor. We had a grant that included improving FP services for AGYW, because that is such a big gap. Every time we included FP elements, we had to justify how it helps meet the 90-90-90 goals. But we couldn’t always link it to 90-90-90 — it was **an uphill battle**.” — South Africa*

*“There are so **many more resources on the HIV side** through PEPFAR and Global Fund. When we were trying to push integration of FP into HIV services, we were advocating to PEPFAR to support integration and it will likely be the same here — the only issue is that you can’t purchase the commodities.” — Global*

Procurement

HIV and FP procurement are centralized and coordinated so that PrEP can be easily procured in FP facilities and programs.

*“Integration would be ideal, but we haven’t done it yet and **commodities are our biggest challenge**. In Lesotho, another NGO is responsible for FP implementation in communities. When we go to the district manager to get FP commodities, it doesn’t make sense to them — they see it as the other NGO’s role. So, we have commodities for PrEP and we’ve trained providers to deliver both PrEP and FP, but we cannot get the FP commodities. We just had a meeting about it today, but it requires coordination across multiple units within the Ministry. Those silos then flow down to the service point.” — Lesotho*

*“The procurement and distribution of FP commodities is independent of PrEP. We will need to see how to **harmonize** that— how can people receive both at the same time?” — Uganda*

Supply chain management

FP sites have effective mechanisms to forecast demand, avoid stock-outs, and manage PrEP stores.

*“In the supply chain, **FP sites are not set up to work with ARV medications**. ANC clinics are better — they have a dedicated cabinet for ARVs and accountability logs to account for the medication. From the start of our work [to deliver PrEP in FP clinics], the medications were not at the clinic, so we needed to work with [the national and county governments] to ensure that the drugs were getting to the facility. It just took a few months to work out, but we needed to do that.” — Kenya*

*“It’s not just procurement, but also ongoing **storage and management** of PrEP that FP clinics will need to think about.” — Zimbabwe*



Service delivery key interview findings

SERVICE DELIVERY



Risk screening & HIV testing

FP providers and/or counselors regularly provide risk screening, HIV tests, and referrals to HIV services for FP clients in accordance with guidelines and/or standard operating procedures (SOPs).

*“**Screening for HIV** in FP and maternal and child health services is standard. It’s something that happens in all FP services.” — Zambia*

*“For FP services, we know that clients could be at high risk for HIV, but in that context, they’re mothers, they’re married, and so providers don’t ask clients to take an HIV test. Implementing **risk assessments is a good first step**. Even if providers need to refer clients to another office, implement the risk assessment questionnaire in FP settings and share information about PrEP. That could go a long way.”*

— Kenya

*“Our HIV **job aids** have some FP prompts in them. But our FP job aids generally do not have any HIV information in them.” — Zimbabwe*

Provider training

PrEP training is widely available to FP providers (e.g., FP providers are invited and able to attend training, and training time is not prohibitive).

*“You need to carry your providers along, invest in their training and orientation, and explain the program. At the beginning, we had to slow rollout and provide the training. You have to carry them along and invest heavily and **get their buy-in**.” — Zambia*

*“A lot of HIV providers have FP training, but the other way around is not true. There’s a certain level of competence among HIV providers for FP, but the same **competence and confidence** is not there for HIV among FP providers — it’s seen as a specialty.” — Kenya*

Ongoing mentorship/supervision

Regular mentorship/supervision exists for integrated service providers (e.g., by cross-cutting teams at county or district level).

*“The way that FP services are offered is very different. We don’t need to do a lot of education on FP. We help people make a method decision, but not to make a decision to use it overall, but this will be different with PrEP. It requires a more sensitive type of training and support. You’ll need **on-the-job support — observation, mentorship — to ensure high quality**.” — Global*

*“Providers will do a 3-day training on PrEP — that’s the MoH curriculum. The MoH also has a standard quarterly **supervisory visit with multi-disciplinary teams** that encompasses HIV, TB, FP, and many other things. That supports integration.” — Malawi*

Support staff capacity

Support staff (e.g., lay counselors, navigators, community health workers) enable provider task-shifting to support integrated service delivery

*“If HIV testing isn’t implemented regularly in facilities and FP service is quickly dispensing boxes of contraceptive pills, incorporating something that is going to take 20 to 30 minutes per client is a lot. Having some way to screen for HIV testing before getting to the provider is better. We’re also looking at **implementing self-testing at the facility**, as women are waiting for FP services — so that HIV testing isn’t a health personnel bottleneck.” — Kenya*

*“The other dimension we’ve looked at is the PrEP service cascade. What is the minimum that this provider would need to do? Risk assessments can be done by **non-clinical staff** so that the provider is focused on administration of PrEP.” — Zambia*



PrEP use key interview findings



PrEP USE

Demand creation

National/local communications promote comprehensive prevention (e.g., HIV and FP) and PrEP availability in FP sites.

*“The low-hanging fruit is to ensure we can **combine community mobilization efforts** to include both PrEP and FP demand generation, and vice versa.” — Global*

*“If we are going to integrate HIV and FP, we need **information in the community** so that people learn about it before they come to the facility. They need information before coming to the clinic and making a decision then and there.” — Zimbabwe*

Client information

Integrated materials on PrEP and FP are available in FP and HIV settings to support uptake and continuation (e.g., covering side effects).

*“When we are creating demand or producing materials for PrEP, we need to **integrate messages for PrEP and FP**, then train peer educators who are doing mobilization for PrEP. In their curriculum, we need to talk about both PrEP and FP.” — Uganda*

*“We’re working on stepped care model. On the ‘Be Wise’ site, people can come with questions and talk to a chatbot or a helpline, and then get linked to a healthcare provider. The whole approach is to **promote self-care around different needs**. Not just a pregnancy test, but also STI screening and HIV prevention, so that young people can understand their comprehensive needs.” —South Africa*

PrEP refills

PrEP users can get quarterly refills aligned with FP visits at FP sites.

*“We need to consider long-acting FP users. If you have a DMPA user, she is coming into the clinic **every 3 months**. Can you get a PrEP refill on that schedule at the same place?” — Global*

*“Our national guidelines for PrEP require clients to come in frequently at the beginning, so [FP and PrEP] are not aligned — especially for those who are on injectable. But the difference is that they don’t need to go to the ART clinic — they can go to a **service that they know and quickly get what they need**. After the initial few months, it is **aligned to a 3-month cycle** for both PrEP and FP.” — Zambia*

Effective use

FP providers and support staff are able to support and counsel PrEP clients on adherence and continuation.

*“Generally, in FP services, individual registers roll up into monthly overall numbers, so you can’t follow an individual. We load up women with information when they initiate a method, but then don’t do much after that to track adherence. The integration of PrEP could change that and put **more focus and resources on follow-up and adherence**.” — Global*

*“PrEP is meant to be voluntary, and people cycle on-and-off — for example, when their partner is home. People may want to discontinue and may need **counseling** to make a decision — but that’s not done in FP settings right now, so that’s an issue.” — Global*



Monitoring & reporting key interview findings

MONITORING & REPORTING



Registers & forms

FP sites have combined registers for HIV prevention, PrEP, HTS, and FP so that providers can use an integrated register to track services.

*“The **registers should be integrated** so that providers can complete it for one person across all of the services. As long as they are separate, healthcare providers will continue to see the different activities as add-ons.” — Zimbabwe*

*“We saw that HIV and HIV testing was much more integrated within maternal and child health (MCH) than FP – MCH already had universal HIV testing — that was part of the register, there were **indicators that MCH programs were reporting**, there was motivation around that. In FP, although there is lots of discussion, it is happening much less — it’s not what’s typically done.” — Kenya*

“One of the challenges that is coming up is that providers are burdened with so many registers for FP, for HIV testing, and now for PrEP. It’s something to think about. We may be able to at least start with integrated quarterly reporting, and then try to work on the registers.” — Uganda

Facility monitoring & reporting

FP monitoring & reporting systems are able to capture data on HIV testing, PrEP eligibility, PrEP initiation, and PrEP use alongside reporting on FP services.

*“For FP services, there is very little data keeping. Client usually has a piece of paper or a card, there is a register. There are no charts kept for FP clients. On the HIV care & treatment side, there is **a lot of paperwork** — for FP, there’s nowhere even to keep those types of records, and those systems don’t exist. How could that be done in a way that you can accommodate in the FP rooms, or who is responsible for tracking that?” — Global*




*“Registers are very fragmented, reporting systems are not aligned, and they’re limited and restricted, so you can’t see a lot of information. With PrEP, we have to open a client file, so we can see a lot more. PrEP is **an opportunity to improve monitoring of integration**, but the other services still need a lot of support.” — South Africa*

*“Initially, the government was having problems with implementing partners trying to meet PrEP targets by doing things like withholding a pregnancy test if clients didn’t take PrEP. That is a real thing to consider — how does this work with such a **target-driven program**?” — South Africa*



This framework can be used to assess progress toward integration

The following slide includes a more detailed PrEP–Family Planning Integration Matrix.

- For each element of the framework, the matrix identifies what is needed for:
 -  Level 1: Significant integration
Readiness to effectively deliver PrEP through FP settings for general population women and AGYW
 -  Level 2: Initial alignment
Some progress towards readiness to deliver PrEP in FP settings or ability to deliver PrEP in a subset of settings, with a focused integration mandate (e.g., youth-friendly services)
 -  Level 3: No integration
Separate systems for HIV prevention and FP that prevent delivery of PrEP in FP settings
- These levels were defined based on interviews and research on current activity to integrate HIV prevention and FP, with a specific focus on PrEP. Some of the elements are relevant for HIV prevention–FP integration more broadly (e.g., registers), while some are specific to PrEP (e.g., eligibility criteria).
- All of these elements are important to support sustainable PrEP delivery in FP settings at scale.

PrEP–Family Planning Integration Matrix

PLANS & POLICIES

Integration plans

1	National PrEP plan includes FP sites as PrEP delivery channels, supported by broader prioritization of HIV–FP integration in national HIV, FP, and/or SRH plans.
2	National plans prioritize HIV–FP integration, without a focus on oral PrEP.
3	National HIV and FP plans are separate and do not prioritize integration.

Coordination bodies & champions

1	National and subnational coordinating bodies (e.g., TWG) drive PrEP–FP integration.
2	National bodies are focused on integration, but there is no subnational support or coordination.
3	No body is responsible for integration.

Guidelines for differentiated delivery

1	Clinical guidelines enable PrEP delivery in a range of FP sites by: allowing non-HIV providers to offer PrEP, not requiring creatinine clearance testing, and allowing multi-month prescriptions for PrEP.
2	Guidelines include some enabling policies.
3	Guidelines include no enabling policies.

Eligibility criteria

1	General-population women and AGYW are eligible for PrEP.
2	General-population women are eligible for PrEP, but an age minimum limits PrEP access for AGYW.
3	Only serodiscordant couples and key populations are eligible for PrEP.

RESOURCE MANAGEMENT

Financing

1	Resources for PrEP procurement and service delivery, including development of integrated systems and procedures, are available to be used at public health sites that also provide FP services.
2	Resources are available for selected FP sites (e.g., donor-funded NGO programs).
3	No resources are available for PrEP in FP sites.

Procurement

1	HIV and FP procurement are centralized and coordinated at national/district/facility levels.
2	HIV and FP procurement systems are separate but allow FP sites to procure PrEP.
3	FP sites have no ability to procure PrEP without changes to procurement systems.

Supply chain management

1	FP sites have effective mechanisms for forecasting demand, avoiding stock-outs and managing PrEP stores.
2	FP sites are able to store and manage PrEP stocks, but experience regular stock-outs.
3	FP sites lack processes or infrastructure to forecast, order, and manage PrEP stores.

SERVICE DELIVERY

Risk screening & HIV testing

1	FP providers and/or counselors regularly provide risk screening, HIV tests, and referrals to HIV services for FP clients in accordance with guidelines and/or SOPs.
2	Guidelines exist for FP providers to deliver HIV risk screening and HIV testing but are not consistently applied.
3	No guidelines exist for FP providers to offer HIV risk screening and testing.

Provider training

1	PrEP training is widely available to FP providers (e.g., FP providers are invited and able to attend training, and training time is not prohibitive).
2	PrEP training is available to some FP providers (e.g., in youth-friendly sites).
3	No consistent PrEP training is available for FP providers.

Ongoing mentorship & supervision

1	Regular mentorship/supervision exists for integrated service providers (e.g., by cross-cutting teams at subnational level).
2	Mentorship/supervision for FP and PrEP is separate, with some focus on integration.
3	No ongoing mentorship or supervision of integrated service delivery are available.

Support staff capacity

1	Support staff (e.g., lay counselors, navigators, community health workers) enable provider task-shifting to support integrated service delivery.
2	Support staff available in selected FP sites.
3	No support staff available in FP sites.

PrEP USE

Demand creation

1	National/local communications promote comprehensive prevention (e.g., HIV and FP) and PrEP availability in FP sites.
2	National HIV prevention and FP campaigns are separate, with project promotion of PrEP availability at FP sites by selected sites or facilities.
3	PrEP is not promoted at FP sites.

Client information

1	Integrated materials on PrEP and FP are available in FP and HIV settings to support uptake and continuation (e.g., covering side effects).
2	PrEP-specific materials are regularly and widely available at FP sites.
3	No materials are shared.

PrEP refills

1	PrEP users can get quarterly refills aligned with FP visits at FP sites.
2	PrEP users can regularly access monthly PrEP refills at FP sites, but refills are not aligned to FP visits.
3	PrEP users are not able to access PrEP refills at FP sites.

Effective use

1	FP providers, support staff are able to support and counsel PrEP clients on adherence and continuation.
2	FP providers, support staff facilitate follow-up visits but do not counsel on adherence and continuation.
3	No follow-up support is provided.

MONITORING & REPORTING

Registers & forms

1	FP sites have combined registers and forms (e.g., lab forms) for HIV prevention, PrEP, HTS, and FP.
2	FP sites have a combined register for all HIV-related services, easily accessible for FP providers.
3	FP sites have multiple HIV prevention, HTS, or PrEP registers that may not be easily accessible.

Facility monitoring & reporting

1	FP monitoring & reporting systems are able to capture data on HIV testing, PrEP initiation, and PrEP use alongside reporting on FP services.
2	FP systems are able to capture data on HIV testing and PrEP initiation.
3	FP systems capture no HIV or PrEP data.

Level 1: Effective integration
 Level 2: Initial alignment
 Level 3: No integration

Key Findings on the Current State of Integration

Detailed Findings on the Current State of Integration

Appendix: Detail by Country



This analysis applies the Integration Framework across 7 countries

Countries included in this analysis

Kenya

Lesotho

Malawi

South Africa

Uganda

Zambia

Zimbabwe

For each country, the following slides include:

- Data on the state of oral PrEP rollout and data on use of family planning in each country, including the method mix for family planning
- Highlights of the key areas of progress and the challenges related to integration of services in each country to date
- An assessment against the integration framework (*see slide 17 for detailed version of framework*) for each country, with an assessment of each enabling element as follows:

 Level 1: Significant integration

 Level 2: Initial alignment

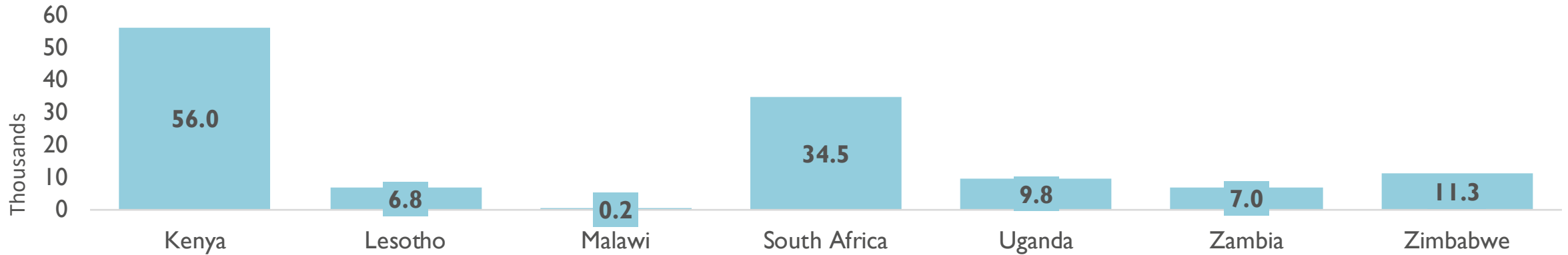
 Level 3: No integration

 No information to date



PrEP context by country

PrEP Users as of October 2019



Kenya
National PrEP rollout includes efforts to integrate HIV, STI, and FP services in “youth-friendly” wings at public health facilities and via donor-funded or NGO-run programs (e.g., DREAMS sites).

Lesotho
With early PrEP rollout focused on serodiscordant couples, PrEP has largely been made available in HIV settings; guidelines note integration, but no translation to FP service delivery to date.

Malawi
PrEP has not yet been rolled out; initial plans focus on PrEP delivery in HIV, STI, and ANC facilities in central and district hospitals (due to required creatinine clearance test).

South Africa
PrEP has been introduced largely in HIV settings, but is currently scaling up. Policies prioritize integration, but with little translation to service delivery, in under-resourced FP settings.

Uganda
Uganda has rolled out PrEP in selected HIV settings. As the country plans for scale-up, they are developing a national strategy and plan to integrate PrEP with FP services to reach AGYW.

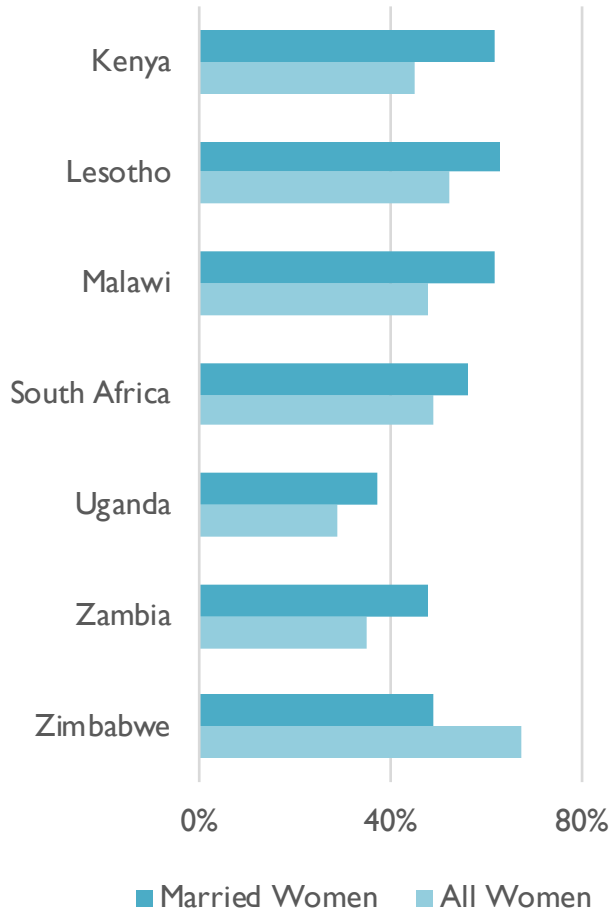
Zambia
PrEP has been delivered largely in NGO-run programs, which focus on integration (e.g., FP providers regularly provide HIV tests), with limited PrEP provision in under-resourced public health FP settings.

Zimbabwe
PrEP is currently available in central & district hospitals, but not in FP settings, with policy-level buy-in for integration, but little follow-through in service delivery.

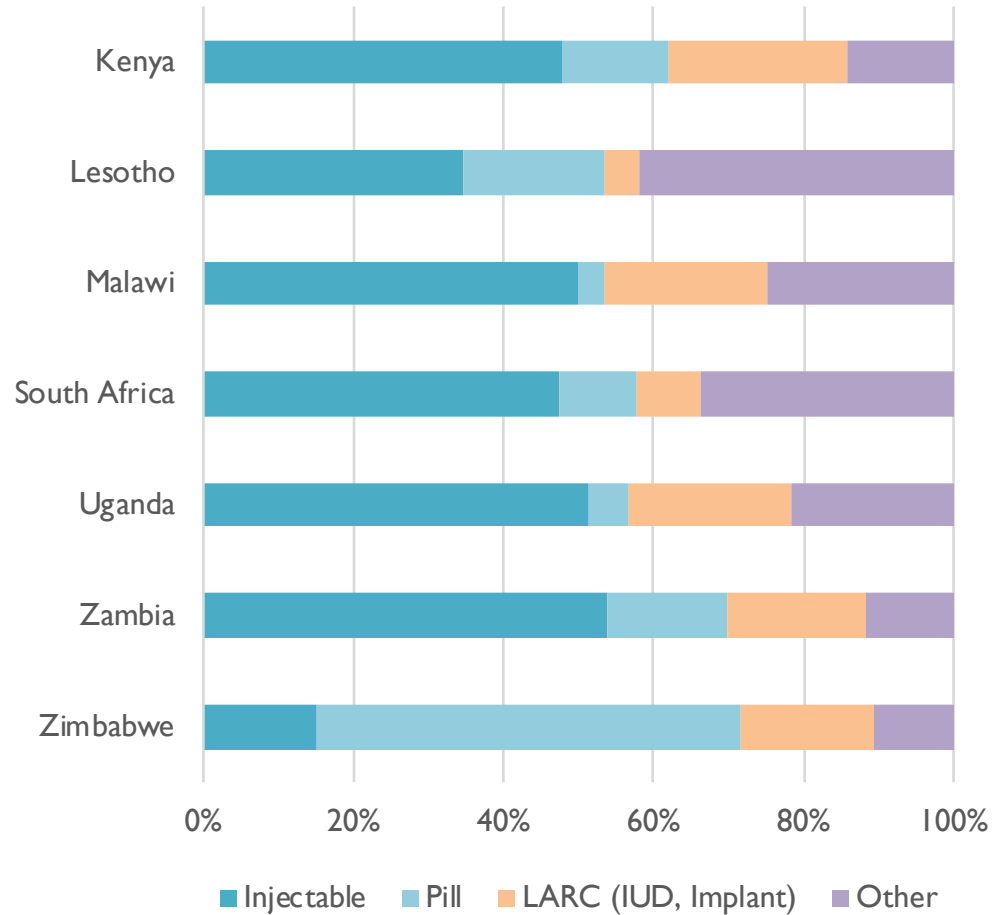


Family planning context by country

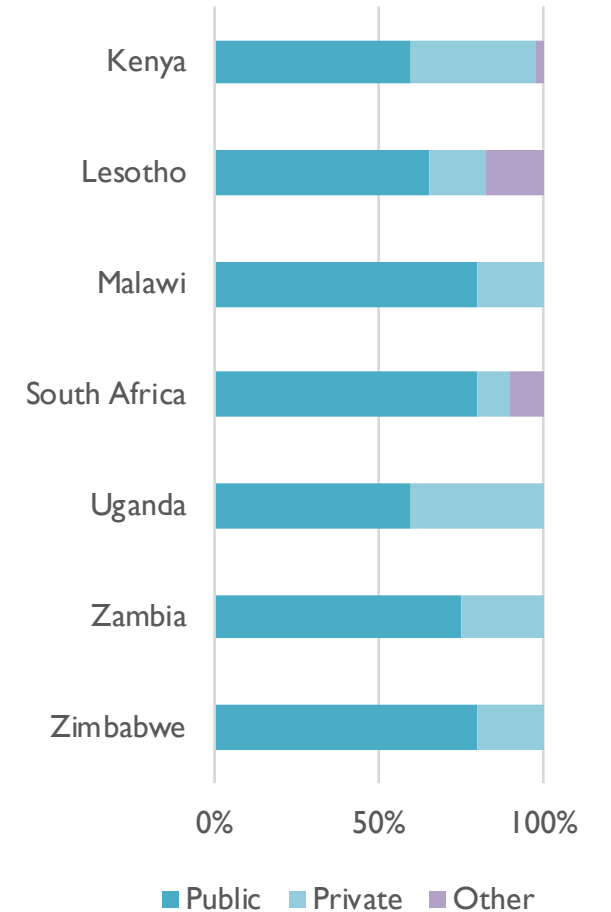
FP Use Trends



FP Method Mix



FP Access Points





Plans & policies

	KE	LE	MA	SA	UG	ZA	ZI
Integration plans	Level 1	Level 1	Level 2	Level 1	Level 1	Level 1	Level 1
Coordination bodies & champions	Level 3	Level 3	Level 2	Level 3	Level 2	Level 2	Level 3
Guidelines for differentiated delivery	Level 1	Level 3	Level 3	Level 2	Level 2	Level 2	Level 2
Eligibility criteria	Level 1	Level 2	Level 2	Level 1	Level 1	Level 1	Level 1

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- No information to date

KEY FINDINGS

- Countries are starting to build from previous experiences with service integration (e.g., HIV/STIs, malaria, and TB integration into antenatal care, PMTCT) to consider integration of PrEP, HIV prevention, and FP, but progress has been slow.
- **Integration plans**
 - Every country in this analysis has a national HIV or FP plan that prioritizes integration of HIV, STI, and FP services.
 - The strongest plans for integrating PrEP and FP explicitly mention PrEP integration into FP and HIV services, such as Uganda’s National HIV and AIDS Priority Action Plan, Zambia’s National AIDS Strategic Framework, and South Africa’s Sexual and Reproductive Health and Rights: Fulfilling our Commitments and Beyond; National Strategic Plan for HIV, TB, and STIs.
 - Kenya is pursuing integrated service delivery and has a focus on adolescents through its National Adolescent Sexual and Reproductive Health Policy. Uganda is developing a new national strategy and implementation plan to integrate PrEP into FP settings to better reach AGYW in PrEP scale-up in 2021.
 - Countries that do not have policies that mention PrEP have a potential window of opportunity to include PrEP alongside broader FP–HIV integration as country plans are refreshed (e.g., Malawi’s Costed Implementation Plan for Family Planning 2016-2020 and National Strategic Plan for HIV AIDS 2015-2020, as well as Lesotho’s National HIV and AIDS Strategic Plan 2006-2011).
- **Coordination bodies & champions**
 - Coordination is critical to ensuring policy on integration is translated to implementation. Some countries have had coordinating bodies leading integration efforts in the past (e.g., Kenya), but none of the countries in this analysis has an active group. Without coordination at the national, subnational, and facility level, integration is haphazard.
 - The few bodies that have existed have been national, although there is growing recognition that coordination at the subnational level is essential to support integration. In Kenya, for example, integration will require coordination between County AIDS and STI Coordinators (CASCOs) and County RH Coordinators. In Uganda, it will require coordination between the district point people for PrEP and FP (unless, as in some cases, these are the same person).
- **Guidelines for differentiated delivery**
 - In most countries (South Africa, Malawi, Uganda, Zimbabwe, and Kenya), PrEP is delivered by ART nurses and clinical staff who have also received training specifically on PrEP, meaning that only a limited subset of FP providers are able to deliver PrEP.
 - Other countries have engaged non-clinical staff in PrEP delivery. In Zambia, PrEP and FP counseling and prescription can be provided by non-clinical staff such as CHWs, program managers, and pharmacists, as long as they have received a PrEP training. In South Africa, the National Department of Health is testing the ability of PrEP users to get refills at pharmacies, thus avoiding a lengthy clinic visit.
 - In Malawi, PrEP users are required to get creatinine clearance tests at initiation and every 6 months. As a result, PrEP will be offered only at central and district hospitals and not in the broader network of FP sites.
- **Eligibility criteria:** Eligibility criteria are not a major barrier, because AGYW are a priority population for PrEP in all the countries included in this analysis. However, countries do have age restrictions for PrEP use, ranging from 12 to 15 years old.



Resource management

	KE	LE	MA	SA	UG	ZA	ZI
Financing	Level 2	Level 3	Level 3	Level 2	Level 1	Level 2	Level 3
Procurement	Level 2	Level 2	Level 3	Level 2	Level 2	Level 1	Level 1
Supply chain management	Level 2	Level 3	Level 2	Level 2	Level 2	Level 2	Level 3

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- No information to date

KEY FINDINGS

• Financing

- The general consensus across countries is that HIV financing will need to cover provision of PrEP in FP clinics (including PrEP and HIV test procurement, healthcare worker training, healthcare worker and support staff salaries) because FP resources are relatively limited and following the model of PMTCT in ANC services.
- Siloed funding for HIV and FP may create challenges to integrated delivery at scale in national health systems, although individual programs have worked around funding silos by using non-PEPFAR funding to purchase FP commodities. This challenge was exacerbated by U.S. Government policy barring funding for organizations that offer abortion services, which has limited FP programs (e.g., International Planned Parenthood in Lesotho was planning integrated PrEP–FP services before funding cuts).

• Procurement

- National procurement in several countries (e.g., Zambia, Zimbabwe, Kenya) is centralized, even when supported by multiple donors, which may facilitate the adoption of nation-wide integrated procurement processes.
- Decentralized decision-making and/or procurement structures (e.g., Malawi, Lesotho) make PrEP procurement processes more complex. While this decentralization leaves room for effective district-level strategies, it also implies that integration efforts may need to occur district by district, with buy-in from local decision-makers.
- In Uganda, separate private and public procurement systems generate issues in FP procurement. While the public system (National Medical Stores) provides centralized FP–HIV procurement, the private sector system (Joint Medical Stores) often does not manage FP commodities for religious reasons.

• Supply chain management

- For NGO-run programs, vertical programming challenges integration. This model is present across several countries, manifesting as separate donor-funded programs for HIV and FP and creating informal siloes between services. For example, the Jhpiego-run community HIV prevention program in Lesotho could not access FP commodities from the district procurement agency because they were designated as the implementing partner responsible for HIV, while PSI was designated as the implementing partner responsible for FP.
- Stockouts are common across countries, a particular challenge for integration where forecasting and supply chain management will require different approaches. Stock-outs have occurred for PrEP as well as long-acting contraceptives. In the case of stock-outs, countries rely on condom distribution for FP and HIV prevention.
- In Malawi, stockouts were linked to staff training and capacity more than access to centralized systems. UNFPA sites made significant progress with implementing logistics management information systems (LMIS) across 28 districts from 2012–2018, helping to avoid FP commodity stockouts.



Service delivery

	KE	LE	MA	SA	UG	ZA	ZI
Risk screening & HIV testing	Level 2	Level 3	Level 2	Level 2	Level 1	Level 1	Level 3
Provider training	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2	Level 2
Ongoing mentoring/supervision	Level 2	Level 2	Level 1	Level 2	Level 2	No information	Level 3
Support staff	Level 2	No information	Level 2	Level 3	Level 3	Level 2	Level 2

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- No information to date

KEY FINDINGS

Screening & HIV testing

- Some countries (e.g., Uganda, Kenya, Zambia) have guidelines for FP providers to regularly provide HIV risk screening and testing. Kenya's Minimum Package for Reproductive Health (RH) and HIV Integrated Services states that in FP clinics, HIV counseling, testing and effective referral and linkage for those testing HIV positive are among the minimum level of services to be incorporated in FP clinics. This guidance provides a foundation for integration, because FP providers are accustomed to asking clients about sexual activity and risk and FP clients are expecting this during an FP visit. South Africa has similar guidelines, but they are inconsistently applied in practice.
- Integrated job aids for FP providers exist but are rarely used or are outdated (e.g., South Africa SOPs for HIV risk assessments in FP services). JSI's integrated FP-HIV program in Zambia uses two separate Ministry-developed job aids for FP and PrEP provision.
- Staff shortages across the healthcare system, especially in FP, is a consistent theme for all countries. A major challenge to integrated service delivery is FP providers feeling over-burdened and unable to add an additional service to their offerings.
- The PrIYA Project in Kenya found that provider concerns about work burden diminished after patient flow proved manageable during initial PrEP provision. The project also tested methods to reduce provider burden, including use of HIV self-tests and on-site support staff providing HIV and PrEP counseling.

Provider training

- Some countries (e.g., Uganda, Zambia) provide pre-service training on HIV to FP providers. In these countries, FP providers are also expected to provide HIV risk screening and testing.
- Some countries have introduced in-service PrEP training and invited FP service providers to participate. South Africa has a 5-day training to receive Nurse Initiated Management of Anti-Retroviral Therapy (NIMART) certification and a 2-day PrEP training. In Malawi, a 3-day training on PrEP will be open to all providers upon rollout.
- Providers in "youth responsive" settings (e.g., Kenya) have typically been trained in integrated care provision and are able to offer both FP and PrEP. Outside of these settings, providers in low-volume clinics or community-based facilities provide a broad range of care, including HIV treatment and prevention and FP, but typically do not provide PrEP (e.g., PrEP is typically limited to central and district hospitals).

Ongoing mentoring/supervision

- Ongoing mentoring for service providers is critical and will require coordination at the subnational government level so that supervision is conducted by multidisciplinary teams. This already happens in Malawi, but does not yet include PrEP.
- Successful pilots and regional programs for mentoring and training in rights-based, age-sensitive FP-HIV care have been identified across countries. For example, Malawi's Safeguard Young People Programme and UNFPA site initiatives have increased the number of trained and mentored providers. In South Africa, an HIV-FP integration pilot in KwaZulu-Natal provided capacity building to selected providers based on community engagement.

Support staff

- Administrative, community-based, and non-clinical health personnel shortages are consistent, reflecting capacity challenges beyond FP or HIV. For example, Uganda reports that 50% of essential non-clinical staff positions are unfilled throughout the health system.
- Malawi has a Health Surveillance Assistant (HSA) model to provide services and coordinate between community and clinical health providers. HSAs make up more than one-fourth of the country's health workforce but are not fully equipped to provide integrated care or PrEP services.



PrEP use

	KE	LE	MA	SA	UG	ZA	ZI
Demand creation	Level 2	Level 3	Level 2	Level 1	Level 3	Level 1	Level 2
Client information	No information	No information	Level 3	Level 2	Level 2	No information	Level 3
PrEP refills	Level 1	No information	No information	Level 1	Level 1	Level 1	Level 1
Effective use	No information	No information	No information	No information	Level 3	No information	No information

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- No information to date

KEY FINDINGS

- **Demand creation**

- There is a “chicken and egg” problem with demand. Clients need to expect and prepare for integrated services, or there is a high probability of drop-off between services (e.g., clients will not want to wait in another queue). However, clinics/programs hesitate to generate too much demand for integrated services, fearing system overload or stock-outs.
- As part of its upcoming PrEP–FP integration plan, Uganda is developing an integrated demand creation strategy, including media communications, integrated materials, and training for peer educators and community outreach workers to provide information on PrEP and FP services together.
- In Zimbabwe, there is an opportunity to leverage “Depo Holders,” community health workers who provide contraceptive pills and information on how to access other methods (e.g., LARCs) to also provide information on HIV testing and PrEP.

- **Client information**

- Early experiences with PrEP and FP provision in Lesotho highlighted that integrated information needs to support not only demand creation, but also ongoing use, especially around side effects. Implementers in Lesotho noticed a drop-off in continuation as a result of “double side effects,” or confusion about which product related to which effects.
- Countries do not have robust assessments of the percentage of facilities providing client information, but facility audits in Malawi revealed that information, education, and communication (IEC) materials on HIV or FP were unavailable in 30 to 50% of sites, showing the potential magnitude of the gap.

- **PrEP refills**

- Across many countries, follow-up does align well for those taking FP (either contraceptive pills or injections) and PrEP after the initial 3 months on PrEP. Both require quarterly clinic visits for refills. Most FP clinics do offer HIV testing, so follow-up for PrEP would be possible at FP clinics. However, those using LARCs (e.g., implants, IUDs) do not need to make frequent clinic visits.
- If countries begin to push for more widespread use of LARCs, such as in SA, the overlap between follow-up schedules for PrEP and FP may decrease over time.

- **Effective use**

- Few FP programs have support for ongoing adherence, although in all countries it was too early to understand how this might change for PrEP offered in FP settings.



Monitoring & reporting

	KE	LE	MA	SA	UG	ZA	ZI
Registers & forms	Level 3	Level 3	Level 3	Level 2	Level 3	Level 3	Level 3
Facility monitoring & reporting	Level 3	Level 2	Level 2	Level 3	Level 2	Level 2	Level 2

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- No information to date

KEY FINDINGS

Overall: There is a philosophical difference between how the HIV and FP fields approach follow-up and monitoring. While HIV (especially PEPFAR-funded) programs frequently set targets that can influence programming choices (e.g., push to grow the number of PrEP users), the FP field avoids this approach to avoid real or perceived coercion of clients to use FP. This difference is reflected in systems to support ongoing monitoring, follow-up with clients, and support for adherence to PrEP — which is not a typical approach in FP services.

Registers & forms

- Monitoring and reporting for integrated services can be a burden for healthcare providers, facilities, and programs. No country included in this analysis currently uses a combined register across HIV, FP, and/or PrEP services. In Kenya, for example, an FP provider who offers PrEP services will be required to complete several registers for FP, HIV prevention, and PrEP.
- Some countries have made progress in tracking selected integration indicators — for example, Uganda’s HIV registers track whether clients receive other SRH services during a visit.
- Early steps can be taken to develop a combined HIV register for use in FP sites (e.g., do not have separate HIV testing, HIV prevention, and PrEP registers) and to ensure that all relevant registers are available to providers across those services. This will be easier to do in smaller clinics (e.g., with <5 providers) compared to higher-volume health facilities, which may require multiple registers that make tracking across the facility more challenging.

Facility monitoring & reporting

- Project PrEP in South Africa noted that it is standard for PrEP users to have a client file to track ongoing use and continuation, whereas FP does not have those types of client files, relying instead on aggregate monthly numbers of FP users, method choices, and FP services provided.
- In Uganda, stakeholders note that reporting on some metrics of integration at the facility level could be a good first step before working to integrate registers.

Key Findings on the Current State of Integration

Detailed Findings on the Current State of Integration

Appendix: Detail by Country



LESOTHO: Integration Framework

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- Not enough information

PLANS & POLICIES	RESOURCE MANAGEMENT	SERVICE DELIVERY	PREP USE	MONITORING & REPORTING
Integration plans <ul style="list-style-type: none"> National Health Strategic Plan 2017–2022 mentions SRH/HIV integration. National HIV and AIDS Strategic Plan includes universal access to HIV testing. PrEP guidelines include PrEP delivery at FP, adolescent, and ANC clinics. 	Financing <ul style="list-style-type: none"> Funding streams for FP, HIV, and PrEP are siloed. Decentralization of budgeting and planning leaves decision-making to local authorities. 	Risk screening & HIV testing <ul style="list-style-type: none"> No SOPs provide for FP services to include risk screening or HIV testing 	Demand creation <ul style="list-style-type: none"> Lesotho National HIV and AIDS Strategic Plan includes Social Behavior Change Communications (SBCC) goals for HIV/STIs focusing on abstinence and condoms; no mention of FP, SRH, or PrEP integrated communication. 	Registers <ul style="list-style-type: none"> Several registers must be completed for each service: STIs, HIV, FP, and PrEP.
Coordination bodies & champions <ul style="list-style-type: none"> MoH departments for FP (Family Health) & HIV (Disease Control) are separate. The National Coordination Framework (2017) establishes District and Community AIDS Committees with cross-functional membership but no focus on integration with FP. 	Procurement <ul style="list-style-type: none"> Procurement for HIV and FP commodities is centralized via government system through to district level. Implementing partners face challenges to procure commodities outside of their specific mandate (e.g., for HIV program to procure FP commodities). 	Provider training <ul style="list-style-type: none"> SRH training includes HIV and STIs. Often HIV/STI training includes FP. A national curriculum for PrEP training is available and is required for PrEP providers. 	Client information <ul style="list-style-type: none"> No information is available to date, because PrEP is not provided in FP settings. 	Facility monitoring & reporting <ul style="list-style-type: none"> Health management information systems (HMIS) have the capacity to centrally monitor FP and HIV, but they do not include any indicators for integrated care.
Guidelines for differentiated delivery <ul style="list-style-type: none"> Creatinine clearance testing is required at initiation and every 6 months. Counseling is done by counselors and nurses trained on PrEP; prescription can be done by nurses and doctors. 	Supply chain management <ul style="list-style-type: none"> No integrated logistics management information system is used for forecasting, quantification, monitoring, and tracing of health commodities across districts. FP stock-outs occur frequently; however, HIV commodity distribution is effective. 	Ongoing mentorship and supervision <ul style="list-style-type: none"> Occurs in specific programs, such as the Let Youth Lead initiative funded by UNICEF, which supports a network of youth leaders and CHWs in establishing mentorship and continuous improvement strategies across district hospitals for adolescent-friendly, integrated services. 	PrEP refills <ul style="list-style-type: none"> No information is available to date, because PrEP is not provided in FP settings. 	
Eligibility criteria <ul style="list-style-type: none"> PrEP has been available primarily for serodiscordant couples to date, with little focus on women but some efforts to target AGYW at the community level. No minimum age is set for PrEP. Practical restrictions include an age limit of 12 for HTS without parental consent and that PrEP is indicated only for clients weighing 35kg and above. 		Support staff capacity <ul style="list-style-type: none"> No information is available to date. 	Effective use <ul style="list-style-type: none"> No information is available to date, because PrEP is not available in FP settings. 	



MALAWI: Integration Framework

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- Not enough information

PLANS & POLICIES	RESOURCE MANAGEMENT	SERVICE DELIVERY	PREP USE	MONITORING & REPORTING
<p>Integration plans</p> <ul style="list-style-type: none"> 2019–2023 PrEP National Strategic Framework had been developed but not approved. National HIV/AIDS Strategic Plan 2015–2020 mentions HIV/FP integration. National Youth Friendly Health Services (YFHS) Strategy 2015–2020 emphasizes age-appropriate provision of SRH and HIV education, integrated service delivery, and coordinated referrals. 	<p>Financing</p> <ul style="list-style-type: none"> Funding streams from the government are in separate sub-accounts for SRH (encompassing FP, maternal health, and other priorities) and HIV/AIDS. 	<p>Risk screening & HIV testing</p> <ul style="list-style-type: none"> National protocols and tools to integrate FP, antenatal care, cervical cancer screening, and HIV/STI prevention are in development. UNFPA-supported sites prioritize integration of HIV and FP services SOPs and guidelines for PrEP have been drafted but have not been adopted. 	<p>Demand creation</p> <ul style="list-style-type: none"> MoH has allocated budget toward youth-centric and gender-sensitive FP and HIV SBCC campaigns for AGYW, in line with the YFHS. National PrEP demand generation strategies have been developed but not yet implemented. 	<p>Registers</p> <ul style="list-style-type: none"> Separate registers are used for HTS, ART, FP, and PrEP . Often additional donor or agency-specific registers must be used as well.
<p>Coordination bodies & champions</p> <ul style="list-style-type: none"> FP, YFHS, and Safe Motherhood TWGs meet regularly to coordinate activities, but this does not include integration with HIV prevention. National coordination does not consistently translate to the local level. 	<p>Procurement</p> <ul style="list-style-type: none"> Centralized procurement is done by the MoH, but with separate systems for FP and HIV. 	<p>Healthcare provider training</p> <ul style="list-style-type: none"> A 3-day PrEP training curriculum has been developed and approved, but not yet adopted. HIV/STI trainings include FP, but the inverse is not always true. 	<p>Client information</p> <ul style="list-style-type: none"> Audits (2015) revealed that IEC materials were unavailable in 30–50% of sites. YFHS mandates integrated information for SRH, FP, and HIV prevention in mobile clinics, pharmacies, and community settings. 	<p>Facility monitoring & reporting</p> <ul style="list-style-type: none"> No integration metrics are tracked (e.g., provider-initiated FP conversations in HIV clinics, or vice versa). PrEP data collection tools and reporting forms were developed but have not yet been approved. PrEP monitoring will be integrated into MoH quarterly supervisory visits.
<p>Guidelines for differentiated delivery</p> <ul style="list-style-type: none"> PrEP is not yet rolled out, but is planned for HIV, STI, and ANC sites. Creatinine clearance test required at initiation and every 6 months. As a result, PrEP will be offered at central/district hospitals. Currently, only clinical staff (e.g., nurses, doctors, HSAs) can counsel on and prescribe FP methods and PrEP. 	<p>Supply chain management</p> <ul style="list-style-type: none"> FP stock-outs are common. UNFPA sites implemented LMIS in 28 districts from 2012–2018, helping to avoid FP commodity stock-outs. PrEP will be managed through a new system that aims to integrate supply chain data collection tools and space for storage in some health facilities. 	<p>Ongoing mentorship and supervision</p> <ul style="list-style-type: none"> Supervision and mentorship are typically conducted quarterly by MoH multidisciplinary teams, including HIV, FP, and TB, among others. The Safeguard Young People Programme was launched across 6 districts to give technical assistance and mentorship in youth-friendly SRH and HIV prevention. 	<p>PrEP refills</p> <ul style="list-style-type: none"> No information is available to date — information exists only in PrEP demonstration sites. 	
<p>Eligibility Criteria</p> <ul style="list-style-type: none"> PrEP is prioritized for at-risk groups and AGYW. PrEP age of consent is not defined – MoH is currently discussing a minimum age of 16. 		<p>Support staff capacity</p> <ul style="list-style-type: none"> MoH has strongly promoted increasing the number of HSAs, who comprise 1/4 of the country’s health workforce. HSAs not trained to assist with PrEP. 	<p>Effective use</p> <ul style="list-style-type: none"> No information is available to date — information exists only in PrEP demonstration sites. 	



SOUTH AFRICA: Integration Framework

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- Not enough information

PLANS & POLICIES	RESOURCE MANAGEMENT	SERVICE DELIVERY	PREP USE	MONITORING & REPORTING
<p>Integration plans</p> <ul style="list-style-type: none"> National plans for contraception, STIs, HIV & TB, and PrEP have a significant focus on integration, including introduction of PrEP at university-based clinics and technical and vocational education and training colleges that provide FP, STI services. The National Adolescent Sexual and Reproductive Health & Rights Framework (2014–2019) promotes one-stop shops and adolescent-friendly care. 	<p>Financing</p> <ul style="list-style-type: none"> Government is scaling up PrEP provision in primary health clinics (PHC)s, where contraception is already provided. Donors have provided funding for PrEP, but not for integrated service delivery in FP settings. FP programs are under-resourced, especially considering the national initiative for universal FP access. 	<p>Risk screening & HIV testing</p> <ul style="list-style-type: none"> Several tools are available for risk screening and counseling for HIV, FP, and PrEP but are not comprehensive or consistently used. Policy guidance includes a general mandate for HIV risk screening and testing in FP services but has not been translated to implementation (e.g., risk questionnaires, referral networks). 	<p>Demand creation</p> <ul style="list-style-type: none"> The National Strategic Plan for HIV mentions future development of an SBCC campaign, coupled with training of CHW and local leaders on SRH–HIV, which could include PrEP. The new B-Wise site includes information on a range of preventive services, including FP and PrEP. 	<p>Registers</p> <ul style="list-style-type: none"> PrEP and HIV registers are integrated and include STIs. FP is part of the PHC service package register at clinics. FP systems do not include unique client identifiers, so it is difficult to track FP clients over time.
<p>Coordination bodies & champions</p> <ul style="list-style-type: none"> SRH TWG meets infrequently. PrEP TWG focuses more on HIV prevention and less on SRH. 	<p>Procurement</p> <ul style="list-style-type: none"> Procurement systems are separate but can be accessed with significant technical support (e.g., HIV clinics can access and procure FP commodities, and vice versa). 	<p>Provider training</p> <ul style="list-style-type: none"> Majority of PrEP providers are trained in FP/SRH services, but few FP providers are trained in HIV. 	<p>Client information</p> <ul style="list-style-type: none"> Materials for FP, HIV, and PrEP are available. PrEP materials include mentions of SRH and FP services. 	<p>Facility monitoring & reporting</p> <ul style="list-style-type: none"> Grant-funded projects (e.g., Wits RHI, CAPRISA) have begun to test FP–PrEP integration processes at specific sites — processes are currently not at scale.
<p>Guidelines for differentiated delivery</p> <ul style="list-style-type: none"> Non-clinical staff can counsel on FP and PrEP; Only clinicians with NIMART license (5-day training) and PrEP training (2-day training, also available virtually) can prescribe PrEP. National guidelines required creatinine clearance testing at initiation, month 7, and annually. 	<p>Supply chain management</p> <ul style="list-style-type: none"> FP demand forecasting mechanisms are in place in each province but are subject to inaccuracies, resulting in most clinics not offering the full range of FP options. Clinics will be able to order PrEP through the national system via a vertical procurement process. 	<p>Ongoing mentorship and supervision</p> <ul style="list-style-type: none"> Mentorship and supervision are available at selected clinics, primarily in NGO and integration-driven settings. An HIV–FP integration pilot in KwaZulu-Natal provided capacity building to selected providers based on community engagement and ongoing training, resulting in enhanced delivery efficacy. 	<p>PrEP refills</p> <ul style="list-style-type: none"> South Africa is testing PrEP refills in pharmacies. PrEP users are required to collect refills monthly, while FP generally requires 2–3 month appointments. 	
<p>Eligibility criteria</p> <ul style="list-style-type: none"> PrEP is prioritized for all populations at risk, including general-population women and AGYW. At 15, PrEP age of consent is not prohibitive (age of consent for contraception is 12 years). 		<p>Support staff capacity</p> <ul style="list-style-type: none"> Primary care workers providing multiple services experience long queues, with little additional staff support. 	<p>Effective use</p> <ul style="list-style-type: none"> No information is available to date 	



UGANDA: Integration Framework

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- Not enough information

PLANS & POLICIES	RESOURCE MANAGEMENT	SERVICE DELIVERY	PREP USE	MONITORING & REPORTING
Integration plans <ul style="list-style-type: none"> National HIV and AIDS Priority Action Plan 2015/2016–2017/2018 includes PrEP integration with SRH services. Uganda is planning a new strategy and implementation plan focused on PrEP provision in FP settings to reach AGYW. 	Financing <ul style="list-style-type: none"> Government funding for HIV and FP are generally separate. However, with new PrEP funding from Global Fund and PEPFAR, PrEP will be scaled up to all ART sites and will be newly introduced in FP settings. 	Risk screening & HIV testing <ul style="list-style-type: none"> FP providers regularly provide HIV risk screening and HIV testing in accordance with guidelines. 	Demand creation <ul style="list-style-type: none"> The FP Costed Implementation Plan (CIP) includes SBCC plans and school-based education; however, SRH/FP communications strategies do not mention integrated HIV–PrEP–FP. Strong emphasis is placed on ABCs: Abstinence, Be Faithful, use Condoms. 	Registers <ul style="list-style-type: none"> Separate registers are required for HIV, FP, PrEP, and HIV testing.
Coordination bodies & champions <ul style="list-style-type: none"> Little coordination is done between the MoH Reproductive Health Directorate and the AIDS Control Programme. At district level, point people for FP and HIV can be the same or different people; coordination at this level is being considered in the new plan. 	Procurement <ul style="list-style-type: none"> The National Medical Stores (NMS) provides centralized procurement, storage, and distribution of commodities, including HIV and FP. PEPFAR procures PrEP and supplies it in parallel to national mechanisms. 	Provider training <ul style="list-style-type: none"> Most FP providers are trained in providing HTS. The training emphasizes judgment-free care and combating stigma but excludes adolescent-friendly service delivery. A qualitative assessment of public facilities in Mbarara found that providers lack confidence in youth-based approaches, particularly when providing integrated FP–HIV services. 	Client information <ul style="list-style-type: none"> The National HIV and Aids Priority Action Plan mandates the development of IEC/BCC messages and materials for PrEP within HIV materials. FP integrated messaging will be a part of the upcoming plan. 	Facility monitoring & reporting <ul style="list-style-type: none"> HMIS track the number of HIV clients receiving SRH services as an indicator; SRH/FP providers offering HIV services are not tracked. M&E reporting mechanisms (patient cards, checklists) track integration, but not fully.
Guidelines for differentiated delivery <ul style="list-style-type: none"> Creatinine clearance testing is suggested, but not required, within 6 months of initiation. PrEP counseling and prescription require specialized training in PrEP and are limited to clinicians. 	Supply chain management <ul style="list-style-type: none"> No centralized or coordinated information systems exist to forecast demand. FP and HIV/STI stock-outs occur frequently. FP clinics will be able to access available supply chain infrastructure and processes for PrEP. 	Ongoing mentorship and supervision <ul style="list-style-type: none"> Mentorship and supervision are provided by district-level point people for HIV and FP, who often do so separately. 	PrEP refills <ul style="list-style-type: none"> After initiation, PrEP can be refilled every 3 months, in line with refills of most commonly used FP methods. 	
Policies <ul style="list-style-type: none"> AGYW are a focus group for PrEP. The ages of consent align (reproductive age for contraceptives, 12 years for ART/HTS). 		Support staff capacity <ul style="list-style-type: none"> Support staff capacity is insufficient, with the recent FP CIP reporting that over 50% of necessary positions are unfilled. 	Effective use <ul style="list-style-type: none"> Current FP capacity is limited; capacity-building efforts will be necessary to foster PrEP adherence. 	



ZAMBIA: Integration Framework

- Level 1: Effective integration
- Level 2: Initial alignment
- Level 3: No integration
- Not enough information

PLANS & POLICIES	RESOURCE MANAGEMENT	SERVICE DELIVERY	PREP USE	MONITORING & REPORTING
Integration plans <ul style="list-style-type: none"> National Aids Strategic Framework 2017-2021 contains mentions of integration of FP, PrEP, and STIs. Eight-Year Integrated Family Planning Scale-Up Plan 2013-2020 mentions integration of FP and HIV services. National Standards and Guidelines for Adolescent Friendly Health Services includes HIV and FP in essential services. 	Financing <ul style="list-style-type: none"> FP services are under-resourced. Donor-funded integrated programs exist (e.g., USAID-funded DISCOVER-Health). New funding from PEPFAR and Global Fund will facilitate PrEP expansion across the country. 	Risk screening & HIV testing <ul style="list-style-type: none"> FP providers regularly offer HIV risk screening and HIV testing for those at risk. Separate job aids are available for FP, HIV/ART, and PrEP; they are used side-by-side when integrated service delivery occurs. 	Demand creation <ul style="list-style-type: none"> Prevention communication plans are in place that promote messaging about FP, HIV, and STIs. Government efforts to expand FP and HIV education in schools have helped to address stigma and myths about FP. 	Registers <ul style="list-style-type: none"> Separate registers are required for HIV and FP.
Coordination bodies & champions <ul style="list-style-type: none"> Several TWGs, including an FP TWG and an Adolescent TWG have FP-HIV-STI integration in their mandates. Coordination is less structured at the local level. 	Procurement <ul style="list-style-type: none"> Centralized system exists (Medical Stores Ltd) for forecasting, distribution, and procurement of all essential medicines, including FP supplies and HIV/STI kits. 	Provider training <ul style="list-style-type: none"> Providers are trained to task-shift, but there is a shortage of FP personnel. FP providers are largely untrained for PrEP; however, they are trained in HIV/STI testing and treatment. Training for FP, HIV, and PrEP is not integrated. 	Client information <ul style="list-style-type: none"> No information is available to date. 	Facility monitoring and reporting <ul style="list-style-type: none"> HMIS have the capacity to centrally monitor FP, HIV, and PrEP. PrEP is not tracked as a separate item — instead it is captured as ART.
Guidelines for differentiated delivery <ul style="list-style-type: none"> Separate training is needed for PrEP. While non-clinical staff can provide FP, only trained nurses and doctors can prescribe PrEP and provide counseling. Creatinine clearance testing required. 	Supply chain management <ul style="list-style-type: none"> FP and HIV/STI stock-outs occur frequently. 	Ongoing mentorship and supervision <ul style="list-style-type: none"> No information is available to date. 	PrEP refills <ul style="list-style-type: none"> After initiation, PrEP can be refilled every 3 months, in line with most commonly used FP methods. 	
Eligibility criteria <ul style="list-style-type: none"> PrEP is prioritized for general population women and AGYW. The age of consent is not restrictive. 		Support staff capacity <ul style="list-style-type: none"> A large gap in personnel is being addressed through government promotion of CHWs; CHWs are trained on HIV and FP community outreach, information, and supporting effective use. Staff capacity is cited as a major impediment country-wide. 	Effective Use <ul style="list-style-type: none"> Adherence and monitoring support is done by non-clinical staff; training and additional capacity are needed. 	



LESOTHO: notes and sources

Titles and links

Country plans and policies

- National Health Strategic Plan 2022: https://www.childrenandaids.org/sites/default/files/2018-05/Lesotho_Nat%20Health%20Strat%20Plan_2017-2022.pdf
- Lesotho National HIV and AIDS Strategic Plan 2006-2011
- National Coordination Framework 2007: https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_126753.pdf

Integration information (site audits and reports)

- FP 2020: <http://www.familyplanning2020/Lesotho>
- UNFPA Country programme document for Lesotho: <https://www.unfpa.org/data/transparency-portal/unfpa-lesotho>
- UNFPA health facility article: <https://lesotho.unfpa.org/en/news/661-health-facilities-lesotho-offer-modern-family-planning>
- HIV SRH Linkages Data Snapshot 2016: http://srhhivlinkages.org/wp-content/uploads/Lesotho_HIVSRHRLinkagesInfographicSnapshot_EN_final.pdf
- Report on Joint review of HIV/Tuberculosis and Hepatitis Program 2017

Demographic information

- Kingdom of Lesotho Facts and Prospects: Sexual and Reproductive Health and Rights 2019: <https://reliefweb.int/report/lesotho/kingdom-lesotho-facts-and-prospects-sexual-and-reproductive-health-and-rights-2019>
- SWOP 2019: https://lesotho.unfpa.org/sites/default/files/pub-pdf/SWP19%20-%20EN%20report-web-%204%20April_3.pdf
- UN Contraceptive Use by Method: <https://www.un.org/en/development/desa/population/publications/pdf/family/ContraceptiveUseByMethodDataBooklet2019.pdf>
- Lesotho Demographic and Health Survey 2014: <https://dhsprogram.com/pubs/pdf/FR309/FR309.pdf>



MALAWI: notes and sources

Titles and links

Country plans and policies

- Malawi Costed Implementation Plan for Family Planning 2016-2020: https://www.healthpolicyproject.com/ns/docs/Malawi_CIP_FINAL.pdf
- National Strategic Plan for HIV and AIDS 2015-2020: <https://www.childrenandaids.org/sites/default/files/2017-11/Malawi-National-HIV-AIDS-Strategic-Plan-2015-2020.pdf>
- Malawi Growth and Development Strategy 2011-2016: [https://www.mw.undp.org/content/dam/malawi/docs/UNDP_Malawi_MGDS\)%20III.pdf](https://www.mw.undp.org/content/dam/malawi/docs/UNDP_Malawi_MGDS)%20III.pdf)
- National Youth Friendly Health Services Strategy 2015-2020
- National Sexual Reproductive Health and Rights Policy: <https://malawi.unfpa.org/sites/default/files/pub-pdf/SRHR%20POLICY%20FINAL.pdf>
- 3rd Edition of the Malawi Guidelines for Clinical Management of HIV in Children and Adults 2016

Integration information (site audits and reports)

- FP 2020: <http://www.familyplanning2020.org/Malawi>
 - High Impact Analysis
 - FP self-reporting questionnaire
 - Country Worksheet: Prioritized Family Planning Activities
- UNFPA Evaluation: <https://malawi.unfpa.org/sites/default/files/resource-pdf/Evaluation%20Report%20Malawi%207th%20Country%20Programme.pdf>
- Health Policy Project: HIV FP integration 2015 https://www.healthpolicyproject.com/pubs/3876_FINALMalawiHIVFacilityReport.pdf

Demographic information

- Malawi Demographic and Health Survey 2015-2016: <https://dhsprogram.com/pubs/pdf/FR319/FR319.pdf>
- SHOPS, Sources of Family Planning, Malawi



SOUTH AFRICA: Notes and sources

Titles and links

Country plans and policies	<ul style="list-style-type: none">• National Contraception Policy Guidelines 2001: https://www.westerncape.gov.za/sites/www.westerncape.gov.za/files/documents/2003/national_contraception_policy_guidlines.pdf• National Contraception and Fertility Planning Policy and Service Delivery Guidelines 2012• National Adolescent SRH Rights Framework Strategy 2014-2019: https://health-e.org.za/wp-content/uploads/2015/11/National-Adolescent-Sexual-and-Reproductive-Health-and-Rights-Framework-Strategy-pdf.pdf• National Adolescent and Youth Policy 2017 (updated draft in development)• The National Adolescent Sexual and Reproductive Health and Rights (ASRH&R) Framework Strategy 2014-2019• Sexual and Reproductive Health and Rights: Fulfilling our Commitments 2011–2021 and beyond• National Strategic Plan for HIV, TB, and STIs 2017-2022• National HIV Strategic Plan: https://sanac.org.za/wp-content/uploads/2017/06/NSP_FullDocument_FINAL.pdf
Integration information (site audits and reports)	<ul style="list-style-type: none">• FP 2020: https://www.familyplanning2020.org/south-africa• SRH Plan review: http://www.agenda.org.za/wp-content/uploads/2012/09/SRHR-Reviewing-the-Evidence-July-2011.pdf• Achieving Universal Access to Sexual and Reproductive Health Services: https://www.hst.org.za/publications/South%20African%20Health%20Reviews/9%20Achieving%20universal%20access%20to%20sexual%20and%20reproductive%20health%20services.pdf• SAMJ on contraceptive coverage in SA 2017: http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S0256-95742017000400016• Developing a Model for Integrating Sexual and Reproductive Health Services with HIV Prevention and Care in KwaZulu-Natal, South Africa: https://www.researchgate.net/publication/328976062_Developing_a_model_for_integrating_sexual_and_reproductive_health_services_with_HIV_prevention_and_care_in_KwaZulu-Natal_South_Africa
Demographic information	<ul style="list-style-type: none">• National Demographic and Health Survey 2016 https://datacatalog.worldbank.org/dataset/south-africa-demographic-and-health-survey-2016



UGANDA: Notes and sources

Titles and links

Country plans and policies

- Uganda Family Planning CIP, 2015-2020: https://www.healthpolicyproject.com/ns/docs/CIP_Uganda.pdf
- Consolidated Guidelines for Prevention and Treatment of HIV in Uganda (2018): https://elearning.idi.co.ug/pluginfile.php/5675/mod_page/content/19/Uganda%20HIV%20%20Guidelines%20-%20September%202018.pdf
- National Sexuality Education Report 2018: <http://srhrallianceug.org/wp-content/uploads/2019/05/National-Sexuality-Education-Framwork-Final-Copy-May-2018.pdf>
- The National Policy Guidelines and Service Standards for Reproductive Health Services, 2001: <https://www.prb.org/wp-content/uploads/2018/05/National-Policy-Guidelines-and-Service-Standards-for-Reproductive-Health-Services-2001.Uganda.pdf>
- The new version in 2017 was delayed due to a re-shifting focus on abstinence: <https://www.advancefamilyplanning.org/uganda-government-suspends-launch-sexual-and-reproductive-health-and-rights-national-guidelines-and>

Integration information (site audits and reports)

- FP 2020: <http://www.familyplanning2020/uganda>
- Integration report on SRH for Young People: https://www.researchgate.net/publication/332345504_Integration_of_HIV-Sexual_Reproductive_Health_Services_for_Young_People_and_the_Barriers_at_Public_Health_Facilities_in_Mbarara_Municipality_Southwestern_Uganda_A_Qualitative_Assessment
- NCBI Report on Uganda HIV integration and demographic factors: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5029044/>
- AVERT Report: <https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/uganda>
- Link Up Project: Integrating HIV and Sexual and Reproductive Health and Rights: [https://frontlineaids.org/wp-content/uploads/old_site/90635-Link-Up-policy-briefing-\(English\)_original.pdf?1406035772](https://frontlineaids.org/wp-content/uploads/old_site/90635-Link-Up-policy-briefing-(English)_original.pdf?1406035772)
- Linkages Rapid Assessment Report: http://srhhivlinkages.org/wp-content/uploads/2013/10/ippf_ras_uganda_WEB.pdf

Demographic information

- Uganda Demographic and Health Survey 2016 <https://dhsprogram.com/pubs/pdf/FR333/FR333.pdf>



ZAMBIA: Notes and sources

Titles and links

Country plans and policies	<ul style="list-style-type: none">• Family Planning Scale-Up Plan 2013-2020: https://www.healthpolicyproject.com/ns/docs/CIP_Zambia.pdf• Youth Friendly Service Guidelines: https://www.nac.org.zm/sites/default/files/publications/National%20Standards%20and%20Guidelines%20for%20Youth%20Friendly%20Health%20Services.pdf• Zambia National HIV Prevention Coalition Roadmap: https://hivpreventioncoalition.unaids.org/wp-content/uploads/2018/02/Zambia-FINAL-Stocktaking-Exercise-report-3-Oct-2017.pdf• National Aids Strategic Framework 2017-2021• Consolidated Guidelines for Treatment and Prevention of HIV Infection 2018: http://www.hivst.org/files1/Final-Zambia-Consolidated-Guidelines_2018-Print.pdf• National Health Strategic Plan 2017–2021
Integration information (site audits and reports)	<ul style="list-style-type: none">• FP 2020: http://www.familyplanning2020.org/zambia• Nyimba region report on integration: https://link.springer.com/article/10.1186/s12978-019-0788-4• Community stigma article: https://globalpressjournal.com/africa/zambia/zambia-rumors-birth-control-hinder-family-planning-reprohealth/• Zambia FP and HIV integration report (2004): http://www.policyproject.com/pubs/countryreports/Zam_FGD.pdf
Demographic information	<ul style="list-style-type: none">• Zambia Demographic Health Survey 2018• SHOPS, Sources of Family Planning, Zambia



Additional sources

Context Sources

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2. Warren CE, Mayhew SH, Hopkins J. The current status of research on the integration of sexual and reproductive health and HIV services. *Stud Fam Plann*. 2017;48(2): 91-105.
3. Haberlen SA, Narasimhan M, Beres L, Kennedy CE. Integration of family planning services into HIV care and treatment services: a systematic review. *Stud Fam Plann*. 2017;48(2): 153-177.
4. Narasimhan M, Yeh PT, Haberlen S, Warren CE, Kennedy CE. Integration of HIV testing services into family planning services: a systematic review. *Reprod Health*. 2019;16(Suppl 1): 61.
5. Church K, Mayhew SH. Integration of STI and HIV prevention, care, and treatment into family planning services: a review of the literature. *Stud Fam Plann*. 2009;40(3): 171-186.

Sources for Kenya and Zimbabwe*

Information for Kenya and Zimbabwe was sourced from the Prevention Market Manager project, led by AVAC. Their sources on integrated service delivery in Kenya and Zimbabwe can be found at this website: <https://www.avac.org/srh>

** Note that the appendix does not include detailed assessments for these countries as they were conducted under the Prevention Market Manager project. Detailed findings for Kenya and Zimbabwe can be found at the link above.*



Interview list

AVAC: Megan Dunbar, Jessica Rodrigues, Kate Segal

FHI 360 Global: Holly Burke, Rose Wilcher

FHI 360 Malawi: Melchiade Ruberintwari, David Chilongo

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Jhpiego Lesotho: Aleisha Rozario, Tafadzwa Chakare

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