THE DUAL PREVENTION PILL

A catalyst for integrated HIV and family planning services in Zambia

A POLICY BRIEF

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EXECUTIVE SUMMARY

Emerging evidence indicates family planning (FP) and oral PrEP have higher uptake when delivered together. Adolescent girls and young women (AGYW) in Zambia face high risks of both HIV and unintended pregnancy. Despite availability of oral PrEP and contraceptives, services remain fragmented. The Dual Prevention Pill (DPP), a daily pill combining oral PrEP and combined oral contraception for HIV and pregnancy prevention, offers a new opportunity to address both risks simultaneously.

Findings from assessments conducted at seven public health facilities, three community hubs, and five pharmacies reveal readiness and willingness to deliver the DPP across various service delivery platforms, especially in community settings. However, service integration gaps pose barriers, including separate service points for HIV and FP, limited provider training, and lack of integrated tracking tools. Strategic policy action is urgently needed to support integrated delivery systems and ensure equitable access to the DPP. This will increase the coverage of oral PrEP and contraception and put Zambia on a path to better control of HIV incidence and unintended pregnancy.

INTRODUCTION & BACKGROUND

Zambia has made major strides in increasing access to FP and HIV prevention through national guidelines and rollout of oral and injectable PrEP. However, siloed service delivery continues to limit convenience, uptake, and continuation, particularly for AGYW. The 2024 Zambia Demographic and Health Survey reports an adolescent pregnancy rate of 28%, which leads to school dropouts, early marriage, and economic vulnerability. At the same time, the Zambia National Adolescent Strategic Plan 2022 to 2026 reports gender disparities in the HIV burden among adolescents and young people (AYP), with estimated new infections among adolescent girls six times higher than adolescent boys.

While these health issues share overlapping risk factors, services are often delivered in silos. FP and PrEP are typically provided in separate departments, sometimes in different buildings, requiring multiple visits. This can make it especially challenging for AGYW, who face added barriers such as stigma and cost constraints, to access the services they need.

> "We have different dates for refills of Depo [injectable FP] and oral PrEP which leads to a challenge. It is costly getting to the facility/hub on the separate dates. Sometimes appointments find you out of town for one of the services. Oral PrEP and FP dates need to coincide."
> Young female sex worker, Lusaka

The DPP presents an opportunity to address these gaps by integrating prevention in a single product and reducing the number of clinic visits required for contraceptives and oral PrEP. In 2025, the Ministry of Health (MoH) included the DPP in its updated National PrEP Guidelines and Implementation Plan, anticipating its approval by early 2026.

APPROACH

Copper Rose Zambia, in partnership with AVAC, conducted 15 facility assessments to evaluate the readiness of the Zambian health system to deliver the DPP and to identify existing integration models that could support rollout. Assessments were conducted between May and June 2025 across seven public health facilities, five private pharmacies, and three community hubs serving AGYW and young female sex workers. Assessments were carried out using two complementary tools:

Structured facility checklist to document available services, staffing, infrastructure, and existing integration of FP and PrEP. This provided quantitative data on service availability and delivery models.

Key informant interviews with healthcare providers, community hub coordinators, pharmacists and AGYW to capture qualitative insights on provider and client experiences, challenges, and opportunities for integrating DPP.

This approach yielded both descriptive data (e.g., number of facilities providing certain services) and thematic insights (e.g., barriers to PrEP retention, client preferences for contraceptive methods). Together, the findings provide a holistic picture of integration opportunities and gaps across platforms.

RESULTS

PUBLIC FACILITIES

All seven public health facilities assessed reported offering both FP and PrEP services. However, delivery is largely siloed, with FP typically provided in the MCH department and PrEP in ART or MCH for pregnant and breastfeeding women. Only two of the seven facilities had ART staff trained in FP provision, meaning integration depended on a small number of individuals. In one case, infrastructure limitations forced staff to borrow space from MCH to provide FP, disrupting integration opportunities.

> "Because of staffing we are not always able to provide FP, but we are supposed to provide everything. If I have been assigned to triage or do something else, what time will I squeeze in FP? That's where the challenge is. But we are supposed to provide because it's integrated FP and my room has been taken away. I used to have a room for FP, but I don't have a room at the moment. So when I have a client, I go to MCH to ask for a room." PrEP provider, Public Facility, Lusaka

Across facilities, clients seeking both services must make multiple visits or queue separately, increasing missed opportunities for integrated care. While informal referrals between departments do occur, there is limited documentation or follow-up to confirm whether referred clients receive the second service, leading to weak linkage and poor continuity of care. Notably, four of the seven facilities reported extending oral PrEP to all women who requested it, even though guidance limits provision to pregnant and breastfeeding women.

COMMUNITY HUBS

All three community hubs assessed, DREAMS (prior to January 2025), Rise Up Houses, and Key Population Alliance of Zambia (KPAZ), provide integrated, client-centred services with extended hours, privacy, and peer follow-up. However, one of the hubs follows a system more similar to public facilities, with services divided across different rooms and providers. In this hub, young women seeking PrEP and FP are required to move between the HIV testing room, the lab for pregnancy testing, and then separate providers for PrEP and FP, creating multiple service points.

> "So they go and do the HIV test in the HTS room, then they go to the lab and do the pregnancy test. So it's different departments. But it can be better where they do the HIV test, they also do the pregnancy test in one place. Because I don't think a pregnancy test is a very complicated thing. It's better than taking someone to do an HIV test and then go that side again for a pregnancy test. We can have those discussions so that we lessen someone's movements from one room to the other." Hub coordinator, Lusaka

Across all hubs, only short-term FP methods were available on site, with AGYW seeking long-term methods referred to the mother public health facility. Referrals are typically escorted by staff using project vehicles to reduce loss to follow-up. Unlike siloed public facilities, these hubs offer extended hours, privacy, proactive follow-up through peer networks and reduced stigma, factors that increase uptake and continuation.

PHARMACIES

All five pharmacies assessed stocked oral contraceptives, while two also stocked injectables. Oral contraceptives were mostly purchased by repeat clients, with few new initiators.

Pregnancy test kits were available in all five pharmacies, and four stocked HIV self-test kits. One pharmacy operated a small laboratory offering HIV and pregnancy testing on site. However, none of the pharmacies provided PrEP or had a formal referral system to facilities authorized for PrEP initiation.

Counselling practices varied. Two pharmacies reported asking new clients questions and offering basic information on side effects and correct use of oral contraceptives, while the rest assumed clients already had sufficient knowledge.

> "We get to ask sometimes depending on if they've come for advice. There are those who are already on these pills so they're just refilling. There are those that want to start and ask a little bit of questions and we counsel them before we dispense. Counselling is on side effects, how they are supposed to be taken, just the normal basic information." Pharmacy staff, Lusaka

Across all pharmacies, referrals to public facilities were informal and inconsistent, with no mechanisms to track whether clients accessed follow-up services.

FEEDBACK ON THE DPP

Across facilities and community hubs, providers generally viewed the DPP as a promising innovation. In the community hubs, staff felt the DPP could be beneficial particularly for AGYW and female sex workers by reducing pill burden, offering dual protection, and helping address stigma since it resembles regular contraceptives.

In public facilities, where services remain siloed, providers highlighted that the DPP could streamline care by reducing the need for separate visits to FP and HIV departments

> "A product like the DPP would make my job easy because there will be no need for me to refer the patient to MCH (for FP). It will be everything in one shop." PrEP provider, public facility, Lusaka

At the same time, providers emphasised the importance of adequate training, reliable supply chains, and clear eligibility screening tools to support successful rollout. Both facility and community hub staff noted the importance of community sensitization to address myths about contraception and PrEP, and to ensure the DPP is not mistakenly associated with ART.

POLICY RECOMMENDATIONS

The following policy recommendations aim to support equitable access to the DPP, reduce duplication of services and costs and, ultimately, improve health outcomes for AGYW and young female sex workers.

1. INTEGRATE FP AND PREP SERVICES AT PUBLIC FACILITIES

- Introduce a shared screening tool to be used at first client contact, whether in Maternal and Child Health, ART, or Outpatient Departments, to assess both HIV prevention and contraceptive needs in the same consultation.

- Implement dual-service registers to record provision of both FP and PrEP in one place, allowing providers to track referrals, monitor integration, and reduce missed opportunities. This approach would ensure that a client presenting for one service (e.g., FP) is routinely screened for the other (PrEP).

Lead: MoH, supported by District Health Offices for supervision and facility in-charges for daily coordination.

2. SUPPORT COMMUNITY-BASED DPP DELIVERY

- Expand integrated service models, piloted by DREAMS, Rise Up and KPAZ, where young women can access both HIV prevention and contraception in a single visit from one provider in a youth-friendly, non-clinical setting.

- Include community hubs as formal delivery points for the DPP, leveraging their trusted relationships, integrated counselling approach, and ability to reach AGYW and key populations who may not visit public health facilities.

Lead: MoH (commodity supply, training, supervision). Partners: community-based organizations for delivery and follow-up; donors for funding and operational support.

3. ENGAGE PHARMACIES IN DPP ROLLOUT

MoH is currently exploring a pharmacy-based model for oral PrEP delivery in an effort to de-medicalise the PrEP program. The recommendations below build on that direction so the DPP can be incorporated when the product becomes available.

- Authorize and train pharmacists to dispense the DPP alongside existing oral contraceptives, ensuring they can provide basic counselling on daily adherence, side effects and when to seek medical follow-up.

- Establish clear referral pathways for HIV testing and follow-up care, including formal linkages to nearby public facilities or community hubs.

- Stock the DPP in high-demand pharmacies, prioritizing locations already serving large numbers of AGYW for contraceptives and HIV/pregnancy self-test kits. Expanding DPP access to pharmacies could increase convenience, extend service hours beyond public facilities, and reach clients who prefer the privacy of pharmacy settings.

Lead: MoH (policy approval, supply chain integration, pharmacy training). Partners: pharmacy networks to implement service delivery.

CONCLUSION

Zambia's policy environment is already favourable to DPP introduction. To realise the full potential of this innovation, the health system must invest in practical, scalable integration of PrEP and FP services across delivery platforms. This will ensure Zambia is positioned to deliver multipurpose prevention technologies and course-correct for high rates of unintended pregnancies and HIV acquisition, a long-overdue milestone. By leveraging existing platforms, especially community hubs, Zambia can position itself as a leader in integrated HIV and reproductive health service delivery. Failure to act risks reinforcing health system inefficiencies, delaying uptake of the DPP, and worsening the dual burden of HIV and unintended pregnancy in young women.