The future of HIV service delivery is integration

AIDS 2026

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Tsitsi Apollo, Ministry of Health and Child Care, Zimbabwe

The future of HIV service delivery is...simplification, self-care, integration, and AI in practice

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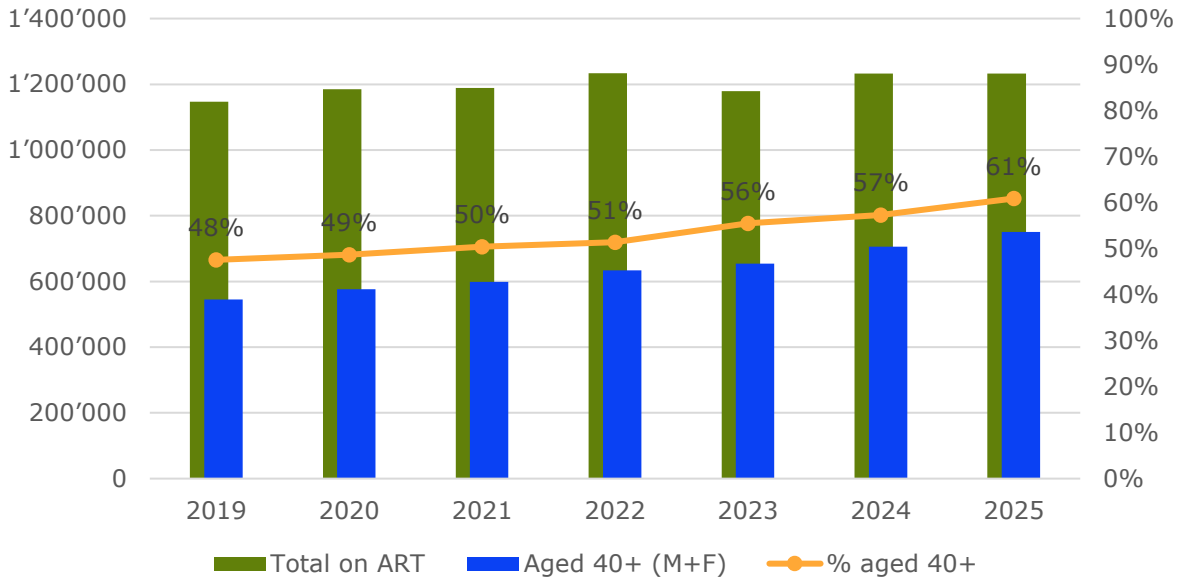
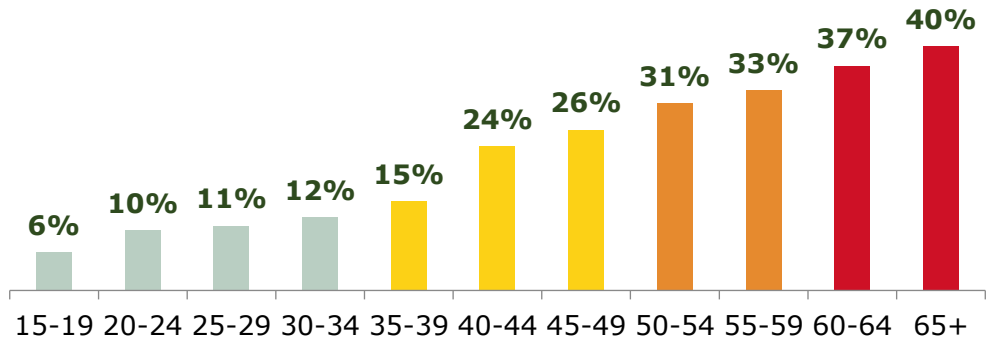
Although new infections have fallen sharply, the legacy of the epidemic is an aging cohort requiring lifelong care.

Zimbabwe's HIV population is ageing: More than half of people living with HIV are aged 40 years and older (2019–2024)



Burden of hypertension is increasing: Hypertension prevalence by age (screened Jan 2023–Dec 2024);

Data reflects Bulawayo and Chitungwiza sites where OPHID's HIV-NCD Integration Program provided technical and data-collection support for coordinated screening (n=113,680).



- Zimbabwe has reduced new HIV infections by 80% and AIDS-related deaths by 77% since 2010.
- Improved survival has shifted the HIV epidemic towards an older population. The share of people living with HIV aged 40+ increased from 47.6% (2019) to 60.9% (2025).
- Hypertension prevalence was 48.2% among PLHIV screen
- The ageing HIV population requires more integrated management of HIV and chronic diseases, including multimorbidity and polypharmacy.

Source: UNAIDS AIDSinfo, retrieved 10 July 2026, 09:00 hrs.

Treatment cascades for HIV and hypertension at very different stages in Zimbabwe

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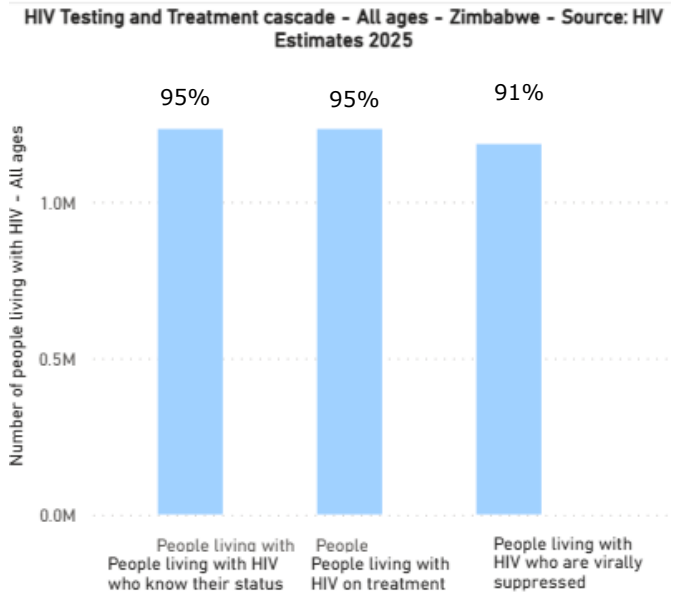
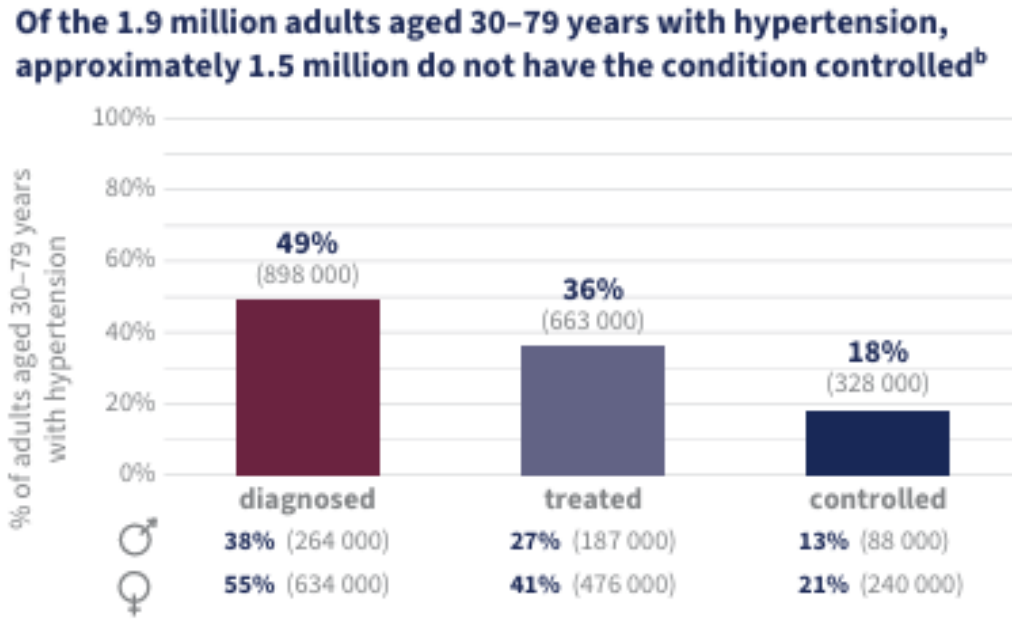
HIV cascade 2025 (*AIDSinfo | UNAIDS DATA 2025*)



Hypertension cascade 2024 (*WHO Global report on hypertension 2025)*



Will integration of HIV services into OPD and primary care maintain the quality of HIV services?
Could integration of HIV services into OPD and primary care strengthen other areas of chronic care?

Source: UNAIDS AIDSinfo, retrieved 10 July 2026, 09:00 hrs.

Zimbabwe's integration agenda meets a funding cliff

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The same population is aging into higher-risk, costlier-to-treat years

60.9%
of the ART cohort is now aged 40+, up from 47.6% in 2019

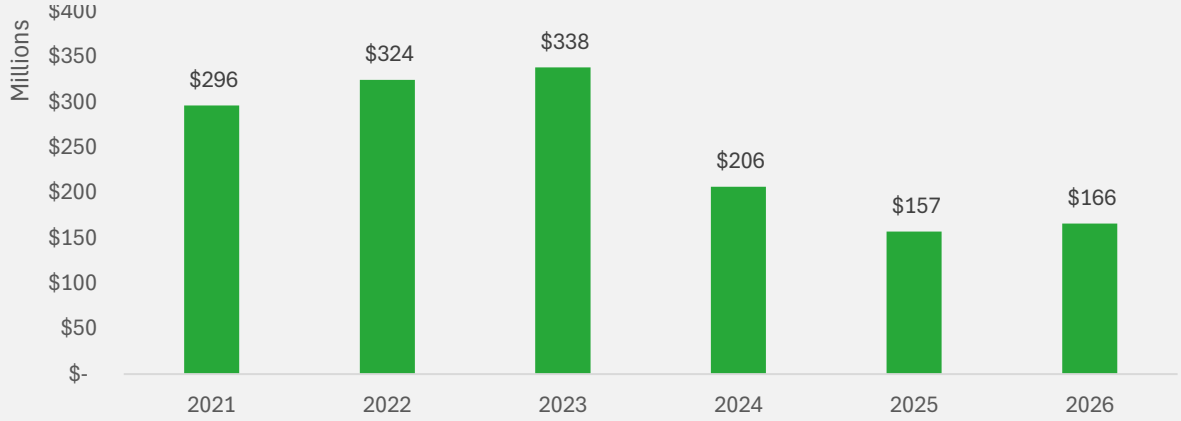
1.23M
people on ART in 2025, up from 879K in 2015

48.2%
hypertension prevalence among PLHIV screened (vs. 46.4% HIV-negative)

24% → 40%
hypertension prevalence, ages 40–44 to 65+ — the bands the cohort is aging into

Changing HIV Resource Envelope in Zimbabwe (2021–2026)

−39% Decline from the 2023 funding peak to 2025



HIV financing has fallen sharply just as integration becomes urgent.

1. A growing, aging ART cohort is arriving at exactly the age bands where multimorbidity becomes common. Integration is how this population gets served without a proportional rise in visits and cost; the funding decline makes that harder to achieve, not less necessary.
2. GC7 absorption and GC8 planning are proceeding under materially reduced envelopes. Integration is increasingly a resourcing necessity, not only a service-quality goal.
3. Zimbabwe's ISA was commissioned to establish where the health system already supports integration and where funding-constrained choices will bite hardest.

Source: MOHCC Resource Mapping & Expenditure database 2025, OPHID HIV-NCD Integration Program, & UNAIDS AIDSinfo, retrieved 10 July 2026, 09:00 hrs

What the situational assessment covered

A mixed-methods assessment of 20 facilities across 5 provinces, benchmarked against the national standard.

1. Facility checklist - 20 facilities: infrastructure, HR posts, guideline availability, lab/pharmacy integration
2. Key informant interviews - 7 respondents: governance, coordination, financing, cost perceptions
3. Focus group discussions - 14 sessions: wait times, missed opportunities, stigma, acceptability

Benchmark - MOHCC Operational and Service Delivery Manual (OSDM) for HIV, 2022 edition

How scores are calculated

Binary (yes/no) facility indicators > mean per domain > expressed on a 0–5 scale > classified into a band.

Integration bands

Fully integrated	4.5 – 5.0	Same-provider, same-day delivery across service points
Strong integration	4.0 – 4.4	Most indicators met; isolated gaps remain
Partial integration	3.0 – 3.9	Co-location present; internal referral is the norm but no follow up
Minimal integration	0 – 2.9	Gates open; downstream pathway fragmented; services parallel

How the domain scores were built

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Two worked examples from Nyanyadzi Rural Hospital, showing how the same underlying question style differs by domain

ART INTEGRATION

11 co-managed services, scored per entry point

What was asked: for each of 11 services (TB screening, TPT, hypertension, diabetes, family planning, VIAC, and others), does the client's own ART provider deliver that service at the same ART visit?

Scoring: 5 = same provider, same visit | 3 = co-located, different provider | 2 = internal referral | 1 = not offered together

WORKED EXAMPLE

TB screening & treatment

Same ART provider delivers it at the same visit

5

VIAC (cervical cancer screening)

Not offered alongside the ART visit at all

1

+ 9 more services, averaged in

ART Integration Domain Score: 3.00 *(Partial integration)*

PHARMACY

2 structural practices, scored as Yes/No

What was asked: two direct structural questions — are HIV and non-HIV medicines dispensed from the same point, and are multi-month supplies (MMD) issued together for clients on both types of medicine?

Scoring: 5 = Yes, the practice exists | 1 = No, it does not. No partial credit — the question itself is binary, so there is no intermediate state to score.

WORKED EXAMPLE

HIV meds dispensed with non-HIV meds

No — HIV medicines are dispensed separately

1

Multi-month dispensing (MMD) for both

Yes — issued together for eligible clients

5

Just these 2 questions make up the whole domain

Pharmacy Domain Score: 3.00 *(Partial integration)*

Same band, different reasons: Nyanyadzi lands in "Partial integration" for both domains — but ART Integration reflects wide variation averaged across 11 separate services, while Pharmacy reflects a straight 50/50 split between two structural practices.

Facility integration performance across seven HIV service delivery domains

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- Facilities are ranked by overall integration score while highlighting strengths and gaps across seven key service delivery domains.

Facility	Facility Type	HIV Prevention & Testing	PMTCT	ART Integration	Chronic Care	Lab	Pharmacy	Continuity of Care	Overall	Band
St Luke's Mission Hospital	Mission Hospital	5	5	5	5	5	5	5	4.86	Fully integrated
ZPS Khami Max Prison Hospital	Other (Specify)	5	5	3	5	5	5	5	4.78	Fully integrated
Mutambara Mission Hospital	Mission Hospital	5	4	4	3	5	3	5	4.17	Strong integration
Victoria Chit Provincial Hospital	Provincial Hospital	5	5	4	5	5	1	No data	4.09	Strong integration
Nyanyadzi Rural Hospital	Rural Health Centre	5	4	3	3	5	3	5	4.02	Strong integration
Mpilo Central Hospital	Central Hospital	4	4	4	5	3	3	5	4.01	Strong integration
Father O'Hea Mission Hospital	Mission Hospital	4	4	4	3	5	5	3	3.98	Strong integration
Chakohwa Clinic	Rural Health Centre	4	5	4	5	5	1	3	3.89	Strong integration
Jotsholo Clinic	Clinic / Medical Centre	4	4	4	5	3	3	No data	3.88	Strong integration
Lupane Rural Health Centre	Rural Health Centre	2	4	4	3	3	5	5	3.76	Strong integration
Nketa Clinic	Urban Clinic / Polyclinic	3	1	3	5	5	5	No data	3.68	Strong integration
Mzilikazi Clinic	Urban Clinic / Polyclinic	1	4	4	5	1	5	5	3.55	Strong integration
Cowdray Park Clinic	Urban Clinic / Polyclinic	4	4	4	5	3	1	No data	3.51	Strong integration
Umguza Council Clinic	Clinic / Medical Centre	1	4	5	5	3	5	1	3.41	Partial integration
Sanyati Mission	Mission Hospital	4	5	3	3	3	5	1	3.41	Partial integration
Darwendale Clinic	Rural Health Centre	5	1	3	3	5	3	1	2.99	Partial integration
Zvipiripiri Rural Health Centre	Rural Health Centre	4	4	2	3	1	No data	3	2.98	Partial integration
Chegutu District Hospital	District Hospital	5	5	3	3	3	1	1	2.87	Partial integration
Chinengundu Clinic	Urban Clinic / Polyclinic	3	5	1	No data	3	1	No data	2.50	Partial integration
Nkulumane Clinic	Urban Clinic / Polyclinic	2	1	1	No data	3	3	No data	2.07	Minimal integration

High scores do not always mean true integration

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1 The Chronic Care paradox

- 10 of 20 facilities have a co-located NCD-HIV service, which is what the score measures. Yet PEN/PEN+ clinical guidelines are present at only 1 of 20. A facility can therefore score fully integrated on Chronic Care while having no protocol for evidence-based NCD-HIV management. This form of co-location does not constitute clinical integration.

2 Continuity of Care: most polarised domain

- The continuity of care domain shows a clear bimodal pattern, with facilities tending to perform either very well or very poorly. This suggests that continuity is more strongly influenced by deliberate facility-level systems and practices than by gradual, incremental improvement. The four facilities classified as having very limited continuity of care likely lack structured mechanisms for patient follow-up and care coordination.

3 Pharmacy: the lowest and most-felt barrier

- Pharmacy separation from the consultation room is the most frequently cited service flow barrier across all 15 FGDs. When ART medicines are dispensed through a separate pharmacy, patients must join an additional queue after completing their clinical consultation, further extending their overall time at the facility. Addressing this bottleneck is primarily a matter of redesigning patient flow and service organization rather than investing in new infrastructure.

Support for integrated service delivery is nearly universal, but it is strongly conditional.

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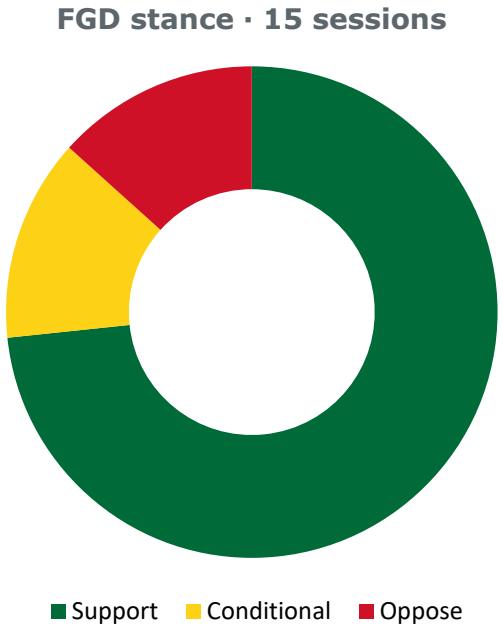
How we coded sentiment

Each of the 15 FGD sessions was coded for stance (support / conditional / oppose), stigma direction and dominant concern — drawn from the documented findings in the integrated and Mash West reports.



13/15

FGDs support a one-stop shop

~12/15

say integration reduces stigma

2/15

warn it could increase stigma

0/15

were consulted in integration design

Key insight

Demand is not the barrier, the community want integration, overwhelmingly for anonymity. But support is conditional on service quality, queue management and green-book privacy, and it was designed without them. An integration rollout that overlooks these conditions risks generating some kind of resistance.

The drivers of support and the conditions that can reverse it

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WHY THEY SUPPORT IT

Anonymity is the dominant driver.

- In a shared queue, HIV status is less identifiable. Participants also cite time savings and lower transport costs.
- Support is strongest where the stand-alone OI clinic has itself become a stigma marker. Neighbours read presence at the OI clinic as confirmation of status. Some young people default ART rather than be seen there. (Raised at: 1 FGD)
- Green book in the queue - ART cards handed out in shared waiting lines reveal status before a patient reaches the room. (Raised at: 1 FGD)

"Services will be under one roof. It will be discreet and secret. It will also save on time."

"saze sambamba" — "finally we know she is HIV positive."

A participant recalling how being seen at the OI clinic confirmed her status to neighbours.

THE CONDITIONS AND THE COUNTER-VOICE

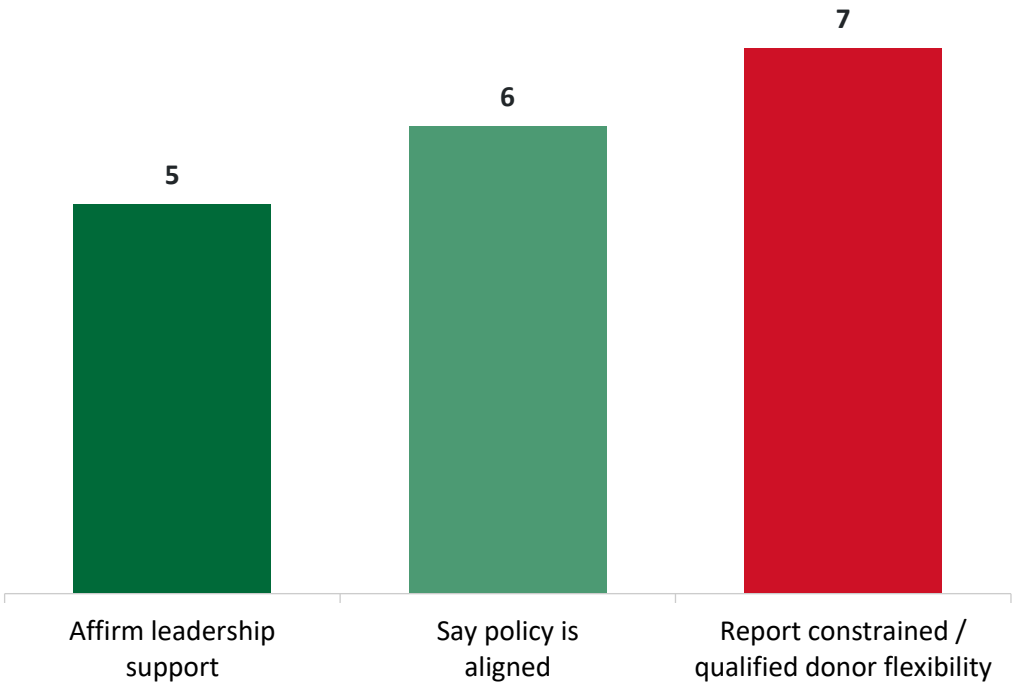
Support is conditional rather than unconditional.

Some participants rejected integration on quality grounds: fast service, familiar nurses and a therapeutic community are real benefits of the stand-alone clinic that must be preserved, not assumed away. Queue management and pharmacy co-location must be solved first.

"Why did you isolate us first? Our nurses know us better. We don't want new nurses."

Implication for design: the therapeutic relationships and service familiarity built within the OI clinic are real assets that integration design should actively preserve. Integration that fails to maintain service quality and familiar relationships is likely to be experienced as a deterioration in care.

Leadership support for integrated service delivery is strong in principle but translating that commitment into practice is constrained by financing.



Policies don't speak to each other

DHE

"The policies are present but do not speak to each other… HIV is being treated as a specialty but it should just be integrated like all other diseases."

Will heard, not acted on

DHE

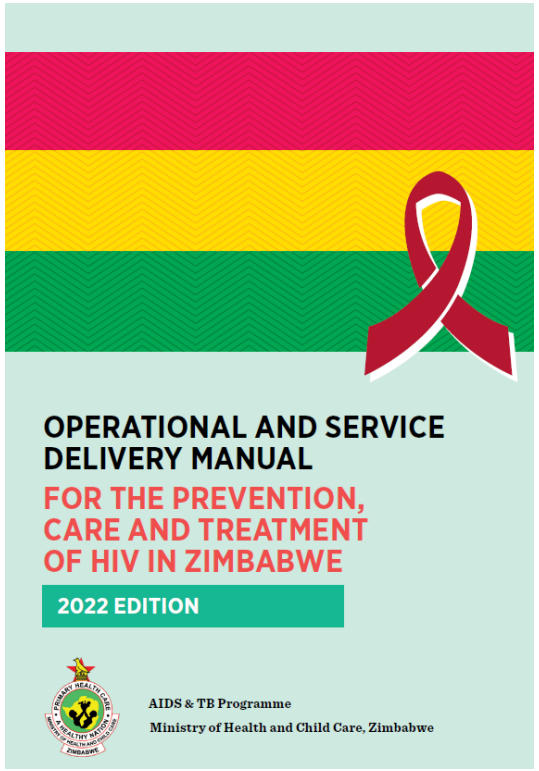
"The will is heard but not acted on. For 2025 only fuel was received. No allocation has been received yet."

Funding is disease-specific

Multiple (5/7)

Funder support is tied to predefined, disease-specific objectives; only UNICEF and WHO were named as flexible. One funder declined to redirect malaria fuel to an HIV outreach run.

Next steps: A phased approach: highest-impact, lowest-cost actions first



IMMEDIATE · 0 - 6 months

- Update and disseminate guidelines to standardize minimum standards of integrated implementation.
- Launch structured community consultation on integration design.
- Scale blended in service training for integrated service delivery pathways.
- Refine the tool and deploy widely for facility self assessment & facilitate facility re-orientation through quality improvement initiatives.

MEDIUM · 6 - 18 months

- Saturate in-service training for integrated service delivery and dissemination of guidelines
- Embed integration competencies in pre-service nursing/clinical curricula

LONG TERM · 18+ months

- Address space constraints through targeted infrastructure investment
- Move HIV care fully into OPD; retire the OI-clinic / green-book model

Acknowledgements

- Ministry of Health and Child Care, Zimbabwe
  - Facility, district, and provincial respondents who took part in the assessment
- Mutare and Bulawayo City Health Directorates
- National AIDS Council
- Zimbabwe National Network of PLHIV+
- Zimbabwe Health Interventions (ZHI)
- Organization for Public Health Interventions and Development (OPHID)
- Clinton Health Access Initiative (CHAI)
- Zimbabwe Technical Assistance, Training and Education Center for Health (Zim-TTECH)
- Communities consulted within each facility catchment area.