



Integration and dHTS

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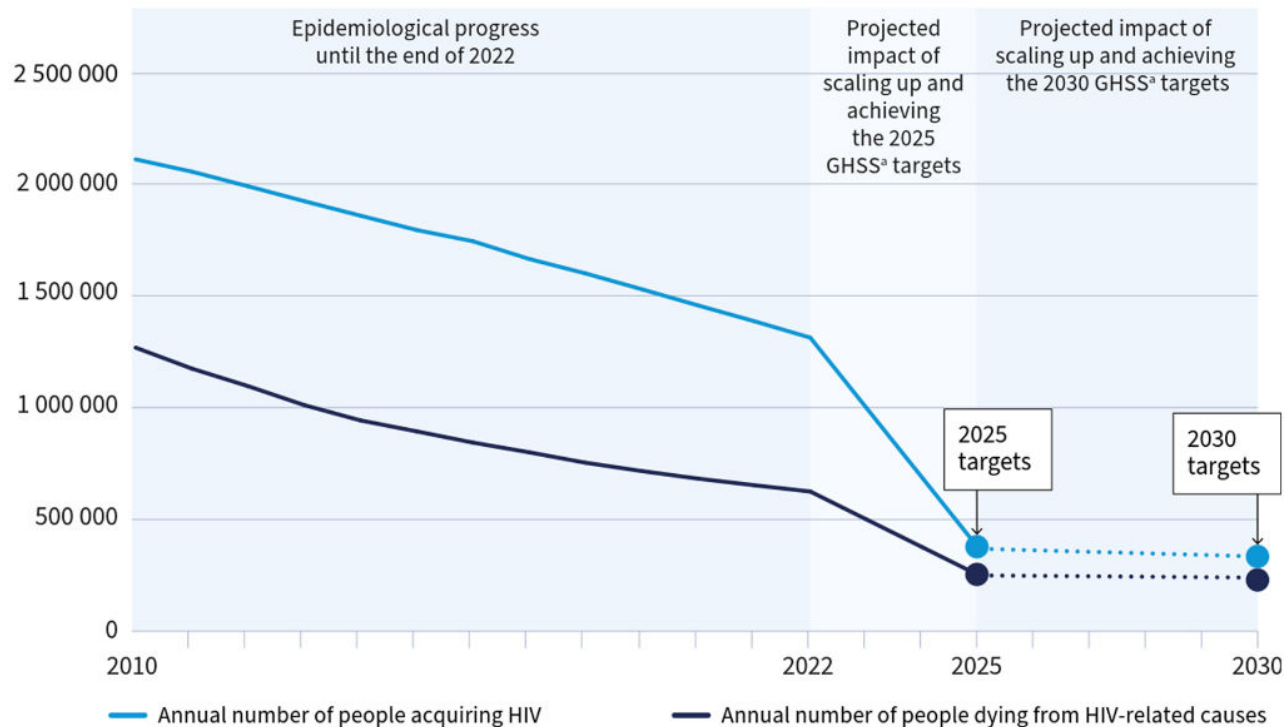
“Integration is not complicated...it’s complex.”

- Miriam Rabkin, Co-Founder, CQUIN



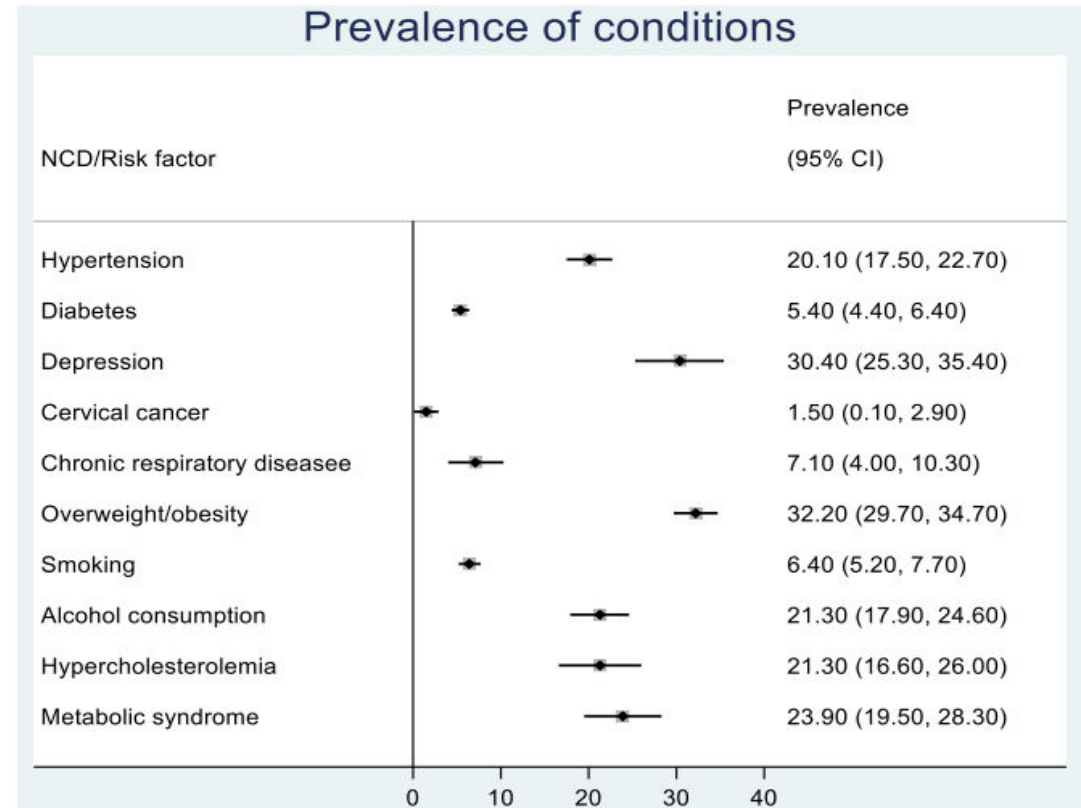
Why Integration?: Epidemiological Trends

Global trends in people acquiring HIV and people dying from HIV-related causes, 2010-2022 and projections to 2030



Source: WHO, HIV data & statistics, Avenir Health, using 2025 targets and UNAIDS/WHO epidemiological estimates, 2023

Forest plot of pooled estimates generated by meta-analyses for prevalence of selected conditions among PLHIV in SSA (data sources 2010-2023)



Source: Moyo-Chilufya, M. et al, "The burden of non-communicable diseases among people living with HIV in Sub-Saharan Africa: a systematic review and meta-analysis", Oct 2023, Lancet

Why Integration?: HIV Financing Trends

Trends in Resource Availability for HIV by Funding Source, USD Billions (All LMICs)



Source: UNAIDS Financial Estimates, July 2023

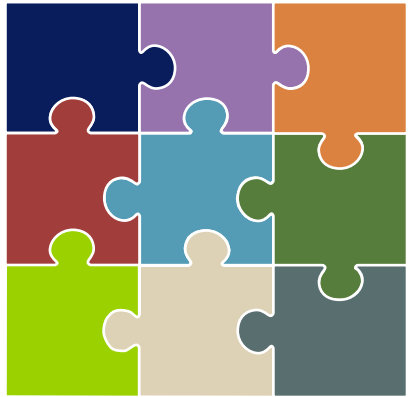
The Problem



- 1 With the longer lifespans that antiretroviral therapy programs have made possible, NCDs are occurring due to a mix of chronic immune activation, medication side effects, coinfections, and the aging process itself (Venkat Narayan, 2014)
- 2 Although HIV continues to have a high prevalence among adults in sub-Saharan Africa (SSA), the burden of NCDs such as diabetes and hypertension is increasing rapidly. There is an urgent need to expand the capacity of healthcare systems in SSA to provide NCD services and scale up existing chronic care management pathways (McCombe, 2022)
- 3 In their current form, health systems are not set up to accommodate/support the integration of chronic disease service delivery
- 4 Funding is most often verticalized, inhibiting the integration of chronic conditions at both the systems and point-of-care of service delivery levels
- 5 Integration of HIV services with other health services (e.g., NCDs, TB, FP) has been proposed as an important strategy for the sustainability of the global HIV response – **but this is still only an assumption**. More research and evidence needs to be developed to support this hypothesis

Source: Borrowed from slides presented by Neeta Bandari, BMGF at CQUIN Integration meeting 2024 in Kenya

The Definition: Systems vs. Services



1 There is a difference between integration of health *systems* and the integration of health *services*

2 Here, we refer to “the health system” as the building blocks of a national health system beyond service delivery – e.g., laboratory, supply chain, healthcare workforce, health information systems, financing, etc.

3 “Health services” refers to actual point-of-care health service delivery (e.g., public facilities, private facilities, community clinics, etc.)

4 In order for health services to be integrated, they must be at least partially supported by an integrated health system

5 HIV *service delivery* can be integrated into *broader health services* (i.e., primary healthcare services) – this would require un-verticalizing parallel systems and institutionalizing them into the existing national health system

Source: Borrowed from slides presented by Neeta Bandari, BMGF at CQUIN Integration meeting 2024 in Kenya

Directionality of Integration – Which Way Do We Go, and Does It Matter?

Example Types of Integrated Models*

Non-HIV Services into HTS	HTS into non-HIV services	Simultaneous Integration of non-HIV services and HTS Services
<p>Non-HIV services integrated into HTS. Clients coming in for HTS are offered other services such as TB, NCDs, FP as well as other relevant and adjacent services such mental healthcare, viral hepatitis screening, treatment for substance abuse disorders. This can include multiplex testing used for populations and delivery points where most relevant. E.g. syphilis</p>	<p>HTS services integrated into non-HIV services such as FP, SRH, MNCH, TB clinics. Clients who have come for other non-HIV services are offered HIV testing and linked to either treatment or prevention depending on test results.</p>	<p>HTS and non-HIV healthcare services are simultaneously introduced and integrated during outreach or at the same clinic site.</p>

Adapted from the work by Duffy et al, "Non-communicable diseases and HIV care and treatment: models of integrated service delivery," Tropical Medicine and International Health doi:10.1111/tmi.12901; volume 22 no 8 pp 926–937, 2017

Source: Borrowed from slides presented by Neeta Bandari, BMGF at CQUIN Integration meeting 2024 in Kenya

Benefits & risks of services integration

Potential Benefits



- More person-centered
- May be more efficient for recipient of care
- Minimizes missed opportunities – treat the people in front of you
- Likely more effective

- Integration of HTS generate more demand and increase testing amongst priority populations e.g. men
- In some countries, testing centers are being converted into men's health centers that offer a number of different health screenings, including HTS

Potential Risks



- Tradeoffs involving time
- Tradeoffs involving staff
- Tradeoffs involving funding
- Health workforce challenges – training, licensure, scopes of work

- Siloed nature of HIV funding and implementation.
- There are limitations to the number of services healthcare workers can deliver. E.g., child immunization clinics would be a great opportunity to offer testing to breast feeding parents, but really challenging given the high volumes in these clinics

*Source: Miriam Rabkin, "Integration: Setting the Scene", UNAIDS Consultation / Rio de Janeiro / March 2020, ICAP, Columbia University

Integration as part of differentiated HTS requires program assessment:

- **What are the key challenges in HTS program and where / how can integration improve the program and overcome some barriers?**
- **How does the HTS integration look in the context of building blocks? (When, Where, Who, What)**
- **What opportunities are there for integration within the building blocks and HTS program areas? (Mobilization, testing, and linkage)**

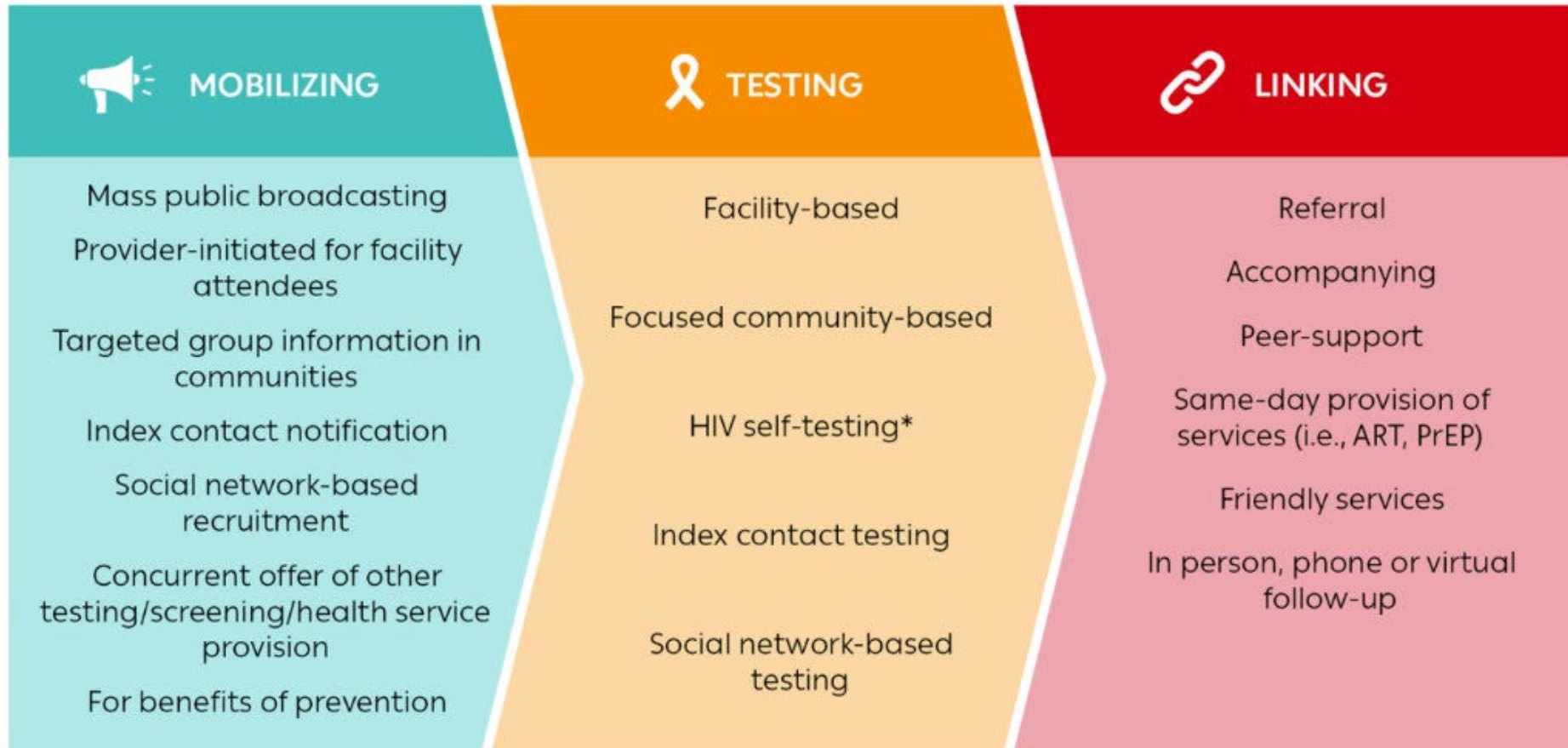
Assess program gaps for integration opportunities

- Testing opportunities and uptake for men remain lower than for women.
- With the highest number of new infections among adolescent girls and young women in Eastern and Southern Africa, only 25% have tested for HIV.^{11, 12}
- Key populations are disproportionately affected by HIV. Yet, their uptake of HTS is limited.
- Systematic testing is lacking for sexual partners of people living with HIV and their children.

dHTS building blocks










3 Components of HTS



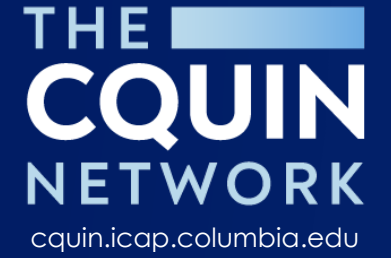
* Self-testing is a testing modality that can be used in all testing approaches, including within health facilities and in the community.

Where and how does integration fit?

	 MOBILIZING	 TESTING	 LINKING
 WHEN	Timing and frequency	Timing and frequency	Timing of linkage activities and timing and frequency of follow-up
 WHERE	Location of mobilization activities	Location of HIV testing	Location of linkage activities
 WHO	Who does the mobilization	Who does the HIV testing	Who supports the linkage activities
 WHAT	The mobilization approach(es) used	The package of services:	The interventions to link to ART services
		The HIV test	and related activities

Conclusion

- Integration is complex
- It can be considered across a continuum from integration in HTS to bi-directional approaches
- Countries must consider and align on goals, assess services, and re-align dHTS based on when, where, who, and what for the components of testing: mobilization, testing and linkage and services being considered
- Person centered and key considerations must include systems integration and service availability as well as financing and operational feasibility



Thank You!

