# Integrating Non-HIV Services into HIV Programs: Delivering Person-Centered Care for People Living With HIV

**April 15 - 18, 2024 | Nairobi, Kenya**

Meeting Report

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## Summary

Since its launch in 2017, the HIV Coverage, Quality and Impact Network (CQUIN) has become a dynamic and influential platform that supports the expansion of differentiated service delivery (DSD) for HIV in Africa. Convened by ICAP at Columbia University and funded by the Gates Foundation, CQUIN aims to hasten the adoption of innovative service delivery models and overcome challenges in implementing high-quality DSD strategies on a large scale. In 2023, CQUIN sharpened its focus on holistic person-centered care for people living with HIV, continuing and deepening the work of its communities of practice on differentiated TB/HIV, differentiated maternal and child health, and differentiated HIV and non-communicable disease service integration (HIV/NCDs).

In line with this shift in focus, ICAP at Columbia University hosted the CQUIN Learning Network's meeting on Integrating non-HIV Services into HIV Programs: Delivering Person-Centred Care for People Living with HIV from 15th to 18th April 2024 in Nairobi, Kenya, in collaboration with the Kenya Ministry of Health.

The objectives of the meeting were to:

- Exchange knowledge, best practices, innovations, resources, and strategies for integration of non-HIV services into HIV treatment programs, with a focus on HTN and FP.
- Share relevant program tools and resources related to integration.
- Identify shared gaps, challenges, and opportunities for future joint learning, co-creation of tools and resources, and country-to-country exchange visits.
- Develop country-specific action plans.

The meeting convened global and regional experts (BMGF, WHO, GHSD/PEPFAR, CDC, USAID, IAS, FP2030, PATA, AMBIT, EGPAF, ITPC), and teams from each of the 21 countries in CQUIN, which included representatives from Ministries of Health (HIV, NCD, FP departments), PEPFAR agencies, implementing partners, national networks of people living with HIV, and civil society. The meeting had 241 participants.

### Key takeaways from the meeting:

- Most countries do not face major policy barriers to integration but **struggle with implementation fidelity.** Most countries have policies for integration, but the **policies are not detailed enough,** and they often do not account for integration within DSD.
- **Siloed planning, implementation, and management** across programs is a challenge and therefore **joint coordination and planning** by the different departments within ministries of health must be considered a priority and counties should establish coordination mechanisms.
- **Definitions of integration within the ART context are unclear** especially for FP integration. It is necessary for the network to **agree on some working definitions** of what is considered integration of services within the context of the network.
- **Define the integration standards**: There is need to establish an acceptable definition of integrated services. What does a service need to include to be considered integrated? Is it all, one of, or a combination of these elements -: (screening, counselling, actual service delivery or referral)?

- There is need to **define what integration success looks** like so that you can measure it. Define: What to measure, how to measure, when to measure, where to measure, who measures and propose an integration M&E framework that countries can adopt/ adapt. A critical next step should be **co-creation of M & E frameworks** for HIV/HTN and especially FP/HIV integration.
- **EMRs are best suited for monitoring of integrated services**. Country governments and donors should prioritize resource allocation that support the development and use of these EMRs.
- **Community Engagement**: Involving care recipients in designing, target setting and monitoring (e.g., through community-led monitoring) of integrated services is vital for ensuring services meet individual and community needs.
- **One-stop shop is the gold standard** – countries must aim for this if resources allow. Alternative integration approaches must ensure peer navigation and effective referral systems to document completed referrals.
- Some critical enablers for DSD for ART and HTN treatment include **non- toxic regimen, simplified clinical guidance**, effective regimen enabling faster time to control**, fixed drug combinations (FDC)** and clinical monitoring tool to determine established on treatment.
- Countries requested for an **integration readiness assessment framework** to act as a baseline which systematically points out the gaps that need to be addressed to ensure smoother implementation.
- **Pre- and in-service capacity building** on FP and HTN counselling and service delivery for HIV providers and supervisors, and the use of peer mentoring or training-of-trainer approaches is necessary to help diffuse new knowledge or skills to providers who need to provide integrated services.
- **Strengthening health workforce capacity**, improving referral networks, and increasing funding commitments are critical.
- **Health systems strengthening** is essential for successful integration, requiring attention to both services and systems. Gains made in disease-specific programs are fragile without **resilient systems** and comprehensive disease management.
- There is need to **leverage and learn from the HIV program supply chain** for a sustained and resilient integration supply chain that supports integrated service provision.
- **Leveraging private sector funding** to ensure standardized, quality, and affordable supplies; utilizing community pharmacies to improve access; using taxes on alcohol and tobacco to fund healthcare initiatives is essential to ensure affordable and reliable supply of NCD medicines. **National health insurance** plans could also assist in ensuring a steady supply of medical supplies.
- There is **need for Donor Flexibility** – how can we walk this talk? Donors should reconsider their funding strategies, emphasizing support for systems, capacity-building, financing, and the broader health agenda.

## Background

Since the 2017 launch of the HIV Coverage, Quality and Impact Network (CQUIN), the network has grown into a vibrant, high-impact forum supporting the scale-up of differentiated service delivery (DSD) for HIV in Africa. Convened by ICAP at Columbia University with support from the Gates Foundation, the CQUIN network is designed to accelerate the scale up of innovative service delivery

models, and to address the barriers between adoption of DSD policies and the implementation of high-quality strategies at scale. CQUIN activities promote country-to-country learning, diffusion of innovation, community engagement, and co-creation of practical knowledge and tools. CQUIN also provides focused and strategic technical assistance, facilitates DSD-relevant data collection and analysis, and supports countries to plan, coordinate, and monitor DSD activities. As of December 2023, CQUIN has hosted 22 multi-country meetings, 57 webinars, and 50 country-to-country learning visits. Ten communities of practice1 are working together to exchange best practices and co-create resources on topics prioritized by network members.

In 2023, CQUIN sharpened its focus on holistic person-centered care for people living with HIV, continuing and deepening the work of its communities of practice on differentiated TB/HIV, differentiated maternal and child health, and differentiated HIV and non-communicable disease service integration (HIV/NCDs). Through webinars, country-to-country visits, community of practice meetings, and a mixed methods situational analysis, network members explored the issue of integration at the systems and service delivery levels, discussed the difference between integration of HIV programs into national health systems and integration of non-HIV services into HIV programs, described barriers and facilitators to integrated service delivery, and exchanged best practices, case studies, resources, and tools.

ICAP at Columbia University hosted the CQUIN Learning Network’s meeting on Integrating non-HIV Services into HIV Programs: Delivering Person-Centred Care for People Living with HIV from 15th to 18th April 2024 in Nairobi, Kenya, in collaboration with the Kenya Ministry of Health.

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- Share relevant program tools and resources related to integration.
- Identify shared gaps, challenges and opportunities for future joint learning, co-creation of tools and resources and country-to-country exchange visits.
- Develop country-specific action plans.

The meeting convened global and regional experts and teams from each of the 21 CQUIN member countries, including representatives from Ministries of Health, PEPFAR agencies, implementing partners, national networks of people living with HIV, and civil society. A summary of the meeting participants is attached at the end of the report. Individual meeting participant profiles can be found here: Participants Facebook

# Integration Meeting Agenda Sketch

| Time | Monday April 15 | Tuesday April 16 | Wednesday April 17 | Thursday April 18 | Time |
|---|---|---|---|---|---|
| 7:30 | | Daily Registration (7:30-8am) | | | 7:30 |
| 8:00 | | Session 1: Welcome & Framing Remarks | Session 6: Keynote | Session 11: Keynote | 8:00 |
| 8:30–9:30 | Registration and pre-meetings | Session 2: Panel: FP/HIV Integration - progress, challenges, and opportunities | Session 7: Panel: HTN/HIV integration- progress, challenges, and opportunities | Session 12: Panel: Strategic Planning - standards, indicators and target-setting for integrated service delivery | 8:30–9:30 |
| 10:00 | | Tea (10-10:30) | Tea (10-10:30) | Tea (10-10:30) | 10:00 |
| 10:30–12N | | Session 3: Panel: FP/HIV case studies | Session 8: Panel: HTN/HIV case studies | Session 13: Single-country action planning | 10:30–12N |
| 12:30–1:30 | | Lunch (12:30 - 2pm) | Lunch (12:30 - 2pm) | Lunch (12:30 - 2pm) | 12:30–1:30 |
| 2PM–3PM | | Session 4: Tools Lab | Session 9: Breakout sessions (FP and HTN) | Session 14: Closing session | 2PM–3PM |
| 3:30 | | TEA (3.30-4.00) | TEA (3.30-4.00) | | 3:30 |
| 4PM–4:30 | | Session 5: Poster Session | Session 10: Report-back from breakout sessions | | 4PM–4:30 |
| | Opening Dinner | | | | |

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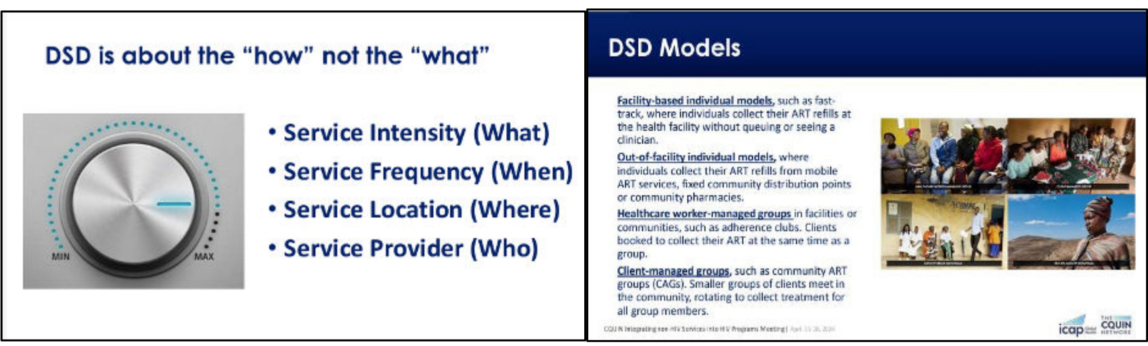
## Session Summaries

### Session 1: Welcome and Framing Remarks

Mark Hawken, ICAP's country director in Kenya, started the session with welcoming remarks. Lazarus Momanyi, MOH Kenya, gave a health and safety briefing to participants.

Peter Preko, PI, and project director of CQUIN delivered the keynote address. More than 50% of the participants attended their first CQUIN meeting. The presentation recapped on Differentiated Service Delivery to participants as summarized below.




Preko further introduced the CQUIN network as a learning network designed to facilitate joint learning, co-creation of resources, and the scale-up of programs. CQUIN activities are participant-driven, opt-in, and demand-driven, intending to improve health outcomes and programmatic efficiencies. The session was concluded with a review of the meeting's agenda. The full presentation is found here.

## Session 2: FP/HIV Integration – Progress, Challenges, and Opportunities

During the session, global experts discussed the progress, challenges, and opportunities of integrating family planning (FP) into HIV services. Four expert presentations were made.

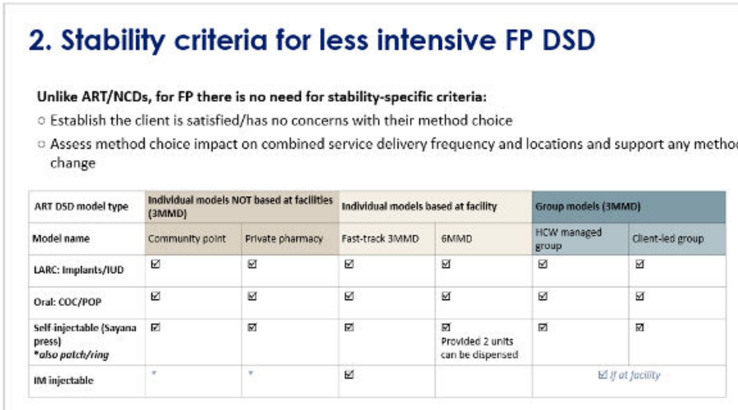
A) Morkor Newman from the WHO talked about the available normative guidance on integrating family planning (FP) into HIV services. WHO provides tools for integrating contraception into HIV services, which helps ensure access to high-quality, right-based contraception care.

The framework for the implementation of triple elimination of vertical transmission of HIV, syphilis and HBV also includes appropriate pregnancy planning as a key component of this strategy as highlighted below in red.

| Pillar One: Primary Prevention of Vertical Transmission | Pillar Two: SRH Linkages and Integration | Pillar Three: Essential Maternal EMTCT Services | Pillar Four: Infant, Child and Partner services |
|---|---|---|---|
| Focus on all women and girls of childbearing age, **whether not pregnant, pregnant or breastfeeding**.<br><br>Objective of this pillar is to **prevent incident** HIV, syphilis and HBV infections in women and girls.<br><br>Achieved through **delivery of testing services, infection prevention interventions** and **linkage to appropriate SRH services.** | Focus on **counselling, care, support** and **linkages to, or provision of SRH care** for women and girls living with HIV and / or HBV and / or seropositive for syphilis.<br><br>Purpose: to enable **appropriate pregnancy planning and prevention of unintended pregnancy** and to **prevent, diagnose and treat other STIs.**<br><br>Objective of this pillar is to **ensure these women and girls receive**, in addition to **appropriate treatment** for these infections, **other SRH care** | Focus on the **prevention of MTCT** to infants of pregnant and breastfeeding women and girls living with HIV and / or HBV and / or seropositive for syphilis.<br><br>Objective of this pillar is to ensure that people in this target population **receive early antenatal testing, appropriate** (antenatal, intrapartum and postnatal) **care** and **treatment to prevent MTCT** | Focus on **testing, treatment, care** (including immunization and well-child care) **and support** for exposed **infants, infected children, household contacts** and **partners** of women and girls living with HIV and / or HBV and / or seropositive for syphilis.<br><br>Objectives of this pillar are twofold:<br>1) **interventions for exposed** infants and infected children ensures a **comprehensive approach** to preventing paediatric **infections and their sequelae**.<br>2) **interventions for household contacts and partners** is essential to identify and treat infections beyond women and girls and their newborns, preventing transmission and reinfection and ensuring **healthy outcomes for the whole family**. |

The full presentation can be accessed here.

B) Lynne Wilkinson from the International AIDS Society (IAS) presented an opportunity to use DART models to align and build new FP care models. Since FP does not require stability-specific criteria, she encouraged the application of differentiated service delivery (DSD) principles, such as separate initiation/re-initiation and maintenance phases.



## 2. Stability criteria for less intensive FP DSD

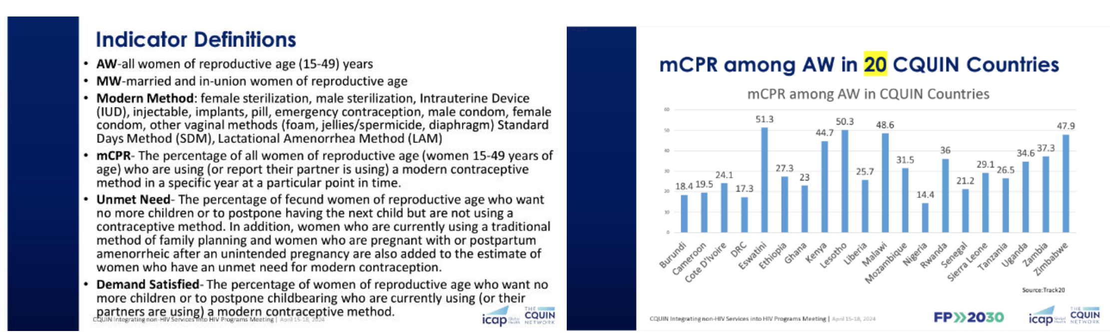
**Unlike ART/NCDs, for FP there is no need for stability-specific criteria:**

- Establish the client is satisfied/has no concerns with their method choice
- Assess method choice impact on combined service delivery frequency and locations and support any method change

| ART DSD model type | Individual models NOT based at facilities (3MMD) | | Individual models based at facility | | Group models (3MMD) | |
|---|---|---|---|---|---|---|
| Model name | Community point | Private pharmacy | Fast-track 3MMD | 6MMD | HCW managed group | Client-led group |
| LARC: Implants/IUD | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ |
| Oral: COC/POP | ☑ | ☑ | ☑ | ☑ | ☑ | ☑ |
| Self-injectable (Sayana press) *also patch/ring* | ☑ | ☑ | ☑ | ☑ Provided 2 units can be dispensed | ☑ | ☑ |
| IM injectable | * | * | ☑ | | ☑ If at facility | |

The full presentation can be accessed here.

C) Tugwell Chadyiwanembwa from FP2030 highlighted their goals of mobilizing country commitments, collecting, and disseminating FP data for decision-making by holding decision-makers accountable and convening a global FP support network. He also highlighted some global FP indicators and the current performance of 20 CQUIN countries against some of these indicators as shown below.




Here's the full presentation.

D) Jessica Rodrigues from USAID emphasized the need to leverage HIV and FP program supply chain for sustained and resilient integrated supply chain implementation. She highlighted the global landscape for HIV and FP procurement and the considerations and opportunities for integrated supply chain as shown below.

## Global Landscape for HIV and FP Procurement

| Funding Source | ARVs | HIV commodities | Contraceptives | Condoms & lubricants | Pregnancy tests | MNCH/SRH commodities |
|---|---|---|---|---|---|---|
| PEPFAR | X | X | | X | | |
| The Global Fund | X | X | Condoms | X | | |
| USAID | | | X | X | X | X |
| UNFPA | | X | X | X | X | X |
| National governments | X | X | X | X | X | X |

- Access to FP is an important part of prevention, care, and treatment, PMTCT, KP and DREAMS programming
- **PEPFAR funds cannot be used to buy contraceptive commodities; however, male and female condoms can be purchased with PEPFAR funds.**
- PEPFAR resources **can be** used for FP/HIV technical interventions, e.g., training, counseling, contraceptive method provision, strengthening supply chain systems, HMIS support, demand generation communications for health, quality assurance.

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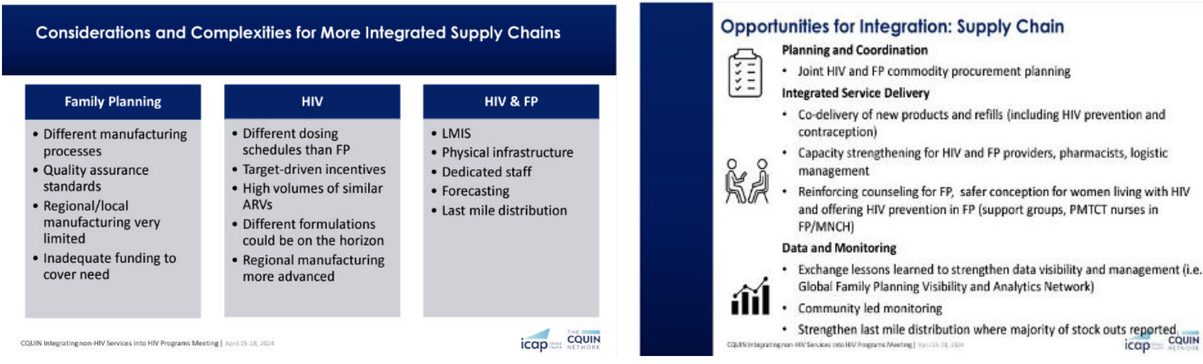



The full presentation can be accessed here.

The following challenges and recommendations were highlighted during the discussion:

- **Stigma can be a barrier to integration**, FP is not stigmatized however ART is and therefore trying to combine these two services may be problematic if not done well with the involvement of recipients of care.
- There is **need for integration at all levels**, including global partners and donors.
- CQUIN should consider extending the meeting **country participation to other key decision-makers** e.g finance experts.
- **Community-led Monitoring (CLM) is an opportunity** to monitor the integration of service provision.
- There is a **lack of information on unmet need among women who live with HIV**. It is currently impossible to estimate the cost of filling the supply gap due to the unmet need in this population.
- FP requires constant assessment of women living with HIV to assert the need and the choice for FP commodities. This should be factored into the metrics of FP/HIV integration.
- There is **a lack of specific FP metrics for women living with HIV** and lack of specific indicators for tracking FP/HIV integration. Countries need to urgently address this issue.
- Countries need to consider FP2030 commitments when determining FP targets for women living with HIV.
    - The Global FP2030 PME Working Group can deliberate on possible indicators that countries can track.

## Session 3: FP/HIV Integration Country Case Studies

This session focused on country case studies highlighting their progress, challenges, and opportunities of integrating family planning (FP) into HIV services.

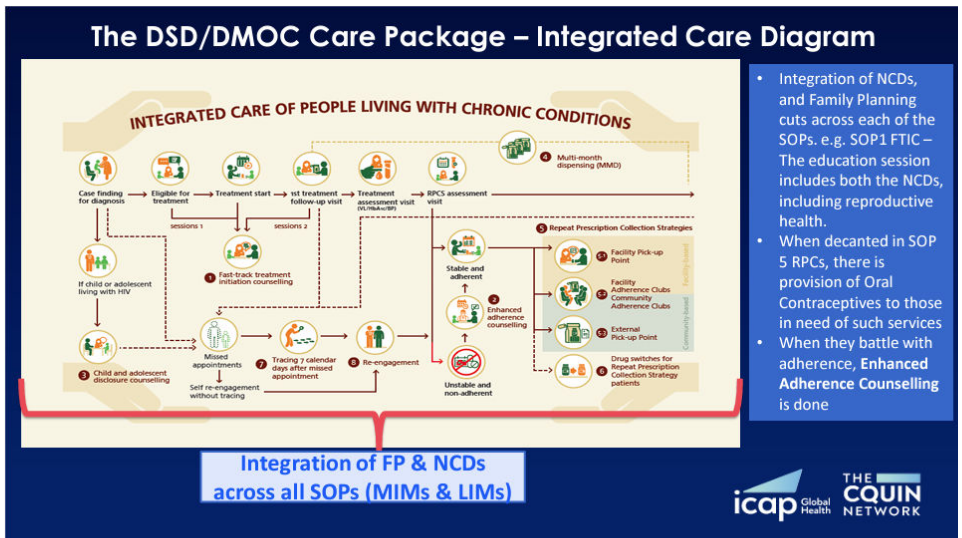
Maureen Syowai from CQUIN presented on CQUIN's approach to FP and HIV Integration. She also presented the findings of the CQUIN situational assessment on FP/HIV integration, the lessons learned from enhanced country-to-country exchange visits and the progress on FP/HIV integration activities in the network. The full presentation can be accessed here.

Two case studies were presented:

A) A Uganda case study highlighted the current FP uptake in Uganda, including the FP indicators for FP/HIV integrated services that are routinely tracked. FP commodities are free in Uganda at

all public facilities. They also highlighted the challenges that include the lack of national targets for FP use/coverage among women living with HIV and myths on FP usage and services outside health facilities. Opportunities presented include, integrating FP methods onto the HIV card, EMR task shifting and some FP provision to community players. Widespread use of Sayana press also provides an opportunity for further integrated FP provision within community-based models. There are ongoing pilots which will inform the development of standard operating procedures for FP/HIV integration. The full presentation can be accessed here: [https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Arinaitwe_Final.pdf](https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Arinaitwe_Final.pdf)

B) South Africa presented their integrated care approach for people living with HIV who have chronic conditions. In South Africa, 91% of eligible recipients of care have been decanted to less intensive models (LIMs). South Africa's national policies do support integration of FP into DSD models, but there is still a lack the national coverage targets. The country is piloting a digital self-care program through vending machines in five provinces. The following figure depicts South Africa's integrated care approach.




Access the full presentation here.

Two other countries were represented on the panel:

C) Ethiopia has indicator proportions of recipients of care receiving modern contraceptive methods embedded within its DHIS. The data is reported monthly although there are issues with data quality, national coordination, which can be improved, supply interruption, and health worker overload affecting provision of quality integrated FP services.

D) In Rwanda CHW provide FP as part of a wide range of primary health commodities and they are required to report their consumption and orders at a facility monthly, data then is transmitted from the community to the facility in this way. All CHW are assigned under a nearby health facility within their catchment area and they manage ROC within their catchment area who are linked to the facility as well, so it is easy to manage and track ROC service provision between facility and community. The CHWs also receive lockers to keep commodities safe.

The following issues were highlighted during the discussion:

- Harmonized commodity procurement and distribution systems are a facilitator of integrated service delivery through providing a platform for all funders to collaborate and this is feasible where there is transparency e.g., in the case of Rwanda.
- Family planning targets need to be specific to unmet need for FP/HIV integration to not be seen as coercive and to ensure that there is choice on the part of the recipients of care.
- During a debate on who should lead coordination of FP/HIV integration in country, the room was divided. Those for the ART program leading integration argued that the already existing donor support can be leveraged to make this a success, while those for the MCH program leading cited the trickle benefits it could have towards them reaching their FP targets. In conclusion, it was put forward that perhaps a better model would be joint leadership between the two programs as both programs stand to gain from the success of the integration approach.

## Session 4: Tools Lab

The 90-minute tools lab session was well attended and generated lots of interesting discussions in each of the 9 stations. It undoubtedly served as an invaluable cross-learning and resource-sharing platform.

Select tools included:

1. Ethiopia Family Planning Toolkit. Download >
2. Kenya EMR+: Managing Hypertension in Recipients of Care. Download >
3. Kenya Facility Readiness Assessment. Download >
4. Kenya NCD SOP. Download >
5. Kenya Migori County - SOP Flip Chart. Download >
6. Malawi HTN Tool in EMR. Download >
7. Resolve to Save Lives HIV/HTN DSD Integration. Download > Toolkit Download >
8. WHO Hypertension Guidelines. Download >
9. Zimbabwe National Guidelines and Tools. Download >

## Session 5: Poster Session

Meeting participants visited the poster exhibition area at the end of Day 2. The session was another platform for knowledge exchange. Business cards and telephone contacts were exchanged between some viewers and poster presenters. A total of 21 posters were presented and these can be viewed here: https://cquin.icap.columbia.edu/event/integrating-non-hiv-services-into-hiv-programs/posters/

## Session 6: Plenary Session

Kufor Osi from Resolve to Save Lives (RTSL) gave the keynote presentation and he addressed the significance of cardiovascular disease, particularly hypertension (HTN), among recipients of care. He emphasized the increased risk of cardiovascular issues for persons living with HIV due to improved life expectancy and the impact of HIV and antiretroviral drugs. Despite the importance of managing blood pressure (BP) even with modest reductions, non-communicable disease (NCD) funding remains inadequate. Osi introduced the concept of the "4th 95," referring to helping recipients of care achieve normal BP, and highlighted successful pilot programs integrating HTN with HIV care.

Challenges he highlighted include medication access, information systems, healthcare worker burden, and equipment shortages. He recommended specific actions for programs, such as setting goals, adopting standardized treatment protocols, ensuring medication and device supplies, training healthcare workers, implementing monitoring systems, and patient enrolment and improvement. Osi also shared resources, including toolkits and approaches from RSL and WHO**.**

The full presentation can be accessed here: [https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Kufor-Osi_Final.pdf](https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Kufor-Osi_Final.pdf)

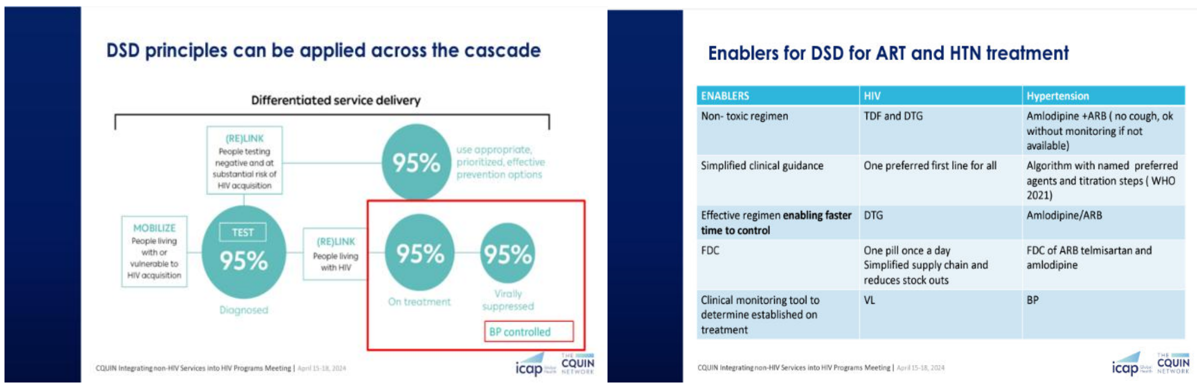
## Session 7: HTN/HIV Integration — Progress, Challenges, and Opportunities

During the session, global experts discussed the progress, challenges, and opportunities of integrating hypertension into HIV services.

A) Taskeen Khan from WHO presented on the latest WHO guidelines for hypertension. After describing the global epidemiology of hypertension, she emphasized the opportunities for integration that the new hypertension guidelines present particularly clear definitions of stability/control, simple treatment protocols, and cost-effective strategies that can be implemented at the primary health care level.

The full presentation can be found here.

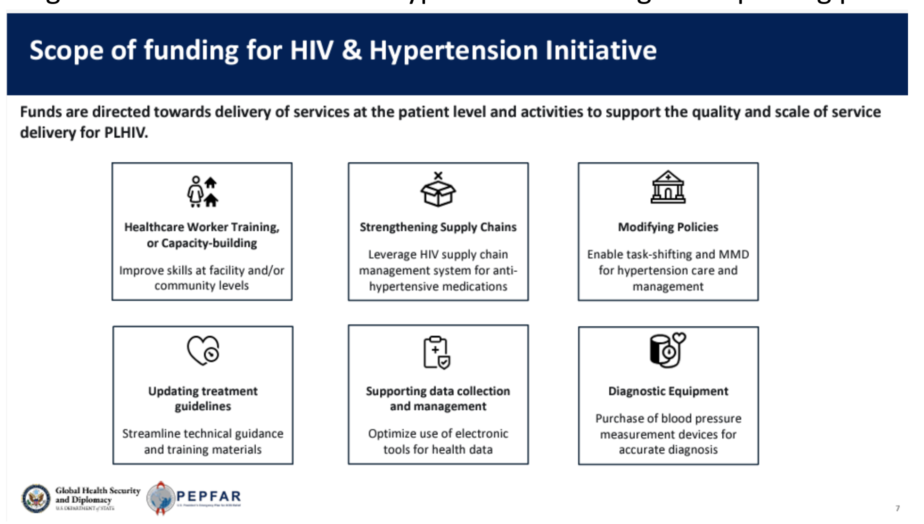
B) Helen Bygrave from IAS presented on *Differentiated Service Delivery for Hypertension*. She noted that DSD principles can be applied to other chronic diseases including HTN. The presentation highlighted some enablers for DSD for ART and HTN treatment, which include non-toxic regimens, simplified clinical guidance, effective regimens enabling faster time to control, fixed drug combinations (FDC) and clinical monitoring tools to determine establishment on treatment. She also emphasized that limitation of HTN drug supply (either stocks within public facilities or the limitation of amount recipients of care can pay at one time out of pocket) should not stop multi-month prescription. Nigeria and Uganda have adopted the new WHO HTN algorithm in their country guidelines whilst Zimbabwe has clearly documented the definition of established on treatment for HTN in their HIV national guidance.




| ENABLERS | HIV | Hypertension |
|---|---|---|
| Non- toxic regimen | TDF and DTG | Amlodipine +ARB ( no cough, ok without monitoring if not available) |
| Simplified clinical guidance | One preferred first line for all | Algorithm with named preferred agents and titration steps ( WHO 2021) |
| Effective regimen **enabling faster time to control** | DTG | Amlodipine/ARB |
| FDC | One pill once a day Simplified supply chain and reduces stock outs | FDC of ARB telmisartan and amlodipine |
| Clinical monitoring tool to determine established on treatment | VL | BP |

The full presentation can be found here.

C) After giving a background on the increased risk of cardiovascular disease among recipients of care compared with people without HIV and the high rates of untreated and uncontrolled HTN among recipients of care, Ritu Pati from PEPFAR/GHSD presented on the GHSD-PEPFAR Integrated Models of Care for HIV and Hypertension Initiative. PEPFAR is planning to provide supplemental funding of up to $5 million USD to support models of care that integrate hypertension diagnosis and management with HIV services in five PEPFAR-supported countries over the course of a year, pending congressional notification. PEPFAR plans to have a standardized reporting indicator for hypertensive services for recipients of care on ART for the 5 funded countries which is TX_HIV_HTN: The number of recipients of care on ART who are diagnosed and controlled for hypertension during the reporting period.

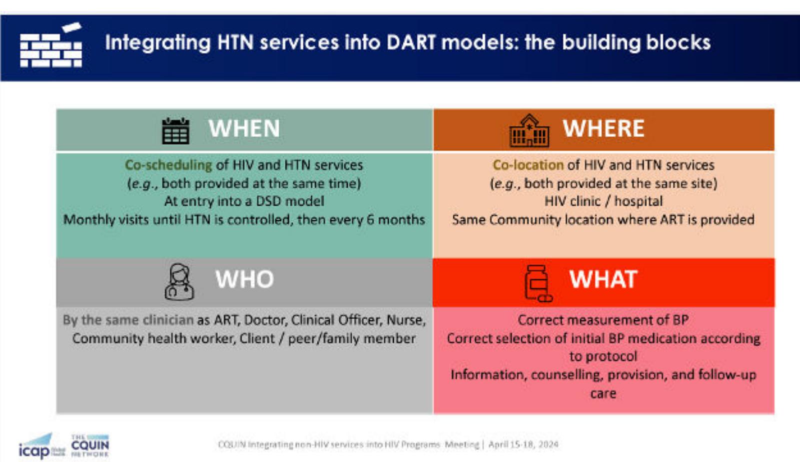



The full presentation can be found here: https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/FINAL_CQUIN_PEPFAR-HIV-HTN-Initiative_041224.pdf

D) Aniset Kamanga from the AMBIT and Retain6 Projects presented findings from their studies which showed that recipients of care report a preference for a "one stop shop" hypertension and HIV care. The studies also showed that South African clients largely receive integrated HIV and hypertension care in facilities and DSD models, but integration of data and M&E systems should now be a priority. Opportunities to improve integration of NCD care in existing HIV clinics in Malawi and Zambia remain. The full presentation can be accessed here: https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Kamanga_Final.pdf

## Session 8: HTN/HIV Case Studies

The session provided valuable insights into country case studies of integrating hypertension (HTN) care into HIV services, emphasizing the need for context-specific approaches rather than a one-size-fits-all model. Various integration models were discussed, such as co-scheduling and co-location of services, and the importance of tracking service delivery. The impact on patient satisfaction, health outcomes, and program efficiency was stressed. The high prevalence of HTN among recipients of care highlighted the need for better HTN treatment coverage and program feasibility.




Three case studies were presented.

A) Nigeria:

- Implementation of DSD models and integrating non-HIV services like HTN have enhanced care delivery.
- The "One-Stop-Shop" model facilitates streamlined services, supported by multidisciplinary teams and integrated health information systems.
- Monitoring and evaluation through specific indicators for HTN screening, diagnosis, treatment, and control are crucial.
- Challenges include limited human resources, weak referral systems, funding gaps, and supply chain dependencies, which require strategies like workforce reinforcement and improved referral networks.
  The full presentation can be accessed here: https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Nigeria-Presentation-on-HIVHTN-integration-into-facility-and-community-models-Final-Edittion1-2.pdf

B) Kenya

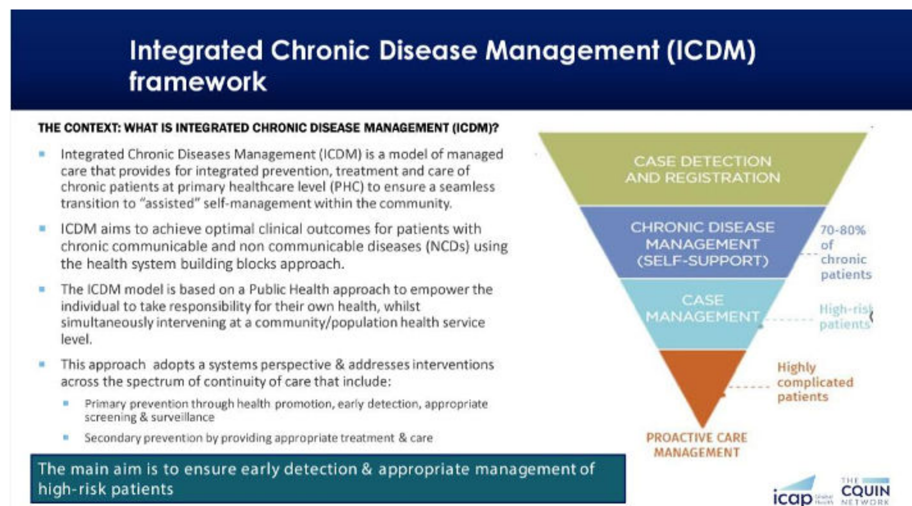
- The prevalence of HTN in Kenya is about 6%, with gaps in documentation needing improvement.
- Integration models co-locate HIV and HTN services, focusing on patient-centric approaches with synchronized appointments and differentiated care.
- Robust data systems, adequate human resources, and partnerships are essential for access to medications and referrals for complex cases.

- Kenya is considering HTN/HIV integration as part of the bigger Universal Health Coverage (UHC) and Primary Health Care (PHC) thrust.

The full presentation can be accessed here: https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Session-8_Ngugi_Final.pdf

C) Eswatini

- Significant burden of both communicable and non-communicable diseases, with high prevalence of HTN and diabetes.
- Integrated chronic disease management at the primary healthcare level is essential to optimize outcomes for patients with both types of diseases.
- Strengthening primary healthcare and leveraging successful HIV care models can address the rising NCD burden among recipients of care.




The full presentation can be accessed here: https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Session-8_Ntombi_Final.pdf

Overall, the session highlighted the need to address challenges such as limited human resources, weak referral systems, and funding gaps to ensure regular care for recipients of care living with hypertension. Strengthening workforce capacity, improving referral networks, and increasing funding commitments are critical. Additionally, policy makers should prioritize monitoring and evaluation, promote multidisciplinary care teams, and leverage integrated health information systems. Synchronized appointments and multi-month prescribing of HTN medications were recommended to improve treatment adherence and reduce clinic visits, contributing to sustainable integrated care models.

## Session 9 and 10: Breakout Sessions (Family Planning and Hypertension)

The session was made up of 8 parallel sessions (Session 9). The objectives of this session were to identify challenges to integration and to propose possible solutions to the common challenges of integration using some structured and unstructured discussions. Four groups presented in the report back session (Session 10).

### Session 9a: Coordination – Family Planning

- HIV integration into FP services has been ongoing; FP integration into ART has recently started.

- FP integration into vertical transmission services is easier because midwives, trained in both HIV and SRH services, provide these services.
- Countries do not face policy barriers to FP/HIV integration but struggle with implementation.

**Challenges:** Siloed planning, implementation, and management across HIV and SRH programs; lack of a joint coordination body for FP/HIV integration (e.g., TWG); partial alignment of FP and HIV guidelines, especially around DSDM and MMD for FP; siloed funding by donors, which challenges coordination, as donors influence program directions; ART clinic HCWs are often uncomfortable or do not prioritize FP services; policies allow FP/HIV integration, but implementation fidelity is lacking; DSD guidelines mention FP integration, but it's often treated as optional rather than a minimum package.

**Best Practices:** Policies and guidelines are aligned to integrate FP into HIV services across all countries; Joint development of guidelines ensures non-contradictory guidance; integrated TWGs exist at the country level (e.g., Uganda); community distribution of Sayana Press through supportive policy, allowing lay providers to offer it.

**Proposed Solutions**: Establish a coordination entity led by MOH leadership in the form of a SRH/HIV Integration (TWG) with clear TORs; integration of financing mechanisms and supply chain management; leveraging lessons learned from TB/HIV TWG; coordinate partners supporting both programs; align FP and HIV guidelines to DSD, clearly stipulating FP considerations where ART is provided through DSDMs; and developing a donor coordination mechanism at the country level to address overlaps and leverage different funding streams effectively.

### Session 9b: Coordination – Hypertension

**Challenges:** Drug shortages; client fees; inadequate data systems; restrictive insurance policies; and non-specific policies that don't meet CQUIN CMM criteria.

**Best Practices**: Use of specific targets (like the three 95s for NCDs or WHO targets); effective TWG coordination; a successful financing example from Uganda where funds were pooled to negotiate lower prices; and healthcare workers escorting patients to pharmacies.

**Proposed Solutions**: Adopting TB/HIV integration models; using a unified M&E platform; creating a joint operational plan based on the ministry of health's strategy; engaging private insurers and pharmacies through public-private partnerships; seeking alternative funding for NCDs; and using toolkits to fill knowledge gaps.

### Session 9c: Data for Decision-Making – Family Planning

**Best practices**: Use of integrated EMRS (e.g. Kenya and Malawi); integrated quarterly visits (Ghana example) and checklists to evaluate different levels; integrated registers (Zimbabwe); use of FP estimate tools, which use different data sources; and use of SIMS visits within PEPFAR, which have structured questions for facility-level FP services.

**Challenges:** Lack of clear, commonly understood definitions of the FP package and how to measure it; lack of a clear definition of integration; and siloed M&E systems.

**Potential Solutions:** Developing integrated data systems; better coordination between departments; defining DSD building blocks for an integrated framework; use of the CMM-type tool for integration; regular joint meetings; DPR with SIMS-type questions; and tracking FP targets.

Participants finally discussed on major knowledge gaps requiring co-creation of resources or tools especially:

- FP data measurement processes
- Setting targets in DHS
- Definition of a FP package of service and how it is measured
- Clear definition of FP/HIV integration

### Session 9d: Data for Decision Making – Hypertension

**Challenges:** Siloed/verticalization of the reporting tools; there is no HIV data disaggregation to capture information on other services (NCDS) received by PLHIV; data are available at the facility level (in primary tools) but not in the reporting tools at higher levels including the DHIS2; donors have not prioritised financing for HTN services; there is variation in targets for HTN when considering each specific program (HIV program and NCDs program); and no joint planning or coordination even at the implementation level.

**Best Practices:** Use of EMRs which make it easier to add data elements as programs evolve (Kenya example).

**Proposed Solutions:**

- Effective measurement requires clearer definitions and standards for integration and coupled with well-defined targets
- Measures should be consistent and with the ability to generate reliable, interpretable data
- Country data systems typically include some, but not all data elements needed for integrated HIV-HTN diagnosis and treatment
- EMRs are best suited for monitoring of integrated services and there is a need to further invest in strategic data use – management, analytics, visualization, and dissemination

### Session 9e: Implementation / Service Delivery Models – Family Planning

Most countries have policies for integration, but not detailed enough and they don't account for DSD.

**Best Practices:** Capacity building on FP/HIV indicators; training service providers on FP; integration of professional bodies; and an example from DRC where MOH involves religious leaders right from the start and throughout the process.

**Challenges:** Unavailability of free FP commodities in some countries; shortage of stock/challenges with quantification; poor coordination between programs; increased workload for the country programs who need support for financing supply chains etc.; myths and misconceptions limiting uptake of FP; faith-based, supported health facilities often don't accept FP; and mobility challenges with mobile populations, especially across borders.

**Best Practices:** Capacity-building efforts including training modules and job aides in countries like Cote d'Ivoire, Lesotho, and Kenya, were cited as successful strategies.

**Proposed Solutions:** Developing global guidance; developing detailed integration roadmaps at high levels (national blueprints); streamlined supply chain and financing mechanisms to facilitate effective integration; and developing streamlined indicators to decrease reporting burdens.

### Session 9f: Implementation / Service Delivery Models – Hypertension

**Best Practices:**

- Involvement of MoH leadership at the highest level to advocate for integration.

- Presence of national policies and guidelines such as strategic plans, guidelines, and SOPs to support integration of HTN into HIV treatment services including into less intensive DART, and having one M&E plan
- One-Stop-Shop Approach: Co-location of services, where both HIV and HTN clinic visits are aligned and synced.
- Availability of approaches informing decisions for what to Integrate such as:
    1. COP planning guidance to integrate HTN
    2. National MoH database tracking trends in morbidity and mortality data
    3. WHO STEPS,
    4. Data from surveys and implementation science to determine the burden of NCDs
- Involvement of recipients of care in co-creating integration models
- One plan. One budget. One report in Malawi
- Use of virtual platforms for capacity building.
- Facility-based training (multi-partner involvement)

**Challenges:**

- NCD care is not being decentralized as fast as HIV care; there are HCW capacity and training gaps
- Integration is still in very early stages in many countries
- No specific joint document that addresses integration of both HIV and HTN. In some countries, there are elements of integration in several policy documents, but not one joint document.
- Limited funding/resources to support NCD care including insufficient drugs for NCDs impede successful integration
- Out-of-pocket payment for HTN drugs, raising questions around sustainability of integration
- Inadequate HRH for service delivery, leading to an increased work burden for those in the system
- Frequently changing guidelines negatively impact decision making for integration
- Poor dissemination of guidelines to all providers
- Low capacity of providers: some ART providers have inadequate capacity to manage HTN and non-HIV providers may not have capacity to provide ART care.
- Inadequate calibrated HTN measurement devices
- Some countries do not have a clear M&E framework with indicators to track integration
- Pill burden on recipients of care who are living with both ART and HTN, especially if they are also on statins.

**Possible Solutions:**

- Increased advocacy within recipient of care (RoC) organizations to increase knowledge and engagement of RoC.
- Countries to develop/ identify **one consolidated guiding document on integration** of services.
- Identify a lead for HTN Integration within the MoH, as well as a TWG or task force for integration.
- Capacity-building for service providers:

- Development of national training curriculum for integration of HTN based on a standardized package of care; CDC and other implementing partners prioritizing training of providers on NCDs
    - Digital Health Solutions (e.g Virtual Academy) to support training of providers
    - Communities of Practice for providers conducting integration
    - Pre-service training in universities and other medical training institutions
- **Task shifting**: Train nurses to manage HTN and reduce the burden on doctors
    - Develop a policy to allow trained nurses to prescribe HTN medicines
- To address pill burden: counselling, support groups, prioritize dispensing Fixed Doze Combinations (FDCs); countries to consider pooling resources to buy cheaper FDCs.
- Scale-up appointment systems support to reduce frequency of visits
- Reorganize care to allow for optimal referral services for eligible clients (both intra and inter facility to tertiary care)
- Involve community peers to expand prevention messaging at Community-level

### Session 9g: Supply Chain – Family Planning

There is need for planning and coordination, with joint planning and quantification initiatives.

**Challenges:** Import taxes for FP commodities in some countries and commodities are often stuck in customs and not reaching the last mile; transport challenges for FP commodities.

**Proposed Solutions**: Leveraging platforms used for HIV to transport FP commodities (e.g. engage IP to help with transport); develop SOPs for the last mile distribution; design and think through flow of services, especially if there are space or infrastructure constraints.

### Session 9h: Supply Chain – Hypertension

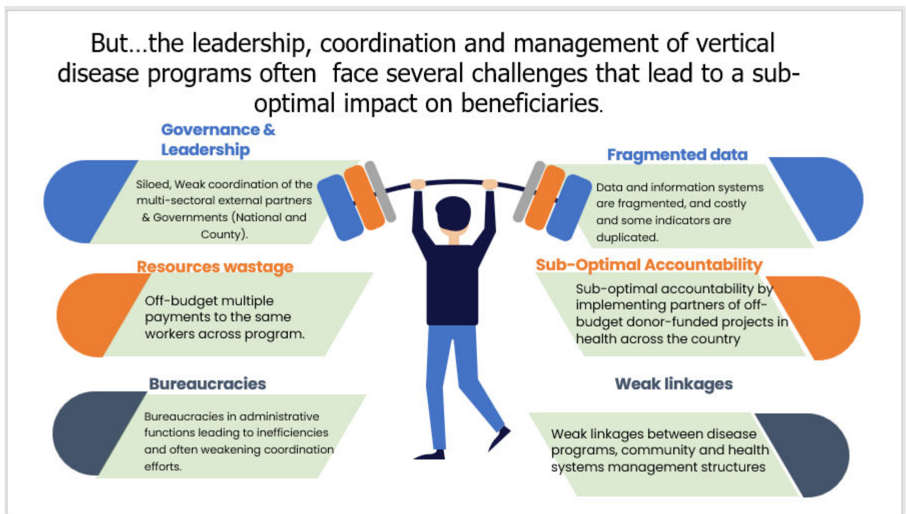
**Best Practices:** Joint quantification for better planning; the importance of using data, such as integrated electronic medical records (EMR), for quantification; and national health insurance plans could assist in ensuring a steady supply of medical supplies.

**Challenges:** Insufficient funding was identified as a major obstacle; lack of data for accurate quantification posed a challenge; parallel distribution of products complicated procurement efforts; shortages of drugs for hypertension (HTN); some drugs were not aligned with current medical guidelines; and attracting suppliers with low quantity orders is difficult.

**Proposed Solutions:** Streamlining coordination among stakeholders; updating national protocols and guidelines to ensure procurement of appropriate drugs; leveraging private sector funding to ensure standardized, quality, and affordable supplies; utilizing community pharmacies to improve access; using taxes on alcohol and tobacco to fund healthcare initiatives; utilizing PEPFAR funding for procurement of certain commodities; and increased advocacy efforts through civil society channels.

## Session 11: Plenary Session

Dr. Ruth Laibon-Masha from the National Syndemic Disease Control Council in Kenya delivered a keynote address discussing the challenges of managing syndemic situations within vertical programs. She pointed out that donors and political leaders favor vertical programs due to their quick results and simpler management. However, she also highlighted that these programs often face leadership, coordination, and management issues, resulting in a less-than-optimal impact on beneficiaries as depicted below:

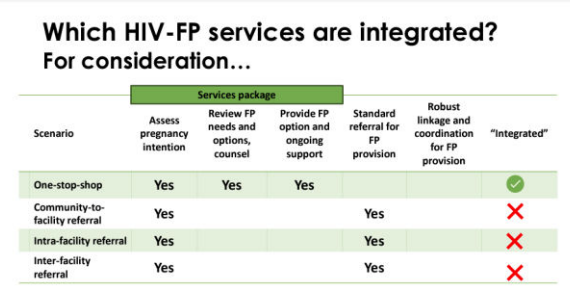



She emphasized that the gains made in disease-specific programs are fragile without resilient systems and comprehensive disease management. Sustaining progress and investments requires reforms in care delivery models. Additionally, integrating initiatives like social health insurance must bolster local institutions to achieve universal health care, and transparency in resource allocation is crucial. She concluded by encouraging continuous mutual learning.

## Session 12: (Panel) Strategic Planning – Standards, Indicators, and Target-Setting for Integrated Service Delivery

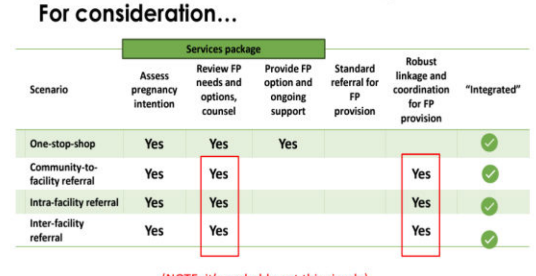
The objective of this session was to brainstorm on standards, indicators, and set targets for integrated services, particularly focusing on FP and HTN integration within HIV programs.

Bill Reidy from ICAP gave an overview of the monitoring and evaluation challenge of integrated services. He emphasised the need to establishing minimum standards for integrated services as this is an important step towards understanding how to measure progress.



**Which HIV-FP services are integrated?**
**For consideration…**

| Scenario | Services package | | | Standard referral for FP provision | Robust linkage and coordination for FP provision | "Integrated" |
|---|---|---|---|---|---|---|
| | Assess pregnancy intention | Review FP needs and options, counsel | Provide FP option and ongoing support | | | |
| One-stop-shop | Yes | Yes | Yes | | | ✓ |
| Community-to-facility referral | Yes | | | Yes | | ✗ |
| Intra-facility referral | Yes | | | Yes | | ✗ |
| Inter-facility referral | Yes | | | Yes | | ✗ |



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| One-stop-shop | Yes | Yes | Yes | | | ✓ |
| Community-to-facility referral | Yes | Yes | | | Yes | ✓ |
| Intra-facility referral | Yes | Yes | | | Yes | ✓ |
| Inter-facility referral | Yes | Yes | | | Yes | ✓ |

(NOTE: it's probably not this simple)

The full presentation may be found here: https://cquin.icap.columbia.edu/wp-content/uploads/2024/04/Reidy_Final_S12.pdf

Other key takeaways from the session included:

- **Unified Framework**: There's a crucial need for a country-led process that integrates planning, budgeting, and M&E systems into one cohesive framework, aligning with the London Consultative Round Table's recommendations.
- **Integrated Planning and Budgeting**: Achieving this requires strong leadership, stakeholder engagement, and harmonization across health programs.

- **Historical Lessons**: The integration of TB and HIV highlights the importance of developing clear standards and targets. These lessons should be applied to FP/HIV and HTN/HIV integration.
- **Policy Gaps**: Ministries of Health recognize the need for more evidence and tools to formulate integration policies, emphasizing the importance of robust data and research.
- **Community Engagement**: Involving care recipients in target setting and monitoring is vital for ensuring services meet individual and community needs.
- **Service Delivery Models**: Discussions covered the complexity of integrated service delivery, ranging from co-located services to inter-facility referrals.
- **Minimum Standards**: Establishing minimum standards for integrated services is essential, but approaches need to be tailored to the diversity of service delivery models.
- **Challenges**: Key challenges include the need for clearer definitions and standards, improved data systems, and more resources for data management and analytics to support quality FP and HTN services within DSD models.

## Session 13: Breakout Session |Single Country Action Planning

In this session, countries continued to develop and finalize their integration action plans, addressing key gaps, and prioritizing activities that can be funded through MOH, COP, and GC7, as well as other donors. Individual country action plans are submitted to CQUIN who in turn offer TA and track progress on the action plans.

## Session 14: Country Action Plans and Way Forward/ Closing Remarks

In this session, a select group of six countries presented their draft action plans. Peter Preko, CQUIN PI/ project director, gave his closing remarks and summarized his interpretation of the meeting's key themes as shown below:

### Integration Meeting – CQUIN Key Messages

- **Joint coordination and planning** by the different departments must be considered a priority
- **Define your standards** – clarify what you are integrating and how it should be integrated
- **One-stop shop is the gold standard –** countries must aim for this if resources allow
- Alternative integration approaches must ensure **peer navigation** and **effective referral systems** to document completed referrals
- **Define what success looks like** so you can measure it
- **Donor Flexibility** – how can we walk this talk?
- **Put the recipient of care at the center**

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He ended with the following next steps:

- Countries are encouraged to conduct in-country meetings to validate the final draft action plans with key stakeholders.
- Validated final action plans will be shared with ICAP by June 3, 2024.
- CQUIN will continue learning exchanges on integration in respective communities of practice virtual meetings and future webinars.

## Appendix: Summary of Meeting Participants

| CQUIN Integration Meeting participants summary by Entity/Organisation | | |
|---|---|---|
| **Entity/Organisation** | | **Number of participants** |
| **MOH** | MOH HIV | 66 |
| | MOH NCD | 18 |
| | MOH FP/SRH | 14 |
| **ROC** | ROC | 25 |
| **Implementing Partners** | Implementing Partners | 41 |
| **Country PEPFAR Agencies** | USAID | 9 |
| | CDC | 12 |
| **Global Partners** | EGPAF | 1 |
| | CDC | 2 |
| | B&MGF | 6 |
| | WHO | 5 |
| | IAS | 2 |
| | AMBIT | 1 |
| | USAID | 1 |
| | GHSD/PEPFAR | 2 |
| | ICWEA | 1 |
| | PATA | 2 |
| | ITPC | 2 |
| | FP 2030 | 1 |
| **ICAP/CQUIN** | ICAP/CQUIN | 25 |
| | **Total Number of Participants** | **241** |