Integrating HIV Services into Broader Health Delivery Platforms: Country Experiences from CQUIN Webinar Q&A (Recorded: February 10, 2026)

Question	Answer
These are just my few comments in response to Helen's presentation: 1. I would strongly suggest referring to/talking about or focusing on integration, not only for HIV treatment and care but all HIV services, including HIV prevention and testing as the local context demands. 2. Integration of HIV services should not be viewed only regarding integration of HIV and non-HIV services, but rather integration of HIV with/into PHC. It would be useful for the audience to know WHO's policy guidance on HIV-PHC convergence: https://www.who.int/publications/i/item/9789240077065, in addition to WHO's 2025 guidance that was referenced in the presentation. 3. Cervical cancer/precancer screening, diagnosis, and treatment should not be viewed as part of only MNCH, but rather critical services to be available and recommended to young and adult women living with HIV, regardless of whether they are mothers or not. Those should be part of both HIV care and integrated PHC. – Ani Shakarishvili, UNAIDS	Thank you for your thoughtful comments and for taking the time to share these insights. Your points about considering the full range of HIV services, emphasizing integration into primary healthcare, and ensuring cervical cancer services are accessible to all women living with HIV are very valuable. This aligns closely with CQUIN's definition of integration, which is the integration of all HIV services into routine healthcare across all levels of the health system. We also appreciate the references to WHO guidance-they'll be helpful for the audience as we think about integration more broadly. -- Rachel Mudekereza Thanks for the comment. Completely agree on the need for a broad look at HIV/PHC convergence. I think going forward, e.g., for cervical cancer, the challenge will be that it is offered during an annual review within a chronic care clinic (for any woman with HIV, HTN, diabetes, etc.) - same date, same place, same person. Or a strong referral to an SRH service providing cervical screening for all women in the primary care/ OPD setting. Of course, this could also be simplified if HPV self-screening were offered. -- Helen Bygrave
In Nigeria's "full integration" model, are the HIV services integrated into routine OPD services, or are there integrated chronic care clinics?	HIV Services are integrated into routine OPD services, particularly at PHC clinics.

You referenced facility-level coordination between the ART coordinator and existing service delivery structures. Will ART coordinators continue to exist (e.g., will there continue to be people with specialized skills and protected time) following full integration?	Full integration at the PHC, there is nothing like an ART Coordinator; rather, the clinician sees every patient, whether HIV or non-HIV. -- Peter Nwaokenneya HIV service integration will not erode the achievements of the past but will build on it to strengthen the entire health system. We expect that ART site coordinators, whose capacities have been built over the years, will expand their services to cover other diseases and provide client-focused care that meets all client needs, not only HIV. – Dr Chioma Ukanwa
Will differentiated HIV treatment services continue to be available in Nigeria following integration? What about differentiated prevention and testing services?	Differentiated service delivery will no longer focus only on HIV, but will be expanded to include other related health services for the optimization of resources.
Your efforts and experience with integration are commendable. I wonder if you could comment on how HIV services for key populations (including HIV prevention, harm reduction, testing, care) are being integrated into/with PHC in Nigeria - both in and outside facilities, and what challenges you have been encountering.	We have commenced gradual transfers of key population services to government-owned health facilities, especially for PrEP, since the change of the USG's AIDS policy. We plan to revise our capacity building tools to ensure more emphasis on the delivery of non-discriminatory services to all client however, funding challenges are also delaying the full rollout of the capacity building and re-orientation of all relevant stakeholders, so we hope that going forward, we will receive support for roll out integrated non-discriminatory HIV services across all our public and private hospitals and community structures
HIV care and treatment may include adherence sessions and peer-led counseling, either in groups or one-on-one. Were these options considered in your setting?”	Yes, they were all considered during the delivery of HIV services at the facility.

“Dr. Chioma. What informed the selection of facilities from one part of Nigeria for the facility integration assessment? I think a more geographically diverse spread would have been better.	The initial assessment was done with support from the CDC. You may wish to note that these health facilities cut across the six geo-political zones of Nigeria; however, with increased funding, we intend to engage all the health facilities across the three tiers of health care in all the states and LGAs.
Que deviennent les intervenants sociaux dans cette nouvelle approche (soins integrés) en rapport avec leur prise en charge?	Dans l'approche intégrée des services VIH au Cameroun, les intervenants sociaux (accompagnateurs psycho-sociaux, ASC polyvalents, pairs éducateurs, mères mentors) voient leur rôle renforcé à travers la délégation de tâches (task-shifting type 3), leur permettant d'exécuter des activités comme le dépistage, l'orientation et le suivi communautaire, initialement réservées aux structures sanitaires. Leur prise en charge est améliorée par des formations continues en cascade, du tutorat/coaching, des supervisions formatives mensuelles, et des mesures incitatives durables basées sur les performances.
For Nigeria, how or which training models were or are used to facilitate integration of service?	In Nigeria, part of the preparatory steps included the development of a national training curriculum, followed by a national training of trainers (TOT) workshop, and the National Clinical Mentors (NCMs) were prioritized. Subsequently, the step-down training across states included physical training, virtual training, face-to-face mentoring sessions, and PowerPoint presentations for high-level stakeholders.

Lastly, at the MOH and State level, what structural changes have been implemented to remove verticalization of HIV and other programmes?	At the Federal Ministry of Health, there has been no structural change. We worked more on the policy environment through the engagement of critical stakeholders and developed a national guideline for HIV service integration, which has been endorsed by the coordinating Minister of Health and Social Welfare. However, at the state level, in some of the pilot states, all the state-owned general hospitals were directed to close down all standalone HIV clinics and integrate HIV services into the GOPD and other service delivery points.
Based on trends over time, despite the short period, what can you quickly infer about service uptake and epidemic control across different subpopulations?	The stakeholder's engagement process included the client community, among the recipients of care; there has been no obvious drop in the service uptake across the pilot facilities. Moreover, we have yet to conduct an impact evaluation of the intervention.
Based on global evidence, which integrated service-delivery and workforce approaches—such as task-shifting or multidisciplinary teams—have shown the most promising results in sustaining HIV services, improving efficiency, and maintaining quality?	The majority of studies included in the systematic review for the 2025 WHO updated recommendation on HTN/DM/HIV integration focused on integrating NCD services into existing HIV clinics. There was, however, one high-quality randomized controlled trial, the INTE-AFRICA study, that demonstrated positive outcomes implementing a chronic care clinic for anyone with HIV, HTN, or diabetes. In many of these studies, care was provided in primary care clinics (decentralized) and by non-physician health care workers (task-shared). In addition to both HIV and HTN, the WHO has clear recommendations that HIV and HTN management can be

	task-shared to non-physicians as long as they are trained and supported. In summary, evidence supports task sharing and decentralization of integrated services, including HIV, which have been shown to maintain retention and viral suppression rates. What there is no evidence for is whether services are just brought into primary care or OPD in the same queue as acute clients, and without maintenance of the essential service delivery components, such as treatment literacy, appointment systems, tracing, etc.
How are evolving funding models influencing countries' ability to integrate HIV services into routine care, and what policy lessons are emerging from these transitions?	This is a moving target at present. It will need to be seen how much flexibility donors provide for governments to redesign services within a One Health approach. In addition, how HIV may fit in developing health insurance schemes and UHC planning will need to be considered. However, the costing work carried out for the INTE-AFRICA study running a chronic care clinic showed both cost savings for the health system and the client. Further costing work will be needed to support the effective transition of HIV services into primary care or OPD.