Extended Abstract

Integrating HIV/AIDS into Maternal and Child Health Platforms: African countries making limited progress

Introduction

The high burden of disease relating to HIV/AIDS, unintended pregnancies, and poor maternal, new born and child health (MNCH) remains a major health challenge in sub-Saharan Africa (SSA). Responses to this challenge have traditionally comprised of well-funded HIV/AIDS programs set up parallel to inadequately funded MNCH and Family Planning (FP) programs. Consequently, integration of these issues over the years has been promoted in order to strengthen Sexual and Reproductive Health (SRH) programs (mainly MNCH and FP) using HIV/AIDS resources. More recent efforts have focused on making the case for using the widely used MNCH platform as a base for integrating FP and HIV/AIDS services. This is because the MNCH platform is accessed by many women and children, the sub-populations that bear the highest burden of disease from HIV/AIDS, unwanted pregnancy, and poor maternal, neonatal and child health.

The purpose of this study was to provide an understanding of the efforts that sub-Saharan African countries with a high burden of maternal and child deaths as well as high HIV/AIDS prevalence are making in order to enable service integration of HIV/AIDS and MNCH using the MNCH platform. The study's main research question was: What efforts are East and Southern African countries putting in place to enable integration of HIV/AIDS services into MNCH services?

Methods

The study combined both qualitative and quantitative methodologies, including document review, collation and analysis of quantitative data, policy audits, key informant interviews and validation meetings. The quantitative data analysis informed the selection of four countries with different permutations of disease burden and service deficiency for rapid national level assessment of the status of and opportunities for MNCH, FP and HIV/AIDS integration. The four countries are the Democratic Republic of Congo (DRC), Malawi, Tanzania and Zambia.

Results

Policy Framework

The findings show that even though there are marked differences in the way the four countries have approached MNCH, FP and HIV/AIDS integration at policy framework level, they face similar integration challenges at the system and service delivery levels. At policy level, Malawi and Tanzania have embraced the global calls for MNCH, FP and HIV/AIDS integration. Tanzania has developed a policy to guide integration efforts and service provision, while Malawi was in the process of developing one at the time of the study. On the other hand, DRC and Zambia have not developed any integration-specific policies and their efforts to meet the broader health needs of the population have focused on the primary

health care paradigm, which underscores the provision of wholesome basic services to clients. DRC is interested in developing an integration strategy to guide service delivery. However, in Zambia there were mixed sentiments on the need for an integration policy, with some officials preferring a health system strengthening approach as opposed to a focus on MNCH, FP and HIV/AIDS integration. Even for those who favoured integration in Zambia, only support integration of MNCH and FP, but not HIV/AIDS into MNCH, arguing that HIV/AIDS' substantial resources and attention would end up overshadowing the MNCH. Although the presence of a policy framework on MNCH, FP and HIV/AIDS service integration does not automatically translate to effective delivery of integrated services, it demonstrates the much needed government leadership on the issue and provides guidance to donors and other stakeholders involved in programming and service provision.

Service Integration Challenges

A functional and supportive healthcare system[1] is very critical in determining success or failure of integration of MNCH, FP, and HIV/AIDS services. The study confirmed the well documented health system challenges to integration, including: vertical structures and planning mechanisms within the government (e.g. within MoH and between MoH and the national AIDS commission); inadequate funding, especially for SRH issues; insufficient and inadequately skilled health workers; lack of equipment; weak supply chain systems occasioning frequent commodity stock outs, weak M&E systems to monitor integrated services, and weak institutional coordination mechanisms, especially on the SRH side. While stakeholders in DRC, Malawi and Tanzania expressed the need to address specific challenges related to MNCH, FP, and HIV/AIDS integration, efforts to enable provision of integrated services should be broadened to address the general health system bottlenecks.

Integration Experiences at Service Delivery Level

At service delivery level, there are many poorly coordinated integration programs being implemented in the four countries. The PMTCT program remains the major integration effort with reasonably high levels of coverage in Malawi, Zambia, and Tanzania, but quite low in DRC. There is, therefore, substantial scope to ensure universal access to PMTCT treatment for the many HIV+ expectant women or HIV-exposed infants to help reduce mother to child transmission of HIV. The four countries could benefit from on-going advocacy and program efforts to integrate PMTCT and MNCH, which research has shown could reduce the loss to follow-up of many mothers and infants.

Other integration programs in the four countries range from integration of FP into HIV testing and counselling, FP into HIV care and treatment, HIV into FP, FP into PMTCT, PMTCT into MNCH, and FP and HIV/AIDS into MNCH. Notably though, most of these programs are funded by donors, implemented by non-governmental organizations, and are implemented on pilot basis in a few regions/districts/health facilities. This means that these programs do not have substantive national level impact and also unsustainable. The main funders of

[1] System refers to structures put in place to support or ensure successful implementation of stated policy actions. In this case they include institutional structures within government, funding, human resources, equipment, supplies and commodities, referral and M&E processes.

SRH programs in the four countries include: USAID, DFID, World Bank, UNFPA, UNICEF, Gates Foundation, KFW-Germany, CIDA-Canada, WHO and EU. The main funders for HIV/AIDS include Global Fund, USAID, and PEPFAR/CDC. These agencies largely fund parallel programs on different aspects of MNCH, FP and HIV/AIDS through local and international implementers. Consequently, there is a myriad of programs collaborating with the MoH to offer different models of integrated services, which not only presents serious coordination challenges, but also overburdens the already weak healthcare delivery system.

Despite calls by global players (mainly the WHO) for countries and development partners to focus on integration using the MNCH platform, there is limited conscious effort to expand HIV/AIDS and FP services through this widely used platform. In fact, the MNCH programs remain greatly underfunded in all four countries, a factor that hinders integration.

Research assessing various integration models has shown that integration has great potential to improve service utilization even though there still exist significant evidence gaps on the actual magnitude of benefits of integration. The literature and stakeholders interviewed highlighted the need to understand service delivery realities, health system challenges, the needs and expectations of patients in thinking about what and how to integrate since not every service can be integrated in any given health facility or context.

Conclusions

The study findings point to various opportunities for countries and their development partners to support and enable HIV/AIDS service integration using the MNCH platform. First, there is need for development partners (donors) to spearhead service integration by funding integrated programs as opposed to their current parallel funding of HIV/AIDS, MNCH and FP programs. Emphasis should be put on funding programs that use the MNCH platform for integrating HIV/AIDS services. Second, there is need for efforts that strengthen African governments' capacity in policy development, planning, operationalization and coordination of integration efforts. This study and others highlight the challenge of governments' weak capacity to enable effective policymaking, planning, operationalization of policies and coordination of partner efforts. It is important to note that this is a challenge whose solution may be complex, and therefore critical for development partners to think through and consider piloting this kind of support in one country in order to draw lessons for sustained improvement, but also for informing similar efforts in other countries. Third is the need to strengthen critical functions of the health system, particularly human resources, commodity supply chain, and M&E system to enhance quality and coverage of integrated services. Fourth, there is need to strengthen community level provision of integrated MNCH, FP and HIV/AIDS information and services. Given the critical role of community level health care provision in extending information and care to rural and hard-to-reach communities, lessons should be drawn from past and on-going successes such as those demonstrated through Ethiopia's health care extension program to inform efforts that seek to strengthen community level provision of integrated services in sub-Saharan

African countries. Lastly, there is need for research that evaluates the effectiveness of on-going integration efforts to generate evidence for program improvement and scale-up.