REPORT ON INTEGRATION OF NCDS WITH HIV PREVENTION AND CARE

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Acronyms

AIDs	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Treatment
ARVs	Antiretrovirals
CSOs	Civil Society Organizations
CVD	Cardiovascular Diseases
FGD	Focus Group Discussion
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
MPHIA	Malawi Population Base HIV Impact Assessment
NAPHAM	National Association for People living with HIV/AIDS in Malawi.
NCD	Non-Communicable Diseases
NCDA	Non-Communicable Disease Alliance in Malawi
NCDIs	Non-Communicable Diseases and Injuries
NAC	National AIDS Commission
OOP	Out-of-Pocket
PHC	Primary Health Coverage
UHC	Universal Health Coverage
UN HLM	United Nations High-Level Meeting
UNAIDS	United Nations Program on HIV/AIDS
VLS	Viral Load Suppression
WOCACA	Women’s Coalition Against Cancer

Executive Summary

People living with HIV are at an increased risk of NCD comorbidities, including cardiovascular diseases such as hypertension, depression, diabetes, cervical cancer, and several other cancers. Given that the global population of people living with HIV is living longer thanks to increased access and uptake of antiretroviral treatment, the risk of NCDs will only increase. Integration of prevention, diagnosis and care of NCDs with HIV services is increasingly important for achieving UHC. It will also improve HIV and health outcomes, well-being and quality of life of people living with and at risk of HIV around the world.

The adoption of this Universal Health Cover global commitment offers an unprecedented opportunity to build on the successes, multi-sectoral and community-led experiences, and rights-based and people-centred approaches to the HIV response. As the treatment options for HIV have expanded and improved, management approaches have transitioned from acute, emergency care to chronic care. Chronic care management for HIV is a platform that can be leveraged to integrate NCD services that are otherwise lacking. There are similarities in prevention, detection, care and long-term management of HIV and NCDs which can enable integration of NCDs into HIV clinics.

There is a growing strong support from in-country stakeholders to pursue greater integration of NCD and HIV services as part of UHC, with a growing body of evidence showing how, when, and with what results this can be achieved. Even incremental changes to the way health services are delivered, which focus on better addressing the NCD care needs of people living with HIV, can lead to equity of access, user satisfaction and trust in programs – all of which increase retention in care and improve health outcomes.

The NCDA in Malawi, through its relationships and collaboration with civil society organizations, advocates and health professionals within the HIV movement held consultative meetings between the HIV and NCD communities to share experiences of/on the health system and the gaps in unmet care needs affecting their lives, in order to realize better health outcomes for people living with HIV and NCDs. This was done by convening a meeting of 28 leaders across the NCD and HIV community, and conducting 2 community consultations with 13 people living with NCDs and 15 people living with HIV. These activities resulted in key findings of low budgetary allocation to NCDs, declining funding towards HIV and AIDs, inadequate medical supplies for NCDs, low level of awareness on NCDs, limited capacity of health workers on NCDs in health centers and HIV clinics, inadequate political commitment towards NCDs due to low level of knowledge and poor health infrastructure to integrate NCDs into HIV care.

Key recommendations include that the government should significantly increase investment and public spending in response to the NCDs, promote the development of manufacturing industries of health essentials, consider setting up a National NCD Commission to work in line with National AIDs Commission. Public domestic funding for both AIDS /NCDS should be top priority by all the stakeholders.

Integration of NCDs With HIV Prevention and Care

1. Introduction

Women's Coalition Against Cancer (WOCACA) as the secretariat of the NCD Alliance in Malawi (Malawi NCDA) is coordinating a project titled "Integration of NCDs and with HIV Prevention and Care" with a small grant from Global NCD Alliance under the Our Views, Our Voices initiative, on cross-fertilization of advocacy efforts. Through this grant, Malawi NCDA built relationships and collaborated with civil society organisations, advocates, health professionals in the HIV health movement with shared agendas to support people living with NCDs and to share their experiences of the health system and the gaps in unmet care needs affecting their lives. Malawi NCDA has been identifying opportunities and sharing successes and lessons learned from national efforts for better integration of services for NCD prevention and care into existing HIV health platforms. The projects goal is to promote resilient integrated, people-centered care across the NCD and HIV movements in Malawi, by building linkages with stakeholders within the HIV movement, facilitating dialogue with people living with HIV to identify and promote awareness on needs and shared priorities for integrated, people-centered NCD care.

2. Background

2.1. NCDS in Malawi

NCDs account for nearly 70% of deaths worldwide with an estimated 75% of these deaths occurring in low- and middle-income countries which includes Malawi. In low- and middle-income countries like Malawi, NCDs contribute to 82% of premature deaths (before the age of 70). The major four chronic non-communicable diseases are: cardiovascular diseases (CVD), diabetes, cancers, and chronic respiratory conditions.

NCDs are increasingly contributing to the burden of disease in Malawi and are second leading cause of deaths in adults after HIV and AIDS in Malawi. They account for 16% of all deaths with 17% in males and 14% in females. Malawi has very high levels of hypertension at 32.3% in adults, which is much higher than many countries in the region. Malawi also has a very high burden of cervical cancer (age standardized incidence more especially in young girls). The burden of NCDs is rapidly increasing in low-income countries which means it includes Malawi. The major four conditions (diabetes, cardiovascular diseases, cancers, and chronic lung diseases), while causing 48% of the NCD burden of disease in Malawi, only account for 39% of the NCD burden in Malawi, indicating a broader definition of NCDs that needs addressing in Malawi. The probability of dying from an NCD between the ages of 30 and 70 is highest in sub-Saharan Africa including Malawi.

2.2. HIV/AIDS in Malawi

The recently released results of a new nationwide HIV survey of MPHIA implemented in Malawi offer evidence of continued progress toward controlling the longstanding epidemic in the country and provide guidance toward further steps that need to be taken. HIV prevalence among adults was 8.9 percent, indicating that approximately 946,000 adults are living with HIV in Malawi. HIV prevalence was twice as high among women compared to men in each five-year age group between ages 20 and 39, hence HIV continues to wear more of a female face than a male one. Generally, HIV prevalence increased with age until the late 40s for women and the early 50s for men (MPHIA 2020-2021).

HIV prevalence varies by region. Among women, HIV prevalence ranges from a low of 5.6% in Northern region to 15.7% in Southern region. Among men, HIV prevalence is lowest in Central region (4.4%) and highest in Southern region (9.2%). Though from all; 6 districts of Lilongwe, Blantyre, Mangochi, Thyolo, Mulanje and Zomba account for 53% of the new infections.

Based on the survey results of MPHIA, 2020-21. 88.3 percent of adults living with HIV were aware of their HIV-positive status. Among adults living with HIV who were aware of their status, 97.9 percent were on antiretroviral treatment (ART), and among adults on ART, 96.9 percent had suppressed viral loads. These results indicate that Malawi has met the second and third UNAIDS 95-95-95 targets before the 2025 target date. However, the first 95 target – ensuring that 95 percent of all individuals living with HIV are aware of their status – remains below that threshold.

Among all adults living with HIV in the country, irrespective of knowledge of HIV positive status, 87.3 percent had viral load suppression (VLS), suggesting that Malawi is well-positioned to achieve the UNAIDS goal of ending the AIDS epidemic in the country by 2030. VLS prevalence, however, was lower among younger adults. Improvements in timely diagnosis, linkage to care, and retention on ART, particularly among younger adults, are critical factors to ending the AIDS epidemic.

2.3. HIV, NCDS and UHC

People living with HIV have nearly a two-fold increased risk of cardiovascular disease (CVD), compared to their HIV negative counterparts, and women living with HIV have nearly a six-fold increased risk for cervical cancer. Financing for NCDs has remained low for many years, while HIV financing is declining. Domestic financing is vital and needs to be scaled up in view of waning donor aid which will help in integration of NCDs into HIV people-centred care. There is need for strong support from country stakeholders to pursue greater integration of NCD and HIV services as part of UHC.

3. Methodology

A meeting to convene 28 leaders across the NCD and HIV communities, and 2 community consultations of 12 people living with NCDs and 11 people living with HIV were held on 18th July 2022 and 19th August 2022 respectively.

Programs for the leadership meeting and the community consultations were produced and circulated to all participants 3 weeks before convening. Presentations were delivered during the meetings by representatives from the NCD and HIV communities. This was followed by break-out sessions and then plenary for the leadership meeting whereas for the community consultations focus group discussions were held. All meetings were participatory.

3.1. Leadership meeting

Table 1 Number of Meeting Attendees by Gender

MALE	FEMALE	TOTAL
14	14	28

Twenty-eight members attended the meeting, 14 women and 14 men as shown in Table 1.

3.2. Community consultations

Table 2 Number of Meeting Attendees by Gender

MALE	FEMALE	TOTAL
16	12	28

Twenty-eight members attended the meeting, 12 were women and 16 were men as shown in Table 2. Out of the 28 participants 11 were people living with HIV and 12 were people living with NCDs respectively as shown in Table 2.

3.3. Attendees by communities

Table 3 Number of Meeting Attendees by communities

<table>
<tr><th colspan="2">People living with NCDs</th><th colspan="2">People Living with HIV/AIDS</th><th rowspan="2">TOTAL
PARTICIPANTS FOR FGDs</th></tr>
<tr><th>MALE</th><th>FEMALE</th><th>MALE</th><th>FEMALE</th></tr>
<tr><td>7</td><td>4</td><td>5</td><td>7</td><td>23</td></tr>
</table>

Out of 28 participants, 23 people living with NCDs and HIV were engaged in the community consultations as shown in Table 3.

4. Key Findings

A series of two consultative meetings were conducted by NCD Alliance, targeting 56 stakeholders from the HIV and NCDs movement, including other civil society, media, MoH, and people living with NCDs and HIV. The aim was to address key needs and priorities when it comes to integrating NCDs into HIV services. The findings are listed below:

4.1. Health financing

- Low budgetary allocation to the healthcare sector and poverty as the key financial challenges faced by NCD health care system.
- The national health budget is already constrained by communicable diseases such as HIV/AIDS whereas funds allocated for NCDs are insufficient. It is therefore of paramount importance to act now with cost-effective, proven strategies for NCDs in order to tackle the double burden of disease. In collaboration with other stakeholder NCD Alliance is working to make sure that the general public are given the right information of all the types of NCDs.
- The implication of inadequate financing of healthcare by the government leaves the burden for healthcare financing on households, usually through OOP expenses, which have been shown to be catastrophic to households, pushing some households into poverty. For instance, the drugs for NCDs are scarce in public hospitals and buying them from a private facility/ pharmacy is very expensive and for the low-income levels are unable to afford hence there is high mortality among poor people living with NCDs whereas HIV/AIDS drugs are readily available in public hospitals.

4.2. Barriers to integrating NCDs into HIV services

4.2.1 Inadequate medical supplies

- Access to quality health services is often limited and patients are burdened with costly out-of-pocket expenditures, frequent stock-outs of NCD medicines and scarcity of basic medical devices, limited patient tracking and ineffective referral systems.
- Participants consistently reported incurring substantial OOP payments for medical treatment at private health facilities and/or when purchasing NCD drugs at private pharmacies. Despite their awareness of and experience with free healthcare provision at public facilities when it comes to the provision of HIV opportunistic infections medication, respondents reported frequently being compelled to seek care at private facilities, incurring substantial OOP. They justified their need to do so with regards to a number of shortcomings in public health service provision, namely: shortages of NCD medicines, and health workers, insufficient health facilities and equipment, poor access to emergency services, long distance and transportation

difficulties, poor attitude of health workers, overcrowding and hence perceived poor quality of care.

4.2.2 Inadequate funding for NCDs

- There is no dedicated budget for NCDs in particular for promotion, prevention, and research and achieving a successful health care financing system continues to be a challenge in NCDs compared to that which has been invested towards HIV/AIDs.
- There are no mechanisms for financing health care to help in delivery of health services and building advanced infrastructures for NCDs. The major challenges of health care financing in Malawi includes, poor funding by government, overdependence on donors, high out-of-pocket payment as public hospitals do not have enough medical supplies, inadequate implementation of health care financing policy and corruption.
- The unavailability of some NCD medication and particularly drug stock outs were the issues raised in the leadership and community consultations. Stock outs were attributed to limited government funding for drugs, a fragmented drug procurement system, inadequate drug supply and distribution, insufficient supply chain and theft. There are also resource constraints in funding treatment to specific vulnerable groups such as people with albinism, prisoners, people living with NCDs to mention a few.

4.2.3 Low level of awareness

- There is very minimal awareness of NCDs among policymakers, health workers, persons living with NCDs, people living with HIV and the general population, only a low percentage of respondents at the village level know about the country's NCDs.
- The awareness of risk factors of NCDs and knowledge regarding prevention of NCDs is not low. The results highlighted the need and scope for health education and interventions to improve the awareness about NCDs and their risk factors.
- Previously, NCDs were considered a problem of rich urban population but with changing trends, the poor have been found to be more vulnerable to NCDs and related complications. This scenario in Malawi especially among rural people could be due to decreased awareness about risk factors, low health care facilities, unplanned urbanization and few or no national programmes. Therefore, increasing awareness about the risk factors and rapid change towards health-promoting behaviours which are mostly practiced by people living with HIV/AIDs will be cost effective in modifying the prevailing health status in rural and urban people with or without NCDs.

4.3. Barriers to delivery of people-centered, integrated services for NCDs and HIV

- Staff at HIV clinics are not specialized in NCDs and health centres lack NCD personnel.
- There is limited capacity of human resources in primary health centres (PHC) on NCDs.
- HIV and NCD clinics are held on alternative days at health centres which is inconvenient for patients.
- Health care staff frequently reside far from health facilities which affects the commencement of NCDs or HIV clinics resulting in long waiting times by patients.
- Large portion of the population reside far from public facilities. If unable to seek care at private facilities due to the affordability concerns described earlier, community residents are forced to travel long distances to receive care free of charge. Respondents reported that due to long distance and lack of adequate transport, they often arrive at public facilities after standard clinic working hours.
- Often negative attitudes of health workers in public facilities results in lower likeliness to seek medical attention.

4.4. Barriers to commitment to enhancing integration of people-centred care for NCDs/ HIV

4.4.1 Inadequate political commitment to health

- Political commitment was seen as a major challenge to health policy, as leaders like advocating more than implementing.
- The failure of formulating the policy of providing health insurance and services to the undeserved and not paying much attention to how to reach those services is leading to poor funding of healthcare, and primary health care in particular.
- Gaps in stewardship and governance as evidenced by lack of clarity of the role of government, at all levels in financing health care, such there is no one to be accountable for funds allocated towards health

4.4.2 Risk of corruption

- Inadequate or non-implementation of health policy that clearly spells out how funds are to be allocated and spent in the health sector. Some drugs go missing and some funds are misused, there is no one to hold accountable. Such circumstances make donors to withdraw their support and discourages potential donors.

4.5. Integration of people-centred care of NCDs and HIV/AIDs into the UHC Agenda

- Malawi has not yet fully invested in quality health infrastructure for integration of NCDs and HIV.
- At present, it is very challenging to note that most health facilities are poorly equipped for diagnostics for NCDs and there is weak integration with HIV cascade of treatment. Frequent breakdowns of equipment such as CT scanners and other vital NCD equipment creates problems.

5. Recommendations

5.1. Ministry of Health

- Government should significantly increase investment and public spending on NCDs.
- Facilitate the provision of essential equipment, drugs and infrastructure to all HIV clinics for early diagnosis, treatment and monitoring of priority NCDs.
- Prioritise the availability of essential health commodities (e.g. drugs, health equipment) and employment of accountability mechanism to track down the utilization of these purchased items.
- All the essential NCD drugs should be subsidised or be free as ARVs to enable patients access them to improve their health status.
- Promote the development of manufacturing industries for health essentials.
- Government must consider setting up a specific NCDs National Commission to bolster the national NCDs response that integrates HIV and other communicable diseases.
- Public domestic funding for HIV/AIDS and NCDs should be the top priority rather than relying on donors.
- There is an urgent need for Malawi to set up a national health fund urgently to achieve Universal Health Coverage to also adequately finance NCDs and HIV integration people-centred care.
- Progress on the national health insurance scheme has stalled in Malawi, this needs fast tracking as well.

5.2. Health Systems Actors Including Community Healthcare Providers

- Scaling up and strengthening of human resource capacity through education and training to on both HIV and NCD health workers.
- Ensure the engagement of all populations, including older people and women living with HIV and NCDs, in these initiatives for example; cervical cancer.
- Build on existing service delivery modalities, platforms and systems to link or integrate HIV and NCD services. Through support more integrated prevention and care services, including in national health systems.
- Introduce an HIV mobile clinic to provide services to hard to reach areas and integrate NCDs to enable the community to access treatment without travelling long distances
- Increase awareness campaigns to influence the general public to increase a prompt response to both NCDs and HIV and reduce the stigma and discrimination faced by people living with NCDs and HIV.
- Develop and disseminate contextually appropriate, person-centred, evidence-based advocacy campaigns and knowledge products, which demonstrate successes and lessons learnt from integrative services.

- Develop and disseminate education materials about NCDs and NCD risk factors for people living with HIV to help mobilize communities living with HIV and NCDs to demand integrated and user-friendly services.
- Meaningfully involve and support people living with HIV and NCDs to develop, lead, implement, and monitor progress (including community-led monitoring) toward a country-led and context-driven agenda, and to leverage HIV platform adaptation.

5.3. Civil Society Organizations

- National AIDS Commission (NAC) and CSOs should look at NCDs critically and find ways of integration with the HIV response rather than working in siloed approach.
- Raise awareness of the need for both HIV and NCD services and call for integration through existing networks, campaigns (including UHC), and other civil society-led advocacy and accountability initiatives.
- Review the policies and involve the politicians in dealing with the response of both NCDs and HIV, lobby to increase the budget allocation for both NCDs as well as HIV which is primarily funded by the Global Fund and there is a need for proper sustainable funding plan to support people using ART.
- Facilitate the provision of essential equipment, drugs and infrastructure to all health care centres for early diagnosis, treatment and monitoring of priority for both NCDs and HIV.

6. Conclusion

The outcome of the consultation meetings to promote resilient integrated, people-centered care across the NCD and HIV communities revealed key data pertaining to integration of NCDs and HIV in Malawi. It was found that the main barriers to integration include low budgetary allocation for NCDs, declining health financing for HIV, inadequate medical supplies for NCDs, low level of awareness of NCDs by the public as well as health workers, and inadequate political commitment to health. These barriers would limit implementation of integration of NCD services at HIV clinics.

As such, recommendations to reduce these barriers are aimed at ensuring that the HIV clinics are properly equipped with NCD services such as availability of diagnostic equipment, medicines on NCDs and training of HIV health workers on NCDs. Public domestic funding for both NCDs and HIV should be one of the priorities of the stakeholders including government, hence there is a need to set the national health funding and the speed the progress of national health insurance. This is a cost-effective intervention to achieve the best possible health outcomes for people living with and affected by HIV and NCDs contribute towards achieving UHC. For these recommendations to be implemented, it is critical there is buy-in and commitment from the public and government about the importance of integration as a means for achieving better care for both the HIV and NCD populations, as well as for achieving UHC in Malawi.

7. Annex

7.1. Pictorial focus

BREAKOUT SESSION 1 (LEADERSHIP MEETING ON NCD/HIV INTEGRATED)
18/07/2022

BREAKOUT SESSION 2 (NCD/HIV INTEGRATION)
18/07/2022

BREAKOUT SESSION 3 (LEADERSHIP MEETING ON NCD/HIV INTEGRATED)
18/07/2022

CROSS SECTION (NCD/HIV INTEGRATION)
18/07/2022

CROSS SECTION COMMUNITY CONSULTATION
19/08/2022

FGD 1 (COMMUNITY CONSULTATION)
19/08/2022

FGD 2 (COMMUNITY CONSULTATION)
19/08/2022

CROSS SECTION ON COMMUNITY CONSULTATION
19/08/2022

7.2. Shared advocacy agenda on integrated people-centered care

7.2.1. Leadership meeting

TIME	ITEM	PERSON RESPONSIBLE
8:30am -8:40am	Arrival & Registration	Secretariat
8.40am – 8.50am	Opening Prayer	Volunteer
8.50am – 9.00am	Welcome remarks & introductions	MWNCDA[1]
9.00am – 9.10am	Overview on NCDs in Malawi	Project Coordinator - NCDA
9.10am – 9.20 am	Overview on HIV in Malawi	UHCC
9:20am - 10:00am	Integrating a people's centered approach to NCDs and HIV into the 2023 UN High Level Meeting Agenda	Programme Manager - JournAIDS[2] & Member - UHCC[3]
10.00am – 10.30am	Health Break /Photo session	Secretariat
10.30am – 11.30am	Group discussions	MWNCDA
11:30am - 11:50am	Plenary - **Shared Advocacy Agenda**	MWNCDA
11.50am – 11.55am	Closing remarks	MWNCDA Chairperson
11.55am -12:00pm	Closing Prayer	Volunteer
12.00pm	Lunch	Secretariat & All

[1] Malawi NCDs Alliance
[2] Journalists Association Against AIDS
[3] Universal Health Coverage Coalition

7.2.2. **Community Consultations**

TIME	ITEM	PERSON RESPONSIBLE
1:30pm -1:40pm	Arrival & Registration	Secretariat
1.40pm – 1.50pm	Opening Prayer	Volunteer
1.50pm – 2.00pm	Welcome remarks & introductions	NCDA[4] - Chairperson
2.00pm – 2.10pm	Overview on NCDs in Malawi	Project Coordinator - NCDA
2.10pm – 2.20pm	Overview on HIV in Malawi	UHCC[5]
2:20pm – 2.30pm	Integrating a people's centered approach to NCDs and HIV into the 2023 UN High Level Meeting Agenda	Programme Manager - JournAIDS[6]
2.30pm – 3.20pm	Group discussions	NCDA
3:20pm – 3.50pm	Plenary	NCDA
3.50pm – 3.55pm	Closing remarks	NCDA Chairperson
3.55pm - 4:00pm	Closing Prayer	Volunteer
4.00pm	Health Break / Photo session	Secretariat

[4] Malawi NCDs Alliance
[5] Universal Health Coverage Coalition
[6] Journalists Association Against AIDS

7.2.3. Leaders' Meeting Participants List

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7.2.4. Community Consultations Participants List

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2	Chembezi Longa	Mwaiwathu CBO	M
3	Adrew Josephy	Chimvita CBO	M
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5	Chales Kumalonga	Mbuna CBO	M
6	Neliyi Vito	Belesi CBO	F
7	Mapulanga Chinga	Chirijani CBO	F
8	Zakeyo Khombe	Dunde CBO	M
9	Bitilesi Maliamu	Alinafe CBO	F
10	Alice Donlop	Nsungwi CBO	F
11	Issaac Chimkaola	Heamphilia Association	M
11	Ellen Matambula	Dental clinic	F
12	Virginia Majawa	Dental clinic	F
13	Taonga Wanda	Area 23 CBO	F
14	Milika Chimbazi	Area 23	F
15	Fannuel Tapani	Stroke Association	M
16	Andrew Mijoni	Kidney foundation	M

17	Salomy Mtambo	Cancers Guardian	F
18	Hannah Munthali	Dental clinic	F
19	Hennery clayton	Kidney Foundation	M
20	Paul Manyamba	NAPHAM	M
21	Dingaani Mithi	Journal Aid	M
22	Samuel Kumwanje	MW-NCDS	M
23	Jimmy Bamusi	WOCACA	M
24	Thom Kasimbi	WOCACA	M
25	Nellie Kawale	WOCACA	F
26	Emmie Mwase	WOCACA	F
27	Maud Mwakasungula	MW- NDCA	F
28	Kefasi Banda	WOCACA	M

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