PLHIV Voices on HIV Services Integration:

Case Studies from Six Countries

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Foreword

This report, ***PLHIV Voices on HIV Services Integration: Case Studies from Six Countries,*** is a companion to the GNP+ 2025 World AIDS Day report on PLHIV minimum asks and requirements for integrating HIV services into Primary Health Care for HIV sensitive Universal Health Coverage (UHC).

Through the lived experiences of people living with HIV across six diverse contexts, these case studies reveal what truly person-centered integration looks like: reduced fragmentation, restored trust, and health systems that respond to whole person's needs. They also expose persisting barriers including stigma, breaches of confidentiality, and services that remain insensitive to the needs of PLHIV and that continue to undermine progress toward HIV epidemic control.

To realize the promise of Zero new HIV infections, Zero AIDS-related deaths, and Zero stigma, the HIV response community must accelerate the shift to HIV sensitive UHC with PLHIV and communities leading the way.

These stories provide clear, evidence-based pathways for governments, donors, and health workers to act on now.

Immense gratitude to all the PLHIV national network leaders for their steadfast leadership in making this vision real. ***We are PLHIV Leaders Now.***

*Sbongile Nkosi & Florence Riako Anam–**Co-Executive Directors, GNP+***

Introduction

> ***"Integration is the way forward. When we keep HIV separate from general health services, we deny people with HIV the opportunity to benefit from universal health coverage. Yes, it comes with challenges, but this is also our chance to address stigma. Parallel systems create a visible cohort—when people go to an HIV-specific clinic, you're exposing them. Integration will take time, but it's necessary."*** Nelson Otwoma, Executive Director of the Network Empowerment of People Living with HIV in Kenya (NEPHAK)

In early 2025, the global HIV response entered crisis mode when abrupt funding cuts from international donors sent shockwaves through countries heavily affected by HIV. Clinics closed their doors. Health workers were sent home. Community programmes that had been lifelines for millions were forced to shut down. The funding that had sustained the HIV response for decades vanished almost overnight.

For people living with HIV, this was not an abstract policy shift, it was personal. It meant missed appointments, medications running out, and the fear of falling through the cracks of health systems already stretched thin.

Countries began integrating HIV services into primary healthcare as a path to sustainability. But what does integration mean when the money disappears? When the community organizations that knew how to reach marginalized populations got defunded? When health workers trained in HIV care were let go?

In November 2025, GNP+ conducted in-depth interviews with national people living with HIV network leaders in Nigeria, Kenya, Indonesia, Ghana, Zimbabwe, and Eswatini—countries at different stages of integration, each navigating the funding shifts in their own context.

These case studies show what integration actually looks like on the ground: the innovations, the struggles, and the gaps between policy and practice. In some places, integration is opening doors; in others, it's closing them. This document curates what the community is seeing, what it needs, and what must change if integration is to work.

Chapter 1: Dismantling What Worked: The Disappearance of Community Infrastructure

"After the funding freeze and now with this integration, they are no longer there. They are trying to counteract this by saying, 'At the hospital, you will find a nurse.' Albertina Nyatsi's words, spoken from Eswatini, echo across six countries. She is the founder and Executive Director of Positive Women Together in Action, speaking about mentor mothers—women living with HIV who guided pregnant women through PMTCT and sat with newly diagnosed mothers in their fear.

Albertina Nyatsi, Director at Positive Women Together in Action, in an open forum with community members in Eswatini

They're gone now. Not because they stopped being needed, but because when funding disappeared, governments made a choice about who was expendable, and it was the community. This is echoed in the recent UNAIDS report released on World AIDS Day 2025 titled *"Overcoming Disruption: Transforming the AIDS Response,"* which states that across sub-Saharan Africa, 450,000 people have lost access to mother-to-mother mentors—peer educators who counsel and support pregnant women and new mothers—and other health services critical for their own health and the prevention of new HIV acquisition among children.

A vital part of integration is bringing HIV services into mainstream health facilities. But the people who made those HIV services work, the community infrastructure, are not being integrated.

Besides mentor mothers, this infrastructure includes adherence counselors who call when you miss a refill and outreach workers who meet key populations where they are. This is why viral suppression rates climbed. This is why vertical transmission declined. This is how people whom health systems had given up on were reached.

"Government are focusing on HIV services going to be done in the hospital, but what about services outside of the hospital, like advocacy? Nyatsi wants to know. ***"These are not being discussed. We are not even making preparation for the services outside of hospital, that is another concern."***

Community health agent during a home visit in Zimbabwe

In Kenya, Nelson Otwoma, chairperson of the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK), explains: ***"USAID used to support lower-cadre staff—adherence counselors, mentor mothers. For the time being, that is an area that the Ministry of Health in Kenya is not considering."***

In Zimbabwe, Clarence Mademutsa from the Zimbabwe National Network of People Living with HIV (ZNNP+) observes the same pattern: ***"The community voice has diminished because, under the previous PEPFAR setup, we had community-led monitoring (CLM) to give feedback on service provision. But since it was terminated, the voice also diminished, and we are receiving services as they are available, not necessarily what would be preferred."***

According to UNAIDS, many of the over 350,000 health and community workers whose salaries were paid by PEPFAR globally were temporarily laid off during the funding cuts earlier in 2025, resulting in documented losses of essential health worker positions.

The situation is the same in Indonesia. Meirinda Sebayang, Executive Director of Jaringan Indonesia Positif (Positive Indonesia Network), explains: ***"Until now, community health workers are funded by donors, Global Fund, or before it was the US government. So once HIV integration is fully implemented, where can we get the resources for the community health workers to work together with the health facilities?"***

In Ghana, the immediate problem is not the lack of community infrastructure—they still have it—but uncertainty about its future. Abdul-Fatawu Salifu, Executive Secretary of the Ghana Network of People Living with HIV, explains: "***The biggest problem is that we still get support from the Global Fund to conduct community-led activities. We are trying to see how the government can also support these initiatives so that we can actually monitor and track the progress of integration."***

The Myth of "Government Cadres"

Governments are responding by saying: we already have community health workers, village health workers, government cadres who can do this work.

Zimbabwe's Community Health Strategy recognizes only one cadre: the village health worker on the government payroll. ***"It doesn't fully recognize other community cadres supported by partners or volunteers,"*** Mademutsa explains.

"Mentor mothers, community health agents—they are not recognized within the strategy." While they have advocated for government recognition of these cadres, the government cites financial constraints—even village health workers are currently funded by the Global Fund, not the government.

Kenya tried a similar approach by suggesting community health promoters, recognized by the government, take over the work of community peers and adherence support. But for Otwoma, this is not sufficient: ***"Community health promoters come from the same neighborhoods as the people taking medication***

and may not respect confidentiality. People don't want their neighbors to know their status. We are still stressing to the Ministry of Health the importance of lower-cadre HIV community staff."

For Otwoma, the greatest loss has been in preventing vertical transmission: ***"Where quality of care has been compromised most is in eliminating mother-to-child transmission. This isn't just about issuing ARVs. You need dialogue, education, and constant monitoring to ensure the virus isn't passed to the child."***

> **Mentor mothers knew how to do this. They'd been there. They could sit with a woman and say:** *I was scared too. I was worried about transmitting HIV to my baby too. Here's what helped. You're not alone.* **Without them, PMTCT becomes a checklist: A nurse will test the mother, give ARVs, check viral load, hope she doesn't interrupt treatment, hope she comes back after delivery, hope the baby is negative.**
>
> **Hope is not a strategy.**

For Sebayang from Indonesia, the challenge is different: the Ministry of Health is willing to integrate community led initiatives, but they need evidence. ***"The Ministry of Health is already open to community-led initiatives being implemented at health facilities, but the strong question from the Minister and other authorities is how you can show that this will contribute to improving the HIV program outcomes. How can we ensure that community led initiatives can improve service quality, reduce loss to follow-up, and increase the number of people living with HIV accessing treatment? This is our homework for the next year[2026]: to prove to them that community led initiatives are important."***

Governments also argue that community work is too expensive. Sebayang notes that during a recent field visit, she discovered the cost to identify one HIV-positive female sex worker through Global Fund investments is high. While these funds cover outreach worker salaries, meetings, education campaigns, PrEP, and condom distribution, the government uses the cost-effectiveness argument to block local funding for community programs.

Feedback from PLHIV communities is clear: you can't dismantle community infrastructure and expect people to keep showing up at clinics. You can't eliminate the people who made HIV care trustworthy and expect trust to remain. Integration without community is not integration.

UNAIDS World AIDS Report emphasizes: Governments, donors and other stakeholders must ensure all facets of community-led responses are adequately supported, with minimum thresholds for domestic allocations for community-led service delivery established to ensure consistency and equity in financial support.

Visit to a Primary Healthcare Facility in Indonesia

Chapter 2: From Safe Spaces to Shared Spaces: Integration’s Promises and Pitfalls

“Integration is good, and it is welcome. It will reduce some level of stigma that is associated with stand-alone clinics for HIV. Because if we continue having stand-alone HIV clinics, people will continue to make reference and call it ‘a clinic for those people living with HIV.’ But that being said, you still don’t know how health workers in general hospitals will behave, so integration may also increase stigma in other ways.” This reflection from Abdul Dangirma, National Secretary of the Network of People Living with HIV/AIDS in Nigeria (NEPHWAN), captures the tension felt across communities: integration brings both opportunity and risk.

Dangirma also emphasizes what people stand to gain: ***“Another good thing is you may be able to go and access multiple services in one clinic, now everything is under one umbrella.”*** For him, integration improves continuity of care. With shared patient histories, health workers can manage other health conditions more easily.

Otwoma strongly agrees. He notes that Kenya now has ***“a large cohort of persons with HIV who are presenting with other non-communicable diseases—hypertension, diabetes, kidney problems.”*** For him, integration is essential if health systems are to treat people holistically. He also sees integration as an opportunity to reduce stigma: ***“If it’s parallel, you are just having a cohort that when they go to an HIV clinic, you are exposing them.”***

Salifu from Ghana echoes this sentiment. People prefer completing everything in a single visit: ***"I would prefer to just go to the health center and have everything done at one point and leave."*** He stresses that integration must also include decentralization and digitalization: ***"You don't have to go around carrying test results, papers, medications. It makes it easier to manage patient data."***

From Indonesia, Sebayang supports integration in principle but warns against rushing. ***"I personally agree with the integration because it opens more access for everyone to come into public health facilities, but we should start with baby steps."*** She calls for piloting in selected districts, both to identify gaps and prepare health workers.

Yet even where communities welcome the benefits, they fear losing the personalized, relationship-based care found in specialized clinics.

Nyatsi from Eswatini describes the loss of relationship-based care: "***Let's say there was this nurse at the HIV clinic that knows me, that I've been sharing all my history with for a long time. And now I will be going today and finding Nurse B or Doctor C. The following day I come, I find a different person who doesn't know me."***

In HIV clinics, continuity meant trust. Nurses didn't need long explanations—they already knew when someone was struggling with adherence or facing life stressors.

Ghana faces this more acutely due to the country's rotation system. As Salifu explains, ***"The way the National Health Service is structured, they have rotating nurses, so you don't see the same nurse fixed at the ART unit or at the outpatient clinics (OPD). They change."*** Constant rotation makes it impossible to train all providers adequately.

The impact is profound. Stigma in the health system feeds internal stigma. Salifu further explains that this makes people deliberately avoid nearby health centers: ***"Most people who live in a district wouldn't want to go to the District Health Center. They prefer to go outside the district to avoid meeting someone they know."***

This is often labeled self-stigma, but self-stigma exists because actual stigma exists. Because people have been judged, gossiped about, discriminated against. ***"People are dealing with it and are not able to cope, so they travel long distances, which also increases the cost of accessing their health services, even though accessing care nearby would be beneficial."***

Stigma from healthcare workers is not new. The GNP+ 2023 Global PLHIV Stigma Index report shows that 25% of PLHIV experienced external stigma. Common incidents included gossip (15.3%) and unauthorized disclosure of HIV status (15.3%) during non-HIV care. Fear of negative treatment or disclosure prevented 34.3% from restarting HIV care, and 16.5% avoided care due to prior bad experiences. Internalized stigma affected 84.8%, harming mental health and well-being. What has worked previously is that in specialized HIV clinics, community oversight, training, and accountability kept stigma in check.

But PLHIV Networks and communities are not silent about what needs to change and strategic engagement with their national governments offers opportunities to inform policy and program adaptations for HIV sensitive public health adaptations.

Ms. Flavia Kyomukama, ED of National Forum of People Living with HIV/AIDS Networks Uganda (NAFOPHANU) and her team getting experiences from recipients of care in a District Hospital in Uganda

In Kenya, Otwoma reports progress: ***"When it started, we had issues of privacy and confidentiality, which have since been ironed out. Modifications have been made so that anonymity is granted and privacy is respected. And those are things we've communicated to the National AIDS and STI Control Program, NASCOP, and they have been having a series of sensitization meetings with healthcare workers."***

From Nigeria, Dangirma describes a growing partnership with the government: ***"We are engaging much more deeply with the government to make them own the whole process. The only thing is the continuous training and the human resources to provide that needed training for people to be well informed about the use of language, how to treat people at a larger scale."***

Nelson Otwoma, the Director of the National Empowerment Network of People Living with HIV/AIDS in Kenya (NEPHAK) gives his remarks during the Nairobi PLHIV Leadership Summit

Mademutsa from Zimbabwe outlines efforts to safeguard service quality: ***"A couple of weeks ago, we did a field visit, and the conclusion was there's a need to ensure greater training for healthcare workers around basic customer care and how they provide services to clients."*** He explains that the Ministry already includes sensitivity content in pre-service training, but implementation must be strengthened.

Integration may be inevitable, but lowering standards is not, and Medemutsa makes it clear. ***"We've done so well as the HIV community to ensure quality services, and it would be unfortunate to have that standard watered down just because we've been integrated into the mainstream health delivery system."***

Abdulkadir Ibrahim (centre), National coordinator Network Of people Living with HIV and Aids in Nigeria (NEPHWAN) visits a support group in Nigeria

Chapter 3: Integration With Equity: Confronting the Risks We Cannot Ignore

"The people who suffered most are people who are not virally suppressed, people with advanced HIV disease, people newly diagnosed, and key populations." Otwoma's words capture a pattern that emerges whenever health systems transition: those already at the margins fall even further behind. For newly diagnosed people, the challenges were immediate. In the months surrounding the stop-work order, those who were diagnosed needed intensive support that simply wasn't there.

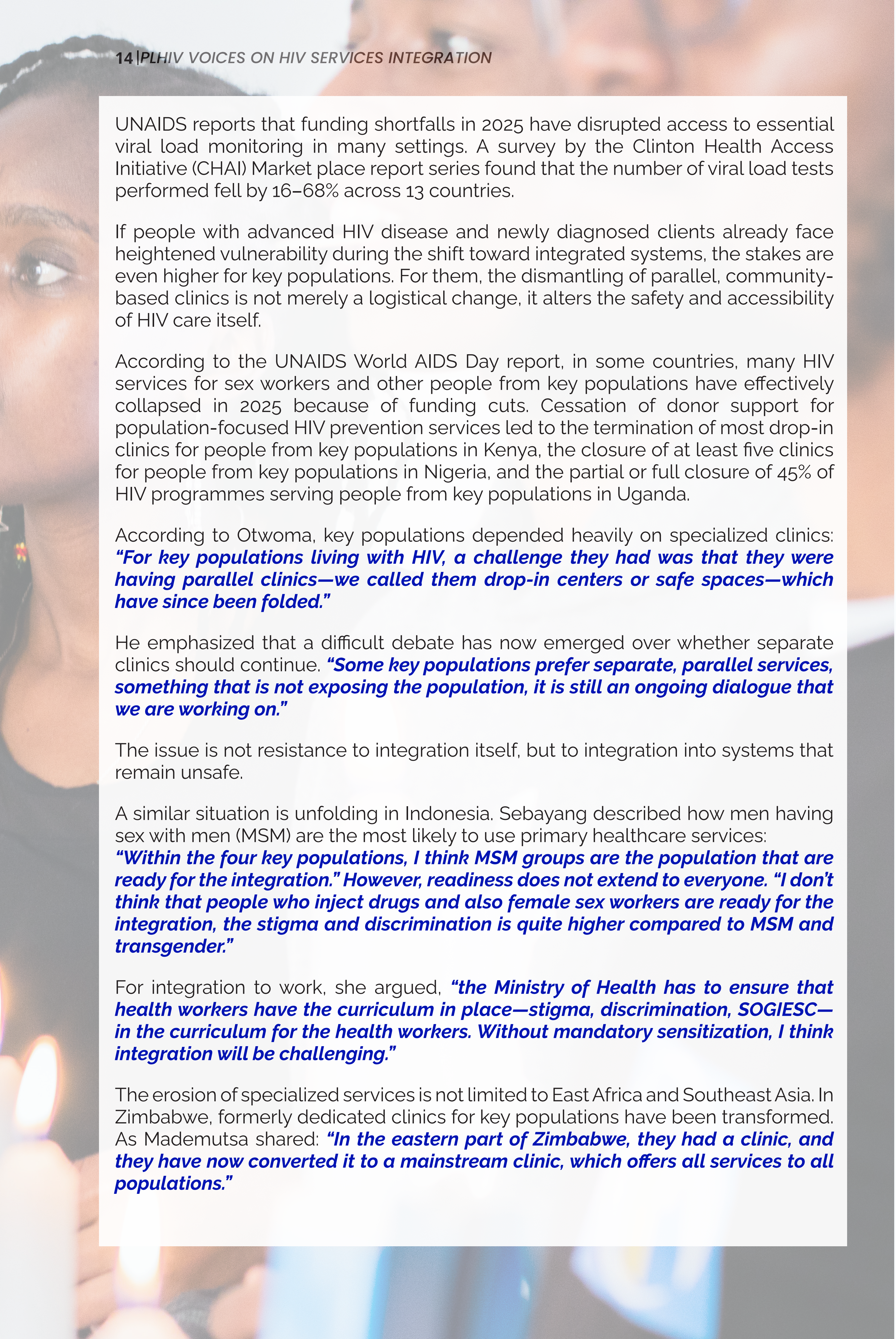
This aligns with the Dec 1 UNAIDS report that highlighted the numbers of people initiated on antiretroviral therapy in the first three months of 2025 dropped between 2% and 22% across 13 countries in sub-Saharan Africa and southeast Asia.

Mwenenzi Support group members in Zimbabwe

For Advanced HIV Disease (AHD), Zimbabwe offers a stark view of what happens when essential services are already fragile before integration begins. Mademutsa explains that AHD services were struggling long before the funding cuts: ***"For us, even before this discussion around the funding cuts, our coverage for AHD services was low, and the cuts have actually worsened an already bad situation."***

He describes a health system where AHD services exist mainly at referral hospitals, not at the primary care level where people first seek help. CD4 testing—critical for diagnosing AHD—has nearly collapsed.

From Nigeria, Dangirma confirms that people with AHD face the greatest risks under integration. ***"People who are coming up with advanced HIV disease, especially people who are aging, this is also very critical,"*** he says, emphasizing that healthcare personnel are not adequately equipped to manage complex cases in general health settings.



UNAIDS reports that funding shortfalls in 2025 have disrupted access to essential viral load monitoring in many settings. A survey by the Clinton Health Access Initiative (CHAI) Market place report series found that the number of viral load tests performed fell by 16–68% across 13 countries.

If people with advanced HIV disease and newly diagnosed clients already face heightened vulnerability during the shift toward integrated systems, the stakes are even higher for key populations. For them, the dismantling of parallel, community-based clinics is not merely a logistical change, it alters the safety and accessibility of HIV care itself.

According to the UNAIDS World AIDS Day report, in some countries, many HIV services for sex workers and other people from key populations have effectively collapsed in 2025 because of funding cuts. Cessation of donor support for population-focused HIV prevention services led to the termination of most drop-in clinics for people from key populations in Kenya, the closure of at least five clinics for people from key populations in Nigeria, and the partial or full closure of 45% of HIV programmes serving people from key populations in Uganda.

According to Otwoma, key populations depended heavily on specialized clinics: ***“For key populations living with HIV, a challenge they had was that they were having parallel clinics—we called them drop-in centers or safe spaces—which have since been folded.”***

He emphasized that a difficult debate has now emerged over whether separate clinics should continue. ***“Some key populations prefer separate, parallel services, something that is not exposing the population, it is still an ongoing dialogue that we are working on.”***

The issue is not resistance to integration itself, but to integration into systems that remain unsafe.

A similar situation is unfolding in Indonesia. Sebayang described how men having sex with men (MSM) are the most likely to use primary healthcare services: ***“Within the four key populations, I think MSM groups are the population that are ready for the integration.” However, readiness does not extend to everyone. “I don’t think that people who inject drugs and also female sex workers are ready for the integration, the stigma and discrimination is quite higher compared to MSM and transgender.”***

For integration to work, she argued, ***“the Ministry of Health has to ensure that health workers have the curriculum in place—stigma, discrimination, SOGIESC—in the curriculum for the health workers. Without mandatory sensitization, I think integration will be challenging.”***

The erosion of specialized services is not limited to East Africa and Southeast Asia. In Zimbabwe, formerly dedicated clinics for key populations have been transformed. As Mademutsa shared: ***“In the eastern part of Zimbabwe, they had a clinic, and they have now converted it to a mainstream clinic, which offers all services to all populations.”***

This shift was accompanied by a new financing model: ***"It has adopted a new model, asking users to pay. It's subsidized, but people have to pay essentially now."***

For key populations, who already face criminalization, stigma, and economic precarity, introducing user fees, however small, can be enough to push them out of care.

In the context of rapidly integrating responses, UNAIDS states that it is important to ensure integrated services preserve person-centered approaches and protect human rights and gender equality. These approaches are critical to sustain the demand and coverage of services.

GNP+/Afrocab/RRP+ pre-conference workshop on Advanced HIV Disease (AHD) on July 12 ahead of IAS 2025 Conference in Kigali

Chapter 4: Show Me the Money: The Resource Reality Behind HIV services Integration

"How can integration take place when we have some of the primary health care centers seeing between 500 and 600 people and yet are manned by sometimes even two people? How can you expect them to dispense ART, do the mental health screening, do adherence sessions and even counseling? Then it means that there's not going to be full integration taking place when we have limitations for the key capital resource we need."

This reflection from Tatenda Makoni, Executive Director of the Zimbabwe National Network of People Living with HIV (ZNNP+), could be repeated across Africa. Integration is not only about clinical know-how; it is about the physical capacity to deliver care, the staff to run clinics, and the resources to keep services functioning.

In Nigeria, Dangirma echoes this concern from the perspective of facility readiness. He explains that some local government facilities have only one site offering HIV treatment, while others provide testing without any treatment at all, forcing patients to navigate referral chains that defeat the purpose of integrated care. His bottom-line expectation is simple and powerful: ***"At a minimum, anywhere you go, you should be able to have access to these services all at the same time."***

Even lifesaving medicines have not been immune. In Eswatini, communities report continuing stockouts: ***"The government doesn't have resources, at some point, we've been having stockouts for ARVs. There's no money for that, not unless it is going to come from partners,"*** says Nyatsi.

Ghana tells a similar story when co-financing commitments fail. Salifu notes that the government's share of Global Fund financing has not materialized, leading to stockouts of malaria medicines, rapid diagnostic tests, and reagents. ***"If it is not forthcoming, then we are not going to get the supply adequately,"*** he explains.

The government promised to fund its share. That promise isn't being kept. So commodities run out. And people go without. According to UNAIDS, the policy requires that recipients of Global Fund support meet co-financing requirements and increase their co-financing over each allocation period.

Every country describes a shortage here, a stockout there, but when you step back, the pattern becomes undeniable. Integration is being built on foundations that were already cracking. Zimbabwe shows just how deep those fractures run.

Mademutsa highlights that close to 80% of the national HIV program relies on external sources, and 90% of all commodities are donor-funded—just for HIV alone. The mainstream health sector itself has struggled for funding, so integration without domestic resources is an uphill battle.

Zimbabwe has a framework for domestic resource mobilization, including the National AIDS Trust Fund. ***"We have the airtime levy, each person who buys airtime is also levied, and that money is earmarked for health services. We also have tax***

IAS 2025 conference in Kigali, where GNP+ elevated PLHIV community voices on issues such as global funding cuts, advanced HIV disease management, and sustainable, integrated health services

on fast foods," Mademutsa lists. So where's the money? ***"At one point, about 30 million had been said to have been collected, but we don't know how it was used."***

But growing regional momentum for greater domestic health financing is building. In September 2025, African leaders launched the Accra Reset, calling for the creation of new governance and financing models for regional health and development. The Accra Reset acknowledges the need for continued health assistance but aims to "foster a new era of health sovereignty rooted in national ownership, investment and leadership."

In Nigeria, integration is being pursued through a program called Nigeria State Health Investment Project (NSHIP), supported by World Bank, government funding and working with state health insurance schemes. Dangirma explains that this approach aims to streamline services through existing insurance structures, offering a potential path toward sustainability.

Ghana is trying a comparable strategy: there was a promise to use National Health Insurance Scheme funds to cover HIV services—an idea that, if implemented, could anchor HIV care within broader health financing.

Kenya is also pushing for inclusion of HIV care under its Social Health Authority (SHA) insurance. Otwoma reports advocacy efforts to ensure HIV services, diagnostics, and laboratory tests are covered. Some facilities in Nairobi have already begun enrolling people living with HIV under this scheme, expanding their patient base and thus their funding through capitation.

These examples are not perfect solutions, but they signal a shift from emergency donor funding toward health financing reform that could keep integrated services alive.

As Salifu from Ghana concludes: ***"I know many countries depend on the Global Fund grant, but a country like South Africa is highly independent of the grants. We can also get there. We just have to make sure all these things are happening."***

Chapter 5: When Policy Meets Reality: What Governments Have Built and What Comes Next

"We have meaningful involvement of people living with HIV—our MIPA forums—which operate at district, provincial, and national levels. These spaces are where we regularly consult with our constituency on key issues. Through them, we've held discussions on the minimum package, on integration, and on how ready communities feel for these changes. They also allow us to share feedback on national priorities, supported by data we collect through our situation reports."

Mademutsa from Zimbabwe is describing a process in which people living with HIV are genuinely consulted and their feedback is not only heard but carried forward. Their insights help shape what ultimately appears in policy, rather than receiving policies already decided from above.

The GNP+ Nairobi PLHIV Leadership Summit, held in April 2025, brought together 80+ leaders from 18 countries to set advocacy priorities and strengthen sustainable HIV care amid funding cuts & shifting global health priorities.

But this level of meaningful engagement is far from universal. Across the six countries, governments are drafting policies and producing guidance on integration—yet the depth of consultation and the readiness for implementation vary widely. Guidelines are being written, frameworks are emerging, and strategies are taking shape. What differs is how grounded they are in community experience, and how prepared systems are to turn policy into real, functioning services.

Yet almost everywhere, the message is the same: policy exists; implementation lags far behind.

Ghana's Salifu puts it plainly. ***"We have the concept on paper. We have the principle. The policies are there for integration. However, implementation has been really poor." The tools exist, but the translation into practice has stalled.***

Nigeria has moved further, developing both guidelines and training manuals. ***"There are some policy documents that have been developed already. The government has developed some policies and also some training manuals,"*** Dangirma explains.

Kenya, too, has begun laying a strong policy foundation. Otwoma outlines the documents under development: ***"NASCOP developed what we call an integration advisory, and has worked on an integration blueprint. The National Syndemic Diseases Control Council is also working on the Kenya AIDS Integration Strategic Framework."***

Importantly, Kenya's blueprint is anchored in evidence, based on a baseline survey that included people living with HIV, implementers, and health workers. That kind of inclusive process is essential for making integration workable on the ground.

Indonesia started earliest. Sebayang says: ***"I know the idea has been there since two years ago. The Minister of Health at the level of the policy, the presentation shows it's already well established. The concept, the system mechanism is already there."***

Two years of planning. Five clusters for integration organized by life cycle, not by disease. PMTCT embedded in mother-and-child services. TB and HIV in the communicable disease cluster.

But having a design is not the same as having the capacity to implement it. And consultation does not guarantee that concerns are addressed. Eswatini's experience shows how fragile participation can be. Nyatsi recounts being one of the few community members able to attend steering committee meetings because others couldn't afford transport. ***"I was the only one person living with HIV against 15 government workers," she says. When she raised concerns, "people got irritated, but they forget that they are the ones that called you there—not to sit and keep quiet."***

Even when consultation happens, training rarely matches the scale of need. Eswatini trained a small group expected to cascade knowledge nationwide. ***"Those people were trained, and they also go down to various places and educate others,"*** Nyatsi recalls. But sensitization is not the same as skill-building. The gaps remain wide.

And Sebayang from Indonesia warns of something similar, ***"We don't have strong integration SOPs between health workers and community health workers, it's still fragmented."***

Some countries are using the integration moment to rethink their entire HIV strategies. Zimbabwe is revising its National HIV/AIDS Strategic Plan. ***"By the end of the year or early next year there should be the 2026–2030 strategy,"*** Mademutsa says. Networks are using the review to push for safeguards: integration, they argue, must not be ***"wholesale and without consideration to communities."***

Ghana's midterm review raised similar issues. Salifu recalls debates about whether to conduct a joint review of all disease areas. ***"We ended up doing a separate review because services have not been integrated very well."*** The lack of integration became evidence itself.

Abdul Fatawu Salifu of NAP+ Ghana addresses stakeholders at the GNP+ PLHIV Lead Integration Summit in Ghana, held ahead of ICASA 2025

Across all countries, networks consistently emphasize what integration must guarantee. Kenya's Otwoma stresses that guidelines must protect privacy, confidentiality, and freedom from discrimination—and must ensure ***"specialized and trained healthcare workers." Zimbabwe's Makoni identifies two non-negotiables: "observance of privacy and confidentiality" and ensuring "client satisfaction is embedded within the integration arrangement."***

Ghana's Salifu focuses on accountability: ***"We are trying to put in an indicator to track integration, the current indicators don't include it."***

If integration cannot be measured, it cannot be improved—and governments cannot be held accountable. So where does that leave us? Across the six countries, policy frameworks exist. Some are detailed, some are partial, and some remain aspirational. But the gap is not policy. The gap is the capacity, financing, and political commitment required to turn policy into reality.

Nigeria's Dangirma is clear: governments must now ***"really show up."*** Zimbabwe is similarly focused on systems that can track whether integration is protecting quality. As Makoni notes, ***"One of the things that was dismantled was the database, which was collecting HIV data under PEPFAR. So it's more important that as integration takes place, we emphasize the aspect of quality data management."***

This is what success begins to look like: integration that protects quality, maintains privacy, and strengthens, not weakens, the gains of the HIV response.

Salifu from Ghana offers a grounded vision. ***"Integration requires documentation, proof of impact, political support, and continuous monitoring.***

If governments sustain funding, if quality is protected, if PLHIV Voices lead, and if integration becomes about strengthening what works, then integration is not just possible. It becomes the future.

Conclusion: Integration Must Strengthen, Not Replace

The interviews with network leaders across Nigeria, Kenya, Indonesia, Ghana, Zimbabwe, and Eswatini reveal a stark reality: *integration is not a technical exercise in policy design. It is a test of whether health systems will honor the people and infrastructure that built the HIV response, or whether they will discard them in the name of efficiency.*

What emerges most clearly is that integration has the potential to improve access, reduce stigma, and create more sustainable health systems. But only if it is done right. Only if it includes the community workers who made HIV care trustworthy. Only if it protects the privacy and dignity of people living with HIV. Only if it reaches those most marginalized people with advanced HIV disease, newly diagnosed individuals, and key populations who have been pushed to the edges.

The current crisis shows what happens when integration is attempted without adequate resources, without genuine consultation, and without protecting what works. Clinics close. Community infrastructure disappears. People fall through the cracks. Stigma increases instead of decreasing. The most vulnerable are left behind.

But there is another path forward. Countries are exploring innovative financing mechanisms: health insurance schemes, earmarked taxes, domestic resource mobilization. Some are genuinely consulting communities, ensuring people living with HIV shape the policies that affect them. Training programs are being designed. Guidelines are being drafted. The blueprints exist.

What is needed now is political will. Governments must fund what they have promised. They must recognize and integrate—not discard—community cadres. They must measure integration not just by policy documents produced, but by outcomes: Are people staying in care? Are viral suppression rates maintained? Are key populations accessing services? Is stigma decreasing?

Integration should not be a story of loss. It should be a story of systems that finally treat people living with HIV from a person-centered care approach; as whole people deserving of comprehensive, dignified care. But that story can only be written if PLHIV networks and communities are empowered to document real time lived experiences as they access HIV services integrated into PHC, when communities lead, if resources follow commitments, and if integration strengthens rather than replaces the foundations that have kept millions alive.

The question is not whether integration is possible. The question is whether governments will choose to do it right.

Panel session on ending AIDS in children during the GNP+ PLHIV Leadership summit in April, 2025

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1. **Nelson Otwoma** – Director, National Empowerment Network of People Living with HIV (NEPHAK), Kenya
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