CONCLUSIONS

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This report highlights how the ACF International Network has adapted some of its programme approaches in Malawi to address the impact of HIV on malnutrition, and some of the challenges this presents. While HIV/AIDS remains a global problem, its effects are being hardest felt in sub-Saharan Africa where evidence has demonstrated a significantly high percentage of children and adults feeling the combined burden of HIV/AIDS and malnutrition. This extends to more than health systems but also poses challenges to social and economic development. Significant advances have been made in the integration of HIV and nutrition, leading to an international acceptance that HIV and malnutrition should be addressed together. As HIV prevention and treatment services scale up globally, it is now evident more than ever that vertical programming is an obstacle to addressing the inextricable and mutually reinforcing link between HIV and nutrition. Some of the initiatives from Malawi support this and demonstrate how steps can be taken to integrate HIV and nutrition.

The studies conducted in Malawi have demonstrated a high prevalence of HIV in severely malnourished children in a country where poverty, HIV/AIDS and malnutrition levels remain consistently high. One of the first steps to accessing effective treatment for HIV/AIDS is through HIV counseling and testing. Whilst challenges to implementation of this still exist the studies in this report challenge the previously commonly held beliefs that HIV testing in children would not be well accepted. Lessons for programming and policy can be learnt from contexts with a high uptake of HCT. NRU staff need to be empowered to be comfortable with discussing HIV with caretakers of children admitted to their units. As HIV treatment services continue to scale up, routine access to HIV counseling and testing, supported by adequate supplies of materials and well trained staff would ensure that both children admitted into therapeutic feeding programmes and their carers receive timely and appropriate clinical interventions along with psychological support. International guidelines able to be adapted on a local level to support this are urgently called for. Training and supply resources need to be improved for both HIV and nutrition programmes for identification and management of severe malnutrition and HIV, prevention of malnutrition including nutrition counseling for PLWHA and their caretakers, targeted food or food supplement supplies. Human resources and facilities need to be provided to support maximum screening and testing opportunities with regular training planned as rotational to prevent a loss of knowledge due to the high staff turnover regularly seen in high HIV prevalent populations.

Evidence from clinical research shows increased mortality in HIV infected children despite 24 hour medical and nutritional care. Mortality rates in HIV positive children were not within international standards compared to acceptable rates in HIV negative children indicating a high prevalence of medical complications rather than poor quality of care. This suggests that minimum clinical standards, devised for emergency contexts, require revision for the treatment of children with complicated severe malnutrition in the context of HIV. With the high level of mortality occurring within the first ten days of hospital admission, the complexity of medical management is highlighted and must be considered as community based therapeutic feeding initiatives scale up. This also raises questions as to whether the higher risk of mortality lies in the treatment phase and the suitability of milk based products. Further analysis on morbidity is urgently needed. Results from this study are also suggestive of the need for urgent revision of CD4% criteria for commencing ART in children with SAM. This should include when is the most appropriate time to start ART in SAM, and the pharmacokinetic implications.

Stigma and discrimination still remain one of the biggest barriers to effectively addressing the HIV pandemic, though reports continue to support that adequate health education messages, and access to quality treatment and care services all contribute to the reduction of stigma and discrimination. The stigma component of the research shows that access to quality and easily available HIV services integrated within nutrition services made the biggest difference in terms of service uptake. Integration of services should take place in a holistic manner addressing stigma through quality of care and staff training on promoting positive living with HIV. The follow up data however still suggests the existence

of stigma in the communities, which can negatively impact the household, further emphasising the need to address stigma at both health centre and community level.

During the research programme, follow up of children was limited to four months due to funding constraints. The Hunger Watch follow up of these children provided an opportunity to further follow the progress of the families of severely malnourished children. Many positive outcomes are apparent from this follow up in terms of no relapses of acute malnutrition. A more severe level of stunting was however noted in the HIV positive children. The high level of access to ART is likely to account in some part to the HIV positive children doing so well. While these outcomes in the children are very promising, equally important is the health status of the mothers. It was evident from the follow up that for various reasons mothers may pursue health care for their children but may not be accessing adequate care for themselves. This highlights the need for maternal and family centred healthcare approaches, linked to HIV and/or nutrition care education and counseling on infant and young child feeding that not only prevents HIV transmission but also prevents or reduces malnutrition. These programmes should incorporate suitable infant feeding options that take into account individual counseling and appropriate support; support of exclusive breastfeeding to reduce breastfeeding complications and increase successful feeding, and the screening and treatment of opportunistic infections and sexually transmitted infections and access to ART.

Throughout the mainstreaming of HIV into nutrition services in Malawi, the gap in nutrition services being integrated into HIV services was apparent. This was addressed through the adult and adolescent therapeutic and supplementary feeding programme and provision of training in communities on positive living. The results of the pilot programme highlight the need for improvement of the implementation of the guidelines for the management of acute malnutrition in adolescents and adults. This includes training of staff, distribution of materials (including guidelines) and supervision. It also reinforces the need for interventions to identify patients at an earlier stage of malnutrition considering the significant relation between low BMI and mortality. HIV and nutrition service capacity building are equally important and need to be done both separately and together: if we want to integrate nutrition and HIV systems together to produce good practice, we must integrate two strong and healthy systems. Integrating a strong HIV system into a weak nutrition system (or vice versa) cannot produce best practice; although solid structures from one system can be used to improve the other: for example a good system of community based screening for malnutrition, if combined with HIV testing could increase coverage in both areas.

A recurring theme throughout this report is the need for integration whereby HIV and nutrition forms part of a comprehensive care package. Equal importance should be given to the mainstreaming of HIV in nutrition services and nutrition into HIV services.

The programmes conducted by the ACF International Network in Malawi have been done in collaboration with many partners (see list below). Regular communication is invaluable to maintaining quality control and inputs to the project and it has been apparent that clear roles and flow of command and information are important to ensuring all responsibilities are followed-through. Information sharing must be frequent and transparent.

Considerable developments have been made in the integration of HIV and nutrition in previous years and Malawi should be recognised as one of the leading examples of this. HIV and nutrition now have an acknowledged importance on the international agenda. This momentum must be maintained and developed in order to make further advances in both fields. HIV and malnutrition are for the first and foremost preventable diseases and efforts must continue to prevent further incidence whilst mitigating the unacceptable burden of those already affected in order to ultimately save lives.