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FAMILY PLANNING AND HIV INTEGRATION IN MALAWI

*Key Stakeholder
Interviews*

This publication was prepared by Laili Irani, Madison Mellish, Erin McGinn, and Pierre Dindi of the Health Policy Project.

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Family Planning and HIV Integration in Malawi

Key Stakeholder Interviews

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This publication was prepared by Laili Irani,¹ Madison Mellish,² Erin McGinn,² and Pierre Dindi² of the Health Policy Project.

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Disclaimer: The findings and views shared in this report are derived from an analysis of key informant interviews held in Malawi in September 2014. All efforts were made to validate this information by speaking to key informants and reviewing policy documents. The authors have done their best to present an accurate picture of the status of FP-HIV integration in the country as well as efforts being made to address some of the barriers. They apologize, in advance, for any misinformation or misrepresentation that may have occurred inadvertently.

ABBREVIATIONS

ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral (drug)
BCC	behavior change communication
BLM	Banja la Mtsogolo
CHAI	Clinton Health Access Initiative
CHAM	Christian Health Association of Malawi
CMED	Central Monitoring and Evaluation Department
CMST	Central Medical Store Trust
DfID	Department for International Development
DHO	district health office
DNHA	Department of Nutrition, HIV and AIDS
FP	family planning
FPAM	Family Planning Association of Malawi
GIZ	Gesellschaft für Internationale Zusammenarbeit
HCT	HIV counseling and testing
HMIS	health management information system
HPP	Health Policy Project
HR	human resources
HSA	health surveillance assistant
IEC	information, education, and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JHU-CCP	Johns Hopkins University Center for Communication Programs
JSI	John Snow International
M&E	monitoring and evaluation
MOH	Ministry of Health
MSH	Management Sciences for Health
NAC	National AIDS Commission
NGO	nongovernmental organization
NYCOM	National Youth Council of Malawi
PIFP	provider-initiated family planning
PITC	provider-initiated testing and counseling
PMTCT	prevention of mother-to-child transmission
PSI	Population Services International
RH	reproductive health
RHD	Reproductive Health Directorate
SRH	sexual and reproductive health
SSDI	Support for Service Delivery Integration
TWG	technical working group
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
YFHS	youth-friendly health services

INTRODUCTION

Integration of family planning (FP)/sexual and reproductive health (SRH) and HIV services is seen as a promising practice to address unmet need for contraception as well as reduce mother-to-child transmission of HIV. The government of Malawi has shown much political support for integrating health services in its policies; this is an important first step to integrating services within health facilities.¹ A recently conducted policy analysis by the USAID-funded Health Policy Project (HPP) showed that all SRH and HIV policies, strategies, and guidelines discussed integration of FP/SRH and HIV services to some degree. There was significant mention on the need to integrate FP services into HIV services, for example within antiretroviral treatment (ART) clinics. On the other hand, very few general health policies addressed FP-HIV integration explicitly. In addition, most policy documents did not go into details of how integration could be implemented within health systems and at the facility level.

In order to better understand how FP-HIV integration is being implemented, HPP conducted a situational analysis of the policy and program environment by speaking to national- and district-level stakeholders. The purpose of the interviews was to understand stakeholders' perspectives on how integration of FP and HIV services as mentioned in the policies was being implemented and how integration of services could further be improved.

METHODOLOGY

In September 2014, we conducted 48 key informant interviews² with stakeholders at the national and district levels. The key themes of the interviews focused on how FP and HIV services were being integrated, what was working, and what were some of the challenges that still needed to be addressed. With a specific focus on addressing integration at the health systems level, we spoke to representatives of various Ministry of Health (MOH) departments, namely the Reproductive Health Directorate (RHD), HIV and AIDS Department, and Central Monitoring and Evaluation Department (CMED). We also spoke to the National AIDS Commission (NAC) and eight representatives of various district health offices (DHOs). Donors were interviewed, namely the United Kingdom's Department for International Development (DfID), USAID, the United Nations Population Fund (UNFPA), and the Clinton Health Access Initiative (CHAI). Implementing partners interviewed included Futures Group, John Snow International (JSI), Johns Hopkins University – Center for Communication Programs (JHU-CCP), Management Sciences for Health (MSH), Jhpiego, the University of North Carolina, Population Services International (PSI), the local Marie Stopes affiliate Banja la Mtsogolo (BLM), and Christian Health Association of Malawi (CHAM). Additionally, the research team spoke with civil society organizations: National Youth Council of Malawi (NYCOM), JournAIDS, and the Malawi Interfaith AIDS Association. Medical training and registration institutions were also interviewed; these included the Medical Council of Malawi, Kamuzu College of Nursing, and the University of Malawi's College of Medicine. In addition, a representative of the Central Medical Stores Trust (CMST) was also interviewed to get its perspective on the logistical challenges. All the participants were selected through snowball sampling of known key stakeholders in FP and/or HIV programming in Malawi.

The semistructured interviews covered various topics including institutional arrangements; processes for addressing integration within health systems such as human resources, commodities, infrastructure, and monitoring and reporting; financing mechanisms; integration within health facilities; the role of the

¹ EngenderHealth. 2014. *Integrating Family Planning and Antiretroviral Therapy: A Client-Oriented Service Model*. New York: EngenderHealth.

² A total of 52 interviews were requested.

private sector; and behavior change communication (BCC). The full questionnaire is included in Annex A.

The interviews were audio recorded after seeking consent and then summarized by the research team. The summaries were coded for main themes, which guided our findings described below.

RESULTS

Our findings cover stakeholder perspectives on the institutional arrangements at the national and district levels through which health services and programs are being implemented within the public sector. We further assess opinions on the progress made in integrating FP and HIV services across the components of the health systems, such as trained healthcare workers, availability of commodities, facility structures to ensure integration, and joint monitoring and reporting. Stakeholders also described how FP and HIV services are currently being implemented in the majority of the facilities and shared some successful pilot programs of integration. This report also highlights the role of the private sector in assisting to provide FP and HIV services to the people and also pays special attention to the progress made in reaching youth. Finally, this report will describe how information on FP and HIV is currently being addressed in BCC and mass media campaigns.

Institutional Arrangements

National-level arrangements

At the national level, three key institutions lead the implementation of FP policies, programs, and systems within the public sector: the Reproductive Health Directorate and the HIV and AIDS Department within the MOH and the National AIDS Council within the Office of the President and Cabinet. It is helpful to understand how these departments function and interact with each other to better understand how FP and HIV services and systems can be better integrated.

MOH Reproductive Health Directorate

The RHD plans, leads, and monitor activities related to maternal and reproductive health (RH), such as antenatal care (ANC), family planning, labor and delivery, postnatal care, cervical cancer prevention, and fistula management. They also pay special attention to providing SRH services to youth. They are responsible for drafting strategies and curricula, leading trainings of RH providers, revising registers, and ensuring that FP commodities are distributed and available at all sites. They perform these functions with the support of implementing partners and by collaborating with other departments, such as the HIV and AIDS Department. RHD also leads and convenes several technical working groups (TWGs) for various long- and short-term activities, such as TWGs for youth-friendly health services (YFHS) and family planning. Several stakeholders noted that donors/implementing partners are relied upon heavily to convene TWG and other meetings, assist with policy development, and other planning and implementation processes. As such, some stakeholders felt that the directorate needed efforts to build its capacity to carry out its governance functions, especially in the area of policy development and high-level coordination and as well as its overall capacity to plan, implement, and monitor its activities. One stakeholder noted:

“There is need to strengthen the capacity of RHD because to some extent it seems like they are driven by partners. Most of the TWG meetings are funded by partners, much as they are hosted within RHD.”

Increased governance capacity within the directorate would lead to better coordination with other departments, more focused planning, and increased ability to use monitoring data to improve services.

MOH HIV and AIDS Department

The HIV and AIDS Department was established in 2001 to coordinate HIV programs in Malawi. Later, it also began coordinating services for sexually transmitted infections and prevention of mother-to-child transmission (PMTCT) of HIV. In recent times, it also coordinates the national voluntary medical male

circumcision program. Along with this, the department serves as the main policy implementer for HIV policies in the country.

The department has a strong monitoring and evaluation (M&E) section that monitors commodity supplies and the provision of services very closely. The HIV and AIDS Department is well funded through the Global Fund to Fight AIDS, Tuberculosis and Malaria. This ensures that they have the capacity to execute programs effectively. The ART program has grown over the years starting with about 30 sites in 2004 to 700 sites currently. The interviewees noted that despite their strengths, they have some challenges and barriers to integrating FP-HIV services. These challenges include the department not being receptive to providing an extensive array of FP methods at their ART clinics. Another main concern cited by interviewees was the unwillingness of the department to work collaboratively and closely with other departments and partners to find ways to provide FP services to their ART clients.

Interaction of RHD and HIV and AIDS Department

Interaction between the RHD and the HIV and AIDS Department is key to improving integration of services at the facility level. Interviewees noted that the primary means of interaction between the RHD and the HIV and AIDS Department was through participating in the various TWGs, such as SRH, FP, and HIV treatment. In addition, various departments are invited and represented when a particular policy or guideline is being developed or reviewed, for example, the *YFHS Strategy* (2015) recently developed by RHD or the *Clinical Management of HIV Guidelines* (2014) led by the HIV and AIDS Department. Members from both RHD and the HIV and AIDS Department are invited to these TWGs, but interviewees noted that sometimes the representatives are unable to attend due to conflicting priorities. In addition, sometimes RHD or the HIV and AIDS Department may be represented by someone who is not familiar with the technical area or specific activities of the TWG. This creates a challenge in ensuring that the departments are consistently collaborating and working together effectively on technical issues.

Most interviewees agreed that the relationship between RHD and the HIV and AIDS Department could be strengthened so that they effectively develop policies, plan activities, and conduct joint monitoring exercises. Many also suggested that the HIV and AIDS Department could support the MOH by building the capacity of others in the ministry to better plan, implement, and monitor their programs since it was a well-funded and better-organized department compared with others.

While various stakeholders agreed that the RHD and HIV and AIDS Department need to work more closely for FP-HIV integration, they pointed out several reasons why this would be difficult to achieve and has not yet been done. A main concern was the lack of political will to collaborate, as departments/people collaborating are fearful they will lose their positions. One of the stakeholders pointed out:

“Government department(s) should work together. Integration doesn't necessarily mean abolishment of departments, e.g., HIV and RHD can do monitoring exercises together.”

In addition, several interviewees pointed out that funding for departments has historically been in silos, creating problems for integration. Hence, better coordination is needed to fund integrated programs.

National AIDS Council

The NAC was established within the Department of Nutrition, HIV and AIDS (DNHA) in the Office of the President and Cabinet.³ It distributes Global Fund money to various institutions and programs to fund various HIV-related activities. Hence, many of the stakeholders we spoke to refer to them as a donor. The

³ Due to government reorganization, the DNHA has recently been moved to MOH, and so the NAC now sits within the DNHA under the MOH.

Policy Support and Development Department of NAC also facilitates the development of policies in liaison with DNHA.

Besides funding programs, NAC also conducts joint monitoring of HIV services and facilities with the MOH HIV and AIDS Department and other implementers to ensure that the programs they fund are adhering to standard guidelines. They have a checklist that guides them when doing supportive supervision on partners and health facilities. This creates duplication of efforts at the facility level with various MOH departments and entities (such as NAC) conducting separate monitoring visits of the same services every quarter. Stakeholders noted that NAC could strengthen its governance and coordination functions by working with the other MOH departments and being more transparent about its distribution of funds and activities it supports. NAC could further integrate family planning into the HIV activities it is overseeing.

District-level arrangements

The 28 districts of Malawi each have a district health office (DHO) that creates plans, budgets, and operates the public health system within its boundaries. The DHO is a decentralized structure of the MOH. The districts are aggregated into zones and then further into three regions, the Northern, Central and Southern regions. However, the districts have been given the most autonomy and authority of all decentralized structures. The districts develop their district implementation plans (DIPs) and conduct joint supervisions of facilities with RHD, the HIV and AIDS Department, and implementing partners.

Stakeholders identified a few key challenges to integration of services at the district level. Prominent among them was the lack of adequate funding for districts to fund all their planned activities and operate autonomously. As a result, districts seek support from the central MOH, donors, and partners and, as a result, have multiple priorities. One stakeholder commented:

"It is easier to coordinate issues at district level. However, they are driven by those at central level."

Another issue noted was the lack of adequate communication and coordination between the districts and central MOH. One district officer noted:

"Mostly it's the ministry communicating to us, [rather] than the other way around."

Besides the MOH, the NAC is represented by district HIV/AIDS coordinators who support and monitor HIV activities. At the district level, there is also a multisectoral district AIDS coordination committee that comprises partners and representatives of several ministries besides health, such as information, agriculture, education, and labor. This committee plans and monitors multisectoral activities targeting HIV and AIDS interventions and supports community health workers as well.

Hence, Malawi appears to have a well-established central and district health infrastructure.

Health Systems Processes

Human resources for health

An essential ingredient to effectively integrated FP and HIV services in public health facilities is the presence of adequate well-trained health workers who are motivated to serve clients and provide integrated services.⁴ Interviewees noted several challenges related to human resources such as lack of

⁴ EngenderHealth. 2014. *Integrating Family Planning and Antiretroviral Therapy: A Client-Oriented Service Model*. New York: EngenderHealth.

adequate number of staff, limited training on how to provide integrated services, and demotivation leading to low retention of qualified staff.

In particular, client load and time pressures are perceived as a major factor in successful integration. Many interviewees expressed concern that the current lack of healthcare workers in facilities is a barrier to integration since fewer staff lead to longer waiting times for clients, and providers who are employed in the facilities are overwhelmed with volumes of clients. One interviewee pointed out

"[In ART clinics,] clients may be referred [out to another facility] because of few providers, and not because [FP] methods are unavailable."

In order to address this ongoing problem, health surveillance assistants (HSAs), who are the lowest cadre of healthcare providers, are being trained to provide integrated services, such as dispensing antiretrovirals (ARVs) and administering injectable contraceptives within facilities. This task sharing has only helped to a certain degree as HSAs are already expected to provide a lot of other facility- and community-based services. HSAs are now working with community-based distributors to build the latter's expertise to provide integrated services in communities, including FP counseling and some short-acting FP methods, such as condoms and pills, along with providing HIV counseling and testing (HCT) using rapid test kits within communities.

Mentorship programs are another potential way to address this issue.

"We have trained some providers in PITC (provider-initiated testing and counseling), but we have noted that in only one in 10 of them apply these skills. Mostly we get reports that they are too busy to apply skills trained"

MSH is currently implementing a mentorship program to increase provider-initiated family planning (PIFP) within ART clinics.

One of the main reasons given for the shortage of skilled providers was poor retention of skilled providers, especially doctors and registered nurses. Interviewees gave two main reasons for this shortage—one is the lack of institutions, funding, and staff to train providers, and the other was brain drain of the most qualified staff to other countries within and beyond the region. One stakeholder highlighted this saying:

"I don't think providers are trained, at a pace that is needed."

These findings were particularly raised by the Medical Council of Malawi, a parastatal medical regulatory body that licenses and registers public and private health facilities and service providers, vets curricula, and monitors training institutions and in-service trainings. Interviewees acknowledged that some planning on the need for human resources has been done. However, this planning has not been conveyed to training institutions. In addition, the lack of detailed planning and funding has prevented the planning from moving ahead.

Contributing to the human resources issue is that historically, clients have received different services in silos, and so providers have generally not received any training to provide integrated services, either during their preservice or in-service training. In addition, not all FP providers offer HCT due to lack of training, which can take up to four weeks. While some providers have been trained in PITC, interviewees reported that very few providers actually apply these skills in practice as they are often too busy. One stakeholder put it succinctly:

"There is need to have multiskilled service providers to reduce to-and-fro sending of clients [to other facilities]."

As a result, more training of providers on how to provide integrated services is needed. Lack of financial resources for trainings was noted as a major concern—money to hold trainings and travel expenses for providers to attend trainings. Several efforts are under way to improve training of providers. CHAM is working with MOH-RHD and the DHO to identify gaps in training and capacity. CHAI is currently supporting the MOH in developing a costed training plan (with targets) for the health sector and has also conducted a mapping of providers trained to provide long-acting FP methods. With regard to training providers on integration, many partners are currently working on programs to increase PIFP as a way to integrate FP-HIV services. MOH-RHD, with support from UNFPA, has a pilot project that has trained service providers at selected facilities on SRH-HIV integration. In addition, BLM conducts in-service trainings that are limited to their facilities. Several interviewees suggested that in order to have the greatest impact from trainings, better training techniques are needed with improved follow-up and monitoring.

Conversations with preservice medical institutions showed that teaching healthcare providers to provide integrated services is slowly picking up pace, but more efforts are needed. Stakeholders expressed concern that didactic training is not always adequately accompanied by practical training. For example, one stakeholder noted:

“The reality on the ground is that none of them [students] even gets to insert an IUD (intrauterine device) [during preservice training]”.

Multiple stakeholders also noted the need for putting systems in place to track those who had been trained in various topics. While these systems appear to exist in some places, not all stakeholders were aware of them, as many stakeholders said they did not exist. The MOH HIV and AIDS Department, however, has a system called *Trainsmart* that tracks providers trained in HIV-related topics. The department also identifies providers who are in need of extra mentoring. These good practices need to be scaled up to different areas of training across the country.

“There is need to have a database of who has been trained. Thus, we can address the gaps, i.e., providing mentorship and supervision to the already trained providers, instead of repeating full trainings.”

More than one interviewee mentioned that part of the reason providers are not providing integrated services may not be that they are not trained but rather that the providers do not feel confident and worry about being blamed in the event of a medical complication. Lack of motivation among service providers was also mentioned in several interviews as a barrier to integration. Many health workers feel that integration adds an extra layer of work and thus do not feel motivated to integrate services. Potential reasons for this mentioned in interviews included the low salaries, working conditions, and a lack of career development options currently offered to service providers. Interviewees mentioned a need for Malawi to “*think outside of the box*” in order to attract and retain good-quality staff who will work toward service integration. Strategies to combat these attitudes and retain staff are important for FP-HIV integration.

Commodities

The CMST is an independent government trust mandated to handle essential commodities on behalf of the government. It sends commodities from its central warehouse to regional centers from where they are distributed to facilities via road.

The supply chain for all health commodities in Malawi is a pull system, i.e., facilities take inventory and order drugs on a paper form that is submitted to the DHO. At the district level, the paper order forms are compiled and entered electronically on a monthly basis, and that information is transmitted to the CMST. This system however has been fraught with several challenges; some of these include the limited capacity

and timeliness of facility staff to order commodities on time, a delay in ordering at the district level due to high workload and erratic electricity, a lack of commodities at the central level, and, most commonly, a poor distribution system. These challenges have resulted in severe stockouts and delays of all essential commodities. Hence, various donors have stepped in over the years to provide temporary support, resulting in parallel supply systems.

Due to the severe stockouts of essential commodities, the USAID-funded JSI DELIVER Project has been working to improve the FP commodity supply chain. They support the logistics management information system by training central- and district-level staff on how to operate the electronic system, procuring computers, and installing supply chain management software across all districts. They also manage the central database, the National Stocks Status Database, that the MOH logistics department uses. In addition, DfID is currently partnering CMST with a private company to support distribution and provide technical assistance to CMST through December 2015. UNICEF is also providing technical support to CMST. While the DELIVER Project may distribute commodities across the country, over 90 percent of FP commodities are procured by UNFPA. The JSI DELIVER Project only procures small amounts of FP commodities to provide emergency support when necessary. One interviewee mentioned that there had been a major improvement in stockout rates as a result of these interventions, especially for FP commodities.

HIV commodities are distributed through a parallel system. The HIV and AIDS Department of the MOH procures ARVs through the Global Fund. They use an independent road transportation system to distribute ARVs and other commodities to their 700 ART sites and monitor this distribution closely. Since male condoms and injectables are offered at the ART sites, the department includes these commodities in their supplies too; however, the department admitted that since condoms are bulky during storage and transportation, they are given less priority than ARVs and other commodities in the supply chain. Hence, condom stockouts in public facilities are common in Malawi.

We thus see that FP and HIV commodities are procured and distributed using parallel systems. A few years ago, donors began using parallel supply systems to try and address the commodity stockout issue, but in the long run, interviewees noted that it created a problem as the government stopped prioritizing the supply system. In effect, the parallel systems, which were supposed to be temporary, became more permanent, and there is now confusion in facilities over ordering commodities. Even though the commodities may be heading to the same facilities, distribution is done separately as well, thus creating a great deal of duplication. If integration of services is to be achieved, more advocacy and greater coordination is needed. Using one system to distribute commodities could save resources and also improve health outcomes. A need to strengthen accountability mechanisms was mentioned by several of the stakeholders to make sure that commodity supplies are being distributed fairly and transparently as well. This accountability mechanism could be achieved by taking more frequent and accurate stocks at warehouses and facilities as well as holding individuals accountable for managing commodities. One of our interviewees pointed out:

"I think one of the problems is also that no one is held responsible on advent of stockouts, and possible implications that may come. There is need to do an analysis on how stockouts have affected households in terms of infections and pregnancies. Such information, if presented rightly, can make people accountable."

Infrastructure

Lack of adequate physical infrastructure to provide integrated services was brought up in several interviews as a key concern in integrating services. A primary reason services currently are not integrated is due to a lack of space. Hence, in smaller health centers and facilities, specific services are provided on certain days of the week as there might be just a couple of providers operating from a couple of rooms

with no privacy for clients. In bigger facilities, there might be separate structures for different facilities, such as the ART clinic, the FP clinic, etc. Stakeholders shared their views in the following words:

"FP clinics are not integrating with HIV because there isn't enough time and space to do so."

"Because of infrastructure issues and HR, it's only depo that is being provided in ART facilities."

A lack of space and privacy negatively affects contraceptive choices such as IUDs and, to a lesser extent, implants, which take more time and require a higher degree of infrastructure and privacy to provide than short-acting methods. Interviewees described these challenges as follows:

"At implementation level, it seems like everyone wants facilities to integrate everything, but there is limited funds and providers. Besides, a provider needs extra training, time and room on IUDs and implants."

"Ideally, facilities are supposed to integrate FP and HIV. But practically, the clinical setup of most facilities don't allow for this. For FP, you may have one room with a lot of clients, which makes it difficult to do PITC. Besides this, there is not enough room(s), time and skills to provide IUDs."

One stakeholder also noted the missed opportunities for FP-HIV integration that can be caused by infrastructure:

"We lose clients because they have to move around different rooms. This is a problem."

Stakeholders not only described a lack of rooms for integrated services, but also a lack of training institutions and classrooms for trainings. Hence, infrastructural needs should be accounted for when considering integrating services.

Monitoring and reporting

Monitoring and reporting are essential to reducing stockouts of commodities and making sure that quality integrated services are being implemented in facilities. One of the interviewees astutely pointed out:

"There are two elements of integration, one is on services and the other is on monitoring. If the monitoring isn't integrated, then nothing can be fixed."

Healthcare providers enter data on patient care in registers daily. Thirteen different registers are used for different services, such as FP, ART, HCT, ANC, in-patient care, etc., which poses a major hindrance to integrating services. Data from these registers are compiled by a data clerk or health management information system (HMIS) focal person on a monthly basis. The compiled data forms are then submitted to the district HMIS focal person who enters the data electronically; these data are received by CMED and made available to various programs. In order to improve this paper system, the district health information system was introduced, which is a centralized web-based system. It is currently being piloted for malaria programs and needs to be rolled out to other programs, like HIV. CMED is also currently working on a mobile version of the system that will allow data to be entered electronically from facilities.

There are generally no on-site supervisors monitoring the quality of services and data reporting. Those responsible for data collection are often times low-level data entry clerks or staff members who are busy providing services. Supervisors from the district offices monitor the quality of services and check on routine data monitoring; they are often accompanied by national-level MOH staff, partners, donors, NAC members, etc. RHD conducts supervisory visits using questionnaires and standard survey tools. The HIV and AIDS Department has a 70-person M&E team that conducts facility visits to all 700 sites every quarter where they monitor and collect data, such as commodities used, FP services provided, etc. As

such, the HIV and AIDS Department's monitoring system is the stronger of the two, and even includes SRH data, which they then share with the RHD. The Medical Council of Malawi also monitors training institutions and in-service training but due to resource constraints can only visit facilities every three years. Some donor, implementing partner, and private programs also have their own reporting systems, but the degree of data sharing with MOH or district HMIS varies and the programs' data are thus not likely to be used systematically.

These numerous parallel monitoring systems are putting great strain on facilities and service provision. Facilities have numerous reports to produce with many indicators to capture. With limited staff, this often results in data not being accurately captured. Interviewees also raised concern that lower cadres of providers are often left to fill in registers and compile data while they are overburdened with patient care; this leads to poor motivation. Hence, better coordination between data collection processes is needed, including more standardized tools and a collaborative approach between units.

There has been a move toward integrated registers as a step toward FP-HIV integration. The USAID-funded Support for Service Delivery Integration (SSDI) project just updated the FP register to capture clients' HIV status. ART registers capture whether the HIV client received condoms and/or an injectable (if female). There is an integrated maternal health register that captures FP and HIV indicators, but it is currently too large to accommodate any more indicators. The ANC register has been revised to capture data on PMTCT, FP, and malaria (it took three years for the register to be revised at the national level). SSDI has also integrated checklists from various health programs (FP, ANC, HIV, etc.) electronically by entering data through a mobile device; the data can then be seen at the district and central levels. The innovation has been piloted in three areas (Salima, Zomba, and Balaka); however, it does not seem scalable at this time, since the public health system does not currently have the resources or technical capacity to convert record keeping to a digital system.

Integration at Service Delivery Level

Even though generally FP and HIV services are provided in separate structures or on separate days of the week, interviewees shared several examples of integration of services that were a direct result of policy implementation as well as donor support.

Integration of some family planning services into ART services should be occurring at scale in Malawi, since the national guidelines on the *Clinical Management of HIV in Children and Adults* recommends offering all ART clients age 15 and over condoms and injectables and referring for other FP methods. While some interviewees believed that integration of condoms and injectables at all 700 ART sites was taking place, other interviewees were skeptical. Interviewees however noted that this integration was feasible since nurses and clinicians dispensing ART already knew how to give injections. Injectables also appear to be a popular contraceptive method in Malawi for several reasons, as pointed by one of the stakeholders:

"One of the reasons Depo has been preferred is that women can access it without notifying their husbands. This is the case with women that have husbands who don't allow them to access FP."

Several stakeholders, however, mentioned that providing condoms and injectables alone was not enough and providers should provide adequate counseling and promote multiple FP options, especially since at present this means that if clients want another option they will have to be referred elsewhere and often not able to receive the method they desire the same day either. Several stakeholders also highlighted that very few good examples of integrated services existed in the country and hence more needed to be done. In addition, providing PMTCT at ANC clinics was also noted as an example of integrated services.

One of the districts we interviewed described a unique approach of integration they are pilot testing with donor support in their district hospital. This hospital has established a family health department where PMTCT, under-5 visits, ART, postnatal, and family planning are offered in the same room on the same day. So clients may receive multiple services in the same room. Also, clients coming for different services all wait in the same area and are seen by the same provider thus reducing stigma and increasing confidentiality. Providers conduct group counseling on HIV, after which, clients may do one-on-one consultation and testing with providers. They also encourage clients to bring their partners for testing. HCT has also been integrated in labor and delivery at the same district hospital. The district official noted the positive impact of this integrated program, saying:

"[This hospital] is the busiest hospital because of the volumes of clients who have preference for integrated services."

The MOH and UNFPA are currently running a pilot program to integrate SRH and HIV services in 15 facilities—five facilities in each of three selected districts. This project began in 2010 and is currently expected to end in 2015. Through this project, providers have been trained to provide integrated services. This pilot intervention also includes a community outreach component to sensitize the public on what integration is and what to expect (i.e., the benefits it can provide even if the wait time is longer). One of the district health officers from the districts receiving this pilot stated:

"Service providers are reporting that integration is easing their work. Clients also have preference for facilities that are integrated as they face less stigma... In the beginning, providers were skeptical about integration as they anticipated more workload. Having initiated the integration it was noted that the service was more efficient."

Efficiency was achieved since clients did not have to visit multiple rooms for various services and did not have to come back to receive other services.

Other partners are also supporting integration. SSDI Services has established a mother-infant day where mothers and infants are provided with integrated services, including FP and HIV services. This project also supports service integration in the 15 USAID priority districts through outreach, mobile clinics, and provider training. CHAI provides integrated services, with a focus on retaining infants and mothers in HIV care. They have also been providing supervision and mentoring to public sector providers on integration.

While these pilot projects for integrated services are being implemented successfully in a small setting with much support, expanding integrated services to the entire country will require more effort and interventions. Hence, collaboration and a systematic process for assessing, planning, and implementing support for service integration between the MOH departments, district officials, and partners are needed to better understand the various needs of the facilities to better integrate services.

Role of private entities

Approximately 40 percent⁵ of health services in Malawi are provided by private providers, thus the private sector plays a key role in providing healthcare services. The largest group of privately run facilities belongs to CHAM, which makes up approximately 37 percent of the health services in Malawi.⁶

⁵SHOPS Project. 2013. *Creating a More Vibrant Private Health Sector in Malawi*. Bethesda, MD: SHOPS Project. Available at http://www.shopsproject.org/sites/default/files/resources/Creating%20a%20More%20Vibrant%20Private%20Health%20Sector%20in%20Malawi_0.pdf.

⁶SHOPS Project. 2013. *Creating a More Vibrant Private Health Sector in Malawi*. Bethesda, MD: SHOPS Project. Available at http://www.shopsproject.org/sites/default/files/resources/Creating%20a%20More%20Vibrant%20Private%20Health%20Sector%20in%20Malawi_0.pdf.

They have 10 hospitals, 10 community hospitals, and 167 health centers across the country, and all facilities are owned by member churches of CHAM. Providers working in the facilities are government employees and receive salaries through the MOH. Clients to CHAM facilities pay a nominal fee to offset the cost for running the facilities and purchasing commodities not provided by CMST. Initially, Catholic-run CHAM facilities did not discuss any FP methods at all. However, in recent times, they counsel their clients and discuss natural FP methods (such as calendar method, withdrawal, and abstinence) only. Interviewees considered this a success and shared the following perspective:

"... we have come a long way [with Catholic facilities], we started from nothing to a situation where we have this, and I think it's better that we respect their practices because if we propose more, they will close completely."

CHAM facilities not providing modern FP methods have begun strengthening their referral mechanisms by sending clients to nearby public facilities for FP services as their contribution to improving integration of FP and HIV services in country. However, there is no formal mechanism for follow-up to determine if clients went to the facility and received the FP services they needed. Some providers may make a note about the referral in the client's health card and check the card upon the patient's return. However, there is no formal systematic mechanism of referral.

The remaining privately run services are a mix of for-profit and not-for-profit (nongovernmental organizations). Many of these facilities provide integrated services and conduct outreach programs to reach people in remote areas. For example, the Family Planning Association of Malawi (FPAM), an International Planned Parenthood Federation (IPPF) affiliate, runs a number of clinics that focus on integrated service provision of FP and HIV services. BLM (Marie Stopes International) centers are champions of integration in their clinics across the country; they have outreach teams that provide services in communities and mentor lower-level cadre of providers. PSI also provides services through its private sector franchises.

Apart from FPAM, BLM, and PSI, the private sector is only slowly picking up momentum in providing FP services, largely due to FP services being offered free in the public sector. As one of the stakeholders pointed out:

"There is really a long way to go for the private sectors to get the confidence from clients as FP providers."

One of the main challenges coming out of the stakeholder interviews for FP-HIV integration is a lack of communication between the government and the private sector. Stakeholders commented:

"I don't think there is a relationship between the government and the private sector facilities."

Primarily, the stakeholders were concerned that CHAM or private facilities were not required to provide routine monitoring data on the services they provide or the number of patients they see. The facilities also did not follow any standardized service delivery guidelines that private sector facilities would be expected to meet. In order to improve FP-HIV integration in the future, the government and private sectors need to collaborate and establish better lines of communication and coordination. Better coordination will enable the public and private sector to learn about the various integration models working within the Malawian context and also improve referrals of clients to receive the best possible care across facilities.

Integration within youth-friendly health services (YFHS)

Almost half of Malawi's population is under the age of 15. Given these demographics, addressing the SRH and HIV needs of a young population is key to combating the spread of HIV and preventing unwanted pregnancies. Since 2007, the government of Malawi has put an emphasis on providing YFHS

where young people can access SRH and HIV services together and in a nonjudgmental environment.

Stakeholders reported that not much has been done to provide YFHS in facilities, which confirmed findings from a 2013/14 evaluation of YFHS conducted by the Evidence to Action (E2A) Project. This evaluation found that the implementation of YFHS standards was low for several key elements, such as a clear sign advertising YFHS, outreach services specific to youth, YFHS-trained providers, and youth-specific information, education, and communication (IEC) materials.⁷

RHD and the HIV and AIDS Department both shared their individual efforts at reaching youth. With support from the NAC, RHD is leading the implementation of YFHS in the country. They have developed a training manual on providing YFHS for participants and facilitators and lead the effort to developing a new *Youth-friendly Health Services Strategy* (launched August 2015). Within their PMTCT program they also address youth issues. The HIV and AIDS Department mentioned that their provider trainings do involve YFHS and PIFP components so that providers do not assume that some clients are too young for FP. They explained that one logistical difficulty for providing HIV YFHS is that the ART program is split into two age groups—children (below 15 years) and adults (15 years and above). Therefore, having targeted integrated services for youth is quite tricky with the current breakdown. They also acknowledged that they could be doing more to promote YFHS.

Our interviews yielded information on several pilot projects to providing YFHS.

- With funding from UNICEF, some districts are conducting outreach for HCT and FP in schools. FP services are more concentrated among secondary school students. They do this in conjunction with BLM and the district council.
- One of the district health officers mentioned that they had recently begun providing YFHS. They target youth in schools through sensitization campaigns to get them access to counseling, both FP and HIV. They then refer those wanting more services to the nearest YFHS site for comprehensive counseling and other methods.
- With funding from NAC, NYCOM is implementing a project that involves advocating with district officials to increase YFHS; the project is called “Catalyzing Youth Response to HIV and AIDS.” Under this project, they have conducted facility assessments in nine districts and systematically trained and mentored youth organizations in HIV prevention and leadership. For these trainings, NYCOM uses three manuals: one developed by the Joint United Nations Program on HIV/AIDS and UNFPA, another one developed by the MOH, and the third developed by the NAC. Training of youth organizations occurs in their respective districts, and the topical areas of training are based on periodic reports NYCOM gets from them. These trainings are then followed up by mentorship activities that aim at monitoring and assessing performance of the

Malawi YFHS Minimum Package

By definition, YFHS in Malawi are integrated services offering a range of reproductive and other health services in a youth-friendly manner. Services vary by level of facility but may include

- Contraceptive counseling and method provision
- HCT, PMTCT, ART
- Prevention, diagnosis, and treatment of sexually transmitted infections
- ANC, delivery, and postnatal care, post-abortion care
- Gender-based violence screening, counseling, and referral; treatment of sexual abuse

⁷ Feyisetan, B., Munthali, A., Benevides, R., Kazembe, A., and Mutombo, N. (2014). *Evaluation of Youth Friendly Health Services in Malawi*. Washington, DC: Evidence to Action Project.

organizations. During this process the organizations develop their own action plans to guide them in achieving objectives.

- PSI also has a project working on branding and distributing condoms that would appeal to youth in facilities, as the unbranded silver packets seem not to be appealing to them.
- The Malawi Interfaith AIDS Association has interventions that target youth groups in churches and mosques. They also have a program on couple communication that encourages parents to discuss sexuality with young people. They reach out to youth in schools to share information on FP and HIV prevention, as well as availability of services. In order to reach these youth in schools, the Malawi Interfaith AIDS Association works with the Association of Christian Health Educators in Malawi; the latter manages 52 percent of educational institutions in the country. Since youth tend to feed off each other's often misinformation, there have been a number of BCC and sensitization campaigns targeted toward youth in Malawi. During school holidays, programs organize open days and mobile outreach for sensitization. Several outreach programs are implemented by PSI and BLM, with funds from DfID, as well as Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ).

Interviewees noted that in order to achieve FP-HIV integration in YFHS, education and training of providers alone are not sufficient. Providers need to be willing to serve youth. As one of the stakeholders said:

"Training itself does not change the mind-set of people. There are some providers who have undergone training and are still adamant [against providing service for youth]".

Hence, more YFHS need to be established, and better reporting and monitoring of services are needed. Political will to implement the new YFHS strategy will significantly help to address these issues.

BCC on Integration

There are also some cultural issues that may be a significant barrier to fully integrated FP-HIV services that can be addressed through strategic use of BCC programs. As mentioned above, injectables are popular in Malawi in part because they are discreet—women seemingly still experience resistance for FP methods from spouses, or at least fear that resistance. Likewise, particularly for youth, some providers have difficulty initiating FP methods with clients either due to negative attitudes, lack of skills, or lack of confidence in their skills. Continued stigma surrounding HIV and FP still persists.

BCC programs offer a way to educate the public, dispel myths prevalent at the community level, and increase uptake of integrated services. Stakeholders commented:

"I think we have a bright future. If PLHIV (people living with HIV) know that they can have healthy children they are likely to use FP more. What we need now is more health education."

"There is need to create awareness on integration, and the message should be very clear to people."

Various stakeholders noted several BCC efforts to share information on HIV and FP among the public. Below are a few of the campaigns mentioned:

- Through the BRIDGE II Project, JHU-CCP and JSI have a radio program called, "chenicheni n'chiti." The program tells listeners where HIV and FP services can be found. They also target youth and share messages on the importance of delaying the first pregnancy, condom use, and emergency contraception.

- PSI runs a youth-focused radio program, “Youth Alert,” which looks at SRH issues. The program focuses on sharing three main messages: contraceptives are safe for young people; youth should seek the right information on SRH; and where youth can access YFHS.
- BLM goes into communities and provides long-acting FP methods at healthcare centers. Prior to this outreach, they inform the public of the services they provide through dramas, road shows, banners, and posters. These demand creation and community sensitization activities are also carried out through RH agents and outreach support officers.
- The Malawi Interfaith AIDS Association also carries out BCC activities with a focus on reducing harmful gender and religious and traditional practices, thus addressing the need for FP and HIV prevention practices.
- UNFPA, as part of its pilot project, has also sensitized communities on integration and what to expect in terms of the benefits of visiting just one facility for all services, but also to realize that it may mean a longer wait time or consultation time.

Stakeholders acknowledged that more needs to be done to share integrated messages, with a special focus on reaching youth. These issues need to be addressed in coordinated BCC campaigns, community outreach, and provider trainings in order to better advance FP-HIV integration. Furthermore, innovative approaches of FP-HIV integration need to be tested and applied across various categories of facilities to increase uptake of services.

DISCUSSION

The stakeholder interviews showed that national- and district-level stakeholders were aware of the policies around integrating FP and HIV services. They were able to cite several efforts currently underway to improve FP and HIV integration. However, they did acknowledge that many challenges existed within the healthcare system that would need to be addressed in order to improve the integration of services.

Coordination needs to be improved among national-level stakeholders, namely the RHD, the HIV and AIDS Department, and NAC. Stakeholders felt that the MOH needs to play a leadership role in coordination at the central and district levels and in driving the national agenda for integration. Further, information flow needs to improve between the national and district levels. Districts need to be more proactive about identifying systems-level challenges to integration within their facilities and working with district offices and national-level stakeholders to address those challenges. Apart from the national structures, many stakeholders also discussed the need for donors and implementing partners to spend more effort on coordination to reduce duplication of efforts and overlap of services. At the service level, health facilities need to better coordinate efforts for referrals and integrated services. Data need to be gathered on referral systems within the facility and outside while identifying what specific systems need to be strengthened to support service integration.

Several interventions are needed to improve health systems and ensure better integration of services. At present, healthcare staff are not adequately trained to provide integrated services. More trainings and mentoring programs followed by supportive supervision is needed to ensure that clients can receive all their services in one place. However increasing provider capacity should be paired with a more holistic vision for human resources for health, such as addressing workload burdens at high-volume sites and provider motivation issues.

A common electronic system for distributing commodities needs to be developed. It would be ideal if this system would also include bar coding for tracking of orders and commodities to ensure timely delivery and minimize/eliminate loss or theft. This will save resources as well as provide a better mechanism for ensuring that facilities do not have stockouts. Pharmacists and others will have to be trained on how to monitor stocks, but with supportive supervision this is possible.

Infrastructural barriers were a major concern for integrating services among the key informants. A few considerations for facility reorganization were raised among the various stakeholders: for smaller facilities that provide FP and HIV services on different days of the week, these services could be provided daily; for larger facilities where clients are referred to special clinics for FP and ART, the referral mechanisms could be improved. As part of its exploration into FP-HIV integration in Malawi, HPP also conducted a recent facility assessment (*FP and HIV Integration in Malawi: A Facility-Level Assessment*). These forthcoming results may suggest additional changes at facilities that could improve the integration of services.

From the interviews, it was clear that monitoring systems are also currently operating in a very uncoordinated manner across multiple entities. Current systems are not sufficient nor do they encourage integration as they are oftentimes monitoring and reporting FP and HIV in parallel. Improved systems for integration of M&E systems will allow for critical analysis of what is working in integration and where the gaps remain. Facilities should also use data to identify areas where they can improve provision of multiple services under one roof or identify smooth and efficient referral mechanisms.

An overarching theme from this analysis was that more technical and financial support is needed to improve integration within facilities. One stakeholder put it clearly:

“There is need for resources in facilities this including human resources, infrastructure, and equipment.”

Knowledge of effective methods of integration that work in the Malawian context will assist the government, donors, implementing partners, and policymakers to know where exactly to invest and make the most efficient use of resources, as stated by several stakeholders:

“We need to find out what works and what doesn't work, then put interventions on what works.”

“There is need for evidence-based awareness among policymakers on integration.”

In order for FP-HIV integration services to scale up, it is pivotal to have strong leadership and a clear plan of action. Champions for integration at the national level should assuage the fears of those who worry about losing funding with integration and help them understand instead the benefits that it will bring to them. At the district level, FP-HIV integration also needs champions who can reflect these priorities in the district implementation plans. Then at the service level, there need to be providers and healthcare workers who can champion the benefits of integration to their institutions, colleagues, and clients to move this work forward, sustain it, and continue scale-up. The MOH needs a better system to identify and promote promising practices from one district to others. As one stakeholder put it:

“Providers who are doing integration should testify to the benefits. That's one way of convincing other providers.”

Stakeholders need to work together to ensure that FP and HIV commodities are available at all locations where these services are being provided. As services become further integrated and new models of integration are tested, detailed inventory of commodities will assist healthcare providers to administer the appropriate care for clients. In addition, monitoring registers and tools need to be revised to enable providers to easily enter information on care provided to clients seeking multiple/integrated services. This will reduce workload for providers and assist in institutionalizing integrated services.

The key informants identified several significant challenges within the Malawian health system that are preventing the integration of FP and HIV services, despite it being highlighted in policies and guidelines. Key among them included the need for better coordination and planning among institutions responsible for providing FP and HIV services. In addition, they reported several systems-level issues at the facility level that are barriers to integration, such as limited training of providers to provide integrated services, lack of adequate drugs and commodities in one location, infrastructural challenges, and different monitoring tools for various services. Some of these challenges have persisted for years and were documented in earlier assessments by MSH⁸ and IPPF.⁹ The earlier assessments also found that the RHD and the HIV and AIDS Department were running parallel systems due to individual funding. Our assessment noted similar findings but acknowledges that some effort has been made to integrate at the policy level by reviewing each other's policies and attending joint TWGs. Our report also highlights new topics of conversation that arose during our interviews, such as the role of the private sector in FP-HIV service provision, the need for strengthened relationship between the district- and central-level government entities responsible for FP and HIV, and BCC strategies being used to promote increased demand for FP-HIV service provision at the community level. Besides going into further detail in describing the challenges of integrating the RH and HIV health systems processes as well as service

⁸ Management Sciences for Health. 2010. *Community-Based Family Planning and HIV & AIDS Services in Malawi: A Study of Integration of Family Planning and HIV and AIDS Services in Malawi*. Lilongwe, Malawi: Management Sciences for Health.

⁹ International Planned Parenthood Federation (IPPF), United Nations Population Fund, Joint United Nations Programme on HIV/AIDS, and World Health Organization. 2011. *Malawi: Rapid Assessment of Sexual and Reproductive Health and HIV Linkages*. Blantyre, Malawi: IPPF/UNFPA/UNAIDS/WHO.

provision, we uncovered new issues to integration such as demotivation of staff being a factor in not supporting integration. In addition, YFHS were featured as a prominent component of the conversations in our key informant interviews, and stakeholders acknowledged that addressing the reproductive healthcare needs of youth is pivotal to reducing the prevalence of HIV and unwanted pregnancies. Generally, more efforts are being made at the policy, systems, and service delivery levels to integrate services, and the stakeholders were able to share more details on the steps taken as well as challenges ahead compared with the earlier assessments. Also encouraging were reports of some new pilot programs on integration that are currently being conducted with the support of various partners and donors, which look to be promising practices. A more systematic analysis of those interventions is needed to identify what methods are working and if they can be scaled up nationally.

Conclusion

Much has been written in Malawi's current health policy documents on the need for better integration of FP and HIV services. Key stakeholders acknowledge that many steps toward FP-HIV integration have been taken in this regard. However, several respondents noted a great deal of hesitation on the part of both the RHD and the HIV and AIDS Department to seriously communicate with each other in order to truly integrate services. As a result, many of the system-level challenges to integration have yet to be addressed, such as training of healthcare providers, commodity logistics, and monitoring of services. These challenges are not unique to FP-HIV integration but rather reflect overall weaknesses in the health system. A systematic process that assesses service sites and identifies the needs of vulnerable health system elements within a core service in order to develop tailored interventions with periodic monitoring will go far to maximize resources, minimize duplication of efforts, and contribute to sustainability.

Advancing FP-HIV integration can happen through strengthening overall health systems generally, with specific attention to key service delivery elements such as supervision, training of providers, recordkeeping, supplying commodities, referral, community engagement, and monitoring of services provided at facilities and the community. In addition, YFHS need to be ramped up and knowledge about their existence needs to be disseminated widely. Key to this will be stronger leadership and coordination at the national level between the RHD and HIV and AIDS Department of the MOH, as well as DHOs and their planning teams.

ANNEX A. QUESTIONNAIRE USED FOR STAKEHOLDER INTERVIEWS

Primary list of questions

1. Can you tell us your experience in implementing/facilitating in FP-HIV service integration?
2. Can you tell us the role that your organization/institution is playing with regards to FP-HIV integration?

Probes include: technical assistance – program design, training, commodity logistic support, materials development

Policy development

3. What are the main national laws, policies and strategies as well as assessments related to FP and HIV integration that have been published in the past 5 years that you are aware of?

Probes will include the Clinical Management of HIV among children and adults, MSH assessment, IPPF assessment

- a. What is your opinion/experience with these policies/guide lines being disseminated and explained to key stakeholders at the local level and front line service providers?

Institutional relationships

4. What multi-sectoral or inter-agency working groups/venues exist that routinely discuss FP-HIV integration issues? What coordination mechanisms are used to harmonize efforts of various partners?
5. Probe for UNFPA would be: What is the role of the newly formed TWG in supporting policy implementation and provision of services? Who are the members and what is the purpose of this group?
 - a. How are the coordination, collaboration and co-location of partners progressing overall, and specifically to the implementation of FP-HIV activities? Probes include interactions of donors such as USAID and UNFPA, and USAID-funded implementing partners, and even government officials.
6. How does the MOH interact with other entities such as NAC, district authorities to specifically implement FP-HIV integration?
7. How have the roles of the HIV and AIDS coordinators changed since services have become integrated?
8. What type of role have the professional associations played in advancing FP-HIV integration? Advocacy? Education? Clinical Guidance?
9. Are any key population groups participating in the conversation related to service integration? If so, what is their mandate and what are they advocating to integrate?
10. Are there any key and influential PLHIV groups that have been involved in integration initiatives? What roles they are playing?

Service delivery

11. What services is the private sector providing to supplement the public health sector?
 - a. How are they helping to absorb the increased demand for healthcare services?
 - b. Since healthcare services and medical supplies in the public facility are free, does the private sector receive any subsidies to provide services? How does it manage to compete and survive in an environment where public healthcare services are free?
 - c. Are they assisting with ensuring commodity supplies, i.e. through the social marketing projects?
 - d. What is the government interaction with the private sector: Regulation? Collaboration? Sharing supplies? Referral?

Probes for types of private sector include NGOs, for-profit facilities, pharmaceuticals, social marketing, etc.
12. What kinds of integration services are being provided?
 - a. Probes include types of integration mechanisms such as within the facility, referrals, etc.

Specific questions from the clinical guidelines

FP

13. The clinical guidelines for HIV state providing preventive services to clients via Provider Initiated FP (PIFP) by supplying condoms and DMPA injectables (depo-provera). How are those services currently being provided?
 - a. Is this integration taking place and if so, what does it look like? For example services at the same facility, or referral elsewhere?
 - b. What have been some challenges with this approach?
 - c. Do you think HIV+ clients have access to a range of FP options/informed choice?
 - d. What have been the extent and distribution of the services? What are the logistics systems for providing FP services at HIV centers?
14. The clinical guidelines also state the all patients >15 years should be assumed as sexually active. Are providers informed of this? What steps are providers expected to take/currently taking to address that?
15. The guidelines also state that patients should be given the opportunity to refuse or get referred out if they want other methods.
 - a. For national-level stakeholders: Do you feel that that HIV clients have access to a range of FP choices/informed choice, etc.?
 - b. For a service delivery or advocacy group: Is this being carried out? How is this being currently carried out? What are some of the challenges clients and providers face in this regard?

HIV regimen

16. What is the most common treatment regimen being given to HIV patients? What is the distribution of the various regimens among the population?
17. Where are these being administered?

Probes include all the various types of clinics, such as standalone, integrated, outreach, mobile, etc.

18. Are these drugs subject to stockouts, at the central and district levels?

M&E

19. Use of FP is a secondary outcome of HIV programming (ART and pre-ART) that is expected to be reported. How is this being measured?
20. HIV positive patients have a patient card with them. How does this card help the patients? How is FP use demonstrated generally? Is there any notification made on those cards? Are those cards always in stock/any problem with patient records in remote areas? Does the data from these cards get recorded anywhere?
- (Member of the team to get a copy of this card)*
21. How is FP use within HIV programming being reported?
- Probes include monthly/quarterly reports, etc.
22. Who is responsible for HMIS? What FP and HIV services are being captured? How is the data shared and to whom? Who is using these data for programming?

FP integration into other services

23. To what extent is FP integrated into antenatal, delivery and prenatal services?
- Probes include a description of the integration model.
24. What is the current situation of providing integrated services to youth and adolescents?
25. Are there regular joint coordination meetings at the national, district, and local level for SRH, HIV prevention and youth development?
26. What has been National Youth Council of Malawi's (NYCM's) experience in integrating services for youth?
27. How well are youth-friendly health services covering both HIV and FP?
28. Are there Youth Action Committees at the local level? What are their roles and responsibilities?

Pre-service training

29. What is taught in schools with regards to service integration? At the colleges of nursing? At the medical schools? At midwifery schools?
30. What is the level of training provided to the students with regards to service integration? Didactic? Practical?
31. How are the implementing partners assisting in the provision of pre-service training?

In-service training

32. What in-service training is ongoing to facilitate service integration?
- (Member of team will get a copy of the FP curriculum from RH Unit)*
33. How are trainees selected?
34. How significant is the problem of trainees being transferred/leaving post such that they don't practice service integration?

35. Who is conducting these trainings, i.e. planning, budgeting, implementing, and evaluating?

Probe includes: Who produces the trainers (didactic/practical) and plans/implements/evaluates in-service training for service integration?

Healthcare workforce

36. Who among the cadre of providers are currently qualified and permitted to provide integrated services- at the facility level? At the community level?

BCC (specific section for SSDI-JHU/Communications)

37. Is there a national SBCC strategy related to integration?

38. What BCC activities have been ongoing with regards to integration?

Probes include: What types of IEC messages are being disseminated? Any posters, radio and TV spots to talk about integration? Any other IEC/BCC messages?

39. What plans are there to expand IEC/BCC messages?

Questions related to integration among youth, managed by the Ministry to Youth Development and Sports, as noted in the National Plan of Action for Scaling up SRH and HIV Prevention Initiatives for Young People

40. The National Plan notes the need to focus on young women in secondary schools and on improving comprehensive HIV knowledge among young people and among TEACHERs. What activities are being done to implement this?
41. There is mention of a Technical Working Group on Young People. Does it exist? How often does it meet? What is its mandate and some of the activities it has been involved in?
42. How is the monitoring of the National Plan proceeding and where are the data coming from?
43. In Sub objective 1.1.2: Policies and laws harmonized, it does have, “linkage of SRH and HIV prevention seen in policies”. What policies and laws have been reviewed and where is the report? How is this information being utilized?
44. Sub objective 2.1.1 asks for “Scaled up LSE for out of school youth, Key activity 15 is Establish networks for young people in each TA”. Do these networks for young people exist and if so, are they integrating FP into other HIV BCC messages/peer support activities?
45. Obj. 2.1.4: Improved SRH peer education, Activity 20. Train peer educators. Are the peer educators counseling on FP and referring for services other than condoms?

Decentralized structure and autonomy

46. What financial and decision-making autonomy do the districts have in providing FP-HIV integrated services?

47. What is the role of the district officers in ensuring integrated services?

Probes include: Do the district officers directly support the facility supervisors/administrators who support on-site staff and providers in providing integrated services? What do they do to support that? Is there any training of supervisors on how to engage in integration?

Closing questions

48. What research has been conducted with regards to integration?

Probes include: How is this informing integration practices?

What needs to be done further to ensure integration?

49. What are the main challenges facing the delivery of integration services?

Probes include: Where do you see the gaps in integration?

What are the barriers to providing integrated services?

50. What is your most pressing question about the status of FP-HIV integration in Malawi?

51. What are feasible approaches to integration in Malawi at this present time?

52. What governance structures and systems do you think should be in place to ensure integration?

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