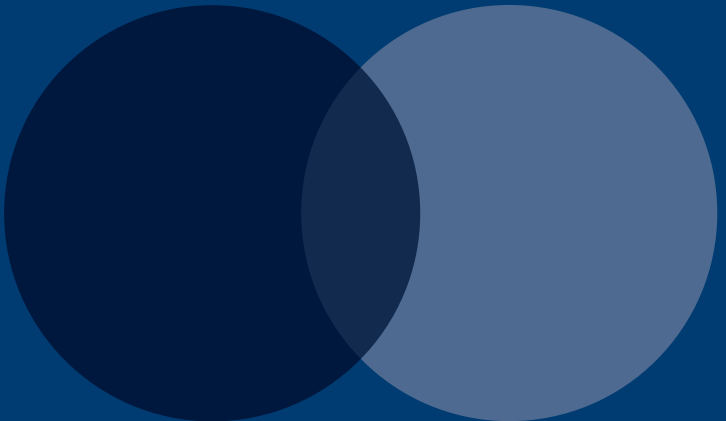




MALAWI



RAPID ASSESSMENT OF SEXUAL AND REPRODUCTIVE HEALTH AND HIV LINKAGES



This summary highlights the experiences, results and actions from the implementation of the *Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages* in Malawi¹. The tool – developed by IPPF, UNFPA, WHO, UNAIDS, GNP+, ICW and Young Positives in 2009 – supports national assessments of the bi-directional linkages between sexual and reproductive health (SRH) and HIV at the policy, systems and services levels. Each country that has rolled out the tool has gathered and generated information that will help to determine priorities and shape national plans and frameworks for scaling up and intensifying linkages. Country experiences and best practices will also inform regional and global agendas.

RECOMMENDATIONS

What recommendations did the assessment produce?

To policy makers:

- Developing a strong political and legal framework to support SRH and HIV integration and protect the rights of women, men and young people regarding access to information/services.
- Strengthening the links between SRH and HIV programmes by carrying out joint policy making, planning and advocacy.
- Advocating for and supporting SRH and HIV linkages at the policy, systems and service levels, as they have been demonstrated to improve outcomes.

To programme managers:

- Lobbying for equal and integrated financing for SRH and HIV programmes.
- Training and deploying more staff in SRH and HIV services and improving their working conditions.
- Ensuring that all essential drugs, equipment and commodities are available at all times.
- Rigorously monitoring and evaluating SRH and HIV programmes during all phases of their implementation to improve current and future programmes.
- Strengthening health service infrastructure and resources to support improved SRH care.

About service delivery:

- Increasing the SRH and HIV competency of health workers through in-service training.
- Incorporating existing competency packages, such as for midwives.
- Strengthening health monitoring systems through staff training on the use of integrated monitoring tools and capacity building on data synthesis for SRH and HIV.
- Orienting District Health Management Teams (DHMTs) on the supervision checklist and health indicators.
- Ensuring the timely procurement of essential drugs, equipment and HIV commodities.
- Improving providers' attitudes through offering customer care training.
- Improving patient waiting times – by ensuring that facilities open in good time.

1. This summary is based upon: *Rapid Assessment for the Integration and Linkages of Sexual and Reproductive Health and HIV*, Centre for Reproductive Health, University of Malawi, May 2010.

PROCESS

1. Who managed and coordinated the assessment?

- The assessment was carried out by the Centre for Reproductive Health, under the leadership of the Ministry of Health (MOH) and with support from the Family Planning Association of Malawi (FPAM).

2. Who was in the team that implemented the assessment?

- The assessment was implemented by two teams of experts, offering extensive knowledge and experience in SRH and HIV research and programmes, at both local and international levels.
- The teams consisted of representatives of the MOH (Reproductive Health Unit and HIV/AIDS Unit), National AIDS Commission (NAC), WHO, Management Sciences for Health project, UNFPA, UNICEF, FPAM and College of Medicine – Centre for Reproductive Health.
- One data collection team focused on in-depth interviews and focus group discussions with policy makers, programme managers, civil society, donors, partners and other stakeholders. A second team visited all of the selected health facilities to interview the DHMTs, service providers and clients seeking SRH and HIV services.

3. Did the desk review cover documents relating to *both* SRH and HIV?

- The literature review addressed both SRH and HIV. It included published articles, surveys, research, plans, reports and situation analyses. Examples of documents from the MOH included the National Sexual and Reproductive Health and Rights (SRHR) policy, SRH training manuals and standard of care documents.
- Documents on the legal environment for people living with HIV (PLHIV), women and key populations were sourced from the Law Commission and Malawi Human Rights Commission.

4. Was the assessment process gender-balanced?

- The assessment team was gender-balanced, with five males and six females. The field data collection teams were also gender-balanced.
- The service providers were 41.2 per cent male and 58.8 per cent female. Among the service users, the majority (86.2 per cent) were female.
- The assessment addressed issues relating to women/girls and men/boys – as both groups seek SRH services within the health care system.

5. What parts of the Rapid Assessment Tool did the assessment use?

- A task force reviewed the generic *Rapid Assessment Tool*. This found that most of the tool was applicable to Malawi. As a result, no major changes were made – except for editing, refining and reorganizing some of the questions – and almost all parts of the tool (the key informant interviews, focus group discussions and the clinical service delivery tools) were used.
- To ease the data collection process, separate tools were compiled for different target groups, such as policy-makers, programme managers, civil society groups, legal institutions, donors and development partners. Also, new tools were developed to collect additional information from PLHIV and representatives of other government departments.

6. What was the scope of the assessment?

- The assessment aimed to support the government to understand the current situation of linkages at policy, systems and service levels, and to identify gaps to address within national plans and frameworks to intensify and scale up linkages.
- The data collection was carried out in four weeks during February to March 2010.
- The assessment covered all five health zones and targeted 20 health facilities: North (3 facilities); Central East (3); Central West (5); South

East (5); and South West (5). The districts were selected on the basis of provision of SRH and HIV services and being in the jurisdiction of the MOH, served by faith-based organizations (FBOs), non-governmental organizations (NGOs) or the private sector.

7. Did the assessment involve interviews with policy-makers from *both* SRH and HIV sectors?

- 20 in-depth interviews were carried out with selected key informants among policy-makers, programme managers, youth groups, civil society, donors, partners and DHMTs in selected district hospitals.
- 10 focus group discussions were carried out to generate consensus responses. They mainly involved programme managers, civil society groups, legal and training institutions, private-sector, regulatory and professional bodies.

8. Did the assessment involve interviews with service providers from *both* SRH and HIV services?

- The assessment involved 68 service providers working in public and private hospitals and primary health care clinics; school-based services; youth centres; prisons; refugee camps; and places where civil services and rights are accessed.

- A questionnaire was administered in the selected facilities, focusing on assessing the extent of SRH and HIV integration at different service delivery points.
- The service providers were: medical doctors (4); nursing officers (8); clinical officers (5); a community health nurse (1); medical assistants (24); midwife-nurse technicians (5); and nurses (21).

9. Did the assessment involve interviews with clients from *both* SRH and HIV services?

- Exit interviews were held with 231 service users from the selected SRH and HIV services. They focused on questions about the quality of services, integration of SRH and HIV and suggested changes to service delivery.

10. Did the assessment involve people living with HIV and key populations?

- The assessment involved PLHIV as well as managers of institutions providing services for PLHIV.
- It was difficult to identify other key populations, such as men who have sex with men (MSM), as the practice is illegal in Malawi. Sex workers were identified and interviewed through sexually transmitted infection (STI) clinics. Injection drug use was reported in one district, but no service users were readily available to be interviewed.

FINDINGS

1. Policy level

National policies, laws, plans and guidelines:

- Linkages are evident in key policy documents to guide SRH and HIV programmes, including:
 - **National SRHR Policy (2009):** revised to respond to the Maputo Plan of Action, including the need to incorporate emerging issues in various components of SRHR which include: basic emergency obstetric and neonatal care, community-based neonatal care, cervical cancer screening, youth-friendly health services, antiretroviral therapy (ART) and prevention of mother to child transmission (PMTCT).
 - **HIV Policy and Strategy:** integrates SRH through PMTCT programmes within routine antenatal (ANC) and maternal health care. Pregnant women are a key target for HIV counselling and testing (HCT), with those who test positive receiving PMTCT services and information on sexuality and reproductive choices. The policy also recognizes condom programming for dual protection.
 - **National HIV Prevention Strategy (2009–13):** promotes HIV-related SRH education through life skills education for young people in school (through the curriculum of primary and secondary schools and teacher training colleges) and out of school (including through youth clubs and support groups with

SRH peer educators). Also addresses SRH and HIV linkages through interventions relating to gender-based violence and cultural issues. The National HIV Prevention Strategy also promotes HCT as an entry point for linkage of HIV- and SRH-related services such as PMTCT and ART.

- National SRH and HIV policies and guidelines are often poorly disseminated by DHMTs to service providers, resulting in low levels of awareness.
- There is no legislation that specifically addresses SRH and HIV, apart from some references to SRH issues in the Public Health Act. The Law Commission is in the process of drafting a bill on HIV.
- Malawi has signed international agreements of relevance to SRH and HIV linkages, including the: Beijing Declaration; Southern African Development Community (SADC) treaty on human rights; SADC protocol on gender and development; and Maseru Declaration on HIV/AIDS.

Funding and budgetary support:

- The main sources of funds for SRH are government, donors and development partners such as USAID, UNFPA, UNICEF and others through the Sector-Wide Approach (SWAp) and as direct funders of various programmes and districts.
- The main source for HIV is the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the President's Emergency Plan for AIDS Relief (PEPFAR).
- Overall, HIV has more partners and receives more funding than SRH.
- About 15–25 per cent of the HIV budget is allocated to SRH-related activities.
- Donors tend to earmark funds for either SRH or HIV programmes, targeting specific activities addressed within the district implementation plans.

2. Systems level

Partnerships:

- **Ministry of Health (MOH):** The MOH is the national body responsible for SRH programmes and works in partnership with the NAC and Office of the President and Cabinet (OPC) for HIV programmes. Within the MOH, there are two relevant coordinating units:
 - **Reproductive Health Unit (RHU):** mandated to: coordinate the integration

of RH services at all levels; develop RH policies, strategies and guidelines; guide RH implementation; and monitor and evaluate RH services. The National RH Programme includes: family planning (FP); maternal, neonatal and child health (MNCH) including prevention and management of unsafe abortions; prevention and management of STIs and HIV; prevention and management of fistula; early detection and management of cervical, prostate and breast cancers; young people's SRH services; development of human resources for SRHR services; elimination of harmful maternal practices, including domestic and sexual violence; male involvement in the development, promotion and delivery of SRHR services; and strengthening of support systems for delivery of SRHR services.

- **The HIV and AIDS Department:** largely responsible for coordinating the biomedical response to HIV and AIDS in areas of HIV counselling and testing, HIV treatment and care, PMTCT, and syndromic management of STIs.
- **National AIDS Commission (NAC):** This body is responsible for coordinating the national response to HIV and AIDS that goes beyond the biomedical response reflected above. It provides leadership in HIV programming and monitors the national response. The NAC is the principal recipient of GFATM HIV grants, of which the MOH is the biggest sub-recipient.
- **Department of Nutrition and HIV/AIDS in the Office of the President and Cabinet (OPC):** This department provides policy direction on matters relating to HIV and nutrition.

Planning:

- The two MOH units and NACs are key in spearheading the development of guidelines that relate to SRH or HIV services or activities. They work through HIV and RH Technical Working Groups, set up to support planning and implementation within the SWAp and national GFATM governance structures. Members of one group are invited to attend the planning meetings of the other, although participation varies. There is no group specifically for linkages.
- Overall, despite clear policies supporting integration, the two MOH units and NAC tend to work 'vertically' – as separate entities, with separate plans and budgets. This lack of national coordination translates into inconsistent guidance

for those working at the service delivery level.

Human resources and capacity building:

- Programme managers indicated that there is a human resource crisis at all levels of service delivery. This hinders the provision of SRHR and HIV services because most facilities in the districts have an inadequate number of trained staff. This view was also expressed by service providers and service users. The providers reported that much of the work is done by clinical officers and nurse-midwives, for which the MOH reports vacancy rates of 24.5 per cent and 67.6 per cent respectively.
- Staff shortages mean that, in practice at the service delivery level, it is often the same practitioner that works in both SRH and HIV programmes.
- All institutions that provide health training include SRH and HIV in their pre-service curricula. However, they are taught as separate courses.
- The MOH coordinates in-service SRHR and HIV training for health service providers at the national level, and has a harmonized manual for training them in both SRHR and HIV. At the service level, on-the-job training is provided, including in integrated services and protocols.

Logistics, supply and laboratory support:

- The MOH has a commodity security document to guide procurement at the central level. But coordination on logistics, supplies and HIV commodities is weak. Often, the MOH and NAC procure their supplies separately, sometimes duplicating efforts. Procurement of commodities, especially contraceptives, is highly donor dependent.
- District hospitals procure commodities from Central Medical Stores, funded through District Implementation Plans. HIV commodities are also procured at the central level through the GFATM.
- Laboratory services can support SRHR and HIV integration well in most of the facilities. The MOH's Diagnostics Unit provides technical support to the RH and HIV Units especially in training personnel in testing (including HIV and syphilis), and participates in planning and provision of laboratory services for both programmes.
- Non-availability of supplies and reagents – for example due to delays related to bureaucracy – is reported, threatening the functioning of medical laboratories.

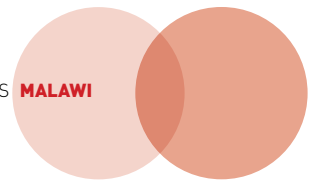
Monitoring and evaluation:

- Supportive supervision is carried out at various intervals depending on the level or type of service. National or regional supervision visits to the delivery sites are done quarterly while district supervision visits are carried out monthly. An integrated checklist is used, but the process is often limited.
- The SRHR and HIV Units and other stakeholders develop standards to assess improvements in the quality of SRHR and HIV services at health facilities.
- Data for monitoring SRHR and HIV programmes are captured at facility, district and central levels. Programmes keep more robust data than the national Health Information Management System that is housed at the Central Monitoring and Evaluation Department in the MOH.

3. Services level

AVAILABILITY OF SRH AND HIV SERVICES:

- SRHR and HIV services are delivered by various bodies including the MOH, Christian Health Association of Malawi (CHAM), private clinics and other NGOs.
- SRHR and HIV services are available in most health facilities and, in practice, are integrated. Youth-friendly health services either found in health facilities or run by NGOs also provide SRHR and HIV services.
- The most commonly available essential SRH services are: FP; prevention and management of STIs; prevention and management of unsafe abortion; management of post-abortion care; ANC; labour and delivery; ART management; maternal and neonatal services, cervical cancer screening and treatment; and youth-friendly services. Services related to gender-based violence are rarely available. Also, FP is limited at some CHAM facilities (specifically those under the Catholic Church) and prevention of unsafe abortion/ post-abortion care services are limited at some government health centres.
- The most commonly available essential HIV services are: HCT; prophylaxis and treatment for PLHIV; home-based care; psychosocial support; HIV prevention information and services for PLHIV and the general population; condom provision; and PMTCT. But HCT and PMTCT services are not provided in



some government and CHAM facilities, largely due to shortages of supplies and commodities.

- There is very limited support for key populations. There are a few services for sex workers and intravenous drugs users, but none for MSMs, as sex between men is illegal.

A. SERVICE PROVIDER PERSPECTIVES

HIV integration into SRH services:

- There is a high level of integration of HIV into SRH services. Over 80 per cent of those in the assessment provide: HCT; PMTCT; prophylaxis and treatment for PLHIV; home-based care; psychosocial support; HIV prevention for and by PLHIV; and condom provision. Services relating to abortion tend to be offered separately, not fully integrating relevant HIV services, such as HCT.

SRH integration into HIV services:

- There is also a high level of integration of SRH into HIV services, with over 70 per cent of those in the assessment offering: FP; prevention and management of STIs; prevention of unsafe abortion and management of post-abortion care; and MNCH. Only services related to gender-based violence were much less integrated (within approx. 30 per cent of services).
- Within HIV services, MNCH was provided through PMTCT – offered in pre-natal, labour, delivery and post-natal care services for all women of child-bearing age and their partners. However, in practice, prongs 2 and 4 of PMTCT recommended by WHO (i.e. prevention of unintended pregnancies for HIV-positive women and care and support for HIV-positive mothers and their families) were not fully included in most facilities. For example, HIV-positive women were not given contraception as part of routine post-partum care.

Overall perspectives on linkages in SRH and HIV services:

- SRH and HIV services tend to be provided in the same facility (unless a specific service is not available, when clients are referred). However, they are usually offered by different providers. The exception is health centres where, due to limited human resources, services tend to be by the same provider, but on different dates.
- Services for PLHIV are available and address their SRH needs, such as through information on reproductive rights, sexuality and reproductive choices. But PLHIV services are not located at the same sites as those for SRH and not offered on the same day or by the same provider. There is collaboration between health facilities (especially health centres) and community groups to provide support and care for PLHIV. Youth centres for young people living with HIV are available in selected places, such as FPAM clinics.

B. SERVICE USER PERSPECTIVES

- The majority of service users (95.1 per cent) would prefer to receive SRH and HIV services in the same facility at the same time. The majority (77.8 per cent) would prefer to have the same providers for both services. Some want to have the services in the same facility, but with different providers. They feared that, with acute staff shortages, if services are offered by one provider in the same site, the person will have too much workload, leading to longer waiting times.
- 76.5 per cent of clients said they were satisfied with the services they received.

LESSONS LEARNED AND NEXT STEPS

1. What lessons were learned about how the assessment could have been done differently or better?

- For successful SRH and HIV integration, it is essential to have the meaningful and ongoing commitment of government and the resources of donors. It is also important that integrated services are routinely and regularly available, with trained staff and reliable supplies.
- In resource-constrained settings, careful attention is needed to maintaining a contraceptive logistics and supply system to support SRH and HIV integrated services and avoid stock-outs.
- Strengthening documentation in general, and capturing of best practices in particular, and operations research that helps to strengthen integration of SRH and HIV.
- A close working partnership between the government and CHAM is an effective way to scale up SRH and HIV integration.
- A close partnership between the community leadership and health providers is an effective way to get people to demand and access SRH and HIV services.
- SRH and HIV integration has particular implications for service providers – involving a new approach (that often goes beyond the boundaries of their job descriptions) and requiring measures to avoid the burnout of individuals/unsustainability of programmes. The removal of policy and practice barriers (such as those relating to what level of provider can provide specific types of service) would increase the availability of integrated services. Meanwhile, effective integration for vulnerable groups, such as women and youth, requires providers to examine their own attitudes and overcome prejudices.

2. What 'next steps' have been taken (or are planned) to follow up the assessment?

The next steps included:

- Dissemination of the findings of the assessment to policy and other stakeholders (including at the service delivery level). This was conducted in July 2010.
- Action plans and a national strategic framework for scaling up and linking SRH and HIV in Malawi. These still need to be developed.

3. What are the priority actions that are being taken forward as a result of the assessment, at the:

- **policy level?**
- **systems level?**
- **services level?**

Policy level:

- Advocating and supporting SRH and HIV linkages at the policy, systems and service levels – as they are demonstrated to improve outcomes.
- Modifying and strengthening relevant policies, SRH and HIV strategic plans and coordination mechanisms to address the gaps and foster integration.
- Disseminating the assessment findings and the revised policy to providers and service users.
- Developing a strategic plan for the integration of SRH and HIV.

Systems level:

- Strengthening SRH and HIV integrated responses through human resources and planning, health provider training, client health education, infrastructure, supplies management and stakeholder involvement.
- Rigorously monitoring and evaluating integrated programmes during all phases of implementation to improve current and future programmes.

LESSONS LEARNED AND NEXT STEPS **continued**

- Ensuring that HIV services – including HCT, PMTCT and ART – are integrated with SRH services. Ensuring that SRH services – such as FP (including MCH), prevention and management of gender-based violence and STI management, as well as male participation – are integrated with HIV services.
- Facilitating and/or advocating for operations research to demonstrate that SRH and HIV integration improves outcomes.

Services level:

- Improving the clinical skills of providers, both through in-service and pre-service training.
- Exploring ways to broaden SRH and HIV integrated services for the population.

4. What are the funding opportunities for the follow-up and further linkages work in the country?

- The Reproductive Health Unit with support from UNFPA has planned two meetings to further discuss the integration of SRH into HIV in Malawi.
- An application has been submitted in a GFATM RCC Phase 2 application to fund the newly integrated ART/PMTCT guidelines. With the introduction of new triple therapy (tenofovir/lamivudine/efavirenz) it was decided that family planning methods should be prescribed to women of child-bearing age living with HIV, as tenofovir has potential effects on early pregnancy.

Abbreviations

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARV	antiretroviral
CHAM	Christian Health Association of Malawi
DHMT	District Health Management Team
FBO	faith-based organization
FPAM	Family Planning Association of Malawi
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GNP+	Global Network of People Living with HIV
HCT	HIV counselling and testing
HIV	human immunodeficiency virus
ICW	International Community of Women Living with HIV/AIDS
IPPF	International Planned Parenthood Federation
MNCH	maternal, neonatal and child health
MOH	Ministry of Health
MSM	men who have sex with men
NAC	National AIDS Commission
NGO	non-governmental organization
OPC	Office of the President and Cabinet
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother to child transmission
RH	reproductive health
RHU	Reproductive Health Unit
SADC	Southern African Development Community
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
SWAp	sector-wide approach
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

FOR FURTHER INFORMATION, PLEASE CONTACT:
Frank Taulo, Director, Centre for Reproductive Health, College of Medicine,
University of Malawi, ftaulo@yahoo.com