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System-level Barriers to FP-HIV Integration Services in Malawi

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Background

- Malawi has several policy documents that address integration of family planning (FP) and HIV services
  - *Clinical Management of HIV in Children and Adults* (2014) recommends provider-initiated family planning (PIFP) within antiretroviral therapy (ART) settings
- The WHO recommends the integration of FP and HIV services in areas of high HIV prevalence and high unmet FP need
- In 2015, the USAID-funded Health Policy Project assessed the status of FP-HIV integration in Malawi*

In Malawi

- HIV prevalence among women: 12%
- Unmet need for family planning: 26%

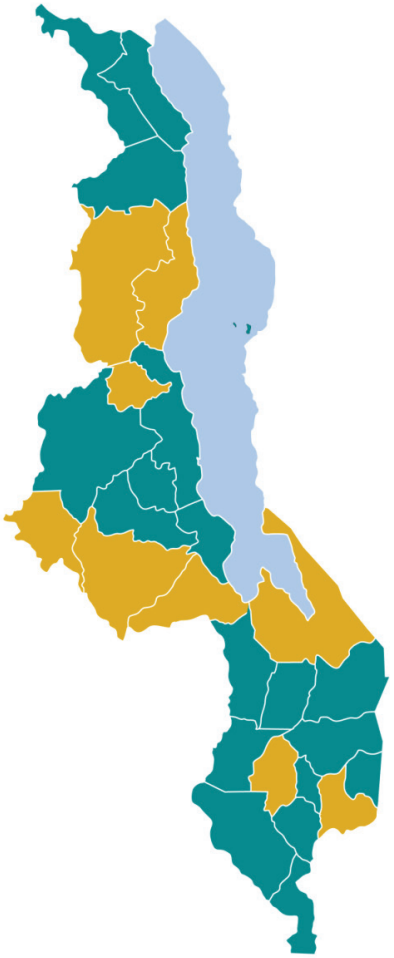
Regionally

- Unplanned pregnancies among HIV-positive women: 51%–84%

*Report: Irani, L., E. McGinn, M. Mellish, O. Mtema, and P. Dindi. 2015. *Integration of Family Planning and HIV Services in Malawi: An Assessment at the Facility Level.* Washington, DC: Futures Group, Health Policy Project.

Methodology

- Sample included 41 health facilities of varying client volume across nine districts and three regions
  - Government health centers and hospitals
  - Private hospitals/health centers
  - Integrated health centers
- Mixed-method approach
  - 41 facility audits
  - 122 provider interviews, 41 in-charge interviews
  - 425 client flow analysis and interviews
  - 58 mystery client visits/interviews
  - 3 focus group discussions (FGDs) with HIV-positive clients



Results

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Workforce (Human Resources for Health)

- Lack of training
  - In-charges: only 39% had been trained on FP/sexual and reproductive health (SRH)/HIV integration
  - In-charges: 20% had no FP training
  - Providers: only 24% had been trained on FP/SRH/HIV integration
  - Providers: 21% had no FP training
    - This affects service priorities and client choice
    - Providers mainly counseled ART clients on condoms, injectables, and pills; fewer mentioned female sterilization (63%), intrauterine devices (IUDs) (55%), or vasectomy (44%)
- High volume of clients exceeds provider availability
  - ART client waiting time ranged from 0–351 minutes (almost 6 hours)
  - Average contact time with ART provider: 10–15 minutes
  - FGD participants reported ART clinics that were not open on time, or that had closed early; some reported sleeping overnight to receive services

Organization of Services

- 83% of providers reported that ART services had been reorganized to accommodate the following for family planning:
  - Protocols (42%)
  - Training (48%)
  - Expanded ART service delivery time (15%)
- Referral for FP services was routine, but providers often lacked important details
  - 44% knew the times at which referred FP services were available
  - 29% knew the transportation costs required to reach referred FP services
  - 14% of providers had **no** knowledge of referred services

Service Delivery

- Various models of integration
  - Same location, same day (fully integrated)
  - Same facility, different room, same day (internal referral)
  - Same facility, different day (parallel services)
  - Referred out to different facility/pharmacy
  - Banja la Mtsogolo (Marie Stopes) outreach services at same facility; (dedicated event)
  - **Many facilities provide services in multiple ways**
  - **Level of integration often depends on type of FP method**
- Larger facilities (hospitals) don't offer family planning at the ART clinic; instead, clients are referred to a dedicated FP room (internal referral)
- Health centers largely referred out for sterilization services, and often for IUDs

Service Delivery (cont.)

- Service quality needs improvement
  - Mystery clients reported harsh treatment and/or denial of services because they were not registered at a facility
  - Only 2 of 58 mystery clients reported PIFP
  - In exit interviews, only 14% of women reported being asked about FP/fertility intentions at that visit
  - Almost half of women reported in exit interviews that they had not been told about the side effects of their current method
  - FGD participants often talked about not getting FP after an ART clinic visit because queues were too long, or because the FP clinic had closed

Commodities

- HIV ⟷ FP Integrated Services
  - 85% of facilities had family planning* available at **HTC clinic** (n=41)
  - 85% of facilities had family planning* available at **ART clinic** (n=41)
  - 75% of FP rooms observed offered **HIV services** (n=33)
- Stock-outs
  - 44% of facilities providing family planning reported FP stock-outs or expired products in past three months (17/39)
  - High stock-out rates of injectables (47%), pills (47%), and condoms (47%)
  - Facilities also reported stock-outs of (or expired) HIV-related commodities
    - HTC kits, 34%
    - ARVs, 24%
    - Opportunistic infection drugs, 15%

*Note: Family planning included condoms; only four HTC and 11 ART clinics had injectables as per national guidance; only seven ART clinics had a range of method choice available

Health Management Information Systems (HMIS)

- Multiple paper registers at HTC, ART, and FP clinics complicated paperwork for providers
- At HTC clinics, data collectors reviewed registers (n=33)
  - 70% had registers that incorporated an FP column
  - 9% used a separate FP register
  - 21% had no mechanism to register FP provision
- At ART clinics, data collectors reviewed registers (n=18)
  - 17% had registers that incorporated additional family planning (beyond condoms and injectables)
  - 23% maintained a separate FP register
  - 11% had no mechanism to register FP provision
  - n=17, data collectors were not able to check register (not available, locked away, access denied)
- Several facilities had no system to capture referrals for family planning
- HMIS do not adequately capture service integration

What Have We Learned?

- Malawi's policy documents aren't resulting in a strong integration of services at the facility level
- There is a need for **improved** and **detailed** referral mechanisms at different levels of facilities
- Commodity stock-outs continue to hinder service delivery (especially in the public sector)
  - Improve logistics systems to address stock-outs
- Needs
  - More provider training on PIFP
  - Improved patient registers and other monitoring and evaluation systems
  - Improved service quality
  - Promotion of a client-centered/rights-based approach

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