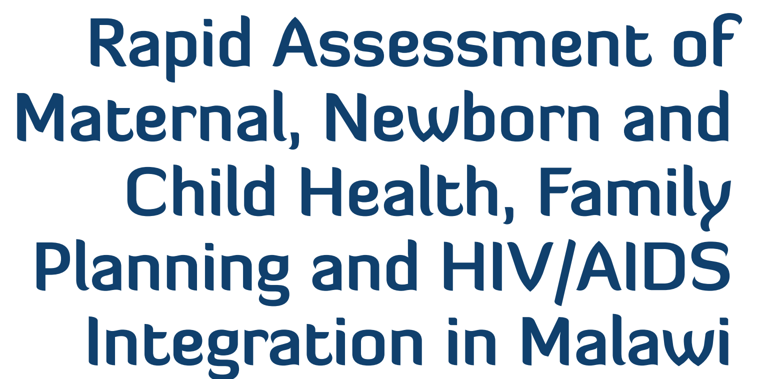

Rapid Assessment of Maternal, Newborn and Child Health, Family Planning and HIV/AIDS Integration in Malawi

July 2014

AFIDEP

African Institute for Development Policy

Bridging Development Research, Policy and Practice

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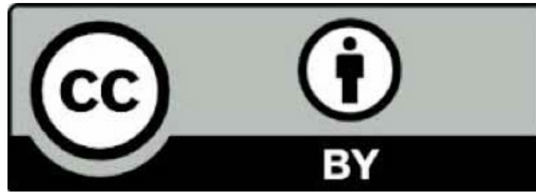

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
BLM	Banja La Msogolo (Marie Stopes)
BMGF	Bill & Melinda Gates Foundation
CBOs	Community Based Organisations
CDC	Centres for Disease Control and Prevention
CHAM	Christian Health Association of Malawi
CIDA	Canadian International Development Agency
CTC	Care and Treatment Clinic
DFID	Department for International Development
DHS	Demographic and Health Surveys
EMTCT	Elimination of Mother to Child Transmission
FP	Family Planning
FPAM	Family Planning Association of Malawi
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit (German International Cooperation Office)
HMIS	Health Management Information System
HIV	Human Immune Deficiency Virus
HTC	HIV Testing and Counselling
IMCI	Integrated Management of Childhood Illnesses
IPPF	International Planned Parenthood Federation
IUDs	Injecting Drug Users
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
KFW	Kreditanstalt für Wiederaufbau, (KFW) a German public-sector Financial institution
MDGs	Millennium Development Goals
ML&E	Monitoring, Learning and Evaluation
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
NAC	National Aids Council
PAC	Post Abortion Care
PEPFAR	US President's Emergency Plan for AIDS Relief
PMNCH	Partnership for Mother, Newborn and Child Health
PMTCT	Prevention of Mother to Child Transmission
PRB	Population Reference Bureau
PSI	Population Services International
RHU	Reproductive Health Unit
VCT	Voluntary Counselling and Testing
RCHS	Reproductive and Child Health Section
SC4CCM	Supply Chain for Community Case Management
SIDA	Swedish International Development Agency
SRH	Sexual Reproductive Health
SSDI	Service Delivery Integrated Services
STIs	Sexually Transmitted Infections
TA	Technical Assistance
UN	United Nations
UNC	University of North Carolina
UNFPA	United Nations Population Fund
UNICEF	United Nation Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Executive Summary

Background

The high burden of disease and death relating to HIV/AIDS, unintended pregnancies, and poor maternal, newborn and child health remains a major health challenge in sub-Saharan Africa. Responses to this challenge have traditionally been comprised of well-funded HIV/AIDS programmes set up separately, and parallel to existing, but inadequately funded sexual and reproductive health programmes (maternal, newborn and child health and family planning). Consequently, integration of SRH/MNCH, FP and HIV/AIDS services has, over the years, been promoted to strengthen SRH programmes using HIV/AIDS resources. More recent efforts have focused on making the case for integration efforts to use the existing MNCH platform, which is accessed by many women and children, the sub-populations that bear the highest burden of disease and death from HIV/AIDS, unwanted pregnancy and poor maternal, newborn and child health.

Study purpose and methods

This study was conducted in order to understand the landscape of MNCH, FP and HIV/AIDS disease burden, policy environment and integration efforts with the aim of informing the Bill & Melinda Gates Foundation's future potential engagement and investments in the area. The study combined both qualitative and quantitative methodologies, including document review, collation and analysis of quantitative data, policy audits, key informant interviews and validation meetings. From the quantitative data analysis, four countries (DRC, Malawi Tanzania and Zambia) with different permutations of disease burden and service deficiency were selected for rapid national level assessments of the status of MNCH, FP and HIV/AIDS integration. This report focuses on the results of the Malawi rapid assessment.

Key findings

The findings reveal that there is support for integration of services at the policy level but the country faces challenges to integrating MNCH, FP and HIV/AIDS at the system and service delivery levels. These challenges typify those of SRH/MNCH, FP and HIV/AIDS service integration faced in the Eastern and Southern Africa region.

At the policy level, Malawi has bought into the global calls for SRH/MNCH and HIV/AIDS integration. Malawi is in the process of developing a strategy to guide integration efforts and service provision. Although the presence of a policy framework on MNCH, FP and HIV/AIDS service integration does not automatically translate to the provision of integrated services, it demonstrates much-needed government leadership on the issue and provides guidance to stakeholders involved in funding, programming and service provision.

The existence of a supportive healthcare system remains a critical factor in determining the success or failure of any integration efforts. The study's findings confirmed extensively documented health system challenge to integration, i.e. vertical structures and planning mechanisms within the government (e.g. within MoH and between MoH and the national AIDS commission), inadequate funding, too few and inadequately skilled health workers, lack of equipment, weak supply chains occasioning frequent stock outs and weak Monitoring and Evaluation (M&E) systems. As such, the health system presents a critical entry point for supporting integration efforts.

At service delivery level, there are various integration programmes being implemented in Malawi. The PMTCT programme remains the most advanced integration effort, even though the programme's coverage is still below 100 percent, meaning that many HIV+ expectant women or breastfeeding mothers are still not on ART to help reduce mother to child transmission, and many HIV-exposed infants are not receiving the necessary care to protect them from infection. Malawi could benefit from on-going advocacy and programme efforts to effectively integrate PMTCT into MNCH, which research has shown could reduce the loss to follow-up of many mothers and infants.

Other integration programmes in Malawi, albeit smaller in scale, include integration of FP into HIV testing and counselling, FP into HIV care and treatment, HIV into FP, FP into PMTCT, PMTCT into MNCH and FP and HIV/AIDS into MNCH. These programmes are funded with external sources of funds and are implemented by non-governmental organisations (NGOs), and as such, the programmes only cover a few regions/districts/health facilities. The main

funders of SRH programmes (MNCH, FP) in Malawi include: USAID, DFID, World Bank, UNFPA, UNICEF, KFW-Germany, WHO and EU. The main funders for HIV/AIDS include the Global Fund, USAID, and PEPFAR/CDC. These agencies largely fund parallel programmes on different aspects of SRH/MNCH, FP and HIV/AIDS through different implementers, resulting in a myriad of programmes collaborating with the MoH to offer different models of integrated services. The fact that there are no guidelines on the ideal models of integration further compounds the situation.

Despite calls by global players (mainly led by the WHO) for countries and development partners to focus on integration through the MNCH platform, these calls are yet to bear fruits at the service delivery level in Malawi. In fact, the maternal health programmes remain greatly underfunded, one of the main factors hindering integration.

Research assessing various integration models has shown that integration has potential to improve service utilisation even though there still exist significant knowledge gaps on the actual benefits of integration. Moreover, the success of any integration efforts is fully dependent on the systems available to support the efforts as well as the patients' needs and expectations. Thus, not every service can be integrated in any given health facility; rather countries have to understand the integration models that their systems can support at the different levels of health facilities, and focus on promoting and enabling these integration models.

Current and potential areas of investment on integration for the Gates Foundation

The Gates Foundation's investments in MNCH, FP and HIV/AIDS in sub-Saharan Africa have had the overarching goal of improving quality and expanding access to health care services, particularly to groups that bear the highest burden of poor health. Although the Foundation has largely made parallel investments in these three areas, some of its investments have supported some aspects of MNCH, FP and HIV/AIDS. Some of the key areas of focus for the Foundation's investments in sub-Saharan Africa in these three areas include: strengthening community level health care provision; strengthening routine data capturing and management systems; supporting commodity supplies and the supply chain management; creating demand for services and promoting healthy practices; funding implementation research; demonstrating scalability of programmes; and global advocacy for better policies, funding and leadership.

Moving into the future, it is the aim of the Foundation would work hand-in-hand with governments to support the realisation of national goals in MNCH, FP and HIV/AIDS, with emphasis on improving the quality and coverage of care. The Foundation will move towards making holistic investments in health, particularly for women and children, as well as supporting key health system functions that will ensure improvement in health care quality and coverage.

The Foundation is currently investing in Malawi in all three areas - MNCH, FP and HIV/AIDS. The Foundation-supported Presidential Safe Motherhood Initiative integrates MNCH and FP, whereas the data systems improvement programme focuses mainly on HIV/AIDS and FP. Foundation staff indicated that the Foundation was likely to strengthen its investments in Malawi given the good working relations it has established with the government. From our findings, the Malawi government is already making efforts to facilitate integration.

Given the government's commitment to integration and the Foundation's existing investments in the country, our overall recommendation is that the Foundation should make Malawi its model country for integration investments. Thus, the Foundation should intensify and leverage its existing investments in the country to support larger MNCH, FP and HIV/AIDS integration programmes using the MNCH platform. Such programmes should have a ML&E component to evaluate their effectiveness and efficiency to inform future scale-up efforts. Specifically, the Foundation should:

- Work with the MoH to:
  - Strengthen its leadership and coordination role to ensure integrated rather than vertical programmes by partners. Particularly, the Foundation could support technical capacity development for the office of the Directorate of Reproductive Health, which is currently leading integration efforts in Malawi. This kind of support can go hand-in-hand with support for local advocacy efforts for government's increased investments into the maternal health programme.
  - Support dissemination events for the SRH and HIV/AIDS integration policy that was under development at the time of the study.
- Strengthen the Foundation's current investments in the maternal health programme in order to extend the programme nationwide. Particularly, the Foundation should strengthen its support for skilled birth attendant training, which contributes directly to addressing the grave shortage of health workers in Malawi, which has a significant impact on reducing maternal and neonatal

mortality especially in hard-to-reach areas, as well as the community engagement and advocacy component of the programme.

- Support efforts that streamline and improve the supply chain and logistics to enable joint procurement, storage and distribution across programmes. Lessons can be drawn from the Foundation-funded pilot programme, Supply Chain for Community Case Management (SC4CCM), which has returned positive reviews and has been adopted for national scale-up by the government. Most interviewees felt that scaling-up this programme has the potential to greatly improve logistics and supply chain management in Malawi. At the time of the study, the programme was closing down, but the government, with the support of partners, had hired one of the John Snow International (JSI) core staff to lead the scale-up plans at the MoH.

1 Introduction

1.1 Background

The high burden of disease and death relating to HIV/AIDS, unintended pregnancies, and poor maternal, newborn and child health (MNCH) remains a major health challenge in Malawi, as is the case in most of sub-Saharan Africa (SSA). This is largely a result of a weak health system resulting in low demand for and utilisation of health care services. Malawi is a country with strong political will and a learning and cooperative culture for working with development partners and adopting proven lessons for improving health services. Despite commendable efforts in improving delivery in the three areas, the burden of disease remains very high, pointing to the need to step up outreach and quality of care. The Bill & Melinda Gates Foundation is currently investing in Malawi in MNCH, FP and HIV/AIDS. The Foundation supports the Presidential Safe Motherhood Initiative, which integrates MNCH and FP. The Foundation also supports a programme to improve data systems related to HIV/AIDS and FP.

Integration of HIV/AIDS, Family Planning (FP), and MNCH services is widely seen as part of the solution to improving health delivery in SSA because the three issues are fundamentally interconnected. Clients seeking HIV/AIDS services are mostly in the same age range and share common health needs as those seeking SRH services. HIV is mostly transmitted through unprotected sex or directly from mothers to children during childbirth or breastfeeding.[1] FP is a key intervention that enables families to decide when to have children and how many, while women require quality MNCH services in order to have healthy pregnancies and healthy babies. After giving birth, families become preoccupied with the health needs of the baby while having to worry about preventing unplanned pregnancies and HIV infection.

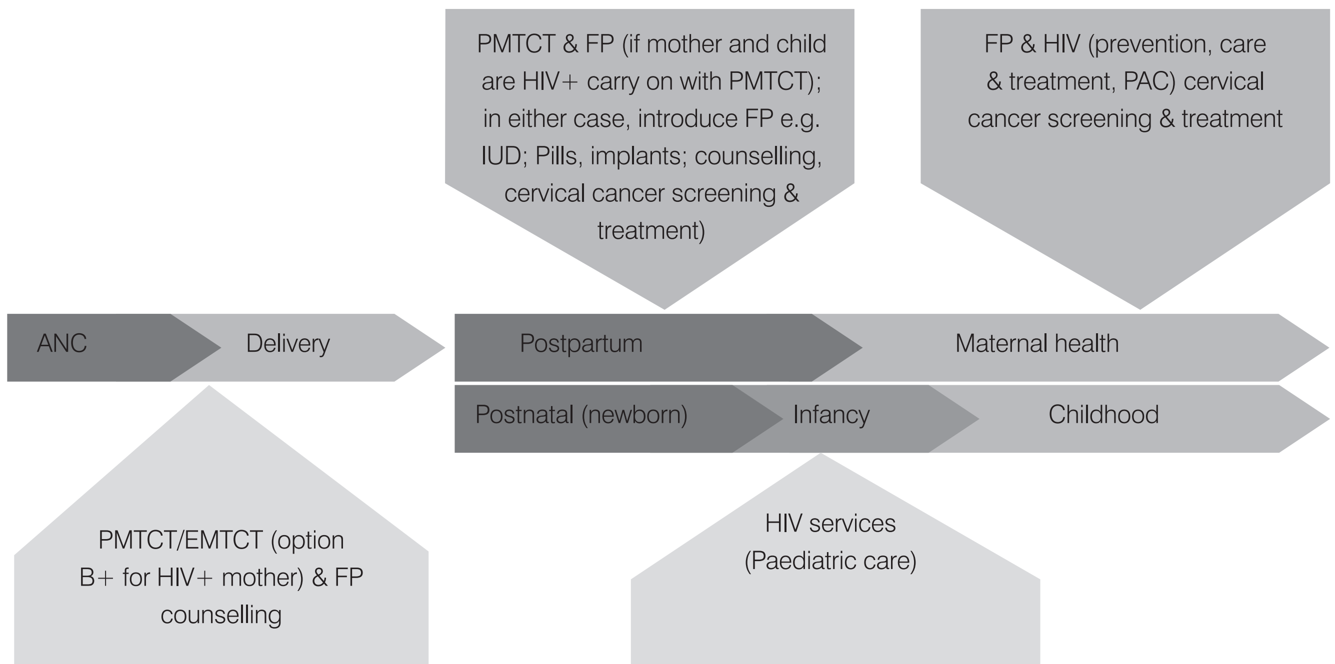
The World Health Organization (WHO)'s HIV/MNCH Technical Working Group defines integration as "the organisation, coordination, and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact, and use (acceptability)."[2] The need to link and integrate SRH and HIV/AIDS responses has been widely recognised at international level since the early 2000s in order to enhance effectiveness and outreach of services and as critical to ensuring universal access to SRH and HIV/AIDS services.[3] This need is evidently more critical in SSA where the burden of HIV/AIDS, unintended pregnancies, and maternal and child mortality are highest.

Despite these obvious linkages and potential synergies, efforts to tackle HIV/AIDS have traditionally been laid out parallel to existing platforms for SRH care, resulting in SRH and HIV services being delivered in separate or semi-specialised facilities and units.[4] The disjuncture has become even more marked as HIV services such as HIV counselling and testing (HCT), prevention of mother-to-child transmission (PMTCT) and HIV care and treatment (CTC) all have been rapidly scaled-up in high-prevalence settings.[5] Furthermore, while SRH services such as FP and MNCH are delivered through the standard primary health care (PHC) structure, treatment-focused HIV services have often been delivered within more specialist units in tertiary health facilities, or by health workers specialised in HIV.[6] The shift of resources and political attention to HIV/AIDS has largely been at the expense of existing SRH programmes, particularly MNCH and FP.

Nevertheless, over the years, various models of integrating SRH and HIV/AIDS services have been tested, including: integrating FP into HIV testing and counselling; FP into HIV/AIDS CTC; HIV into FP; FP into PMTCT; and PMTCT into MNCH services. In the last five years, there is increasingly an emphasis on the need to use the MNCH platform as a base for integrating HIV/AIDS and FP services.[7]

In this report, the MNCH platform refers to the range of care and services given to women during pregnancy and delivery and to women and children during the postpartum period up to childhood (5 years). These services include antenatal care (ANC), delivery care, postnatal care (PNC) and postpartum care, infancy and childhood (Figure 1).

Figure 1: The maternal, newborn, and child health (MNCH) platform



Source: Adapted from PEPFAR 2011's Life Cycle Continuum of Care[8]

Utilisation of various MNCH services is very high in Malawi partly because of high fertility and as a result of government and development partner's efforts to enhance child and maternal health and survival. As such, the MNCH platform offers multiple entry points for integrating FP and HIV services, for example through ANC and immunisation services.

Integration efforts have been boosted since 2008 when the key HIV/AIDS funders (PEPFAR, USAID, and Global Fund) relaxed their policies to incorporate FP and maternal health components into their relatively well-funded programmes. This momentum culminated in WHO's call to enhance integration of PMTCT and MNCH services in order to improve patient follow-up and adherence.[9] Some studies have argued that full integration of PMTCT and MNCH will help address the challenge of high levels of loss to follow-up from PMTCT programmes of women and infants.[10] However, efforts to integrate MNCH and PMTCT services should take account of the fact that some patients attending HIV-only services strongly favour keeping HIV services separate mainly because of stigma.[11]

This report documents the current state of, and demand for, integration of, MNCH, FP and HIV services and identifies opportunities for enhancing such integration in Malawi. The report is based on a rapid assessment conducted in Malawi as part of a landscape analysis of MNCH, FP and HIV/AIDS Integration in Eastern and Southern Africa, aimed at identifying potential investment areas and programme support options for the Gates Foundation.

1.2 Purpose of study

The purpose of this study was to provide an understanding of the landscape of MNCH, FP and HIV/AIDS burden, policy and service delivery gaps, and integration efforts in Malawi to inform the Foundation's future potential engagement and investments in the area. The Foundation was especially interested in integration that uses the MNCH platform. The study mapped the overlapping geographies, population groups, the highest burden areas and lowest intervention coverage for MNCH, FP and HIV/AIDS (i.e. the gap) and identified the entry points for integration approaches at policy and programmes levels. The overarching objectives of the study included:

i. Describing current research on integration of MNCH, FP and HIV/AIDS;
ii. Identifying the major implementers and funders and describing what they are implementing and supporting, respectively;
iii. Defining existing challenges and gaps in policies and programmes and ways to address them;
iv. Identifying geographies and populations of interest for integration using the MNCH platform; and
v. Describing the potential role and areas of development support for the Gates Foundation.

2 Methodology

A combination of qualitative and quantitative methods was used in conducting this rapid landscape analysis over a period of four and half months, from December 2013 to April 2014. The assessments included three main activities:

- Mapping MNCH, FP and HIV/AIDS burden at sub-national level, service delivery gaps and key integration programmes in order to identify the sub-populations with the greatest need in each of the four countries;
- Reviewing policies, strategies, guidelines, project reports and other relevant publications on MCNH, FP and HIV/AIDS to understand the commitment and guidance provided by government to enable integration; and
- Stakeholder interviews and validation workshops on the status of MNCH, FP and HIV/AIDS integration at policy, system and service levels to understand key challenges and identify opportunities for enhancing integration.

The interviews were done with key stakeholders including MoH agencies responsible for SRH and HIV/AIDS, national AIDS commissions, funding partners and programme implementing organisations (see Table 1 below). In total, 24 stakeholders were interviewed in Malawi. The interview guide was adapted from the Rapid Assessment Tool for Sexual and Reproductive Health and HIV Linkages[12] to accommodate this study's specific emphasis on integration using the MNCH platform. To validate the findings from the interviews, we held a key stakeholders meeting to deliberate preliminary findings. In Malawi the validation meeting was attended by 21 stakeholders. Interviews were recorded (in cases where interviewees agreed to be recorded) and detailed notes taken by the research team.

Table 1: List of stakeholders interviewed for the situational analysis

Government officials at national level	**Development partners**
Directorate of Reproductive Health	Banja La Mstologo (BLM)
National AIDS Commission	Christian Association of Malawi (CHAM)
Integrated Management of Childhood Illnesses (IMCI) Unit	Family Planning Association of Malawi (FPAM)
Health Management Information System	FHI360
Central Medical Stores	JHPIEGO
Nursing Services	JSI
Planning and Budgeting including SWAP	PSI
Ministry of Youth	Presidential Initiative on Maternal Health
	DFID
	UNFPA
	UNICEF
	USAID
	WHO

3 Findings

3.1 Disease Burden, Service Delivery Gaps and Opportunities for Integrating MNCH, FP and HIV in Malawi

3.1.1 HIV burden and service utilisation

Malawi has one of the highest HIV/AIDS burden in Africa (10.8 percent prevalence). Table 1a shows how Malawi compares to the rest of SSA. Even the country has made some good progress in expanding access to ARTs (67 percent of those who need ARTs have access to them) and PMTCT (53 percent), these figures are still far lower compared to SSA countries with similar burden of HIV. The high HIV incidence rates and the moderate access to ARTs and PMTCT services point to the need for the expansion of both prevention and treatment intervention programmes in the country. Interventions to bridge these gaps can include increasing uptake of preventive services through increased provision of FP and MNCH services. Alternative approaches include the expansion of FP and MNCH services among people living with HIV through the well-grounded ART and PMTCT programmes.

3.1.2 Unplanned fertility and family planning

Compared to other Eastern and Southern African countries, Malawi, together with DRC, Uganda, Angola, Madagascar, Zambia and Mozambique, has exceptionally high adolescent birth rates (157/1000). Many factors, including youth-unfriendly health facilities, ineffective adolescent and youth reproductive health policies and services and sociocultural practises inhibit young people's engagement with the health system before they become pregnant. Therefore, efforts to improve uptake of FP among this group should focus on non-public service outlets, on making public services more youth-friendly, intense counselling during pregnancy and provision of services in the postpartum period.

The high unplanned pregnancy rates could be because women begin using FP after they've had three or more children, the high unmet need for FP (26.2 percent) and the lack of effective means of contraception (e.g. using contraception for spacing rather than for limiting). These data provide evidence for the enormous scope to improve access and use of FP in the country.

The fact that contraceptive users source over 74 percent of FP products from the public health sector provides an important window of opportunity to promote FP services through integrated programmes. Such programmes could target provision of FP services through the contacts that pregnant women and mothers with children make with the health system, through contacts that people seeking HIV/AIDS preventive and treatment services make and vice versa. This is also because MNCH and HIV/AIDS services are also primarily delivered through the public health sector and to the same population of women and men of reproductive age who need FP. See Table 1b for detailed data in comparison with other SSA countries.

3.1.3 Maternal health

Recent estimates show that even though Malawi has made progress in reducing maternal mortality, the country still has one of the highest Maternal Mortality Ratios (MMR) in the region at 510/100,000 live births. Even though the country has an excellent first ANC visit attendance record (95 percent), this positive trend sees a sharp drop as women proceed to fourth and final visit with only 46 percent completing the four visits (Table 1c).

The use of skilled care during delivery shows that Malawi, with 71 percent of women having access to skilled birth attendants during delivery, has one of the lowest rates compared to the other Southern Africa countries, including Botswana (95 percent), DRC 80 percent), South Africa 91 percent), Namibia (82 percent) and Swaziland 82 percent) with a proportion of 80 percent and above.

The high attendance to ANC at least once, however, presents an opportunity to encourage women to go for more ANC visits and opt for hospital deliveries or deliveries using skilled care. Evidence suggests that use of FP is higher among women who attended the recommended four or more ANC visits, making the case for integration of FP into ANC services (WHO, 2010). In addition, deliveries with skilled care can ensure that women who are HIV positive can receive PMTCT, which is proven to reduce the risk of vertical transmission of HIV to less than 5 percent (or even lower) in breastfeeding populations from 35 percent, and to less than 2 percent in non-breastfeeding populations from 25 percent (WHO, 2010). At the time of the study, Malawi had introduced PMTCT Option B+ to provide care that goes

beyond prevention of vertical transmission for HIV positive pregnant women, to providing life-long care and treatment.

3.1.4 Child health

Malawi has made significant progress in reducing infant mortality rates (IMR) and under five mortality rates (U5MR) over the past decade. Against the MDG target of 76, the country's U5MR stood at 83 in 2010 and 71 in 2012, surpassing the MDG target. IMR has also dropped significantly from 143 in 1990 to 46 in 2012. Immunisation coverage is also moderately high at 71.8 percent, representing one of the best coverage rates in Southern Africa. Access to pneumonia and diarrhoea care and treatment, though not very high (70 percent of under-five having access to appropriate health care provider) and (62.1 percent of children accessing treatment for diarrhoea) still present a good performer in the southern region.

Since almost two-thirds of all child deaths are caused by preventable infectious diseases, including malaria, pneumonia, diarrhoea, sepsis, measles and AIDS[13] there is need to scale up access to these essential services to further reduce IMR and U5MR in the country. Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases. It is also one of the most cost-effective health investments, with proven strategies that make it accessible even to the most hard-to-reach and vulnerable populations. Malawi's high immunisation coverage rates present an opportunity for expanding access to other key MNCH, HIV and FP services across the country, but particularly in the rural areas where there is the most need. Table 1d summarises data on Malawi's child health statistics and compares them to other SSA countries.

3.2 Status of Integration at Policy, System and Service Delivery Levels

The effective delivery of integrated services requires support for policy frameworks and systems. As noted by the WHO,[14] effective integration requires coordination at multiple levels, within and among government and partner agencies and should include policies and guidelines, administration and governance, funding, human resources, information systems and commodity supply chains. In this section, we provide results from country assessments describing the integration landscape at policy, system and service delivery levels. These are considered in the light of the literature and current practice in the region.

3.2.1 Policy framework for MNCH, FP and HIV/AIDS integration

Although the presence of a policy framework on SRH/MNCH, FP and HIV/AIDS service integration does not automatically translate to provision of integrated services, it demonstrates the much-needed global and government leadership on the issue and provides guidance to stakeholders involved in funding, programming and service provision. Since the mid-1990s, various global commitments have been made towards promoting linkages and integration between SRH and HIV/AIDS services. These include: the 1994 International Conference on Population and Development (ICPD);[15] the 2001 (UN General Assembly) UNGASS Declaration of Commitment on HIV/AIDS;[16] the 2004 New York Call to Commitment: Linking HIV/AIDS and Sexual and Reproductive Health;[17] the 2005 Call to Action: Towards an HIV-Free and AIDS-Free Generation,[18] the UNGASS 60 Session Political Declaration on HIV/AIDS;[19] and Achieving Universal Access to Comprehensive Prevention of Mother-to-Child Transmission Services consensus statement.[20]

At the regional level, the African Union's Health Strategy as well as the Southern African Development Community's (SADC) SRH Strategy emphasises integration, whereas the East African Community's (EAC) SRH strategy does not.

At the time of the study, Malawi was in the process of developing a SRH and HIV/AIDS integration policy. Integration commitments are also contained in specific policies for RH/MNCH, FP and/or HIV/AIDS (see Table 2 below).

Table 2: Key policies guiding MNCH, FP and HIV/AIDS Malawi

- National Sexual and Reproductive Health and Rights (SRHR) policy 2009
- National HIV Prevention Strategy 2009-2013
- EMTCT 2012
- National Blood Policy 2012
- Youth-Friendly Services Policy 2007
- National Plan of Action for Scaling up SRH & HIV Prevention Interventions for Young People 2008-2012
- National Youth Policy 2013
- Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi 2007

Specifically, Malawi's 2009 RH strategy adopts an integrated approach bringing together aspects of maternal, newborn and child health (MNCH), FP, and STI/HIV/AIDS. Central to the strategy is enhanced equity and access at service delivery level. The programme includes components such as FP, MNCH (including management of unsafe abortion), prevention and management of STI/HIV/AIDS, prevention, early detection and management of cervical, breast and prostate cancer, infertility, mitigation of harmful practices and obstetric fistula. Stakeholders argued that the policy had brought about improvements in FP, STIs, management of unsafe abortion and cervical cancer prevention.

Most study participants viewed the government as committed to partnership, open to engagement and allowing meaningful stakeholder participation in policy processes.

Policy level challenges

The main challenges at policy level were the lack of policy framework for integration and the weak coordination and capacity for policy development and implementation.

Lack of a policy framework for integration

Lessons from Kenya indicate that having an integration policy demonstrates high-level commitment to integration, which is essential for lower-level implementation. The policy also outlines clear guidelines on possible integration models, as well as specifying a minimum package for integrated services.[21] It was felt that for Kenya, having an integration policy (strategy and guidelines) has been instrumental in the country's achievements on SRH/MNCH, FP and HIV/AIDS service integration.[22] These are worthy lessons for Malawi, suggesting that finalising the development of an integration policy is the right pathway to integration. It's encouraging that both partners and the government are committed to integration as this provides an important starting point for realising an integration policy. As one respondent noted:

> "There is already a strong commitment to integrate; what is lacking is how to do it. At the moment there is no national policy guideline to support integration […]."
>
> - UNFPA interviewee

Some partners, however, felt that there was no sense of urgency in government to accelerate integration, and suggested that in some government quarters, policy makers feel integration is already taking place anyway, especially at service delivery level and as such there was no need for a specific policy on integration.

> "To some 'integration is already taking place anyway' thus no need for a policy; there is a sense of 'no-urgency' for a policy."
>
> – Validation meeting participant

Weak leadership and capacity for integration policy development and implementation

Despite the commitment by the government to engage partners, there was a rallying call for the government of Malawi to take leadership in policy development, championing integration, partner coordination and implementation because it is only when government takes full leadership that integration can be fully implemented in the country:

> "There is need for full government involvement, the government have to lead it [the integration process]; development partners should remain just that, partners […], government must show commitment both in policy and practice. You cannot have integration if the Minister is not leading."
>
> – WHO interviewee

Government attributed this perceived weak leadership and coordination to the challenge of having to deal with multiple partner agencies, expressing frustration at having to deal with numerous partners, all demanding attention from the already-overstretched workforce:

> "It's challenging to work with different partners – a pool system might serve us better especially given the coordination demands."
>
> – Central Medical Stores interviewee

In summary, the key policy challenges and gaps in Malawi include:

- The absence of an overarching integration policy to guide integration efforts;
- Lack of service integration guidelines at national level;
- Inadequate systematic coordination of various integration efforts being implemented by stakeholders;
- Standalone or vertical policies targeted at specific programmes;
- Competing perspectives and interests between stakeholders on what direction integration should take;
- Lack of standardisation – there are several models of integration, resulting in many variations in results;
- There are too many small-scale pilot programmes, but with little or no scaling up;
- Policies do not adequately target men to access SRH;
- Pre-service training curricula do not cover integration thoroughly;
- Legal and cultural context hostile to certain key populations such as men having sex with men, commercial sex workers and adolescents; and
- Policies and programme not well understood at points of implementation.

3.2.2 MNCH, FP and HIV/AIDS integration at system level

The system level refers to structures put in place to support successful implementation of stated policy objectives. The existence of supportive systems that facilitate the actual provision of integrated services remains a critical factor in determining the success or failure of any integration efforts. The study identified vertical structures and planning mechanisms within the government (i.e. within MoH and between MoH and the National AIDS Commission), inadequate funding, insufficient and inadequately skilled health workers, lack of equipment, weak supply chains occasioning frequent stock-outs, and weak M&E systems as the key system barriers to service integration. As such, the system level presents a critical entry point to supporting integration efforts.

Funding and budgetary support for integration

In Malawi, as is the case in many SSA countries, health care is critically underfunded by governments. Currently, government spending on health as a percentage of the national budget stands at 18 percent.[23] Most of the government funding goes toward recurrent expenditure (such as salaries), leaving very little, if any, for programmes on health service provision. Donors provide most funding for integration. This funding takes two main forms:

- Pool/basket funding operationalised through memoranda of understanding (MoU) with bilateral and multilateral funders (funds are provided through government structures and are applied based on the government's needs).
- Discrete-funding, where funds are managed by individual donors (in many cases, funds are given to implementing partners such as NGOs) or through a system where money is put into an account and spent by government, but with donor oversight.

The Malawi government expressed support for basket funding, arguing that it enables the application of funds to key national priorities and facilitates integration since basket funds lose identity and in cases where donors do not earmark them, they can be leveraged to cover programmes with less support such as MNCH.

The main funders for SRH (including MNCH, FP) include USAID, DFID, UNFPA, UNICEF, KFW-Germany and WHO. The main funders for HIV/AIDS include Global Fund, USAID and PEPFAR/CDC. The same funders support integrated programmes, albeit at varying levels. Other funders with significant input include SIDA-Sweden, UNAIDS and EU. This information is summarised in Table 3 below.

Table 3: What is being integrated by whom and where in Malawi

Integrated services	Funding institution(s)	Implementing institution(s)	Region/district
HIV and SRH	EU, SIDA (M&E), UNFPA (TA) UNAIDS (TA)	MoH, FPAM	3 districts - Nkhatabay, Dedza and Mangochi in 5 health facilities per district
RH (Cervical cancer screening) and FP into HIV/AIDS	MoH, NAC, CDC, GIZ, BMGF	Lighthouse	Kamuzu Central Hospital - The Martin Centre (Bwaila Hospital)
FP into HIV/AIDS (PMTCT)	Baylor International Pediatric AIDS Initiative (BIPAI) Malawi	Baylor College of Medicine-Abbott Fund Children's Clinical Centre of Excellence (COE)	Paediatric ward at Kamuzu Central Hospital
MNCH, FP/RH, malaria, nutrition, HIV	USAID	JHPIEGO, Save the Children, CARE, Plan International, 10 CBOs (community mobilisation), JSI (supply chain)	15 districts: Lilongwe, Dowa, Kanzungu, Nkhotakota, Salima, Mangochi, Balaka, Machinga, Zomba, Palomba, Mulanje, Thyolo, Chikwawe and Nsanje
Mobile health services: Integrate HTC & STI testing into FP and refer clients for STI/HIV care Static sites: FP, HIV/STI, ANC (but no deliveries), primary health care	DFID, Norway, Cordaid (Core activities - FP) NAC (HIV) UNICEF and UNFPA (youth SRH)	BLM	31 static facilities - Rumphi, Karonga, Mzuzu, Mzimba, Kasungu, Nkhatabay, Dwangwa, Nkhotakota, Mponela, Mchinji, Area 25, Salima, Mangochi, Kawale, Falls, Dedza, Mwanza, Liwonde, Zomba, Balaka, Ntcheu, Mangochi, Bangwe, Lunzu, Chilomoni, Zingwangwa, Ndirande, Ginnery Corner, Ngabu, Mulanje, and Bvumbwe: outreach in hard to reach areas - 27 of 28 districts

HIV into ANC HIV into FP FP into HIV/AIDS	NAC, DFID	CHAM, MoH	171 member health facilities (20 major hospitals, 30 community hospitals, the rest health centres with or without maternity)
Supply chain for ACTs, HIV test kits, family planning, child health	BMGF (6 districts), WHO (9 districts) Save the children, UN innovations working group	UNICEF, USAID SSDI (6 Districts), Child health, PSI, UNFPA, D-Tree into M-HEALTH, Concern worldwide	23 districts
FP, STI, HIV and PAC	UNFPA, IPPF, NAC, PRB, KFW, UNC	FPAM, MoH/Directorate of RH	Kasungu, Dowa, Lilongwe, Dedza and Ntcheu
15 high impact interventions targeting children under 5 including paediatric HIV (including PMTCT option B+) and FP within ANC care, safe delivery and birth by skilled attendance	BMGF, WHO, UNICEF, UNFPA	IMCI and RHU, PMNCH	10 districts - Karonga, Zimba north and Zimba south, Kasunga, Lilongwe, Ndeza, Njeu, Balaka, Chiradzula, Palombe, Nsanje
MNCH (nutrition, malaria, hospital delivery, exclusive breast feeding & the kangaroo care), FP, HIV, PAC, male involvement & girl child education	BMGF NAC UNFPA	The Presidential Initiative on Maternal and Health and Safe Motherhood in the Office of the President and Cabinet	Lilongwe, Kasungu, Dowa and Mchinji (Dowa and Mchinji, are being used as control districts

Source: Stakeholder interviews

There were two main challenges with funding. The first was the grave inadequacy of funding, particularly for MNCH programmes. A MoH official also in charge of several programmes dealing with MNCH noted that:

> "When cuts are made its MNCH that suffers, curative services receive a priority as most people do not think that FP for instance is a critical necessity As it is now, MNCH gets less funds compared to programmes such as HIV."
>
> – MoH interviewee

The maternal health programme presents many opportunities for integration, yet it is greatly underfunded compared to HIV/AIDS, FP and child immunisation. Thus, efforts seeking to enable integration through the MNCH platform need to first invest in strengthening the maternal health programme.

The second challenge was the vertical approach to programme funding by development partners. Development partners often fund programmes independently. Some respondents felt that donors are the biggest hindrance to integration efforts, since most of them emphasise more on their programme visibility and aim more at outcomes than system strengthening:

> "When donors do their plans, they do not talk the integration language – they are the source of all these problems of slow uptake of integration. People [implementers] talk about 'we have a commitment with SIDA, USAID etc.…if donors integrated at the top, the same would apply at the local level, and integration would be easy."
>
> – WHO interviewee

In some cases, partners were said to put emphasis on their corporate identity rather than engaging in joint plans for which they could not monitor quality:

> "Some partners have strong corporate integrity that they wish to protect; it becomes a challenge to have them buy into pooled integration efforts; it's also about quality."
>
> –WHO interviewee

One result of this is fragmented programmes that are run vertically at health facilities with separate resources and different reporting, supervisory and M&E mechanisms, all of which undermine integration as well as putting extra strain on human resources and potentially even duplicating health systems functions.

The Malawi government has in place a health Sector Wide Approach (SWAp)[24] mechanism that provides an opportunity for funding partners to put money into a common basket for the health sector and address the challenges prioritised by government. The SWAp mechanism ensures policy, technical guidelines and output expectations (also referred to as joint programme mechanisms) match. The SWAp unit carries out annual and bi-annual reviews to ensure resources into the health sector are mapped to identify the sources of

funds and where donors put their money. This information is shared with donors to help leverage funding.

Not all funders, however, participate in SWAp and the mechanism is complex to manage and government capacity weaknesses are a major bottleneck in its effectiveness.

> "Coordinating joint financing by donors is laborious, complex and needs a lot of diplomatic skills […]. Sometimes the politics of the day influence donor cooperation, e.g., recently due to the 'cash-gate' scandal some donors withdrew from pool funding and went discrete […]. Audit of government financial systems revealed some weaknesses, making some donors to move to discrete funding."
>
> – Government official

The Gates Foundation has largely funded MNCH, FP and HIV/AIDS through (NGOs), suggesting an opportunity for the Foundation to explore potential direct funding mechanisms to government. The Malawi government also needs to put in place mechanisms that will give development partners incentives to support government priorities through the basket fund, rather than letting partners run their own vertical programmes through multiple NGOs.

Planning and coordination

As in many SSA countries, multiple vertical structures for SRH/MNCH and HIV/AIDS programmes exist in Malawi. There were separate departments/divisions responsible for SRH/MNCH and FP, while the national AIDS control programme is responsible for HIV/AIDS. There is also the National AIDS Commission, responsible for the multi-sectoral response to HIV/AIDS, placed in the office of the President. While vertical structures present major challenges for integration in many countries in SSA, Malawi has a fairly strong joint planning and coordination mechanism led by the Directorate of Reproductive Health (DRH), which provides a learning example. The SWAp in this case facilitates the alignment of donors to the health sector strategic plan and there are various Technical Working Groups (TWGs) in place that convene relevant stakeholders in the three areas as well as one focused on integration, though its level of its functioning is in question.

In spite of these efforts, there is a need to further strengthen joint planning and coordination while many partners still prefer to run their own programmes. The generously funded HIV/AIDS structures and programmes also need to show leadership and commitment in enabling more meaningful collaboration and joint planning with the MNCH and FP structures and programmes in order to support and facilitate integration on the ground. As one of the main funders of the Global Fund, the Foundation could continue to influence the realisation of this outcome.

Human resources

Inadequate human resources capacity remains a major challenge in the health sector in Malawi, presenting a key barrier to integration. The human resources challenge includes an inadequate number of health workers in facilities, inadequately skilled healthcare workers particularly in providing integrated services, poor remuneration against large workloads causing low motivation, high staff turn-over and poor service quality. Malawi is currently operating at below the WHO recommended client–health worker ratio with only 30 percent of its required workforce. There were on-going efforts by governments and partners to alleviate the problem, including by training healthcare workers to equip them with the skills needed to provide integrated services.

Often, however, these efforts are not nationwide, but rather in regions and districts where partners are implementing programmes. Most partners interviewed had training components in their integration programmes, but argued that high staff turnover and frequent transfers undermined their training investments as health workers often left before using or transferring their acquired skills. For instance, the Foundation, through the safe motherhood programme, supported the recruitment and training of community health workers in areas with the greatest shortage. The problem here is that recruitment and deployment are still done centrally, which does not guarantee that health workers are equitably deployed. Partners also recruited and trained more health workers to support the running of their programmes in government health facilities in the hope that the government absorbs staff when partners' programmes end. However, this might not always end up being the case especially when down-sizing of partner programmes leave staff without jobs, leaving a situation of understaffed facilities and many unemployed/ surplus health workers. Stakeholders were also investing in task sharing and task-shifting in order to alleviate the human resources challenge, albeit with limited and varied success.

The gravity of this challenge requires the government of Malawi to make clear commitments that progressively address the issue over long term. It requires consideration of the policy of task-shifting to increase access to health care. Innovative strategies that address the insufficient numbers of health workers, the skills gap, and the low remuneration and motivation, present opportunities for strengthening human resources, which are a critical element for integration.

Logistics and supply of commodities, and laboratory support

At the time of the study, the government of Malawi was moving from vertical supply chains for different programmes and commodities to integrated systems that include, most, if not all of the essential medicines and other health commodities available through the public sector.

The reported challenges here range from separate, uncoordinated procurement procedures, inadequate transport for commodities, to weak capacity for forecasting, the latter often resulting in stock-outs. For example, while the supply of condoms had been integrated (under the government supply chain) procurement was still vertical. The result was that each partner followed their own estimations and procurement, sometimes leading to oversupply and expiry of products. Some partners, like USAID and UNFPA, set up a parallel supply system to complement the government system. However, the goal was usually not met as partners ended up procuring similar products when in fact these could have been easily avoided if there was a coordinated forecasting and procurement mechanism. Efforts are in place to address some of these challenges, including the CSTOCK programme (see section under M&E below) already supported by the Foundation.

Laboratory support for integrated services is one of the weakest links to integration in Malawi. There were robust efforts to support strengthening of laboratories and a recent assessment by the government showed that quality has improved although there is the persistent problem of inadequate qualified personnel.

Monitoring and Evaluation

Many stakeholders reported using country-specific MoH indicators (part of the HMIS) for M&E, encompassing data capture, supervision, reporting, and referral. Some partners modified these indicators to reflect their programme needs. For instance, the M&E for the RMNCH programme led by WHO and implemented in ten districts was based on seven key indicator areas adopted from the national M&E platform and modified to suit programme needs. Some partners are also piloting innovative M&E programmes using IT platforms (e.g. through mobile phones and collecting information electronically) at the facility level, with impressive results and improvements of the M&E and supply chain systems reported. An excellent example is the CSTOCK programme being implemented by JSI Deliver, which allows Health Surveillance Assistants, facilities, and the District Health Office (DHO) to requisition, monitor, and manage supplies using simple mobile phone technology on an integrated platform. Nonetheless, M&E for MNCH, FP and HIV is still largely vertical given the vertical nature of programmes. Stakeholders expressed need for integrated and easy-to-use M&E tools.

The quality of reporting information was also highlighted as a major challenge. It was argued that data quality was poor mainly because health workers are overworked or do not appreciate the importance of the data:

> "Staff say they are too busy to fill out forms. It is an issue of health worker shortage. Some health facilities are underreporting because of not filling out forms at the point of service delivery."
>
> – MoH Interviewee

This means that the health care system lacks the necessary information needed to inform improvements. A related issue, the referral system, also remains weak, contributing to loss to follow-up and care, particularly with reference to PMTCT.

Given these weak systems, investments in re-orienting the M&E systems at health facility level and piloting/scaling up IT or mobile phone-based M&E systems will contribute to generating useful data required to inform service delivery processes and ensuring more effective referral systems.

3.2.3 Status of integration at service delivery level

Table 2 provides detailed list of integration programmes being implemented in Malawi. Most respondents in Malawi, including MoH officials, felt that some integration is taking place, with some stating that integration of MNCH, FP and HIV was happening "by default."

There were variations in the models and approaches of integration at the service delivery level. PMTCT, which entails integrating HIV counselling and testing, care and treatment into MNCH, remains the only integrated model with nationwide focus. Notably, Malawi has adopted PMTCT Option B-plus, which entails providing life-long antiretroviral to all pregnant women who test positive, without waiting for the CD4 count. This is part of WHO guidelines whose purpose is to reduce chances of mother to child transmission, as well as protect mothers from progressing to full-blown AIDS.[25] However, the programme still runs as a vertical programme, which undermines integration of the two critical services.

This presents an opportunity for development partners to invest in strengthening the existing PMTCT programmes to ensure that all possible opportunities for integration are seized. This is particularly important given that research has shown that integrating FP and HIV/AIDS services into ANC, delivery, PNC and child-care services increases uptake of FP

and HIV/AIDS services.[26] Demand for PNC services is very low and therefore part of the integration effort needs to focus on generating and sustaining demand for PNC services.[27] Efforts that focus on strengthening the skills of MNCH service providers to also offer HIV/AIDS and FP services, motivating health care workers as well as equipping facilities with required equipment and commodities, which could support the provision of integrated services.

Other forms of integration taking place in Malawi are largely being implemented in a handful of regions, districts or facilities. These include integration of FP into PMTCT, FP into HIV CTC, FP into HIV VCT, and HIV into FP and community level provision of FP and HIV/AIDS information and some services. FP into HIV programmes (VCT and CTC) was highlighted as the most common integration model in Malawi.

Community-level service provision is of particular importance to integration efforts since it extends the reach of integrated information and services to marginalised and hard-to-reach communities that would otherwise have no access to these services. Community-level service provision in Malawi takes two forms, outreach services and community-based service provision. The government uses Health Surveillance Assistants (HSAs) to deliver community-based service delivery. The HSAs are trained and supported in using mobile phones to support the M&E and supply chain systems by monitoring commodity stocks and ensuring clients adhere to their medication through simple short message service reminders. A safe motherhood programme supported by the Bill & Melinda Gates Foundation also has a community outreach and advocacy element. The programme uses community structures and functions such as traditional authorities (Chiefs) to educate and advocate for the use and benefits of FP and HIV services. This approach was reported by stakeholders to enhance male engagement in supporting integration services, highlighted as a difficult group to reach, particularly with FP and HIV services.

Despite existing structures and initiatives, provision of integrated MNCH, FP and HIV/AIDS services at community level remains a weak link in the health system. Ethiopia's community health extension workers programme stands out as a model from which other countries in the region could learn.[28] Supporting the provision of community-level integrated services for MNCH, FP and HIV/AIDS has the potential to extend the reach of important life-saving services to rural and hard-to-reach communities.

In terms of the best approach to integration, some stakeholders preferred a synergistic approach, where programmes continue with the vertical approach, with only aspects that could benefit from integration being integrated. Others supported a broad integration approach including a focus on adding FP services into parallel HIV/AIDS programmes (VCT, PMTCT, and CTC). Stakeholders were anticipating the outcomes of the EU and UNFPA supported Sexual and Reproductive Health (SRH) + HIV Pilot Programme 2011 – 2014, stating that it would answer key questions about the best models and approaches to integrating SRH and HIV to inform a national scale-up. The programme is being implemented in 15 health facilities (five health facilities per district) in three districts – Nkhata Bay, Dedza and Mangochi. The programme started as a response to an integration rapid assessment done by the College of Medicine (COM). The assessment revealed that the HIV policy did not mention SRH while SRH mentioned HIV; that health workers were frustrated with receiving instructions from two different centres (SRH and HIV); and that HIV received much more resources than SRH.

As noted earlier, the nationwide MNCH platform accessed by many women and children presents investment opportunities for strengthening integration efforts within countries. It is also important to note that other integration models also offer opportunities for extending the reach of life-saving services to communities, particularly integration of FP into HIV testing and counselling, FP into PMTCT, FP into HIV care and treatment services and provision of community level integration. The common model – FP into HIV/AIDS services – presents opportunities for scale-up in Malawi.

The main highlighted challenges to integration at the service delivery level were inadequate numbers of health workers, inadequate skills, lack of integration guidelines, frequent stock-outs and lack of equipment and laboratory services.

3.2.4 Priority populations for integrated services

Priority populations for integrated services identified included rural populations, mothers and their newborns, adolescents and sexual minorities. Stakeholders argued that these groups bear the highest burden of disease and death associated with MNCH, unwanted pregnancy, and HIV/AIDS, while facilities around serving these populations are generally fewer and widely dispersed. Thus, integration programmes that target these populations are more likely to increase access to lifesaving services.

3.2.5 Entry points for integration efforts

Opinion was divided on the best integration models but respondents most often cited the two best entry points for integration as the MNCH platform (mainly through the ANC platform) and the HIV/AIDS platform (mainly through the PMTCT/EMTCT platform).

MNCH platform – Some interviewees felt that unlike other programmes (FP and HIV), MNCH provides the best linkages and is already integrating other programmes, both at service delivery and policy level, and as such, was 'open to change'. On the other hand, FP and HIV were seen as historically rigid and vertically-oriented.

> "If you put money in FP, they will not want to hear anything about MNCH or child health. MNCH is the way to go with integration."
>
> – WHO interviewee

Stakeholders particularly identified the ANC platform as a good entry point to incorporate many other services such as PMTCT, malaria prevention, screening for TB and FP advice.

If adopted it has the potential to improve access to most services, for example by reducing costs associated with service access such as transportation (women will not have to travel multiple times to the health facility for different services every other day) and by reducing health workers workload. ANC is also cost-effective and meets multiple needs of the clients at one point, besides being the health system point at which most women are captured and thereafter followed.

The immediate post-natal period and child immunisation sessions were also identified as potential entry points for integration, but which are often missed. This is in line with the findings of the INTEGRA Initiative, which reported increased uptake of HIV and FP services following the inclusion of FP and HIV/AIDS services into MNCH.[29] The study, however, pointed out the low demand and uptake of post-natal services and the need to create demand for these services as part of the integration efforts. The on-going efforts to integrate PMTCT into MNCH are critical and provide important entry points for addressing some of the gaps that still exist in the PMTCT programme. The main challenges for using the MNCH platform are its weak financial base and inadequate human resources, particularly in rural areas.

HIV/AIDS platform – Some stakeholders argued that the MNCH challenges above could be overcome easily if the HIV platform were to be adopted. This group argued that given the high political support, huge investments and the robust M&E platform for HIV/AIDS, the programme provided a better platform for integrating MNCH, especially in view of the latter's limited funding and low political priority. Respondents pointed out that HIV was already integrating FP and as such, it might be easy to leverage its financial strength to support other programmes under MNCH. The main challenge for using the HIV platform is its vertical design and in the long-term, funding as it is currently heavily donor-funded.

All in all, respondents emphasised the need for integration efforts to aim for quality and not quantity, to strengthen health systems, target underserved populations and leverage limited resources for maximum benefits:

> "Integration is a quality issue, not a quantity issue. With HMIS, you get quantity."
>
> – Development partner interviewee

3.3 Caution

Not all integration efforts produce a positive impact. There are still significant knowledge gaps on the benefits and effectiveness of SRH/MNCH, FP and HIV/AIDS integration. This partly implies that not all SRH/MNCH, FP and HIV/AIDS services can be integrated at the different levels of health system. While the one-stop-shop model of integration where all services are offered under one roof has been shown, in some cases, to have more benefits than other models,[30,31,32,33] this may not be a realistic model for many health facilities. Integration is context-dependent and so, for practical purposes, facilities are often only able to integrate what is possible according to limiting factors, for example, the number, capacity and motivation of health workers and the equipment and commodities available, making it important that facilities are the focus of support in integration efforts.

Finally, existing vertical structures and programmes cannot simply be wished away. Some of the respondents feared that integrating stronger (e.g. HIV) and weaker programmes (e.g. MNCH) could 'kill' the weaker programmes. This concern cannot just be ignored. With this reality, it may be necessary for Malawi to audit existing structures, programmes and the health care delivery capacity at different stages (i.e. from dispensary to referral), before proposing feasible integration models for the various levels of the health system. Furthermore, national-level research that focuses on assessing the effectiveness of these is needed to generate knowledge that can inform the scale-up of integration efforts in Malawi.

4 Conclusion

4.1. Potential Role for the Gates Foundation in Supporting Integration

The Gates Foundation is currently investing in Malawi in all three areas – MNCH, FP and HIV/AIDS. The Foundation-supported Presidential Initiative on Maternal Health & Safe Motherhood integrates MNCH and FP, whereas the data systems improvement programme focuses mainly on HIV/AIDS and FP. Foundation staff indicated that the Foundation was likely to strengthen its investments in Malawi given the good working relations it has with the government. From our findings, the Malawi government is already making efforts to facilitate integration. Given the government's commitment to integration and the Foundation's existing investments in the country, our overall recommendation is that the Foundation should make Malawi a model country for integration investments by intensifying and leveraging its existing investments in the country to support larger MNCH, FP and HIV/AIDS integration programmes. Such programmes should have a research component to evaluate their effectiveness and efficiency and to inform future scale-up efforts.

We suggest that the Foundation prioritises investments in Malawi in the following specific areas:

- Work with the MoH to:
  - Strengthen its leadership and coordination role to ensure integrated programmes rather vertical programmes by partners. Particularly, the Foundation could support technical capacity development for the office of the Directorate of Reproductive Health, which is currently leading integration efforts in Malawi. This kind of support can go hand-in-hand with support for local advocacy efforts for government's increased investments into the maternal health programme.
  - Support dissemination events for the SRH and HIV/AIDS integration policy that was under development at the time of the study. Beyond events, the Foundation could support the development of integration guidelines and job aids for actual service provision.
- Strengthen the Foundation's current investments in the maternal health programme in order to extend the programme nationwide. Particularly, the Foundation should strengthen its support for the skilled community midwives' training (this contributes directly to addressing the grave shortage of health workers in Malawi, with significant impact on reducing maternal and neonatal mortality especially in hard-to-reach areas) and the community engagement and advocacy component of the programme. Supporting integration of HIV/AIDS into this programme would leverage existing investments for greater impact.
- Support efforts that streamline and improve the supply chain and logistics to enable joint procurement, storage and distribution. Lessons can be drawn from the Foundation-funded pilot programme, Supply Chain for Community Case Management (SC4CCM), which has returned positive reviews and has been adopted for national scale-up by the Government. Most interviewees felt that scaling-up this programme has the potential to greatly improve logistics and supply chain management in Malawi. At the time of the study, the programme was closing down, but the government, with the support of partners, had hired one of the JSI core staff to lead the scale-up plans at the MoH.

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[22]Ibid.

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[24]The Sector-Wide Approach (SWAp) is an approach to international development that brings together governments, donors and other stakeholders within any sector. Under the SWAp, project funds contribute directly to a sector-specific umbrella and are tied to a defined sector policy under a government authority. In essence, a SWAp calls for a partnership in which government and development agencies change their relationships (to clearer government leadership) (http://www.who.int/trade/glossary/story081/en/)

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Appendix of tables showing data used to map disease burden and service utilisation

Table 1a: HIV/AIDS burden and service utilisation indicators in Sub-Saharan Africa

	HIV prevalence	HIV incidence	Deaths due to HIV/ AIDS (per 100,000 Population)	Access to ART	PMTCT	Proportion of population aged 15-49 years without comprehensive knowledge of HIV/AIDS (women)	Proportion of population aged 15-49 years without comprehensive knowledge of HIV/AIDS (men)	Percentage females who tested for HIV in the last 12 months	Percentage males who tested for HIV in the last 12 months
Angola	2.3	0.3	59	38	16	75	68	-	-
Botswana	23.0	1.3	-	95	94	60	68	-	-
Burundi	1.3	0.1	67	54	52	56	54	19	11
DRC	1.3	0.1	32	6	37	84	79	4	4
Eritrea	0.7	0.0	26	49	-	64	-	-	-
Ethiopia	1.3	0.0	47	57	24	76	66	20	20
Kenya	6.1	0.4	148	72	67	53	45	29	22
Lesotho	23.1	2.3	638	58	62	61	71	42	25
Madagascar	0.5	0.0	12	3	-	78	74	4	4
Malawi	10.8	0.8	285	67	53	58	55	-	31
Mozambique	11.1	1.0	310	46	51	64	66	26	13
Namibia	13.3	0.8	223	95	85	35	38	29	18
Rwanda	2.9	0.1	58	82	56	48	54	39	37
South Africa	17.9	1.4	535	66	95	80	-	19	20
Swaziland	26.5	2.0	556	83	95	42	46	22	9
Uganda	7.3	0.8	181	54	50	62	61	42	30
United Republic of Tanzania	5.1	0.3	181	40	74	60	53	30	25
Zambia	12.7	0.8	232	82	86	62	59	19	12
Zimbabwe	14.7	1.0	457	77	54	48	53	34	20

NOTE: Regional figures are median values. Dashes indicate where there is no data.
Data source: DHS & UN Statistics Division MDG indicators

Table 1b: FP and fertility indicators in Sub-Saharan Africa

	Adolescent birth rate (per 1000 women aged 15-19)	Unplanned pregnancies (percent)	CPR	Unmet need for FP	Knowledge of sources of modern contraceptive methods	Sources of FP - Public
Angola	165		4.5	-	-	-
Botswana	51	38	51.2	26.9	-	94
Burundi	65	31	17.7	32.4	-	87
DRC	135	30	5.5	26.9	-	21
Eritrea	85	25	5.1	28.5	-	74
Ethiopia	79	28	27.3	25.3	-	82
Kenya	106	43	38.9	25.6	-	57
Lesotho	92	52	45.6	23.3	-	63
Madagascar	147	12	28.2	19.0	45	73
Malawi	157	44	42.2	26.2	83	74
Mozambique	193	15	11.3	28.5	-	77
Namibia	-	53	53.5	20.7	82	75
Rwanda	41	38	44.0	18.9	91	92
South Africa	54	47	59.8	13.8	-	84
Swaziland	111	64	63.0	13.0	-	45
Uganda	159	44	25.8	38.0	-	47
United Republic of Tanzania	128	26	26.1	25.3	71	63
Zambia	151	41	26.5	26.6	87	68
Zimbabwe	115	32	57.1	15.5	-	73

NOTE: Regional figures are median values. Dashes indicate where there is no data. Tanzania = United Republic of Tanzania
Data source: DHS

Table 1c: Maternal Health indicators in Sub-Saharan Africa

	Maternal mortality ratio (per 100,000 deaths)	Nutrition: women's body mass index (BMI) in kg/square height in meters: BMI mean	SBA	ANC 1 visit	ANC 4 visits
Angola	450	-	49	68	47
Botswana	160	-	95	92	73
Burundi	800	21	60	99	33
DRC	540	21	80	86	45
Eritrea	240	20	28	70	41
Ethiopia	350	20	10	34	19
Kenya	360	23	44	92	47
Lesotho	620	25	62	92	70
Madagascar	240	20	44	86	49
Malawi	460	22	71	95	46
Mozambique	490	22	55	91	51
Namibia	449	24	82	95	70
Rwanda	340	23	69	98	35
South Africa	300	-	91	92	87
Swaziland	320	27	82	97	77
Uganda	310	22	57	95	47
United Republic of Tanzania	460	23	49	96	43
Zambia	440	22	47	94	60
Zimbabwe	570	24	66	90	65

NOTE: Regional figures are median values. Dashes indicate where there is no data.
Data source: Respective country DHS

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