UNIVERSITY OF MALAWI

College of Medicine

Perceptions of HIV Positive Women on Integrated Health Service Delivery's Efficiency: A Review of Public Health Facilities of Lilongwe District, Malawi.

By

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BSc (Social Sciences), MA Dev. Studies

(MPH 201670073502)

A Dissertation Submitted in Partial Fulfilment of the Requirements of the Master of Public Health Degree

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15th May 2019

CERTIFICATE OF APPROVAL

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DECLARATION

I Ivy Violet Chauya hereby declare that this dissertation is my original work and has not been presented for any other awards at the University of Malawi or any other University.

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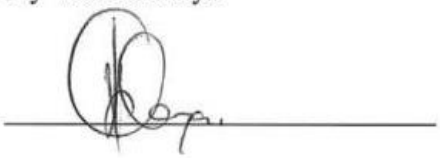
Signature 

Date 15th May 2019

DEDICATION

I dedicate this paper to the almighty God for seeing me through every step of the way and all the people that have given a helping hand to get this far.

ACKNOWLEDGEMENTS

I would like to thank my dissertation supervisor, Mr. Davie Zolowere for tirelessly supporting me during the time I started my research work. Mr. Albert Dube for supporting with review and editing of the research dissertation. Your support is greatly appreciated.

Special thanks go to my family and friends for the encouragement and support rendered during the time of my studies. You have made my work easier by understanding my study schedules.

ABSTRACT

The study reviews perceptions of HIV positive women on Integrated Health Service Delivery (IHSD) efficiency focusing on HIV integration with other health services. HIV/AIDS has proved to be a global health concern impacting more on poor countries and vulnerable populations like women and children.

The study aimed at exploring perceptions of HIV positive women aged 18 and above on IHSD's efficiency in public health facilities of Lilongwe district, Malawi. Specifically describing the nature of IHSD, examining their knowledge and perceptions of IHSD.

This study used a cross-sectional qualitative in-depth study design where 18 HIV positive clients and 6 KIs from 6 health facilities were purposively sampled: 2 from rural, 2 urban and other 2 from peri urban. Three clients and 1 KI were interviewed in each health facility.

Data collected was analyzed using themes. Codes were developed bearing in mind the purpose of the study. The researcher identified the themes by isolating data that was significant and interesting in relation to the study objectives. The results focused on whether IHSD is effectively and efficiently being implemented, focusing on the 4 conceptual models of PATH that include patient centeredness, health operations, the health system as well as inter-sectoral initiatives.

It was revealed that the public health facilities of Malawi are not fully implementing effective and efficient IHSD as perception of clients in the 4 conceptual models proved inadequate to deliver quality IHSD. The challenges of inadequate resources i.e. trained staff, equipment, drugs, poor infrastructure forcing the health workers to refer clients to other departments/health facilities to access a service does not please most clients as it entails a waste of time and money. HIV positive women also perceive IHSD as a good and helpful service, however, they expressed dissatisfaction with delays in the delivery services due to late commencement of work and continuous referrals done for them to access a service. This is also attributed to inadequate resources as few health workers fail to adequately support the increased number of clients. There is need for government to provide effective governance to mobilize resources and improve on resource availability, enforce laws that protect the scarce resources and strengthen collaborations within and between sectors to ensure effective and efficient implementation of IHSD in the public health facilities of Malawi.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-natal Care
ARI	Anti-Respiratory Infection
ART	Anti-Retroviral Therapy
ARV	Anti- Retroviral
CHAM	Christian Health Association of Malawi
COM	College of Medicine
COMREC	College of Medicine Research and Ethics Committee
DHO	District Health Officer
EHP	Essential Health Package
EPHS	Essential Package for Health Services
FGDs	Focus Group Discussions
FP	Family Planning
HIV	Human Immune Virus
HTC	HIV Testing and Counselling
IHS	Integrated Health Service
IHSD	Integrated Health Service Delivery
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated-bed Nets
KCN	Kamuzu College of Nursing
KI	Key Informant
KII	Key Informant Interviews

MNCH	Maternal, New-born Child Health
MPHIA	Malawi Population-based HIV Impact Assessment
NCDs	Non-Communicable Diseases
NGOs	Non-Governmental Organizations
NTDs	Non-Transmittable Diseases
OECD	Organizations for Economic Cooperation and Development
OST	Opiod Substitution Therapy
PHC	Primary Health Care
PLWHIV	People Living with HIV and AIDS
RMNCH	Reproductive Maternal, Neonatal and Child Health
SDGs	Sustainable Development Goals
SRH	Sexual Reproductive Health
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Program on HIV and AIDS
UNICEF	United Nations International Children's Fund
US	United States
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VIA	Visual Inspection of the Cervix with Acetic Acid
WHO	World Health Organization

CHAPTER 1

1.1 INTRODUCTION

The WHO Technical Brief No.1 (1)defines Integrated Health Service Delivery (IHSD) as the organization and management of health services to help people get the care that they need in a user-friendly manner to achieve the desired results and provide value for money. On the other hand, UNAIDS defined program integration as the joining together of different kinds of services or operational programs to maximize outcomes, for example, organizing referrals from one service to another or offering one-stop comprehensive and integrated services (2). Kodner(3), explained that integration is designed to create coherence and synergy between various parts of the healthcare enterprise in order to enhance system efficiency, quality of care, quality of life and consumer satisfaction, especially for complex and multi-problem patients or clients.

The IHSD approach is implemented in replacement of fragmented health service delivery which according to Enthoven(4) is the systematic misalignment of resources or lack of coordination that leads to inefficient allocation of resources or harm to patients. Many governments, according to a World Health Organization's (WHO) Technical` Series on Primary Health Care(5), have implemented structural and financial reforms to move away from fragmented provider-centered models of care to integrated model that ensures everybody have access to a continuums of care that is coordinated and in line with the needs of the people.

It is believed that fragmentation of health service delivery in most health systems has increased the already existing challenge of inadequate resources (6). PAHO described IHSD as an approach that is meant to strengthen the health systems and advance a more equitable, comprehensives and continuous health services to a defined population (6). It is further believed that IHSD can pause as a solution to the existing challenges of shortage resources in the current health system as governments are seeking new ways to do more with the existing resources (1).

IHSD is one of the approaches that is gaining popularity by most governments in the recent years due to the increased disease burden that is causing an increase in the demand for resources (human, financial and physical) which are not adequate to satisfy the growing population with disease.

Human Immune Virus (HIV)/Acquired Immune Disease Syndrome (AIDS) is one of the disease that has contributed to a high disease burden in the health sector in most countries especially the Sub-Saharan Africa(SSA) region and a lot of resources have been channeled to it in efforts to reduce the burden the pandemic has brought. This, therefore, has led to a more focused approach of IHSD in relation to HIV/AIDS. Many developing countries including Malawi, gained interest in the system (7). In 2007, WHO Director General stated the reasons why we need a comprehensive, integrated approach to service delivery and fight fragmentation(1). Some of the reasons mentioned were the dramatic rise in funding for single disease or population group in programs like HIV/AIDS, immunization, malaria and polio eradication where he gave an example of the rise in the funding for HIV/AIDS as a proportion of total health official development assistance from 10% in 1990 to around 30% in 2007. The second reason mentioned was the resource constraints being faced by the health services such as human resources and that there is need to efficiently use the available resources(1).

Thus HIV/AIDS continues to be a global health concern since it was discovered over 30 years ago. Globally, over 70 million people are infected with HIV, of these 70 %are in Sub-Saharan Africa(SSA)(8). Furthermore, an estimated 2.6 million people become infected with HIV annually and women are particularly affected, making up 60 % of people living with HIV in SSA(9). Women in SSA are more affected by the disparities in the pandemic than it is for men. Women account for 58 % of the PLWHIV in Sub Saharan region, a skewed distribution that has existed for years, and women on average acquire HIV as much as 5–7 years earlier than their male peers (10).

It can however, be argued that more women go for HIV test especially during the time they go for antenatal care services that do the men who rarely go for these services despite the government's initiative to have the women being escorted by their male counterparts on their first visit for antenatal care. Thus, prevalence may even be higher in the male population than it is documented. But one can further argue that these infected men who do not know their status may end up infecting more women thereby increasing their prevalence, hence the focus on HIV positive women in this study.

It should be known that people living with HIV(PLWHIV) are faced with many challenges among which is stigma, discrimination and self labelling that make them shy away from accessing the right treatment. Experiences of social rejection, disapproval, and discrimination associated with HIV

may enhance a person's sense of shame regarding their illness and decrease their motivation to maintain optimal health(11). Other challenges include the onset of chronic illnesses [Skin rashes, tuberculosis (TB), Cancer including certain cancers such as Kaposi's' Sarcoma, hepatitis B, hepatitis C, HIV-associated neurocognitive disorders (effects on the brain), other opportunistic infections like cryptococcal meningitis, pneumonia, candidiasis(kind of an sexually transmitted infection (STI)] as their immune system is weakened living them at risk of experiencing opportunistic infections, though medication for these infections is available, being on Anti-retroviral Therapy (ART) is an effective way to avoid these opportunistic infections (12). Thus, integrating the treatments and social aspects of challenges that PLWHIVs face through an effective and efficient IHSD may be a good holistic approach that can help the PLWHIV and AIDS to receive the quality of care that they deserve for their well-being.

Because of the poor resource base that make them unable to support their growing disease burden, developing countries continue to receive donations of drugs and other health promotion materials to fight the pandemic. Since the early 2000s, extraordinary amounts of donor funds have been poured into HIV and AIDS in resource-poor settings, aimed primarily at mitigating the disease's current and future public health and socio-economic costs (13). At the end of 2015, scale-up of ART is on a fast trajectory with 46% (43%-50%) coverage of ART globally (8). This led to more gains for access to treatment in the world's most affected region, Eastern and Southern Africa where coverage increased from 24% [22%–26%] in 2010 to 54% [50%–58%] in 2015, reaching a regional total of 10.3 million people (8).

Nevertheless, providers of HIV/AIDS services realized that within the *'treatment cascade'* alone there was an increased non-compliance among patients along each of the HIV continuum [testing, diagnosis, CD4 counts, HIV care, initiation of ART, staying on treatment and continuing in care to attain viral suppression] (14). This is a public health concern that could be attributed to the fact that HIV/AIDS patients are not satisfied with the way the services are being delivered bearing in mind the inadequate resources that has affected the health system in SSA, Malawi being one of such countries.

1.1.1 The Study Setting

Malawi is densely populated, with about 18 million people (current fertility is estimated at 4.4 children per woman) and youth less than 15 of age account for nearly 50% of the population(15). Based on the Malawi Population-Based HIV Impact Assessment (MPHIA), HIV prevalence among adults aged 15 to 64 years is 10.6 % with annual incidence of the same group at 0.37% (28,000 new cases of HIV annually) and there are an estimated 979,896 people living with HIV (PLHIV), about 104,093 are children younger than 15 years (15). In the year 2011, the Ministry of Health in Malawi rolled out treatment for all pregnant and breast-feeding women and a decision was made by the Ministry to decentralize and integrate ART services into all Maternal, New-born and Child Health (MNCH) settings regardless of CD4 counts(16).

An essential health package (EHP) is the package of services that the government is providing or aspiring to provide to its citizen in an equitable manner (17). EHP services is the driver of primary health care (PHC), which is the first level of contact with the health system bringing health care close to the people and relies on health workers as well as community members (18). HIV, according to the Government of Malawi Ministry of Health (19), has been an integral part of the EHP since it was introduced in Malawi. The EHP in Malawi was introduced in 2004 and HIV is one of the 10 disease categories of the EHP whose interventions revolves around HIV prevention, HIV treatment and HIV testing(20). HIV prevention interventions include Prevention from mother to child transmission (|PMTCT) and cotrimoxazole in children; HIV testing interventions include HIV testing and counselling services while HIV treatment interventions include ART and viral load for all ages(20).

ART is a combination if at-least 3 or more HIV drugs, antiretroviral (ARVs), to help suppress the HIV virus and stop the progression of HIV disease, thus reducing the viral load (21). In Malawi, ART services are usually provided at ART clinics in most health facilities where PHC is also being provided. As response to HIV disease involves the 3 interventions of treatment, HIV testing and prevention, most health facilities have taken a holistic approach to integrate HIV treatment with other priority interventions that will help reduce the number of new infections and provide the quality of life or PLWHIV(22). In Malawi, examples of these priority interventions include HIV diagnosis, management of HIV related diseases (i.e. TB, STI), family planning (FP) services, PMTCT, infant and child feeding, management of MNCH, ARVs starting and continuing (19). On

the other hand, it is anticipated that the integrating HIV services with other PHC services will help reduce the burden of inadequate resources as these will be shared across sectors within the health facility. Integration of HIV services into PHC is therefore defined as, 'the colocation and sharing of services and resources for HIV care and primary care such as clinic space, clinicians, health education, pharmacy, laboratory services and training(23). The study is therefore set out to look at the effectiveness and efficiency of this integration regarding the perception of HIV positive women.

1.2 PROBLEM STATEMENT

Integration of HIV services has been commended as one of the approaches that will help to reduce the drop out of HIV patients along the HIV care continuum (14). This is because integration helps to deliver health services or multiple interventions together on the same patient visit usually by the same health worker. It also provides linkages between the health centre and services at the hospital or community and several other clinics within and outside the health centre as well as between clinicians, the lab and pharmacy(24). It is therefore believed that at one visit to a healthy facility, most of the patient's needs rather than a single problem will be met through the delivery of integrated services which would result in the patient being satisfied thereby visiting the hospital again. The Population Action International, highlighted that offering reproductive health services such as FP, STIs etc. together with HIV services is central to ensuring universal access to reproductive health care and HIV prevention, treatment, care and support and failure to integrate these services is a missed opportunity(9).

Although many benefits are claimed for IHSD, there is limited evidence to support the claims(1). Most health facilities in developing countries are facing challenges of inadequate resources which is deep rooted even in HIV/AIDS programs despite the increased in funding for a single disease like HIV which is also one of the reasons integrated health service delivery was opted against the fragmented kind of service delivery. However, funding towards HIV programs in low and middle-income countries has recently declined by 7% between 2015 and 2016 due to the 2008 global economic crisis(25). This calls for the need to increase resources on HIV funding which has in the past decades relied more on donor funding. Jose Izazola explained that, "historically, the HIV

response has been largely funded by international donors and governments, but low- and middle income countries are now beginning to lead on efforts to finance their HIV response(25)."

The 2016 United Nations (UN) General Assembly, emphasized the need for countries most affected by HIV to finance their own responses and create a more efficient and cost-effective way to do that(25).Despite this call, most low and medium countries have failed to cover the gap and resource constraints in health facilities continue to be an issue. For example, Malawi in 2016 received 86% (74% from global fund and 12% from other donors) funding for HIV, TB and Malaria, there was a gap of 14% which the country was to mobilize through domestic funds. Much as progress has been made so far towards achieving the target, there is still a gap as the country is still at 1.7% in mobilization of domestic funds since 2010/11(26). Therefore, more needs to be done for integration to work efficiently and effectively amidst inadequate resources. The health system needs to manage the already existing resources for IHSD to achieve results in Malawi.

Several studies have been done to assess perceptions of clients on the effectiveness and efficiency of HIV IHSD. Studies have so far focused on the perception of community level actors(policy makers, county managers and community health volunteers) on decentralizing and integrating HIV services in community based health systems(27), perceptions and experiences of IHSD among women living with HIV attending reproductive health service(28), perception on implications of integration HIV testing and counselling into maternal health care on care seeking(29), Effect of integrating HIV care with primary health care services on patient satisfaction and stigma(23).

For example, a study for health personnel's perception of IHSD in Zambia reported improved changes in organization and service delivery across a range of clinic systems, for example, more efficient use of staff time and clinic space, improved teamwork and accountability, and more equitable delivery of care to HIV and non-HIV patients (13).The report also admitted that challenges of human resource shortages or inadequate infrastructure were not addressed limiting the efficacy of the model (13). However, the report pointed out the efficient use of staff and clinic space to have improved which shows something is being done to manage the existing inadequate resources to resolve the challenge.

Another study in Kenya on perception of community level actors (policy makers, county managers and community health volunteers) on HIV community level service integration revealed that HIV-related roles (counselling, testing, linkage, adherence support and home-based care) were being

performed in the community in an ad hoc manner but expressed the need for a more coordinated approach and decentralization of the integration of HIV services to the community level as parallel programming had resulted in gaps in HIV service and planning(27). The study has emphasized the need for more coordination for the effective and efficient operation of the existing IHSD.

In Morogoro, Tanzania, a study on the perception of women attending antenatal care and other women on the implications of integration HIV testing and counselling in maternal care on care seeking care provided a good feedback on the approach(29). The report revealed an increased coverage of HIV testing, particularly among difficult-to-reach populations, and improved convenience, efficiency, and confidentiality for women while reducing stigma(29). Pregnant women believed that early detection of HIV protected their own health and that of their children. However, some women reported dissatisfaction with the approach saying that the integration of HIV testing and antenatal services are compulsory, making them feel powerless and that they intrude in their privacy.

Few studies have been done in Africa to assess clients' perception of IHSD. Because of this, it has not been easy to find information on IHSD in relation to perception of HIV positive clients (women in particular) in Africa and in Malawi. The researcher came across only one, more related study on perception and experiences of HIV positive women's on IHSD done in Kenya (28). The study reported a high appreciation among clients of HIV and SRH integration in quantitative data but qualitative data revealed that most services offered at the clinic were still fragmented as clients conceived integration as receiving all services on the same day, at the same facility, though not necessarily by the same provider. However, that was not the case as it was reported that providers do not provide multiple same day appointments for FP and ARVs which according the to the clients is costly and time wasting (28). This shows that clients viewed the frequent visits to the health facility to get the service as a fragmented not as being efficient as it is costly to them. Clients would prefer to use their few available resources (money and time) for maximum benefits of getting multiple services at once. On the contrary, in the same study by Colombini et. al some few clients reported a preference of getting fragments services saying they would prefer a return visit rather than waiting on long queues to get FP services(28). Thus, the clients were not happy with the model of integration and the way it is operating. This can be interpreted that there were few service

providers, making the delivery of services slow and clients spending a lot of time at the facility. This is not effective as some clients live far and cannot afford to wait for the long queues.

Malawi is one of the countries operating its health system with limited resources and implementing HIV/AIDS IHSD. No study has been done in Malawi specifically in Lilongwe district to assess the perception of HIV positive women on IHSD. One would ask a question, how effective and efficient is the implementation of the IHSD in public health facilities of Malawi where IHSD is implemented considering the highlighted challenges of inadequate resources? What kind of IHSD is offered at these public health facilities? Do HIV positive women have knowledge regarding IHSD? What are their (HIV positive women) perceptions on IHSD? Based on this background, this study is focusing on HIV positive women's perception on IHSD in public health facilities of Lilongwe district in Malawi.

1.3 LITERATURE REVIEW

1.3.1 Introduction

The chapter discusses literature reviewed from different authors focusing on the origin to get a broader perspective of how IHSD came into being. Then an understanding on how IHSD has been implemented over time, its successes, challenges and how different countries have been implementing the approach. The literature is based on studies and views presented in the journal articles, websites/webpages and books. Literature search has mainly used the key words of this research study are Integrated Health Service Delivery (IHSD), integration, HIV/AIDS, perception of patients on IHSD, effectiveness, efficiency. Studies that have written on IHSD, HIV and AIDS integration, Patient/client perception of IHSD were selected if the arguments presented there in fit the study's objective.

1.3.2 Historical Background of IHSD

IHSD is among the models that have been designed and implemented by the Pan American region with efforts and inspiration by the Alma-Ata declaration of the 1978 which states that,' PHC should be sustained by integrated, functional and mutually supportive referral systems…, leading to the

progressive improvement of comprehensive health care for all and giving priority to those in need'(6). Huang et al. agreed by explaining that the desire for better integration can be expressed in many ways and mentioned that a multi-disciplinary integration was a particular concern for the 1960s, while partnership working was expressed in the 1970s and that shared care and management of disease was a concern for the 1980s and 1990s(30). This declaration was signed and adopted by many countries, including Malawi.

A study by Makaula (31) revealed that Malawi has no PHC policy, instead the government of Malawi has adopted the EHP as a vehicle for delivering PHC and that the EHP is supported by a document which defines minimum package interventions. However, after 40 years of implementation the model encountered several challenges among which include: whether PHC should focus on vertical disease programs which is likely to succeed or comprehensive programs that addressed social, economic and political factors for health improvements; whether primary care and PHC are interchangeable approaches to health improvements; how to institutionalize equity and community participation for health improvements and the possibility of financing PHC(32).

Based on these problems, there was a meeting in 2017 in Tokyo where a declaration was made by the WHO, urging its member states to reform their health mechanisms by moving away from the health for all (PHC) approach which emphasized on community led health system centered around the well-being of the people to universal health coverage (UHC) which promote that no person will have to suffer from financial hardship while accessing health care(33). The Alma ata declaration overlooked the financial aspect of health service delivery which is an important aspect for an effective and efficient health system. The Tokyo declaration on UHC according to Pandey(33), also mentioned the delivery of essential services in the reform, much as these were not clearly stated. This simply shows that the EHP is also being implemented under the UHC approach.

Despite the new approach, Malawi has not yet fully adopted the UHC and is still implementing the PHC approach through the EHP package. However, according to Makwero, Malawi has shown a commitment to implement UHC by extending its EHP to include non-communicable diseases and continues to be free to all Malawians in public sector (34). Thus efforts have been put towards the attainment of Sustainable Development Goals (SDGs) focusing on the six building blocks of the health system putting more emphasis on governance to facilitate community ownership and participation for the delivery of PHC(34).

1.3.3 Integrated Health Service Delivery in the Context of HIV/AIDS

IHSD has been a growing priority in the context of HIV/AIDS especially in developing countries due to limited resources and financial problems that has affected the health system as the disease is linked to many other health problems leading to increased demand in health services. Integration of HIV services into primary care addresses the issue of skewed resource allocation, allowing people to access the health care they require regardless of HIV status (23). IHSD has the potential to improve quality and continuity of care for those people living with HIV/AIDS (2). Thus, integration has been introduced to improve the challenges of access, quality care in the health system to reduce the burden of HIV and AIDS among the people.

IHSD approach is channeled through the delivery of PHC which comprise of various disease interventions to curb the burden of diseases affecting the well-being of people. Note that, different countries have different focus priorities on health service delivery. Colombini et al(28),explained that, high income countries (HICs) focus on the process of coordination care from different care provider for better patient outcomes while low income countries (LMICs) focus its attention on integrating specific disease programs such as malaria, leprosy, TB, HIV for reasons of efficiency and cost effectiveness. HIV has featured in the essential packages for most countries. For example, in Malawi as one of the low income country the EHP comprise interventions in the following areas: reproductive maternal, newborn and child health (RMNCH), vaccine preventable diseases, malaria, integrated management of childhood illnesses (IMCI), community health, non-transmittable diseases (NTDs), HIV/AIDS, nutrition, TB, non-communicable diseases (NCDs) and oral health(20).

Although IHSD can be applied to other interventions within the EHP in the PHC system, the growing burden of the HIV pandemic in Africa, has made it lean more on HIV service integration than it is for the other interventions. Integration of HIV health services is therefore defined as HIV services with non-HIV-specific services such as antenatal care (ANC), maternal, MNCH services, SRH and FP, PHC, TB treatment or treatment for substance abuse (opioid substitution therapy-OST)(14).This sounds like a basic definition and can be argued that, HIV is a disease that affect the immune system leading to the onset of other illnesses like TB, pneumonia, cerebral malaria, other non-communicable diseases like cancer among other illnesses. There is a high likelihood that

someone with HIV can develop TB. Therefore, the health system is managing the onset of TB by providing TB prevention and treatment drugs to people on ARVs. This may not be a non-HIV specific service as it is directly related to HIV illnesses. HIV and TB are intimately related, because TB is the most common serious opportunistic infection in people with HIV and the common cause of death as HIV increases the risk of TB tenfold (24). Again, to say integration of HIV services are the HIV services with non-HIV specific can somehow be questionable. For, example under the MNCH mothers who are HIV positive and their unborn babies are given nevirapine at the antenatal and during delivery to prevent the child from contracting the disease, thus HIV services include and is not limited to PMTCT(24). Therefore, the above definition can be argued as integrated HIV-related service delivery point (SDP) is one that provides FP screening to assess voluntary FP needs, FP counseling and at least three modern contraceptive methods available on-site or through referral, in addition to offering one or more HIV-related service, including but not limited to HIV testing and counseling; PMTCT of HIV; anti-retroviral treatment; screening and prophylaxis for opportunistic infections(35).

1.3.4 Benefits of Integrated Health Service Delivery

There are several benefits of HIV service integration. For example, a report on HIV service integration with reproductive health services (RHS) highlighted four main benefits of HIV service integration with other services, it was pointed out that it increases access to life saving services to \improve health outcomes; it promoted dual protection such as unwanted pregnancies as well as sexual transmission of HIV, it saves money as patients do not make multiple trips to receive the comprehensive services they need and that it decreases stigma as access to services is taken at one place(9). Finally, program can benefit as duplication of efforts is reduced and can serve people at the same or reduced costs.

It has however, been argued that, integration is not a cure for inadequate resources, but can provide savings however, integration of new activities cannot be continued without the system as a whole being better resourced(1). On the part of the health provider, there is still need for more resources to be mobilized to support the health system as more new demands are coming forward. On the other hand integration can cure inadequate resources especially on the side of the clients as it

reduces the burden of care seeking as individuals are able to receive services at the same place where they get ART and the services are affordable due to reduced frequency of the visits(36).

1.3.5 Challenges of Integrated Health Service Delivery in Africa

Despite numerous benefits of IHSD, challenges also exist making it difficult to achieve its goals. For example, integrating services places new demands on service delivery system such as; increased workload among the providers, training of health providers to have knowledge in holistic care, logistical challenges and that the demand and requirements for providing one service, particularly a curative one, may squeeze out another service, particularly a preventive one(37).

Most sub-Saharan countries have implemented IHSD model despite the existing challenges in the health system as alluded to in the above paragraph. Other challenges include, though not limited to the scarce resources (human, financial, material), unavailability of drugs and poor infrastructure. The disease burden and other health determinants along with its successes and failures in Malawi are to a greater extent embedded in the performance of the PHC which has reasonable structures theoretically, but the health system in practice is marked by lack of resources, poor staff and funding between the rural and urban settings(34).

1.3.6 Current Knowledge About Patients Perception on IHSD

It is important for HIV patients to have knowledge of the IHSD approach as this will enable the patients to understand what is being delivered under the IHSD approach which will help them to make the right choice on what service they need to take based on the health problems they are facing. Thus, information from both the service provider and the client is important to enable the patient to access the right care option and provider will also understand their needs and will select the right care option for the client(38).

However, the few studies available revealed patient's perceptions on IHSD based on their experiences with various health facilities. Walker et al. (39) conducted a study in the United States (US) on patients' perception on IHSD which revealed that most patients were not clear about the meaning of the term integrated care as what they responded did not include the entire dimension of the term. Patients, according to Walker et al.(39), explained their perceptions based on their

experiences by highlighting the importance of coordination within and across teams and with community resources and sharing information as well as patients' engagement.

Another survey in Malawi by USAID (40) focused on the experience of pregnant women and mothers of under 5 aged children in accessing care in clinics that provide IHS. The study revealed no common definition for the word integrate among participants. Some participants even failed to provide an explanation while a few who were able to explain integration explained it as 'more than one service is provided to the patient at the same site (40).' Participants explained that they perceive the health facility structure set up to have incomplete integration. For example, they said facilities have a separate HIV testing and counselling (HTC) clinic and that within the same compound they would have an ART clinic. Thus, when someone has been found HIV positive, s/he would be escorted to the ART clinic, to them that is partial integration(40). This is not a good situation as it shows that patients have limited powers to request for the treatment option /service being offered within the IHSD. For example, where to go and get FP method in case the facility they go to do not have or in-case the provider who usually give FP is not available at that time.

1.4 JUSTIFICATION OF THE RESEARCH PROJECT

IHSD is an upcoming approach to deal with the challenges the health system is facing. Much as integration can be applied in any sector of the health system, much attention is being put on integration of HIV and SRH to effectively and efficiently provide HIV treatment, care, and prevention in-order to improve quality, access and care among patients. Integrating HIV services to SRH reduced discrimination and stigma related to HIV/AIDS as services are provided at the same time. However, integration faces the challenges of inadequate drugs, working materials, personnel, infrastructure and finances among other things.

Few studies have been done in Africa, including Malawi where focus has mainly been on perception of IHSD on the health workers rather the clients or patients, particularly, women. That is why this study is focusing on the client, specifically HIV positive women in public health facilities of Lilongwe district. Therefore, studying women's perception on HIV/AIDS IHSD would help identify the experiences, challenges and successes on how integrated services are being provided

particularly in Malawi. The results would help the health facilities implementing the approach to develop better strategies of implementing IHSD on HIV/AIDs to patients and improve on health outcomes among women.

Lastly, the choice to study integration for HIV/AIDS services is important considering the integration issues which deals with getting the required health services under one facility without the struggle of being referred to other departments/hospitals to get care for other health issues. IHSD among women will be studied because most health issues that IHSD is targeting in its focus on IHSD affects women of child-bearing age (15 to 49 years) more than it does to men.

1.5 OBJECTIVES OF THE STUDY

1.5.1 Broad Objectives

To describe perceptions of HIV positive women aged 18 and above on integrated health care service delivery efficiency in Public Health Facilities of Lilongwe district, Malawi.

1.5.2 Specific Objectives

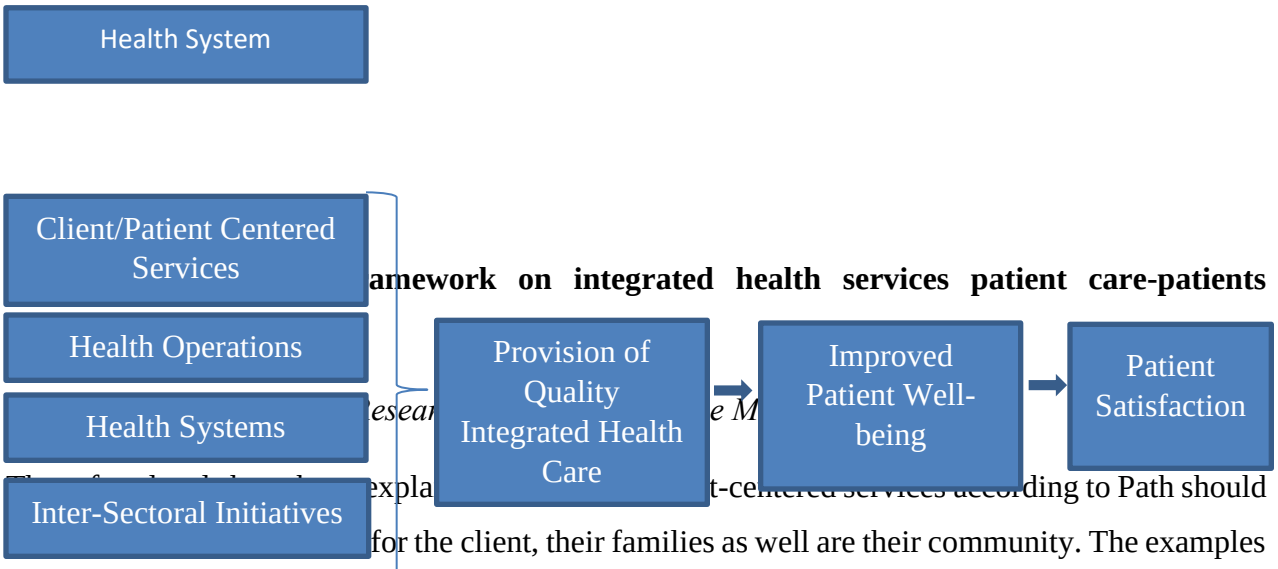
- To describe the nature of integrated health services being offered in public health facilities and how it is being practiced.
- To establish the HIV positive women's knowledge regarding IHSD.
- To explore the perception and experiences of HIV positive women on IHSD.

1.6 CONCEPTUAL FRAMEWORK

The study will use Sherris and Bernson's presentation of Path's four level conceptual framework of an integrated service of a country's health structure which according to Path includes: client centered services, health operations, health system and inter-sectoral initiatives(41). Path is an organization that works towards improving global health by combining HIV and TB diagnosis and care, integrated care for HIV and MCH, and integrated interventions for diarrheal disease and child health in Tanzania, Kenya and Vietnam respectively(42). Based on Path's definition, these four

concepts need to be organized and managed together for the effective and efficient delivery of a continuum of preventive and curative health service as portrayed in Figure 1 (41).

Integrated Primary Health Care



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expla t-centered services according to Path should for the client, their families as well are their community. The examples of which should involve extending clinic hours considering the inadequate staffing, more efficient referral system especially in cases where health facilities are experiencing shortage of drugs, improved use of life saving technologies, improved access to treatment and drugs.

Secondly, the health should revolve around how services are being delivered by the ministry of health, non-governmental organizations (NGOs), local organizations and private agencies. These should work together to properly allocate the health system inputs which are the resources (time, money, expertise) to support management and planning, staffing and interpersonal communication of integrated service. There is need to manage the already scarce resources by ensuring these sectors are not working independently as this may lead to misallocation of resources where some facilities will have more than others making integration

The health system level should look at the broader governance and capacity issues. Specifically focusing on levels of coordination or joint planning of policies and processes and infrastructure. All these may be needed to deliver integrated services where the policy will guide the direction of the various organizations to ensure integration of service delivery is made ideal. This need the involvement and support of stakeholders, donors the ministry itself, advocacy groups, NGOs and the private sector.

Finally, the inter-sectoral initiative involves integration between sectors supporting each other based on the needs for example, health can use the school system to reach out to many students for drug administration which may result into the delivery of quality care which in the end would impact on patient' wellbeing and improved patient satisfaction. The research will, however, look at the extent to which this is done based on the perceptions of HIV positive women on IHSD.

CHAPTER 2

2.1 RESEARCH METHODOLOGY

2.1.1 Type of Research Study

This is a cross sectional qualitative study. The study focused on HIV positive women who were purposively sampled from the population of women living with HIV accessing ART at the selected health facilities. There was no follow up of participants as they were only met once, on the day they visited the health facility.

The study used qualitative in-depth individual interviews to gather information. This provided room for the HIV positive women to express themselves, providing the researcher with a comprehensive understanding of their perceptions and their experience accessing IHSD. To capture these perceptions, the study focused on understanding how IHSD is implemented at the selected public facilities, what services are offered and how these are perceived by the women clients who access them within these respective health facilities.

2.1.2 Study Place

The study was conducted within the Public Health facilities of Lilongwe district. Specifically, the study focused on 6 public health facilities in Lilongwe which included 2 urbans (Light house, Bwaila ART clinic and Area 25 health centre), 2 peri urban (Chitedze and Lumbadzi health centres) and 2 rural health facilities (Chileka and Mitundu). These health facilities were selected as the centres where IHSD is actively being implemented. This helped to have a broad understanding of the way HIV service integration approach is being implemented in various health facilities, at all levels of development (rural, urban and peri-urban) within the district's public health facilities.

The researcher observed that HIV integrations within the health centres happen within the ART clinics. ART clinic is the department within the health facility where they offer HIV related and non-related services treatment (i.e. drugs), care and support (i.e. peer educators) to those people that are infected and affected by HIV.

2.1.3 Study Population

The study focused on HIV Positive women from age 18 to 49 years who came to access ARV drugs in the selected public health facilities of Lilongwe district. HIV positive women have been chosen

in this study rather than men because the current focus of HIV service integration in Malawi is leaning more on reproductive health issues, mainly biasing on cervical cancer, STI, FP, most of these are more applicable to women than men.

2.1.4 Study Period

The took a period of 2 years (24 months) from April 2017 to April 2019. This period includes all activities that have been undertaken by the researcher to complete the study report, from proposal writing to writing of the report on results findings. Table 1 shows a detailed schedule of the study period.

2.1.5 Research Study Schedule

See Appendix 8

2.1.6 Sampling Methodology

Foreit et al. in Johnson, Varallyay and Ametepit (31) defined integration as any two or more services that are offered at the same facility, during the same operating hours and the provider of one service encourages clients to consider using the other service during the visit. Therefore, to sample the health facilities, the researcher used a purposive sampling method. First, a list of health facilities that are implementing HIV IHSD in Lilongwe district was collected from the District Health Officer (DHO) in Lilongwe. The list was exhaustive enough as it also included the health facilities that are under the Christian Health Association of Malawi (CHAM). This provided the researcher with an assurance that all health facilities for Lilongwe district have been considered and reviewed for IHSD implementation.

From the list, and with the guidance of the DHO, the researcher was able to categorize the hospitals in three categories. Those that are within the urban setting, those that are in the peri-urban and then those that are within the rural setting. After categorizing the health facilities, the researcher purposively sampled only those health facilities that were actively implementing IHSD during the time of the study. It is from this list that 6 health facilities, 2 from each setting (urban, peri-urban and rural) were selected to participate in the research study.

The study used a purposive sampling of the participants which is the non-random type of sampling where a deliberate choice of an informants is made due to the qualities they possess(43). The researcher purposively sampled 3 HIV positive women from each identified health facility who visited the hospital during the day of data collection to receive treatment, support or care, to participate in the interviews. These women were approached by the researcher on their visit to a facility just after they have been assisted by the health provider and asked for their consent to take part in the study. The when seeking their consent, the researcher was informing the potential clients of the study objectives, confirmed of their privacy in participation and the duration the study would take for them to participate. Thus, a total of 18 HIV positive women were selected for interviews. The researcher arrived at the figure 18 women because it is expected that the saturation point of the study may be reached by the 18th interview, even before. Guest et al, explained that saturation for homogenous participants occurs during the first 12 interviews in non-probability samples, though basic elements for meta-themes can be present as early as 6 interviews(44). In this regard, the researcher reached a saturation point at the 15th interview at the facility number five when it was observed that no new information was being collected from what had already being collected from the other 14interviews. However, the researcher decided to continue and finish all 18 interviews just in case there will be something different in another health facility (the last one) that was to be visited, but later realized it was not any different.

The HIV positive women sampled were only those aged 18 to 49 years of age. This helped to capture the issues of SRH (FP, STI) as well as cervical cancer among other HIV related issues. Similarly, 6 key informants (KI) were purposively sampled, one from each health facility. It was discovered that there is usually one-focal person at the ARTs facility within the health facilities who could provide information pertaining to IHSD in the respective health facility. Approval for KIIs as well as the client's interviews were sought from facility authorities, particularly the health facility in-charge.

2.1.7 Data Collection

Data was collected by the researcher with the assistance of one research assistant who was trained within a day on the interview guide and qualitative data collection skills. Some of the qualitative skills imparted to the research assistant included probing skills where the research assistant should be able to dig deep for the information related to the study. The study used questionnaire guides

and KII guides to collect data from HIV women clients and health workers respectively. The interviews were conducted in Chichewa because most clients who visit the selected facilities are not very literate. The data collection tool was first piloted to ensure it is fit and relevant to collect data as per the set study objective. The pilot was done at the Area 18 health facility where HIV IHSD is also being offered. The choice of Area 18 health facility was due to proximity to where the researcher stays. All interviews were scheduled in the morning hours because most ART clinics ware done during the morning hours. Each interview was taking a maximum of 30 minutes to be done.

The questionnaires guides were used to conduct individual in-depth interviews with HIV positive women to get their perception on IHSD which was more appropriate than focus group discussion (FGDs) to ensure confidentiality and respect of the women in upholding good research principles.

The KII guide was used to interview the health personnel on their knowledge and perception of IHSD. The information collected has been used in triangulating data collected from the HIV positive women. Data triangulation is where the information reported by the clients/participants was compared with what was reported by the KI to help the researcher better explain the findings.

2.1.8 Data Management and Analysis

The qualitative data was collected using hard copy interview guide and most interviews were recorded to help capture some information that may be missed when taking notes during the interviews. However, 4 of the interviews were not recorded as the phone recorder went out of power due to a long period of writing for the clients to be free for the interviews. Both hard copy and recorded data was transcribed verbatim. During the transcription, data was being translated from Chichewa to English for every reader to understand. The translation was peer reviewed by an expert in linguistics for accuracy on the meaning.

A theoretical thematic analysis was used where the researcher read and re-read the data described getting more familiar with the text and relating it to the specific research questions(45). Whilst reading the data, the researcher made sense to the data and organized it in a systematic way by allocating codes. This was categorized accordingly based on the research questions. Soon after the research proposal was approved, before and in-depth literature review of the study was done, the

researcher collected the data, analyzed it and reviewed the themes further and defined them according to the study objectives which was later used to write and discuss the results, this was done to avoid bias and perceived notions(46).

2.1.9 Results Presentation

The results of the research study have been submitted to the College of Medicine Research and Ethics Committee (COMREC) for approval of the research study and its findings. This has also been submitted to the University Committee in fulfilment of the master's degree in public health.

2.1.10 Dissemination of Results

Soon after approval by the COMREC and University Committee, the study results will be disseminated to the Ministry of Health and the Lilongwe DHO to help them make decisions that will help resolve the challenges found within these health facilities and to consider the approaches being used in implementing IHSD in the public health facilities. This will be done by arranging for separate presentations with relevant directorate in the Ministry and the Lilongwe DHO Management to share the findings bearing in mind that if the document will only be submitted chances are it may not be read and results not used at all.

Lastly, being a topic that is gaining focus in the recent time, the results will also be shared with the various academic institutions dealing with health i.e. College of Medicine (CoM) and Kamuzu College of Nursing (KCN). Thus, a copy will be placed in the Library of these two constituent colleges to feed into the knowledge gap that exist in the academic world enabling students to use the literature in their studies.

2.2 ETHICAL CONSIDERATIONS

The study had some ethical considerations that were followed, and these include:

- Approval sought from COMREC allowing the researcher to carry out the study due to its sensitivity and to fulfil the requirements of conducting a public health research. Before

going out into the field to start data collection, formal written approval was sought from the Lilongwe DHO's office. Based on this letter, approval was granted in all the health facilities to conduct the interviews to both the clients and the KIs.

- A verbal informed consent was sought from the target participants to participate in the study. Before verbally seeking their consent, the participants were first informed of the nature of the study, its objectives and the kind of information they were requested to provide as well as their confidentiality in the study.
- For women who refused to participate, there were no consequences to the health care they anticipated to receive. Efforts were made to sample women who had already accessed their services on the day to avoid disturbing the process at the healthy facility.
- The researcher ensured confidentiality of the clients/participants by not capturing names and location of participants during data collection.
- The researcher has safely kept the information in files under lockable drawers and transcribed information is password secured. This information will later be disposed of when all is done.

CHAPTER 3: RESULTS AND DISCUSSION

3.1 NATURE OF INTEGRATED HEALTH SERVICES BEING OFFERED IN PUBLIC HEALTH FACILITIES AND HOW IT IS PRACTICED.

Results show that all the 6 health facilities where the study was conducted implement IHSD.

Half (3) of the 6 health facilities have been implementing IHSD for about 5 to 10 years while about 2 KIs indicated to have implemented IHSD for about 3 to 5 years with only 1 reporting to have been implementing IHSD for over 10years.

IHSD according to 3 of the 6 KIs are given to everyone coming to the hospital for assistance because the service is applicable to every human being regardless of status while 2 reported that the services are only given to HIV clients on ARVs because they are prone to developing other ill health conditions These services according to one KI are given out to HIV positive clients depending on the clients need.

"We give the services depending on how the client is feeling or looking for at the time of the visit|." (KI06)

KIs from all the 6 healthy facilities revealed availability of services like HIV testing and counselling, TB screening, where the clients give out sputum to check for TB and FP services, while 5 KIs indicated to have cervical cancer screening once they were diagnosed with HIV and before they start accessing any FP method at their facility, 4 KIs also mentioned administration of ARVs and STI treatment and 3 KIs pointed to the availability of TB treatment at their facility as illustrated in Table 2.

Table 2: Services offered under IHSD as reported by health providers (KIs) in health facilities (HF) visited.

Name of Service	Health Facility					
	1 (Light House)	2 (Area 25 HF)	3 (Chitedze HF)	4 (Lumbadzi HF)	5 (Chileka HF)	6 (Mitundu HF)
HIV testing and Counselling	√	√	√	√	√	√

ARVs	√	√	√	√	√	×
Family Planning	√	√	√	√	√	√
STIs	×	√	√	√	×	√
TB Screening	√	√	√	√	√	√
TB treatment	×	√	√	×	×	√
Cervical Cancer screening	√	√	√	×	√	√
Clinical Services/OPD	×	√	×	√	×	×
PMTCT	×	×	√	×	×	×
Male circumcision	×	×	×	×	×	√

It was observed that all services were done at the ART clinics of the 6 facilities visited. Three health facilities (Area 25, Chitedze and Mitundu health centres) indicated that much as there are those service under the IHSD program, some services are accessed or referred outside the ART clinic (other departments within or outside the health facility). KI02 explained that, *"IHSD is basically done on ARV and TB services and that the other services are accessed in other buildings outside the ART clinic."* This was confirmed from what the women clients said when asked why they had visited the clinic that day, all of them mentioned to get ARV drugs apart from the other services that some of these women came to access.

The other 3 health facilities (Lighthouse, Lumbadzi and Chileka),KI did not indicate the access of the mentioned services outside the ART clinic and one of these (Lumbadzi Health centre) clearly mentioned that the services are all accessed at once within the same building.

It was also revealed that delivery of this service is done by different health officers from various departments who also support delivery of other services apart from HIV/AIDS IHDS, if they have knowledge and expertise in areas related to IHSD.

"We do shifts where we rotate the support given to clients from our sections, but that makes it difficult to update records, there are a lot of short cuts, everyone comes to fulfil the shift time but later goes back to their section. But if there can be permanent staff to support these people at the clinic, there won't be problems." KI06

The study reveals that much as IHSD is offered at one place (ART clinic) for almost all the health facilities, there are other services that clients do not access at the ART clinic as they are not available, hence clients have to be referred to other departments within or outside the health facility. This can be attributed to the various challenges the health facilities are facing like, inadequate staff, especially trained staff to effectively deliver IHSD. Although this is the case there are instances when services at the referral centres are not available and there is nowhere to refer clients.

This is contrary to what Kodner (3), explained where he sees integration as designed to create coherence and synergy between various parts of the healthcare enterprise in order to enhance system efficiency, quality of care, quality of life and consumer satisfaction, especially for complex and multi-problem patients or clients.

3.2 ESTABLISHING HIV POSITIVE WOMEN'S KNOWLEDGE REGARDING IHSD.

When asked of what they know about IHSD, half of the clients mentioned FP as one of the things they know in IHSD system. While TB prevention and STI prevention they get from the hospital was mentioned by 3for each. Cervical cancer screening, nutrition supplement services (soya flour) was reported as part of IHSD by 2of the clients for each. Having a health life, counselling and advise to sleep in a mosquito net was each reported by only 1 client.

The clients were asked how they came to know of the IHSD, most (11 out of 18) of them mentioned the time they were first diagnosed HIV positive, half (9) mentioned right at the hospital during the

health education talks that are conducted within the health facilities. *"I knew on the day when I visited the clinic and I tested for HIV positive."* Area 25 Clinic Client 01

When asked what IHSD meant to them, 5 clients reported that it means having a healthy and good life, followed by 2 clients who mentioned being strengthened in health and only 1 client separately reported love, advise on how to take ARVs and use FP, getting ARVs, being encouraged, an opportunity to learn new things, being assisted in other health problems and how to live best their lives. *"IHSD means helping me to live a healthy life."* Light house, Bwaila clinic Client 03. On the other hand, Area 25 Clinic Client 03 said. *"It means I should be strengthened in my health."*

According to the majority (22%) of the clients, this was responded as such because the doctors provide care to them whenever they visit the hospital, 3 clients said it takes away worries and pains of being HIV positive they are able to access care and FP as reported by 2 of the clients, it gives confidence to freely ask how the other services are accessed and the other 2 did not provide any response to this question.

KIs were asked if they think HIV positive women understand the concept of IHSD, half of the KIs said yes women do understand IHSD being offered, 2 KIs feels some do understand and some not, while only 1 KI portrayed doubt by saying that it is possible that the women understand. Those KI who said the women understand, half gave out the reasons that they are taught of the IHSD when they visit the hospital and 2 reported that that the women keep coming to the clinic to access the services. *"Because they keep coming for the services whenever the health talk has been delivered*." Said KI01. While those that said some do and some don't and that it is possible they understand gave out the following reasons; 3 of the women feel that health officers are wasting their time; the other 3 think the clinic building is only for those HIV positive and yet the other 3 reported the use two health passports by some clients which confuses the records of their illness in trying to hide their identity.

All the KI indicated that the health education talks being offered in all the health facilities under study is one mechanism that is making the women know the availability of the IHC. These education talks according to the KIs are provided by the health workers themselves, health volunteers who does community sensitization and some health partner working in close collaboration with the health facilities. *"Every morning there are talks by health volunteers,*

clinicians, nurses and partners like Baylor and KP study and volunteers mainly do the community sensitizations in the community." KI02

Apart from this, half of the KIs mentioned the use of client experts where some HIV positive clients are empowered to talk to their fellow HIV positive clients who have just been diagnosed HIV positive and those that are on ARVs of the IHSD. *"We promote the use of client expert to help and motivate other women not to get discouraged. Every client is attached to the expert client voluntarily to help out in several issues the women will face."* KI03

This was echoed by one HIV positive woman who appreciated the role of client experts, "Last *month (February of 2018), I came here I met some woman who encouraged me unlike how the other people talk on our situation."* – Chitedze Clinic Client 03.

One KI also mentioned the engagement of support services from other hospitals like Lighthouse and another one reported the erection of posters on the hospital walls for people to read and learn. *"Light house staff do come here for support during the clinic days. This reduces pressure on the work. This is the strategy that Light house has put in place. They employed people to come to health centers for support and mentorship."* KI06

3.3 EXPLORINGTHE PERCEPTION AND EXPERIENCES OF HIV POSITIVE WOMEN ON IHSD.

3.3.1 Patient-Centered Services

When the women were asked why they feel IHSD is good, 7 of them explained that it gives them good health and they do not get sick from other ailments.

"this help us to live a health life and we often don't get sick," Said Area 25 Clinic Client 03. Other women literary pointed out that, *"receiving services at one place makes one comfortable and flexible to talk to the doctor."* Chitedze Clinic Client 03

If the patients are flexible to talk to the doctor it shows that integration is taking place as they are empowered with the freedom to express themselves on the health issues affecting them to the doctor. Some 2 women indicated that the services are good to them because they receive general care and other 2 reported that they get support which they cannot find on their own, and another 2 pointed to the availability of specific services as FP being helpful as they no longer get unexpected pregnancies. Yet another 2 reported the counselling they receive upon being diagnosed with HIV as a good thing in IHSD. This was backed up by another woman who mentioned reduction in their worries, *"nkhwawa zathu zimachepa.*" Meaning *"our worries are reduced."* Mitundu Clinic Client 02. This on the contrary shows to much dependence on the health system for their happiness which is not good as they are likely to give up once some service they expect to get at the hospital is not there, especially with the issue of inadequate resources that has affected our health service. This, therefore, needs to be properly coordinated with the community as Path indicated to ensure that IHSD is patient centered where both the individual, their families are available for support to encourage the client in all aspect of life(41).

One other woman mentioned the absence of discrimination at the clinic where IHSD is offered as they socialize within their group, yet another woman mentioned the encouragement and help they get when accessing the service from the health provider

The other 6 women also reported that they can receive diversified services at one place including other activities yet other 6 said they don't go long distances to access care thereby saving on transportation.

"We do not waste money on transport because we do not travel a long distance to access the service." Chileka Clinic Client 02. About 2 of the women reported that with IHSD they are assisted quickly while another 2 indicated the ability to know what they are supposed to do to care for themselves.

On the other hand, though the majority reported that the services are good, it was expressed by 2 women who felt the services are not good, indicating that referral is only good to those people who can be able to access transport. A KI confirmed that referrals are done, and some women do not like it. *"Most laboratory equipment's are not functioning properly i.e. microscope. This make us refer the clients to other hospitals and the clients complain to be going elsewhere."* KI03

On a different note another woman reported not receiving adequate support when at the clinic.

"sometimes when I explain my problems to the doctors, I am not adequately assisted, I don't know why? I complained of heartache, vaginal candidiasis and menstrual pain but they have not given me the proper service." Mitundu Clinic Client 02

This is an indication that IHSD offered at some of these facilities is questionable as they failed to provide the service/care needed by the patients, hence this is contrary to Path's model which said an effective and efficient IHSD should offer patient/client centered services.

A well-functioning IHSD according to Path should be patient-centered having a good referral system as well as improved use of life saving technologies which is this case according to a KI is not available which shows there is inefficiency in the implementation of IHSD.

One of the KI confirmed the challenges with integrations where the facilities are operating but are not focusing on the patient need where he reported that some other women find the service delaying due to inadequate and untrained clinicians and yet another said that some women are reluctant to go up and down in accessing the service. "S*ometimes when they have been referred to other departments within the health facility they do not go, or they have preferences and they do not meet the relevant person hence they are not adequately supported.***"** – KI05

Yes, Paths model states that an effective IHSD should be patient centered where a patient should feel free with the service provider so that they can access the required service.

3.3.2 Health Operations

According to path, this should look at governance issues coordinating activities at policy level to ensure the efficient and effective delivery of IHSD. Even though most (17 out of the 18) women view IHSD as a good thing and 2 of the women indicate that the approach is helpful.

Again, about 8 of the women reported not to have faced any challenges with IHSD since they started using the facility. *"I have never faced any challenge since I started visiting the hospital."* Mitundu Clinic Client 03.

This is however, questionable as only 1 woman expressed the need to train more other people at the health facilities on cervical cancer screening rather than referring them to other hospitals.

"It could have been better if cancer screening was offered here, they just need to train more staff rather than for us to go to Bwaila hospital for cancer screening." Chileka Clinic Client 03

This was concurred by the KI at one of the facilities visited who admitted that there are few trained staff to offer the service. "*Some other staff are not trained in other areas like Visual Inspection of the Cervix with Acetic Acid (VIA) and STI, only one person (myself) hence when am not available the service cannot be offered."*KI05

As evidence that staffing is really a problem, a good number (5 women) reported that there is always a lot of people at the health facilities, making long queues thereby taking long for them to receive care. This makes the women to come to the hospital very early in the morning, 5 a.m. but doctors come in for work as late as 8a.m or 9 am.

"The clinic starting time is usually late, we come here very early in the morning, 5.am but the health workers (doctors) start work late around 9 am. We come early because we are told by the doctors to be coming early and leave early. But when they start late, they still help us." Lumbadzi Clinic Client 01.

Clients also reported that there are so many rooms for the clients to enter to get the required assistance delaying them further.

3.3.3. The Health System

One woman expressed concern over those clients who skip their scheduled dates to come on other people's dates saying they cause congestion on other people's days leading to long queues. *"Everyone should stick to their date of appointment. Those that missed their given date should come late in the afternoon as they contribute to long queues."* Chitedze Clinic Client 03

The survey revealed problems with infrastructure arrangement and availability of the IHSD implementation which compromises the efficient implementation of the service as it contributes to stigma and discriminations with other clients who are not on HIV treatment.

For example, about 4 women reported discrimination as they indicated that there is no privacy to their status as they are served together with everyone (even those that are not HIV positive) and they laugh at them.

"The place where we sit waiting to be assisted we sit interlocking with other people who have only come for the other services like Malaria, so when we enter our rooms to receive the services, they look at us as stupid people which is not such and we feel this is not a good thing they have not thought better for us." Chileka Clinic Client 02

"People laugh at us when we enter the drug receiving room because when we come, we all meet at one place to receive drugs. For example, this other day I met someone from my village who came for postnatal services and she asked me, so you also receive ARV drugs?" I responded, "*where did you see me?"* and she said, *"You were entering that room, that room is for getting ARV drugs.*" Concurred Chileka Clinic Client 01.

The issue of housing infrastructure is reported to influence the operations of the health workers as it was revealed that staff walk long distances to work which could e one of the things that leads to work starting late.

A KI from Lumbadzi health centre confirmed the starting late of the clinic as he says, *"starting time can be reduced if staff have housing close by. This will help staff to walk short distances to the clinic as some staff stay in Area 25."*KI04

This according to Path is a policy level, where policies and processes need to be in place to set standards for the operations of the health facilities regarding IHSD. There is need to provide strong governance in ensuing that resources are being managed properly and resources are allocated to where they are most needed.

3.3.4 Inter-sectoral Initiatives.

Lastly, patients looked at inter-sectoral coordination to operate well. The study has revealed that inter-sectoral initiatives is being implemented within the IHSD in most health facilities to a greater extent. This is evidenced by the mechanisms that have been put in place by all the health facilities visited as reported by all the 6 KIs, where health education talks are conducted to the HIV positive women clients by the health workers of the volunteers who are community members identify to support with these health talks.

This has proved to be effective as it relates to emotional and psychological support which usually do not require finances or physical materials to work but rather the coordinated efforts of the health facility workers without and clients without waiting for a direct support from the central government.

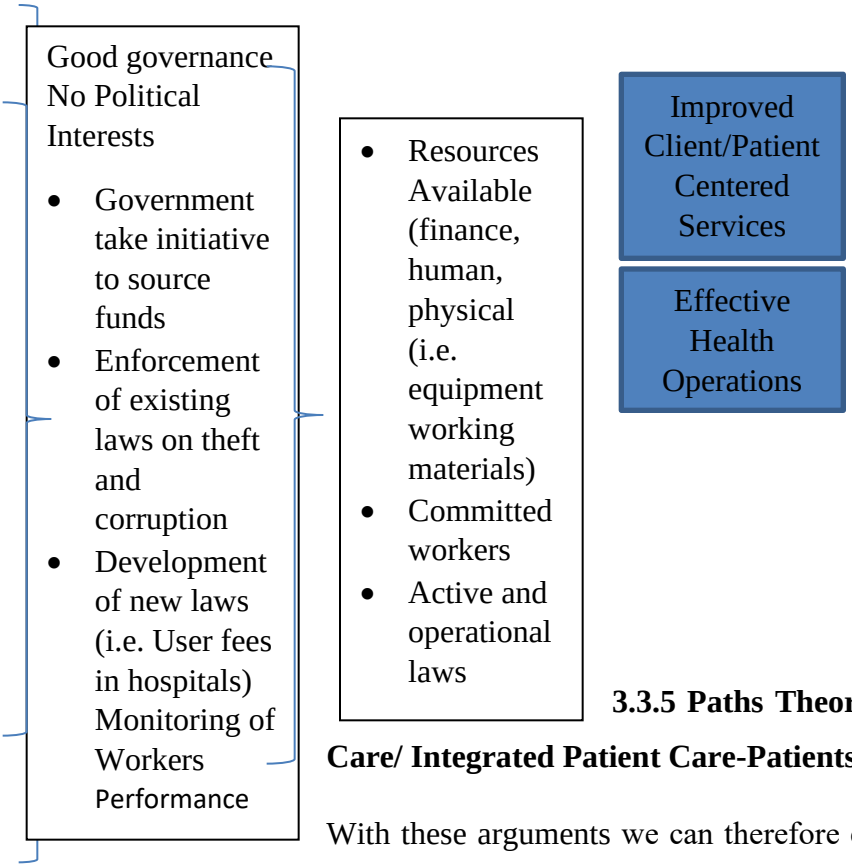
The report has revealed issues of inadequate trained staff to adequately support the delivery of integrated health, where 5 of the s KIs have clearly indicated reporting the matter to their authorities, but nothing has been done to date. Though this is the case, the study has further revealed that there is some kind of support from the side of the other service providers as reported by half of the KIs that some service providers like Light house and Dae-Yung Luke hospitals support them with drugs whenever they request for it and that there is staff support (the case of Mitundu hospital) who come to their rescue in cases of inadequate staff.

But due to the increased demand this support has proved inadequate to the health facilities and to the clients as challenges persist i.e. long waiting hours, discrimination due to inadequate infrastructure and inadequate/lack of proper assistance.

Under the health system, the study has revealed that nothing much is being done by the central government to ensure that health facilities have adequate drugs, adequate infrastructure and adequate staff as well as training of the staff. Much as KIs have indicated the availability of support services from other service providers, it has been observed that this is mainly their internal arrangement and is done with little, if any coordination with the government, especially the issue of sharing drugs between health facilities. The support which seem to be properly coordinated is the visit of Light House staff to support services within the health facilities who lessen the burden of shortage staff. But for the issues of infrastructure, only one health facility at the Light House (Bwaila) reported some progress. Which means the other facilities are still facing the challenge compromising the efficiency and effectiveness if IHSD among HIV positive women as inadequate resources would not allow for this to effectively been done.

Looking at the 4 conceptual levels (patient-centered services, health operations and health system) as highlighted in Path model (41)),are all the effects of inadequate resources faced by the public hospitals in Malawi due to the poor economic stand of the country, Malawi as well as issues surrounding governance. Resources will never be adequate, but if they are efficiently used and distributed based on the needs of the sectors within the country and promote patriotism where

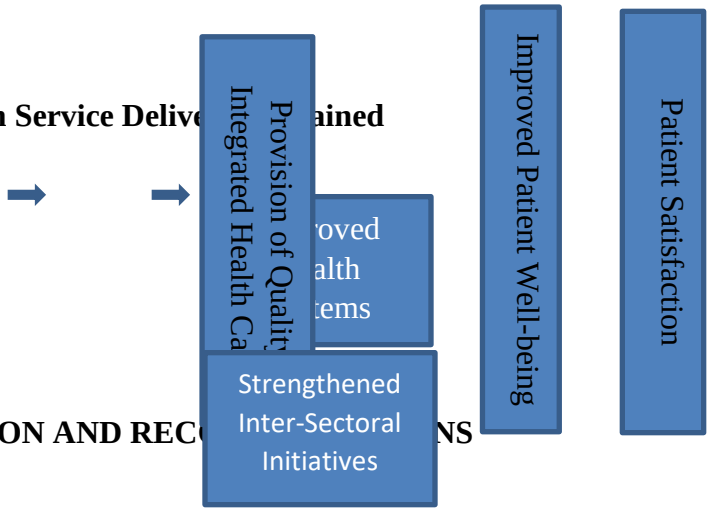
personal interests (i.e. corruption, fraud and abuse of power) are dealt with to safeguard the already inadequate resources things can improve. Much as Malawi is a poor country with inadequate resources, the implementation of some policies i.e. user fees in public hospitals to complement health sector resources can be ideal as well as the enforcement of some policies in proper managing of resources, the Malawian health sector can succeed to effectively implement such approaches like IHSD.



3.3.5 Paths Theory on Integrated Primary Health Care/ Integrated Patient Care-Patients Perspective Explained.

With these arguments we can therefore explain Paths' theory based on the conditions that would allow effective operations in the implementation of IHSD as illustrated in Figure 2:

Figure 2: Integrated Health Service Delive ained



CHAPTER 4: CONCLUSION AND REC NS

4.1 CONCLUSION

In conclusion this study has revealed several issues that are affecting the effectiveness and efficiency of the IHSD approach.

To begin with, the study has revealed challenges within the health system to implement client centered IHSD where clients are not accessing some services like properly and coordinated referrals. Most equipment that would help the clients access a service are not functioning in some health facilities making it difficult to provide an IHS.

Although implementation of IHSD is done to everyone regardless of HIV status, the study shows integration of the services on the people that are HIV positive. If IHSD is being implemented in the other sectors, the significance of it and efforts put are minimal than how it is done under the

HIV/AIDS program. The main services being implemented under this approach are HIV testing and counselling, TB screening and treatment, cervical cancer screening, TB screening and treatment, STI prevention and treatment, as well as FP. HIV positive women are informed of these services during the first time they diagnosed HIV positive and during the education talks happening within the health facilities whenever the women have visited.

Although all these services form part of the IHSD, it can be concluded that not all services are fully and effectively and efficiently being implemented in all the public health facilities as the study has revealed the challenge of inadequate resources that affect the performance of some services related to provide a quality IHSD. The KI and HIV positive women revealed the existence of inadequate trained staff to support IHSD, for example, cervical cancer screening or there is no equipment (i.e. for pulmonary TB screening) and at times there are no adequate drugs or materials especially on other FP services leading to referrals of HIV positive women to other departments and to other hospitals (i.e. Bwaila health centre ART clinic), a thing which to not please most HIV positive women as it means more delays on the queue, expenses on transport and reduced flexibility on meeting new people.

The results revealed little or no coordination of such in the public health facilities of Malawi. For example, when a woman has been referred to another department, she is expected to queue even if she might have been on another queue from the department she is coming from. This frustrates the women as they spend a lot of time at the hospital to be assisted. It has also proved costly when women are referred to another health facility as they must find transport to get to the said facility since no transport money or hospital ambulance is provided for them to use.

Further, the results revealed stigma and discrimination where the women are made to use the same infrastructure with other clients coming to access general services. The same issue of inadequate resource (i.e. staff and infrastructure) has forced the authorities of the health facilities to provide the services to all clients within the same available infrastructure and that the same health workers (with specific specializations).

It has also been noted that the women are able to mention the services that are offered at the health facilities on IHSD when asked on their understanding of IHSD. However, they were not able to state the issue of the services being offered under one roof as IHSD. This can be attributed to the time is spent by health workers to explain IHSD considering the issue of late coming to work it

could be clients are not properly explained on the meaning of IHSD. Although the KIs indicated that the HIV positive women understand IHSD simply because they can access it, this can be a wrong assumption as the women may access a service simply because they want to be assisted.

Much as the women come very early (5 a.m.) to access the services, the study has revealed that the operations in most health facilities start as late (9 O'clock am). This can be linked to inadequate resources (i.e. inadequate staff, inadequate equipment and drugs as well as inadequate infrastructure), clinicians/doctors feel frustrated and/or demotivated to commit to their work hence resort to late coming. On the other hand, doctors can come late because of the work overload they experience each day due to increased number of clients.

Therefore, although most women perceive IHSD as a good initiative as it helps them to have good health, it is further revealed from their responses that the women are not happy with the way the services are being delivered especially looking at the time taken to receive the service, unavailability of some services which requires them to go and access them elsewhere, there by being costlier and ineffective to their satisfaction.

Finally, the results revealed good inter-sectoral initiatives where the HIV positive clients get community support by interacting freely with their fellow HIV positive clients who take up the role of client expert and encourage others to stand strong and access the required services which contributes to their well-being. However, inter-sectoral initiative has proved a challenge between and among sectors within the health facility as they are not properly coordinated leading to poor delivery of the IHS.

4.2 RECOMMENDATIONS

Based on these conclusions, the following recommendations are made.

4.2.1 Recommendations to Government Authorities, Health Workers and HIV Positive Women.

1. Health workers should review the quality of the work they do especially in relation to delivery of information to clients for education purposes.

2. Health authorities and health workers should ensure that there is a well-coordinated system in place to support clients within the various departments and health facilities referred to which will prevent women from being on long queues.
3. The government of Malawi should support the IHSD initiative, by developing proposals to source funds to support the needs of the health facilities specifically issues of staffing, staff training and health facility infrastructure, which would minimize delays when supporting clients and would help in improved operations of the health system.
4. The ministry of Health should make efforts to closely monitor the operations of the health workers to ensure they start work on time so that clients can be timely served which will help increase the uptake of the services. And that they should do their work to the required standards by ensuring documentation of client's records when handling clients.
5. The government of Malawi should enforce laws that discourage misuse of public resources in-order to safeguard the scarce resources.

4.2.2 Recommendations for Further Research Studies.

For further research it will be good to focus on the challenges the government is facing to effectively and efficiently implement IHSD in the public health facilities they have established this approach. This will provide a deeper understanding on the existing challenges the government is facing to effectively implement the initiative it has itself initiated.

REFERENCES

1. World Health Organisation. Integrated health services-what and why? Tech Br No 1 [Internet]. 2008 [cited 2017 Aug 15]; (1) :1-10. Available from: http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:Integrated+Health+Services+-+What+and+Why?+Technical+Brief+No.+1#1
2. Sweeney S, Obure CD, Maier CB, Greener R, Dehne K, Vassall A. Costs and efficiency of integrating HIV/AIDS services with other health services: A systematic review of evidence and experience. Sex Transm Infect. Journal . 2012 ; 88(2):85–99.
3. Kodner D. All together now: A conceptual exploration of integrated care. Heal Care Q [Internet]. 2009 [cited 2017 Dec 05];13(October):6–15. Available from: http://www.longwoods.com/content/2109#tb
4. Enthoven AC. Integrated delivery systems : The cure for fragmentation. Am J Managed Care [Internet]. 2009 Dec[cited 2019 Oct 20]; 15(10 suppl): S284-90. Available from:

https://pdfs.semanticscholar.org/303e/b5cd4e286dade81c48203d79afdae2c47097.pdf?_ga=2.255304264.136096721.1569413118-1527643612.1569413118%0D

5. World Health Organisation (WHO). Integrating health services. Technical Series on Primary Health Care [Internet]. 2018[cited 2019 Oct 20]; (50): 1–14. Available from: https://www.who.int/docs/default-source/primary-health-care conference/linkages.pdf?sfvrsn=bfbb4059_2&ua=1%0
6. Pan American Health Organisation (PAHO). Integrated health service delivery networks: Concepts, policy and a road map for implementation in the Americas. Series for renewing primary health care in the Americas [Internet]. 2010 [cited 2018 Dec 17]; (4): 1-96. Available from: https://www.paho.org/hq/dmdocuments/2011/PHC_IHSD-2011Serie4.pdf
7. Hwang W, Chang J, Laclair M, Paz Harlod. Effects of integrated delivery system on cost and quality. Am J Manag Care[Internet]. 2013[cited 2017 Aug 15];19(5):10. Available from: https://www.pcpcc.org/sites/default/files/resources/Effects%20of%20Integrated%20Delivery%20System%20on%20Cost%20and%20Quality.pdf
8. UNAIDS. Global AIDS update. Prog Rep [Internet]. 2016 [cited 2017 Aug 17]; Geneva, Switzerland. Available from: https://www.unaids.org/sites/default/files/media_asset/global-AIDS-update-2016_en.pdf.
9. Population Action International. The benefits of integrating hiv and family planning programs. Policy Issue Br [Internet]. 2012[cited 2018 Dec 17]. Available from: http://pai.org/wp-content/uploads/2012/07/FPHIV_Integration_FINAL.pdf.
10. Hegdahl HK, Fylkesnes KM, Sandøy IF. Sex differences in HIV prevalence persist over time: Evidence from 18 countries in Sub-saharan Africa. PLoS One. 2016;11(2):1–17.
11. Sebastian ST, Siddanna S. Social , psychological and health concerns of people living with HIV / AIDS in Mysore District , Karnataka. J Clin Diagn Res [Internet]. 2016[cited 2019 Nov 05];10(3):6–10. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4843287/
12. Avert. HIV , other health conditions and opportunistic infections: Managing HIV and other health conditions common co-infections. Global Information and Education on

HIV and AIDS [Internet]. 2018 [updated 2019 Sept 26; cited 2019 Oct 10]. Available from: https://www.avert.org/living-with-hiv/health-wellbeing/health-conditions

13. Topp SM, Chipukuma JM, Chiko MM, Matongo E, Bolton-Moore C, Reid SE. Integrating HIV treatment with primary care outpatient services: Opportunities and challenges from a scaled-up model in Zambia. Health Policy Plan. 2013;28(4):347–57.
14. Heard AC, Peterson K, Modi S, Esper H, Calvo F, Brown AN. Integrating HIV services with other health services to improve care , retention and adherence. 3ie Scoping Paper 7; 2017 June. New Delhi, India: International Initiative for Impact Evaluation.
15. Malawi Population-Based HIV Impact Assessment (MPHIA), PEPFAR. Malawi country operational plan 2017 Strategic Direction Summary [Internet]. 2017[cited 2018 Dec 17]. Available from:

    https://www.pepfar.gov/documents/organization/272017.pdf%0Ahttps://phia.icap.columbi
16. Elizabeth Glazer, UNICEF, WHO. The double dividend. A Synth Evid Action to Improv Surviv HIV-'exposed' Child era eMTCT renewed child Surviv Campaign [Internet]. 2014 February[cited 2018 Dec 17];303. Available from: http://www.springerlink.com/index/R4V32634J1472X82.pdf
17. USAID. Essential package of health services, country snapshot: Kenya. J Heal Financ Gov. [Internet]. 2015 July [cited 2019 Oct 20];1–34. Available from: https://www.hfgproject.org/essential-package-of-health-services-country-snapshot-kenya/
18. UNAIDS. The aids response and primary health care: linkages and opportunities. Tech Ser Prim Heal Care [Internet]. 2018[cited 2019 Oct 20];1–19. Available from: https://www.who.int/docs/default-source/primary-health-care-conference/aids.pdf?sfvrsn=189b259b_2
19. Ministry of Health. Malawi Guidelines for Cinical Management of HIV/AIDS [Internet]. 2016 [cited 2019 Oct 20]; 1–99. Available from: https://aidsfree.usaid.gov/sites/default/files/malawi_art_2016.pdf
20. Government of the Republic of Malawi. Health sector strategic plan (HSSP) II, 2017-2022: Towards Universal Health Coverage [Internet]. 2017 [cited 2018 April 1]; 1-140.

Available from: https://www.csogffhub.org/wp-content/uploads/2019/10/Malawi-health_sector_strategic_plan_ii_030417_smt_dps.pdf

21. AIDSinfo. Glossary of HIV/AIDS-related terms: Offering information of HIV/AIDS treatment, prevention, and research. AIDSinfo.nih.gov. [Internet]. 2018[cited 2018 Feb 18];9:1–204. Available from: https://aidsinfo.nih.gov/contentfiles/GlossaryHIVrelatedTerms_English.pdf
22. Republic of Ghana. Guidelines for anti-retroviral therapy in Ghana. sixth edit. Ministry of Health [Internet]. 2016 September [cited 2019 Oct 20]; 1-132. Available from: https://aidsfree.usaid.gov/sites/default/files/gh_guidelines_arv_therapy.pdf
23. Odeny TA, Penner J, Lewis-Kulzer J, Leslie HH, Shade SB, Adero W, et al. Integration of HIV care with primary health care services: Effect on patient satisfaction and stigma in rural Kenya. AIDS Res Treat. [Internet]. 2013[cited 2019 January 15]; 2013:485715. doi: 10.1155/2013/485715. Available from: https://www.ncbi.nlm.nih.gov/pubmed/23738055.
24. Service integration, linkages and triage. In: WHO, editor. Operations manual for delivery of HIV prevention, care and treatment at primary health centres in high prevalence resource constrained settings [Internet]. Geneva, Switzerland: WHO Library; 2008 [cited on 2019 Oct 20]. p. 23–44. Available from: https://www.who.int/hiv/pub/imai/om.pdf
25. Avert. Funding for HIV and AIDS. Global Information and Education on HIV and AIDS [Internet]. 2019 [cited 2019 Sep 27]. Available from: https://www.avert.org/professionals/hiv-around-world/global-response/funding%0A%0A
26. Avert. HIV and AIDS in Malawi. Global Information on HIV and AIDS. [Home page on the Internet]. 2019 [Updated 2019 February 20; cited 2019 Oct 15]. Available from: https://www.avert.org/professionals/hiv-around-world/sub-saharan-africa/malawi%0D
27. Otiso L, Mccollum R, Mireku M, Karuga R, Koning K De, Taegtmeyer M. Decentralising and integrating HIV services in community-based health systems : A qualitative study of perceptions at macro, meso and micro levels of the health system. BMJ Glob Heal [Internet]. 2017[cited 2019 Oct 20];2(1):2–4. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5321381/%0

28. Mayhew MCSH, Kivunaga RMJ. Perceptions and experiences of integrated service delivery among women living with HIV attending reproductive health services in Kenya : A mixed methods study. AIDS Behav [Internet]. Springer US; 2016 [cited 2019 Oct 20];20(9):2130–40. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4995223/pdf/10461_2016_Article_1373.pdf%0D
29. An SJ, George AS, LeFevre A, Mpembeni R, Mosha I, Mohan D, et al. Program synergies and social relations : Implications of integrating HIV testing and counselling into maternal health care on care seeking. BMC Public Health. 2015;15:24.
30. Huang H, Meller W, Kishi Y, Kathol RG. What is integrated care? Int Rev Psychiatry. 2014;26(6):620–8.
31. Makaula P, Bloch P, Banda HT, Mbera GB, Mangani C, Sousa A De, et al. Primary health care in rural Malawi: A qualitative assessment exploring the relevance of the community-directed interventions approach. BMC Health Serv Res. 2012;12(328):1472–6963.
32. Rifkin SB. Alma Ata after 40 years : Primary health care and health for all — from consensus to complexity. Glob Heal [Internet]. 2018[cited 2019 Oct 20];1:1–7. Available from: https://gh.bmj.com/content/3/Suppl_3/e001188%0D
33. Pandey KR. From health for all to universal health coverage : Alma Ata is still relevant. Global Health [Internet]. Globalization and Health; 2018[cited 2019 Oct 20];14(62):1–5. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6029383/pdf/12992_2018_Article_381.pdf%0D
34. Makwero MT. Delivery of primary health care in Malawi. African J Prim Heal Care Fam Med [Internet]. 2018[cited2019 Oct 20];10(1):1–3. Available from: file:///C:/Users/dell/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/1799-18962-2-PB (1).pdf%0D
35. Measure Evaluation. Family-planning-and-hiv reproductive health [Home page on the Internet]. 2019[no date updated; cited 2019 Oct 20]. Available from: healthhttps://www.measureevaluation.org/prh/rh_indicators/family-planning/family-planning-and-hiv/proportion-of-family-planning-service-sites%0A

36. Johnson K, Varallyay I, Ametepi P. Integration of HIV and family planning health services in Sub-saharan Africa: A review of the literature, current recommendations, and evidence from the service provision assessment healthy facility surveys. I DHS Anal. 2012;30(September):1–77.
37. WHO. Integrating Health Services Research. Technical Series on Primary Health Care [Internet]. 2018 [cited 2018 Dec 17]. p. 273–273. Available from: https://www.k4health.org/topics/integrating-health-services-
38. Smith M, Saunders R, Stuckhardt L, Mcginnis JM, editors. Best care at lower cost: The path to continuously learning health care in America [Internet]. Washington D.C: The National Academies Press; 2012[cited 2019 Oct 20]: 1-416. Available from: www.nap.edu
39. Walker KO, Labat A, Choi J, Schmittdiel J, Stewart Al, Grumbach K. Patient perceptions of integrated care : Confused by the term , clear on the concept. Int J Integr Care[Internet]. 2013 March[cited 2019 Oct 20];13:1–9.
40. USAID, UNC Project, Measure Evaluation. Integrated Service Delivery in Malawi: A Case Study. 2015 August, SR-15-124.
41. Sherris J, Bernson J. Integration of health services: Theory and practices. Havard Coll Glob Heal Rev [Internet]. 2012[cited 2019 Oct 20];iv(1). Available from: https://www.hcs.harvard.edu/hghr/print/spring-2011/health-services-integration/%0D
42. PATH. Health services integration: PATH ' s framework for health services integration. Heal Serv Integr [Web page on the Internet]. 2011 July[cited 2019Oct 20]. Available from: https://path.azureedge.net/media/documents/GP_hsi_overview_bro.pdf
43. Tongco MDC. Purposive sampling as a tool for informant selection. A J Plants People Appl Res [Internet]. 2007 [cited 2019 Oct 20] ;158:147–58. Available from: https://scholarspace.manoa.hawaii.edu/bitstream/handle/10125/227/I1547-3465-05-147.pdf%0D
44. Guest G, Bunce A, Johnson L. How many interviews are enough? An experiment with data saturation and variability. Field Methods. 2006 Feb;18(1):59-82.
45. Hadfield M. Qualitative research in healthcare: An introduction to grounded theory using thematic analysis 1 1. Call Physicians Edimb. 2015;45:201–5.

46. Vaismoradi M, Jones J, Turunen H, Snelgrove S. Theme development in qualitative content analysis and thematic analysis. J Nurs Educ Pract. 2016;6(5):100–10.

APPENDICES

Appendix 1 Data Collection Tools (English Version)

INDEPTH INTERVIEW GUIDE FOR HIV POSITIVE WOMEN

CONSENT FORM

My name is ……. (interviewer's name), I am student for a Master of Public Health Programme from the University of Malawi, College of Medicine. I am conducting a study on ***"The Perception of HIV Positive Women on Integrated Delivery Health Service (IDHS) efficiency in Public Health Facilities of Lilongwe district."*** The main objective is to review perceptions of HIV positive women aged 18 and above on IDHS efficiency in Public Health Facilities of Lilongwe district, Malawi. It is my hope that this research is going to help improve the health services for you.

You have been identified among the other women who come to this hospital to receive treatment, care and support.

You are assured of your privacy and your name or any name you will mention in the course of the interview will be recorded. The information that you will provide will be confidential and only known to you and me. The data that to be recorded will only be used and managed by the interviewer and kept safe until a report is produced and approved by the College of Medicine.

I case of any other questions or further clarifications, I can be contacted at Land O' Lakes ID office, Box A148, Area 12 next to Lingadzi CCAP Church in Lilongwe. My Phone Numbers are: 0888 344 091 or 0998 393 844.

You may not to answer some questions that are disturbing to you or you can choose to stop the interview at any time without any penalty or punishment especially related to you access to medicate services. However, it is my hope that you will answer the questions, which will help me to come up with a report which will further help management to improve the health that you receive.

I have questions which I want you to respond based on your knowledge and experience attending this hospital. This will take us not more than 30 minutes to complete.

At this point, I want to ask you. Do you accept to participate in the study?

Yes ☐

No ☐

The interviewer should stop the interview once the consent has been denied and proceed with the interview if consent is granted. Either way, the interviewer should thank the participant for their time at the end.

a) **<u>Introduction Questions.</u>** Now we are beginning our discussions. I would like to know more about your visit today.

1. What brought you to this healthy facility today?
2. What health service have you come to access?

b) **Questions Related to Integrated Health Service Delivery.** Now we will discuss about IDHS service.

3. What do you know about Integrated Delivery of Health Services (IDHS)?

4. How did you come to know about these services?
5. When you hear of IDHS what does it mean to you/how do you understand by IDHS?

What made you say that?

6. How have you been impacted by the IDHS at this facility?
7. How Often have you ever accessed this service? If not, why?
8. If you have, on what services did you access IDH care?
9. What is your view on HIV service integration approach to health care at this health Facility? Why do you say so?
10. What benefits are there if any in accessing IDHS at this facility?
11. What challenges have you ever experienced accessing IDHS at this facility?
12. What action have you ever taken in trying to solve the problems that you ever faced in relation to IDHS?
13. What support or feedback did you get after the said action was done?
14. What would you want done differently to make this service (IDHS) more effective and efficient?

c) **Concluding Questions.** Now we are getting into the final part of our discussions

15. What do you like the most whenever you come to access health care at this facility? Why?
16. What has been the best time in your experience at this facility since you started accessing IDH care? Why?

This is the end of our interview. Do you have any question for me?

Thank you for your time and for accepting to take part in this study.

KEY INFORMANT GUIDE – HEALTH WORKERS

1. Does your health Facility implement Integrated Delivery Health Care?
2. How does your facility implement IDHS?
3. What does the IDHS implemented at this facility comprise of?
4. For how long has the facility been implementing this IDHS?
5. Who normally access the kind of IDHS your facility offers? Why?

6. Do you think the people who are targeted to access this service really understand it? Why do you say so?
7. What mechanism have you put in place to make sure that patient know about the availability of these service?
8. How do you think those (the HIV positive women) who access this service (IDHS) perceive it? Why do you say so?
9. What successes have been achieved so far since the facility started implementing the IDHS?
10. Why are you referring to these as successes?
11. What have been the challenges?
12. What has the hospital done so far in trying to address the challenges that IDHS face at your facility?
13. What can you recommend to be done to resolve the challenges that IDHS is facing?
14. Why are you proposing that way?

Appendix 2: Data Collection Tools (Chichewa Version)

CHIDA CHOFUNSIRA MAFUNSO KWA AMAYI AMAENE ANAPEZEKA NDI KACHILOMBO KA HIV

FOMU YACHILOLEZO KUTENGA NAWO MBALI MUKAFUKUFUKU

Ine ndine ……. (dzina la ofunsa mafunso akafukufuku), ndikupanga maphunziro anga aukachenjede ku nthambi ya zaumoyo ku school ya u kachenjede ya

college of Medicine ku Blantyre. Ndikupanga kafukukuku okhudzana ndi "maganizo anu pa za ***"Momwe ndondomeko zolandira zisamaliro zosiyana siyana pa malo amodzi ku chipatala ikuyendera, makamaka mzipatala za boma muno mu mzinda wa Lilongwe"*** Cholinga chakafuku fukuyu ndikufuna kuunika maonedwe anu pa za ndondomeko yomwe inakhazikitsidwa makamaka kumbali younika momwe nthito za IDHS zikuyendera mzipatala za boma za mboma lino la Lilongwe, kuno ku Malawi.

Inuyo mwasankhimdwa mmalo mwa amayi onse omwe amadzalandira mathandizo ndichisamaliro kuchipatala kuno, ndiye kuyankha kwnu kukuyimilira enano mwa azimayi ngati inu amene sitingathe kukumana nawo lero kuti tiwafune mafunso.

Mukutsimikiziridwa za chitetezo chanu ngati munthu opereka uthenga. Dzina lanu kapena la aliyense amene adzakhudzidwe ndikupereka uthenga silidzatchulidwa kapena kuyikidwa mu zolemba lemba zathu. Zolemba lemba zones zimene tidzatenge kwa inu, zidzasamalidwa bwino ndikusungidwa malo osaamalika ndikukiyidwa bwino mpaka ma lipoti atalembedwa ndikuvomerezedwa ndi a sukuku ya ukachenjee ya Koleji of medicine.

Ngati mungakhale ndimafunso ena kapena kufuna kuunikiridwa mwapadera zokhudza kafukufukuyu, mutha kundipeza ku Ofesi yathu ya Land O' Lakes pafupi ndi Church cha Lilongwe CCAP ku area 12 mu Mumzinda wa Lilongwe. Foni yanga ya mmanja ndi 0888 344 091 kapena 0998 393 844.

Muli ndiufulu kukana kapenanso kusiyila panjira kuyankha mafunsowa ngati simukusangalatsidwa ndipo izi sizidzapangitsa kuti mulandire chilango chamtundu wina uliwonse makamaka kukhudzana ndimathandizo amene mukubwera kudzzalandira. Ngakhale zilichoncho, ife tidzakondwa ngati mungadzapitirize kuyankha mafundo anthu onse.

Ndkufuna ndikufunseni mafunso pazomwe mukudziwako olo mwakumanako nazo pokhudzna ndi kafukufukuyu. Kucheza kwathu kutitengera maola osapitirira khumi ndi atatu kuti timalize.

Pano ndikufunsani. Mukuvomera kutenga nawo gawo mukafuku fuku ameneyu?

Eya ☐

Ayi ☐

Ofunsa mafunso asapitirize kufunsa ngati ofunsidwa wakana kupitiliza kuyankha mafunso ndipo amuthokoze chifukwa cha nthawi yomwe anamupatsa kuyankhula naye.

a) <u>Mafunso Oyambirira</u>

1. Chakubweretsani pachipatala pano lero ndi chani?
2. Makakaka ndi thandizo lanji limene mukuyembekezera kulandira kuno kuchipatala?

b) Mafunso okhudzana ndi Ndondomeko Yopereka chisamaliro chamatenda Osiyana Siyana pa Malo Amodzi

3. Mumadziwako chani za yolandila zisamaliro zosiyana siyana zachipatala pa malo amodzi?
4. Munadziwa bwanji za ndondomekoyi?
5. Mukamva mau oti kulandira zisamaliro zosiyana siyana pamalo amodzi kuchipatala, zimatanthauza chani kwa inu/mumawamva bwanji? Chifukwa chani mwatero?
6. Inuyo munayamba mwakhudzidwako motani polingana ndi mathandizo osiyana siyana amane amaperekedwa ndi achipatala pamalo amodzi?
7. Mwakhudzidwako mochulukira bwanji ndi ndondomeko imeneyi? Ngati simunakhudzidwe, ndichifukwa chiyani?
8. Ngati munakhudzidwa, munakhudzidwa mumagawo ake ati?
9. Inuyo mumaona bwanji za machitidwe a ndondomeko imeneyi ya IDHS? Chifukwa chiyani mwayankha motere?
10. Ndiphindu lanji limene mwalionako mukukhazikitsidwa kwa ndondomeko imeneyi yolandira mathandizo osiyana siyana pamalo amodzi?
11. Nanga Ndimavuto ati amene mwakumanako nawo kugwiritsa ntchito ndondomeko imeneyi pachipatala pano?
12. Mwachitako chani pa za mavuto amane mwakumanako nawo pokhudza kulandira ndondomeko imeneyi pachipatala pano?
13. Ndi thandizo lanji kapena yankho lanji lomwe munalandirako mutapangako kanthu pamavuto omwe mwakumanako nawowo?
14. Mukuganiza kwanu, mukuona ngati pakuyenera kuchitika zotani kuti ndondomeko imeneyi ikhale yothandiza ndiyodalilika?

c) Mafunso Omaliza

15. Chimakusangalatsani ndichani mukabwera kuchipatala kuno kudzalandira thandizo? Chifukwa Chiyani?

16. Ndi nthawi iti yomwe yakhala yopambana pa moyo wanu chiyambire kubwera kuno kudzalandira mathandizo osiyana siyana opezeka pamalo amodzi. Chifukwa chiyani?

Apa ndipamapeto pamafunso athu. Kodi muli ndi funso?

Zikomo kwambiri chifukwa cha nthawi yanu komanso potenga nawo mbali mukafukufukuyi.

CHIDA CHOFUNSIRA MAFUNSO KWA OGWIRA NTCHITO PACHIPATALA

1. Kodi pachipatala pano pali ndondomeko yolandira thandizo/zisamaliro zosiyana osiyana pamalo amodzi?
2. Ndondomeko imeneyi imapangidwa motani?
3. Ndondomeko imeneyi Imakhudza madera ake ati or zinthu zake ziti?
4. Mwakhala mukupanga ndondomeko imeneyi kwa nthawi yayitali bwanji pachipatala pano?
5. Ndondomeko imeneyi kawiri imakhudza ndani? Ndipo ndichifukwa chiyani?
6. Mmene mukuganizira, anthu omwe mumafikira pa ndondomeko imeneyi, amazimvetsetsa za ndondomekoyi? Chifukwa chani mukunena choncho?
7. Nkuona kwanu, anthu omwe mumawafikira pa ndondomeko imeneyi, amayiona bwanji? Chifukwa chani mukunena choncho
8. Ndizopambana zanji zimene mwazionako pachipatala pano chikhazikitsireni ndondomeko imeneyi?
9. Ndichifukwa chani mukuzitcha zimenezi zopambana?
10. Mwakumanako ndi mavuto anji mukugwiritsa ntchito ndondomeko imeneyi?
11. Mwachitako chani pachipatala panu pano kuyesa kukonza zovuta zimene zikupezeka mundondomeko imeneyi?
12. Inu mukuona kwanu mukuona kuti pakuyenera kuchitika zotani kuti tikonze mavuto amene akupezeka nkugwiritsira ntchito ndondomeko imeneyi?

13. Chifukwa chiyani mukunena choncho?

Appendix 3: Letter Requesting for Approval to Lilongwe DHO to Conduct the Research

Land O' Lakes ID Malawi,

P/Bag A148, Lilongwe

Phone: + 265 888 344 091

Email, vchauya@gmail.com

10th August 2017

To: The District Health Officer (DHO)

Lilongwe DHO

P.O Box 1274

Lilongwe

Dear Sir/Madam

REQUEST FOR APPROVAL TO CONDUCT RESEARCH IN YOUR HEALTH FACILITIES

I am Ivy Violet Chauya (Student Number M20167007352), studying for a Master Program in Public Health and the Kamuzu College of Medicine. I am doing a research dissertation on: *"**Perceptions of HIV Positive Women on Integrated Delivery of Health Service Efficiency: A Review of Public Health Facilities of Lilongwe District, Malawi."***

The study aims to review perceptions of HIV positive women aged 18 and above on integrated health care service delivery efficiency in Public Health Facilities of Lilongwe district, Malawi.

The study is planned to be done from 1st to 28thFebruary 2018. This will involve conducting interviews with HIV positive women who have visited the facility to access treatment, care and support within the days of the interview. In addition to interviewing health officers at the respective sites as key informant.

The study will be conducted in 6 health facilities under your jurisdiction and these include:

Therefore, I am writing to seek your approval to go and conduct the research in the selected healthy facilities.

Yours Faithfully,

Ivy Violet Chauya

Appendix 4: Letter of Approval from Lilongwe DHO to Conduct the Research

Ref. No.:
Telephone No.: 265 726 466/464
Telefax No.: 265 727817
Telex No.:
E-Mail. lilongwedho@malawi.

In reply please quote NO DZH/MALAWI,
Lilongwe District Health Office
P.O. Box 1274
Lilongwe
Malawi

COMMUNICATIONS TO BE ADDRESSED TO:

17th August, 2017

The Chairperson,
College of Medicine Research and Ethics Committee
Private Bag 360, Chichiri
Blantyre 3
Malawi

Dear Sir/Madam

ATTACHMENT LETTER TO LILONGWE DISTRICT HEALTH CENTRES

Permission has been granted to the bearer of this letter: Ivy Violet Chauya Masters Programm in Public Health student, from Kamuzu College of Medicine to conduct a research study at your Hospital.

"Perceptions of HIV Positive Women on Intergrated Delivery of Helath Service Efficiency: A Review of Public Health Facilities of Lilongwe District, Malawi"

Any assistance rendered would be appreciated.

LILONGWE DISTRICT HEALHT OFFICE
17 AUG 2017
DISTRICT HEALTH OFFICER
P. O. BOX 1274, LILONGWE

Dr. E. Rambiki
For: DISTRICT HEALTH OFFICER

Approved by
College of Medicine
13 SEP 2017
(COMREC)
Research and Ethics Committee

Appendix 5: COMREC Letter for Proposal Submission

COLLEGE OF MEDICINE
Public Health Department

TO: Chairperson, COMREC

FROM: MPH Tutor

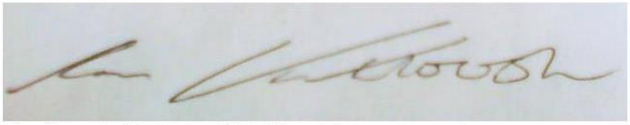
DATE: August 16, 2017

SUBMISSION OF MPH RESEARCH PROPOSAL

Please find enclosed research proposal from our MPH student Ivy Chauya, version I, entitled, **"Perceptions of HIV positive women on integrated delivery health service efficiency: A review of Public Health facilities of Lilongwe District, Malawi".**

The proposal was reviewed by Public Health Research and Postgraduate Committee and was approved for submission to COMREC. The thesis supervisor of this student Dr. Davie Zolowere has endorsed the submission.

Thank you.



Dr. Susan Carnes Chichlowska
MPH Tutor

Appendix 6: Certificate of Ethical Approval

UNIVERSITY OF MALAWI

CERTIFICATE OF ETHICS APPROVAL

This is to certify that the College of Medicine Research and Ethics Committee (COMREC) has reviewed and approved a study entitled:

P.08/17/2239 – Perceptions of HIV positive women on integrated delivery health service efficiency; a review of public health facilities of Lilongwe District , Malawi by Ivy Violet Chauya

On 13th September 2017

As you proceed with the implementation of your study, we would like you to adhere to international ethical guidelines, national guidelines and all requirements by COMREC as indicated on the next page

Dr. L Alfazema-Chiuzeni - Vice-Chairperson (COMREC)

Approved by College of Medicine
13 SEP 2017
(COMREC)
Research and Ethics Committee

13th Sep 2017
Date

Appendix 7 Research Budget

Item	**Unit of Measure**		**Quantity**	**Unit Cost**	**Number of days**	**Total Cost**
Enumerators Allowance	Person		1	8000	12	96, 000
Paper	Rim		2	5000	1	10, 000
Note pads	Each		2	300	1	600
Ball point pens	Each		4	100		400
Transport (fuel)	Litres		12	735	12	105,840
Lunch for Researcher	Person		1	1500	12	18,000
Training Venue	NA		NA	NA	NA	NA
Comrec Proposal Processing Fees	1	1	1	108900	1	108 900
Sub-Total Cost						**339, 740**
Administrative Contribution to COM				**10%**		**33, 974**
						373, 714

Appendix8: Research Schedule

Activity	2017									2018								2019				
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Literature Review																						
Proposal Writing and submission																						
Proposal Approval																						
Questionnaire development																						
Questionnaire Approval																						
Recruitment and enumerator training.																						
Piloting and data collection																						
Data Transcription																						
Data Analysis																						
Report writing																						
Submission of Dissertation Report																						
Dissertation approval																						
Dissemination of Results																						