

COOPER/SMITH

BLANTYRE PREVENTION STRATEGY

Findings from the Civil Society Organization Mapping and the HIV Prevention Data User Study



Cooper/Smith August 2022

TABLE OF CONTENTS

ACKNO	WLEDGMENTS	3
ABBRE	VIATION LIST	4
1. THE	BLANTYRE PREVENTION STRATEGY PROJECT	5
2. CIVII	L SOCIETY ORGANIZATION NETWORK ANALYSIS MAPPING	7
2.1	BACKGROUND & RATIONALE	7
2.2	METHODOLOGY	8
2.3	CSO MAPPING DEFINITION	9
2.4	CSO NETWORK ANALYSIS KEY FINDINGS AND RECOMMENDATIONS	9
3. THE	DATA USER STUDY	14
3.1	BACKGROUND & RATIONALE	.14
3.2	METHODOLOGY	.15
3.3	FINDINGS AND RECOMMENDATIONS	.16
4. DES	IGN AND DISSEMINATION WORKSHOP	27
5. NEX	T STEPS, INSTITUTUTIONALIZATION, AND SUSTAINABILITY	28
5.1	CSO MAPPING: NEXT STEPS, INSTITUTIONALIZATION, AND SUSTAINABILITY	.28
5.2	THE PREVENTION DUS: NEXT STEPS, INSTITUTIONALIZATION, AND SUSTAINABILITY	.30
APPEN	DIXES	31
APPE	NDIX 1. CSO NETWORK ANALYSIS	.31
APPE	NDIX 2. DATA USER STUDY	.34





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ABBREVIATION LIST

AGYW	Adolescent Girls and Young Women
BCC	Blantyre City Council
BDC	Blantyre District Council
BPS	Blantyre Prevention Strategy
СВО	Community-Based Organization
CONGOMA	Council for Non-Governmental Organizations in Malawi
CSO	Civil Society Organization
DH	Data Handler
DHA	Department of HIV and AIDS
DHO	Blantyre District Health Office
DM	Decision-maker
DUS	Data User Study
e-MTCT	Elimination of Mother to Child Transmission
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FBO	Faith-Based Organization
HSA	Health Surveillance Assistant
KP	Key Populations
LAHARS	Local Area HIV/AIDS Reporting System
MACRO	Malawi AIDS Counselling and Resource Organization
MANASO	Malawi Network of AIDS Organizations
NAC	National AIDS Commission
NGO	Non-Governmental Organization
NSO	National Statistics Office
NSP	National Strategic Priorities
NYC	Malawi National Youth Council
ONA	Organizational Networking Analysis
PALMS	Prevention Adaptive Learning Management System
PrEP	Pre-exposure prophylaxis
PSI	Population Services International
SBCC	Social Behavior Change Communication
SRH	Sexual and Productive Health
STI	Sexually Transmitted Infections
TCS	Treatment, Care, and Support
VMMC	Voluntary Male Medical Circumcision









1.THE BLANTYRE PREVENTION STRATEGY PROJECT

Global efforts to expand HIV treatment have increased life expectancy and reduced transmission. Nevertheless, reservoirs of infection remain and will persist unless we deliver effective primary HIV prevention. In sub-Saharan Africa, rapidly expanding populations of vulnerable youth and young adults, combined with threats of decreased donor funding, creates further risks to HIV prevalence and urgency to address it. Current systems experience challenges in supporting the delivery, uptake, and effective use of HIV prevention products, hindering the deployment of novel prevention products that could reduce the risk of HIV infection. These weak and poorly coordinated HIV prevention delivery systems—in particular, those linked to community outreach and delivery—present a barrier to addressing persistent risk and to controlling HIV epidemics over the long-term.

The Blantyre Prevention Strategy (BPS) is funded by the Bill & Melinda Gates Foundation. The program promotes a locally led, contextually tailored, and data-driven systems-based approach to HIV prevention. It aims to identify new ways of delivering HIV prevention services and to embed them into existing health structures. The grant's geographic area of focus is Blantyre District, Malawi.

The Data User Study and Civil Society Organization Network Analysis allows us to better understand prevention delivery channels and the information is needed to rapidly roll out new HIV prevention products.

The **BPS project** team (Blantyre District, the

Government of Malawi, Georgetown University, the Gates Foundation, and other partners) had several questions while developing the program approach: What information is used to make HIV prevention related decisions in Blantyre? How are those data collected? What are the key decisions being made by health leadership in the district? How do the data collected align with those decisions? How are HIV prevention services provided in Blantyre









DUS & CSO Mapping Findings August 2022

5

District? How many organizations provide those services? What is the nature of the relationship between these organizations? Do they share information with each other?

To help answer these questions, we conducted two studies: 1) the Data User Study (DUS) and 2) the Civil Society Organization (CSO) Network Analysis.¹ These studies were supported by Blantyre District and City representatives, the National AIDS Commission (NAC), the Department of HIV & AIDS (DHA), and other partners.

This report summarizes the study findings, methodology, and stakeholder feedback collected during a study results dissemination workshop.

¹ The studies received ethical approval by the National Health Sciences Research Committee (NHSRC Protocol #21/03/2664).









2. CIVIL SOCIETY ORGANIZATION NETWORK ANALYSIS MAPPING

2.1 BACKGROUND & RATIONALE

Civil Society Organizations are instrumental in expanding the coverage of HIV prevention services. However, this network of organizations delivering services outside of the formal health system is complex. These organizations include community-based organizations, faith-based organizations (FBOs), and non-governmental organizations (NGOs). Understanding their activities and their interactions with one another is vital to strengthening the overall delivery of HIV prevention services in Blantyre District. We wanted to better understand how CSO partnerships can be leveraged to strengthen and expand HIV service delivery. Previously, it was not widely known which CSOs are currently operating in Blantyre District or what HIV prevention services they deliver. The relationships between organizations were also unclear. For example, do CSOs share information or refer patients to their partners?

There are multiple databases² in Malawi with information on CBOs, NGOs, and FBOs in Blantyre District. However, the data in these systems do not contain the information needed to conduct a CSO Network Analysis. The systems also lack the standards needed to provide a comprehensive understanding of CSOs involved in HIV prevention. For example, the most prominent of these systems, NAC's Local Authority HIV and AIDS Reporting Form (LAHARF), collects substantial information on organizations' activities but no data on the exchange of information, commodities, and client referrals between organizations.

Several active systems lead to duplication in CSO registration and reporting efforts. This decentralizes pertinent data regarding the organizations' operations and relationships to

² These systems include: National AIDS Commission's, Local Area HIV/AIDS Reporting System/Form LAHARS/LAHARF, The Council for Non-Governmental Organizations in Malawi (CONGOMA), The NGO Board of Malawi, Blantyre District Council, Fast Track Cities, MANASO Network, DHO Partners Mapping, and The Malawi National Youth Council (NYC)







one another. NAC identified these gaps in the 2020 Malawi National HIV/AIDS Monitoring and Evaluation Framework. According to this report, the following weaknesses persist under the current registration systems:

- Incomplete design and launch of some of the databases,
- Limited internet connectivity,
- Limited reporting to populate databases,
- Little utilization of information from databases and thus reduced commitment to get the systems up and running,
- Prohibitive costs for reliable internet, and
- Insufficient desegregation of data in some databases.

Given these shortcomings and the need to better understand HIV prevention service delivery outside of the formal healthcare sector, the objectives of this CSO network analysis are to:

- Provide a comprehensive landscape of HIV prevention services delivered at NGOs, CBOs, and FBOs in Blantyre;
- 2) Visualize the network of CSOs, including how they relate to the formal healthcare system and each other; and
- 3) Use subsequent network analyses to identify well-functioning networks to strengthen and improve future service delivery.

2.2 METHODOLOGY

We created a sampling frame of organizations identified through eight CSO registration systems. We collected the names of every organization listed in these registration systems and, following the removal of duplicates, identified a total of 332 organizations that work in HIV prevention in Blantyre (Appendix 1).

We sent eligible organizations an online survey using Kobo Toolbox³. Participants could fill out the survey using a phone, tablet, or computer. Organizations completed the surveys independently but could request technical support from our team of enumerators. Enumerators followed up with organizations who had not completed the survey within two weeks of receipt. All respondent organizations were offered data bundles to provide access to the online survey. In total, 124 organizations responded to the survey and were included in the analysis. The 37% response rate was due to challenges in tracing organizations.

³ <u>KoBoToolbox</u> is a free and open-source tool for field data collection. Although designed for challenging environments, like humanitarian aid crises, it can be used in a plethora of environments.







Almost half of the initial sample (48%) was excluded since their organizations could not be traced, had closed, did not meet the inclusion criteria of providing HIV services, or their contact information could not be confirmed.

We used two approaches to analyze the CSO mapping:

- 1. We conducted quantitative analysis using Excel and Tableau to generate summary statistics and visuals of the services being delivered by the CSOs.
- 2. We conducted an organizational network analysis (ONA) using the partnership data provided by respondents. An ONA identifies if organizations have a relationship with one another and, if so, how many partners each organization has. The visuals also show information on referrals, information, commodity sharing, joint HIV programming, and the reliability of the relationship. We conducted the ONA using Kumu, an online network mapping tool. The visuals can be accessed <u>here.</u>

2.3 CSO MAPPING DEFINITION

Key terminology is helpful for understanding the outputs and findings of the CSO mapping. These include:

- Cluster: a set of densely connected nodes.
- **Connection:** a line between two nodes indicating a partnership between a CSO and partner organization.
- **Network:** the organizations that make up the mapping (i.e., respondent organizations and their partners).
- Node: a circle that represents a CSO, health facility, or partner organization.
- Organizational Network Mapping: a way to summarize and visualize the relationships between organizations.
- **Periphery/Outskirts:** refers to the outside area of the map where nodes with very few or no connections are shown. This shows organizations that are siloed and not well-connected.

2.4 CSO NETWORK ANALYSIS KEY FINDINGS AND RECOMMENDATIONS

Finding 1: Many CSOs do not partner with other CSOs (Figure 1). 32 percent of CSOs do not have a relationship with another CSO. The lack of coordination and collaboration between CSOs have important implications for service delivery. This includes challenges with resource mobilization, resource allocation, and community outreach and sensitization.







Figure 1: CSO connections



Recommendation: Interventions should be designed to include these siloed CSOs. Future CSO mappings can be conducted to measure the success of these interventions.

Finding 2: 20% of CSOs are not affiliated with or do not work with health facilities (Figure 2). Although CSOs tend to partner with health facilities more than with other CSOs, there is still a lack of partnership between health facilities and CSOs. This raises concerns about whether there is a comprehensive set of services being provided in each catchment area. This may also indicate a duplication of HIV prevention efforts.

Recommendation: CSOs should register their organization so they can be linked to health facilities in their area. A potential platform for CSO registration is the National Malawi NGO Board's database. This will provide information on coverage and assist with resource allocation to the most in need areas. It will also ensure that there is a comprehensive set of services being delivered within each catchment area. Existing platforms and structures, like the District Health Office (DHO) Health Prevention Technical Working Group, can also be used to further strengthen the collaboration between CSOs and health facilities.





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Finding 3: A lack of population-specific data is a barrier to fully understanding service delivery and existing needs. Data on key populations (KP), such as men who have sex with men and transgender individuals, is often grouped with general population data. This lack of disaggregation makes it difficult to assess reach and current need.

Recommendation: Key population data should be disaggregated from the general population data at the facility level. The current policy does not permit the disaggregation of KP data by KP type to protect the privacy and confidentiality of clients. To enable targeted HIV prevention intervention, KP data disaggregation is important. Within key populations, groups should also be disaggregated. For example, female sex workers and men who have sex with men should be identified separately. To realize this, the current policy statements will have to be reviewed. Disaggregated KP data could be captured with the help of digital solutions working silently at backend database level with the help of unique identifiers in the health sector. This would generate such data without compromising the confidentiality of clients.

Finding 4: Most CSOs are involved in community mobilization and sensitization, addressing human-rights related barriers, and sexual and reproductive health (SRH) services. Very few





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CSOs (9%) provide services for STI treatment and only 3% provide TB testing and TB treatment (Table 1).

Recommendation: Coordination and partnerships between CSOs should be strengthened to ensure that there is not a duplication of services and/or efforts. Partnerships between CSOs should be strengthened to ensure their service delivery is complementary and individuals can access a comprehensive set of services. A registration system would assist with this. Further, since most CSOs do not offer services like TB testing and treatment, partnerships with health facilities can assist with referrals for services CSOs do not deliver.

Service Offered	% Of CSOs that Provide the Service
Community mobilization and sensitization	110 (89%)
Human-rights barriers	93 (75%)
SRH / HIV prevention services	91 (73%)
Wellness & HIV prevention	83 (67%)
Condoms	80 (65%)
STI screenings	14 (11%)
PrEP	13 (10%)
TB testing	4 (3%)
TB treatment	4 (3%)

Table 1: Most and least common services delivered by CSOs

*Finding 5: The most common measurements of partnership between CSOs are commodity sharing*⁴ *and joint HIV programming.* Financial sharing and information sharing rarely took place between CSOs. Figures 3 and 4 show client referrals. The width of the line signifies how many referrals occur -- the higher the number of referrals, the thicker the line. More than half of respondents do not refer clients to their partner (57%). Among respondents that do send referrals to their partners, 84% referred less than 100 clients in the past year.

Recommendation: Interventions that aim to increase CSO HIV prevention service delivery and strengthen CSO partnerships should focus on increasing referrals between CSOs, especially those that offer complementary services. CSOs typically specialize in specific service areas as it is costly to offer a comprehensive set of services. This specialization makes CSO partnerships crucial; collaborations among these organizations spurs the synergy that is integral to strengthening service delivery. Referrals between CSOs are especially important for ensuring individuals can access the HIV prevention services they need within the community.

⁴ Commodity sharing in the survey is considered sharing resources such as office space, written materials, pamphlets, posters, supplies, agricultural instruments, and/or equipment.











Finding 6: Well-connected CSOs play an integral role in the community for accessing HIV prevention services. Service delivery information from the survey emphasizes the role that CSOs play in sensitization, outreach, and mobilization. CSOs could also play an integral role in referring PrEP candidates and patients to health facilities that distribute PrEP if a referral system is in place.

Recommendation: CSOs should play an integral role in the scale-up of PrEP and other HIV prevention technology. Well-connected CSOs should be included in the scale up of PrEP.









3.THE DATA USER STUDY

3.1 BACKGROUND & RATIONALE

The Data User Study maps decisions, data elements, systems, and users involved in Blantyre District's HIV prevention program. Data use for decision-making⁵ in HIV prevention is still a relatively unexplored research topic, yet, understanding how data are collected, transmitted, stored, analyzed, and used is critical to improving the provision and delivery of HIV prevention services. Timely and high-quality data are key to maximizing the efficiency of HIV programs. Decision-makers need the right data, at the right time, and in the right format to make informed decisions. A lack of evidence-based decision-making can result in ineffective decision-making, uncoordinated efforts, and missed opportunities for improvements. The DUS explores current and future delivery channels that can be used for administering existing and novel HIV prevention technologies.

The objectives of the study are to:

- 1) Systematically map decisions, data elements, data systems, and data users for HIV prevention data. Specifically:
 - Who makes which decisions related to HIV prevention activities,
 - What data elements they use to make these decisions, and
 - What systems (paper and electronic) they use to collect those data.
- 2) Assess access to technology, educational level, and other key demographic data. The study provides an understanding of access to technology, level of education, and key demographic information to better design training and capacity building programs.

⁵ In this study, "data use" is defined as the practice of collecting, managing, analyzing, and interpreting data for making program policy, management, or healthcare delivery decisions.







3) *Identify the delivery channels used for HIV prevention*. Findings provide insights into current HIV prevention service delivery channels. They also reveal potential new delivery channels that can be explored.

3.2 METHODOLOGY

Primary data collection took place using three mixed methods questionnaires: a decisionmaker interview guide, data handler interview guide, and a facility profile. Each interview was conducted using a digital collection application (CommCare). Quantitative responses were analyzed using descriptive statistics. Qualitative responses were thematically coded, and second order analyses were conducted to identify recurrent themes and patterns. Study outputs are available in a dashboard <u>here</u> (see Appendix 2).

Sample Size & Respondent Profile

A total of 150 respondents participated in the study across all levels of the health system: 71 decision-makers (DM) and 79 data handlers (DH). Respondents in the DUS are categorized as either decision-makers or data handlers. Decision-makers are individuals responsible for making decisions, such as a director. Data handlers are individuals responsible for collecting and aggregating data, such as a community health worker or a monitoring and evaluation officer.

We developed a sampling stratification method to ensure a representative sample at each level of the health system (national, district, city, facility, and community) and across sectors (government, civil society, and private), as shown in Tables 2 and 3. These levels and sectors are representative of the organizations and individuals working in HIV prevention in Blantyre. The sample was also selected to be representative of the potential facilities and users targeted by the BPS project. The prevention delivery channels were based on the National Strategic Priorities (NSPs) outlined in the <u>2020-2025 Malawi</u> <u>National Strategic Plan for HIV and AIDS</u> to understand current and future prevention delivery channels.

Health Level	Decision-Maker	Data Handler
National	18	9
District	12	20
City	14	15
Facility	11	29
Community	16	6
Total	71	79

Table 2: DUS sample size by level

Table 3: Organization type by respondent type

Organization Type	Decision- Maker	Data Handler
CSO	18	9
Government	12	20
Private Sector	14	15
Total	71	79







3.3 FINDINGS AND RECOMMENDATIONS

Finding 1: There is minimal overlap between the data elements referenced by decisionmakers and those referenced by data handlers. This means that data handlers may not be collecting the data that is needed for decision-making. This pattern is seen across all NSPs (Table 4). For example, for Resilient Systems, data handlers and decision-makers did not reference a single data element in common. Even for NSPs where there is more overlap, like elimination of mother-to-child transmission of HIV/AIDS, it is still minimal with only 10 data elements referenced by both groups.

NSP	DH Unique Elements	DM Unique Elements	Elements Referenced by Both
AGYW	37	58	8
Condoms	39	40	9
Differentiated HIV Testing	41	23	6
E-MTCT	67	16	10
Human Rights	18	24	2
Key Populations	73	32	4
Lead, Coor, & Resp	35	53	2
PrEP	39	14	5
SBCC	29	58	3
STIs	42	52	8
TB HIV	83	18	6
Vulnerable Children	25	39	2
TCS	59	44	5
VMMC	19	19	2
Wellness & Workplace	27	24	1
Resilient Systems	18	33	0

Table 4: Data elements referenced by data handlers and decision-makers by NSP

The data being collected should be the same as the data needed for decision-making. One NSP where there is minimal overlap is adolescent girls and young women (AGYW). Data handlers and decision-makers mentioned 37 and 58 elements, respectively (Figure 5). Only 8 of those data elements were the same. AGYW are a key population at risk of contracting HIV. Therefore, making evidence-based decisions and using data to inform programming and service delivery for this group is of the utmost importance. Figure 6











highlights how decision-makers may not have the data they need to make decisions regarding AGYW. For example, data handlers collected the most data on AGYW pregnancy followed by AGYW school attendance. However, decision-makers report using data on AGYW pregnancy and HIV testing. **Given this lack of overlap it is likely that decision-makers working on AGYW do not have the data they need to support their decisions.** This can affect our understanding of the current situation regarding AGYW and influence decisions made around programming for AGYW, such as the interventions being designed and implemented. Not having the right data to support decisions can also affect service delivery. If decision-makers do not have the data they need to understand AGYW pregnancy rates or HIV testing, for example, it can influence the delivery of family planning services and/or HIV testing for AGYW.



Figure 6: Top data elements for AGYW by decision-makers (top) and data handlers (bottom)

Recommendation: Decision-makers should agree on which data elements are the most important for decision-making across all the NSPs. Data handlers should be provided with this information to ensure that the data needed for decision-making are available and





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DUS & CSO Mapping Findings August 2022

17

accessible. This list should be updated periodically to ensure the correct data elements are being collected. Further, data collection tools should be tailored to this list and maintained to include the data elements needed for decision-making. These activities can, for example, take place during annual or semi-annual strategic planning meetings where stakeholders can determine which data elements need to be routinely collected to support decision-making.

Finding 2: Delivery channels like pharmacies, mobile applications, pop-ups, and workplaces are not widely used across NSPs. Furthermore, respondents identified two delivery channels that are currently highly underutilized – mobile clinics and the community – as delivery channels that can be expanded in the future. Additionally, certain NSPs, such as differential HIV testing, key populations, and STIs currently have diversified delivery channels, with potential for improving these channels and enhancing service delivery. Other NSPs, like pre-exposure prophylaxis (PrEP), VMMC (voluntary male medical circumcision), and vulnerable children, span fewer delivery channels, meaning there are opportunities for further expansion. Tables 5 and 6 show current HIV prevention delivery channels and future HIV prevention delivery channels, respectively.

	AGYW	Condom	DiffHIVTest	eMTCT	Human Rights	КеуРор	PrEP	SBBC	STIs	TBHIV	TCS	VMMC	VulnChild	WellWork
ANC Clinic	6	8	8	14	1	3	3	3	10	4	6	0	0	2
ART Clinic	6	12	5	12	4	6	3	3	12	8	17	1	5	1
FP Clinic	8	11	4	3	1	4	1	3	10	3	6	0	0	1
HTS Clinic	5	13	9	8	1	6	0	4	10	7	7	2	2	2
Mobile Clinic	4	8	2	4	1	4	0	2	1	2	1	4	1	1
STI Clinic	6	10	4	2	1	5	2	3	13	3	7	2	0	2
U5 Clinic	1	3	3	7	0	5	0	2	1	3	5	0	0	1
VMMC Clinic	1	7	5	0	1	2	1	2	1	1	2	7	0	1
Other Clinic	2	6	3	2	4	1	6	3	6	6	9	4	3	2
Community	20	21	7	2	8	10	2	21	10	7	8	4	8	1
FBO	2	4	2	1	2	3	0	1	1	1	2	0	1	1
Government	4	4	3	1	1	2	2	5	4	4	2	0	1	1
Mobile	0	0	1	0	0	1	0	1	1	0	0	1	0	0
Pharmacy	0	2	2	0	0	1	0	0	1	1	1	0	0	1
Pop Up	3	11	5	1	0	4	1	1	3	2	2	3	0	0
Workplace	1	10	3	0	1	1	0	3	1	1	2	0	2	7
Other	16	20	6	2	10	9	5	18	14	9	11	7	8	6

Table 5: Current delivery channels by NSP⁶

⁶ The red boxes in Table 5 highlight delivery channels that are least likely to be used currently. This shows opportunities to expand service delivery into these existing channels. The red boxes in Table 6 show the delivery channels that respondents mentioned should be explored as future delivery channels.







		Condom	Diff HIV	EMICT	Hum	Kay Pope	DrED	SPCC	STIC		тле	MAMO	Vulo Child	
ANC Clinic	AGTV	1 1		1 (nignus D 1	ney rops	(C				2	1	vuiri Criniu 1	
ART Clinic		,	1 1	0		. 0	0		2 1	1		2	3	2
FP Clinic			1 (n ·	1 1	. 0	0				1	1	1	1
HTS Clinic			1 .	3		. 0			1 1		. 1		1	1
Mobile														
Clinic		ļ	4!	5	22	2	1	1	LJ	44	5	3	0	2
STI clinic	:	1 :	1 (0 :	1 1	. 1	c) 2	2 2	2 2	2 2	2	1	1
U5 Clinic	(b :	2 (o :	2 1	. 0	c) 1	L 1	L 1	. 0	C	1	0
VMMC														
Other	()	1 :	1 :	1 1	. 0	C) (2	2 2	2 0	2	0	0
Clinic		L;	3;	3	11	2	4	11	4	2	4	2	0	1
Community	, 8	3 9	9 9	9 .	4 6	5 7	e	s g	9 4	а а	5 5	1	4	1
FBO	() :	3	1	1 1	. 1	C) 2	2 1	L 1	. 4	C	2	0
Governme														
nt	() :	1 (0 (0 1	. 1	C) 2	2 4	t C) 1	1	0	0
Mobile	:	1 (0 (0 (0 1	. 2	C) 5	5 () C) 2	C	0	1
Pharmacy	() :	3 (0	1 0	0	C) (0 1	L C	0 0	C	0	0
PopUp	() :	2 :	2 (0 1	. 4	1	. 2	2 3	з с	0 0	C	0	1
Workplace	() :	2 :	3 :	1 0	2	c) 2	2 4	1 2	2 2	1	0	4
Other	24	4 1	6	7	7 8	8	2	2 16	5 17	7 4	12	5	8	7

Table 6: Future delivery channels by NSP

Recommendation: Current delivery channels should be strengthened and expanded where there are opportunities, particularly for NSPs that only use a few delivery channels. NSPs could try expanding services through underutilized delivery channels, such as pharmacies. Additionally, mobile clinics and community delivery channels can be strengthened and expanded.

Finding 3: The community is an important mechanism for HIV prevention service delivery. The 'Other' category was most widely referenced by respondents for future delivery channels (Table 6). Although community delivery channels are the most cited current delivery channels, many respondents felt there are still community platforms that are not being fully leveraged, such as schools, youth clubs, and churches (Figure 7). The private sector was also cited as a future delivery channel across all NSPs. Other delivery channels, like mother groups, are more specific to a few NSPs but may be promising. These future delivery channels also align with the target populations mentioned by respondents. For example, findings showed that students are the 6th most cited target population group. This aligns with using schools and sports clubs as delivery channels. Interestingly, the most common response for future delivery channels is 'none/don't know.' This may suggest that some respondents feel that current delivery channels are sufficient and should be strengthened rather than expanding into new channels. As one respondent said, "the current model works fine." Another respondent stated, "all the available channels for delivering these services are being utilized."











Recommendation: Explore opportunities to deliver services through new community channels. There are avenues that respondents feel are not fully utilized presently but have significant potential. Schools, youth clubs, and churches, which were mentioned across all NSPs, should be explored.

Finding 4: There are opportunities for private sector engagement, particularly at the community and facility levels. When asked which sectors are involved in HIV prevention service delivery by NSP, respondents were less likely to mention the private sector (72 responses) when compared to other sectors such as communitybased organizations (CBOs) (162 responses), the public sector (171 responses), and non-governmental (NGOs) (164)organizations



responses). At the city, district, and national level, private sector service delivery is similar to public, CBO and/or NGO service delivery. However, at the community (Figure 8) and







DUS & CSO Mapping Findings August 2022

20

facility (Figure 9) levels, the private sector delivers services for very few NSPs. Private sector facilities deliver STI, TB, TCS and e-MTCT services. When focusing on specific NSPs, such as PrEP, there are opportunities to expand service delivery across all sectors (Table 7).

Level	Public	Private	СВО	NGO
City	1	2	1	0
Community	1	0	0	0
District	1	1	1	1
Facility	3	0	0	0
National	2	2	3	2
Total	8	5	5	3

Table 7: PrEP delivery by sector

Recommendation: The private sector should be engaged to provide other services; for example: PrEP, VMMC, differentiated HIV testing, and condom distribution to further complement the services provided by other sectors.

Finding 5: There are further opportunities to integrate services. Integrated service delivery refers to combining services for multiple interrelated diseases or conditions to increase efficiency, improve service delivery, and increase convenience for the patient. For example, if a patient is seeking treatment for a sexually transmitted infection, they can also be offered an HIV test and family planning services. Decision-makers were asked about the integration of services among NSPs. Respondents identified that differentiated HIV testing; leadership, coordination, and response; VMMC; vulnerable children; and wellness and workplace are less likely to be integrated (Figure 10). When disaggregated by sector, findings reveal that services are more likely to be integrated within CSOs and the government than within the private sector (Figure 11).











Recommendation: Integrate services into pre-existing structures, like clinics. Respondents mentioned other community-level services, like the Village Development Committee, as an opportunity to integrate service delivery. It was highlighted by a respondent that the Village Development Committee can play a key role in areas like vulnerable children. Across all sectors, there are opportunities to further integrate services. For instance, findings suggest PrEP is not integrated at the government level.

Finding 6: Decision-makers and data handlers are not aligned on which data sources are important. There is also significant variation in the sources decision-makers consult across NSPs and organization type. This means that where data handlers are inputting and storing data may not be the same data sources where decision-makers are accessing data. Figure 12 shows the data sources that were most referenced across NSPs.





Respondents referenced a total of 471 data sources 1,729 times. Of those 471 data sources, 43 were referenced by both data handlers and decision-makers. Data handlers referenced 201 unique data sources whereas decision-makers referenced 227. Even if the data needed for decision-making is being collected, if a data handler is storing this data in a data source that a decision-maker does not use, have access to, or know about, the decision-maker will not be able to use this data to support their decisions. A lack of consensus between data handlers and decision-makers on data storage can act as a significant barrier to data use for decision-making.

Which type of data sources are most consulted varies by sector (Figure 13). All sectors referenced reports, registers, the community, and DHIS2. The private sector has fewer data sources. CSOs rely on facilities, meetings, and communities to provide data. CSOs that are not networked with a health facility may not have access to the data that they need for









decision-making. For example, every decision-maker working on TB and HIV gets their data from a different source.



Figure 13: Most referenced data sources by sector

Figure 14 also shows how this variation occurs across sectors within VMMC. Sixteen decision-makers focus on VMMC, however, they all use different data sources for VMMC

regardless of the sector they work in. If decisionmakers are not consulting the same sources they may be getting different information. Hence, they may be making different decisions than their peers based on disparate data. Similarly, if decision-makers are not accessing the same sources, some, if not all, of the decision-makers may only be accessing a fragment of the data available to them to support decisions. Decision-making should be uniform and coordinated between sectors to ensure effective and efficient programs and service delivery. To facilitate this coordination, the data accessed and available across sectors should be the same.

Recommendation: Data handlers should input and store data in sources that decision-makers frequently access. CSOs and private sector partners should have access to government data sources and vice versa to ensure that all decision-makers are using the same data elements to support their decisions. Though it is









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to be expected that decision-makers access information from different sources, there seems to be no standardized information source. There should be guidance on the data sources where information is stored to ensure decision-makers are both accessing the sources where data is stored and accessing the same information.

Finding 7: Prisoners are a key population but there is limited insight into the decisions, elements, and sources available for this population. In the free text responses, respondents highlighted that prisoners are a key population at risk of HIV acquisition. It is unclear which decisions are being made regarding prisoners, by whom, and which elements and sources are available to support these decisions. For example, do the same decision-makers working in key populations also oversee decisions among prisoners; and, if so, which elements and sources do they reference to provide information on prisoners?

Recommendation: Better data is needed to understand what information is currently available regarding prisoners, a population that is at high-risk for HIV acquisition, and what additional data decision-makers may need. There should a focus on the decisions, data elements, and sources decision-makers use as it relates to prisoners.

Finding 8: The top three decisions for decisions-makers are: coordination, programming, and program design (Figure 15). However, there is significant variation in the top three decisions by NSP (Table 8). The absence of certain decisions within some NSPs could affect policies, access, and service delivery. The top 10 decisions account for 36% of all decisions made (Figure 15). The top decisions for vulnerable children are programming, referrals, and targeting. This aligns closely with the top decisions across NSPs. While we would not expect every NSP to align to the top decision categories, we would expect certain programmatic areas to make decisions regarding service delivery. For VMMC, no decisionmakers reported making decisions on programming or program design, while only two decision-makers reported making decisions on targeting services (Figure 16). Some NSPs did not mention or had few mentions of decisions that could be relevant. For key populations, no respondent mentioned working on targeting or programming. Only one respondent mentioned making decisions on stigma, service access, and hotspots. For human rights, only one decision-maker reported making decision related to law and only one concerning sensitization. Limited decision-making in these areas may signal a lack of data use for decision-making that is critical for service delivery and improving programming. Data can be used to highlight the types of decisions that can be made and is should be used for adapting programs to certain population needs. Different decisions are an example of how data can be used. If decision-makers are not making certain decisions this may point to a gap in data use for decision-making.







Recommendation: Additional research can be conducted to understand how the top decisions by NSP influence service delivery. A data use campaign or training can be conducted to encourage data use for decision-making and highlight how data can be used to support a wide range of decisions.





Table 8. Top decisions by NSP

NSP	Decision 1	Decision 2	Decision 3
Condom & Lubricant Programming	Stock Order	Condom Distribution	Stock Quantification
Pre-Exposure Prophylaxis (PrEP)	Targeting	Referrals	Training
Voluntary Male Medical Circumcision (VMMC)	Referrals	*Training	*Targeting; *Sensitization; *Encourage
Adolescent Girls and Young Women (AGYW)	Programming	Program Design	Encourage
Key Populations	Strategy	*Tracing	*Encourage; *Coordination; *Advocacy
Elimination of Mother-to- Child Transmission (e-MTCT)	Follow-up	HIV Testing	Counseling
Sexually Transmitted Infections (STIs)	Patient Care	*Stock Order	*Referrals
Wellness & Workplace	*Policy	*Nursing	*Encourage
Differential HIV Testing	Stock Order	Programming	Program Design
Treatment, Care, and Support (TCS)	Referrals	Follow-up	Linkages







Vulnerable Children	Programming	Targeting	Referrals
TB & HIV	Testing	*Resource Allocation	*Programming; *Counseling; *Coordination; *Advocacy
Human-Rights Barriers	Advocacy	Privacy	Discrimination
Social Behavior Change Communication (SBCC)	Program Design	*Sensitization	*Coordination
Resilient Systems	*Programming;	*Program Design	*Linkages
Leadership, Coordination & Response	Coordination	Staffing	*Supervision; *Strategy; *Response Management; *Reporting; *Leadership; *Guidance; *Facilitate Meetings

*Number of responses is of equal value









4. DESIGN AND DISSEMINATION WORKSHOP

We held a 'Design and Dissemination Workshop' to familiarize BPS stakeholders with the following project outputs:

- The Prevention Adaptive Learning Management System (PALMS),
- The CSO Mapping,
- The DUS, and
- The Service Delivery Channel Mapping.

This workshop took place in Blantyre from November 1st to 3rd, 2021. Workshop attendees included:

- Government partners such as the National AIDS Commission, Department of HIV & AIDS, the National Statistics Office (NSO), Blantyre District Council (BDC), Blantyre City Council (BCC), and the Blantyre District Health Office.
- BPS partners such as MaiKhanda, Population Services International (PSI), and the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) also attended.
- Other stakeholders from local organizations, such as the Malawi Network of AIDS Organizations (MANASO), Malawi AIDS Counselling and Resource Organization (MACRO), Pakachere, Umunthu Foundation, and the NGO Board.

The goals of the workshop were to:

- 1. Share key findings from the 2 studies and share the navigation tools for Blantyre stakeholders.
- 2. Ensure stakeholders are familiar and comfortable with the tools and able to customize them for their own use.
- 3. Facilitate constructive discussion on how to adjust or expand current prevention programs based on studies' findings.
- 4. Identify opportunities to further triangulate data.

Partners engaged in rich discussions during the workshop as they explored the studies' tools. Stakeholders identified key findings and recommendations as well as how the studies can be institutionalized and sustained. This section highlights how the DUS and CSO mapping can be institutionalized and sustained.







5. NEXT STEPS, INSTITUTUTIONALIZATION, AND SUSTAINABILITY

5.1 CSO MAPPING: NEXT STEPS, INSTITUTIONALIZATION, AND SUSTAINABILITY

1. Establish a central hub or platform where CSOs involved in HIV prevention can be registered and tracked, potentially on the National Malawi NGO Board platform.

The CSO mapping study reveals the difficulty in tracing CBOs, NGOs, and FBOs. The difficulty the data collection team had in tracing organizations highlights challenges around CSO identification. Over half of the initial sample could not be traced. Many who could be reached had stopped operating or a member of the current staff could not be found. Workshop participants suggested creating a central hub or platform where CSOs involved in HIV prevention could register or including them in existing platforms like MyNGO. This would allow for close monitoring of active CSOs and could facilitate coordination between CSOs, and between CSOs and health facilities. The National Malawi NGO Board currently has a platform where all NGOs operating in the country can register. It includes information like organization details, objectives, sectors engaged in, funding sources, and more. To further institutionalize the CSO mapping, participants suggest the NGO board expand its criteria to include CBOs and FBOs. This creates a single registration platform with a standardized format for CSOs participating in HIV prevention.

2. Regularly update the mapping to track progress in measuring connection and the success of incorporating organizations into HIV prevention activities.

The CSO mapping and potential subsequent mappings can be included in the district implementation plan. Participants suggested regularly discussing progress in already existing meetings, such as QI, evaluation, and review meetings. The current mapping would act as a baseline for future collaboration and coordination targets would be set against it.







With regular organizational mappings, a time series could be conducted to understand the success interventions have in connecting with siloed organizations and leveraging well-connected CSOs. It can also show how the network has evolved over time.

3. Integrate CSO geographic data to understand the proximity of CSOs to one another and health facilities.

We are planning to collect geographic data to understand the proximity of the respondent CSOs and health facilities. Overlaying geographic data with HIV indicators, like prevalence and new positives, helps determine the disease burden in an area. This aids in resource allocation. Geographic information will highlight gaps in service delivery and areas for improvement/expansion. For example, if disconnected CSOs serve an under resourced high-burden area, additional resources may be needed in this area.

4. Host the CSO service delivery information on PALMS.

Information on the services being delivered by CSOs will be accessible on the PALMS website. Users will be able to easily access the information on a platform that they are familiar with. As PALMS is transitioned into a fully government owned and operated platform, the CSO information will also be included.

5.2 THE PREVENTION DUS: NEXT STEPS, INSTITUTIONALIZATION, AND SUSTAINABILITY

The DUS provides rich information on data use for decision-making. As we move into Year 3 of the Blantyre Prevention Strategy, this information will be used to further refine usecases for stakeholders that desire more specific information to support their routine decisions. These use-cases will help to up-select information that is valuable and meaningful to decision-makers. Systems design, data quality improvements, and capacity building will focus on these high-value target data.

Conversely, this documentation demonstrates the need to rationalize data, tools, and systems that don't add value and drain critical resources, like health worker time. We will use these results to make recommendations for streamlining to improve the efficiency of the data ecosystem as a whole.

Finally, workshop participants emphasized the need for data synchronization and the key role it plays in service delivery. For example, there is a delay of communication sharing









between the DHO and BCC. Participants note that although these two bodies should be working together, oftentimes the DHO receives data first. We will work with stakeholders and partners to facilitate simultaneous data sharing and access as soon as information is available.







DUS & CSO Mapping Findings August 2022

30



APPENDIX 1. CSO NETWORK ANALYSIS

Figure 17: CSO mapping sample and response rate









Figure 17 visualizes the initial and final sample of organizations for the CSO mapping.

As seen below on Figure 18, most organizations are a CBO or NGO (91 percent). Other organization types are characterized as orphan care, workplace programs, or youth clubs.





Almost a third of organizations (32 percent) have a budget of greater than or equal to 2 million Kwacha per year. Very few organizations have a budget of less than 50,000 Kwacha (8 percent) (Figure 19). Most organizations receive their funding from 'Other' sources or international or local NGOs (78 percent) (Figure 20). The average total number of staff (full-time, part-time and volunteers) is 70. Organizations have operated for an average of 14.8 years. The newest organization is 2 months old and the oldest organization is 28.5 years old. Respondents have an average of 1.75 physical offices in Blantyre.







Figure 19: Annual budget in 2020



Figure 20: Greatest funding source







APPENDIX 2. DATA USER STUDY

All information collected through the HIV Prevention DUS can be found in a dashboard here.

The dashboard includes the following information:

- 1. **Demographics:** demographic information on the respondents, including their job title, education, and time on the job.
- 2. Access to technology: highlights respondents' access to and use of (smart)phones, computers, and tablets.
- 3. **Decisions, elements, & sources:** provides information on the decisions decisionmakers make, the elements data handlers collect and decision-makers use to inform their decisions, and where this information is stored and retrieved.
- 4. **NSP strategies:** displays the information on each NSP strategy. This information includes delivery channels, service delivery, data collection, and data transmission.
- 5. Analysis, visuals, & presentations: describes the additional responsibilities of decision-makers and data handlers regarding their data analysis, data visualization, and data presentation experiences.
- Feedback & support: describes respondents' experiences with receiving feedback, the mechanisms they use to request support, and where they receive support from. This section also includes information on how to improve the process of requesting feedback.



