

Making Family Planning Acceptable, Accessible, and Affordable:

The Experience of Malawi

BACKGROUND

In September and October 2011, the RESPOND Project, in collaboration with the U.S. Agency for International Development (USAID) and Malawian health ministry partners, spearheaded a review of Malawi's family planning (FP) program, to better understand the factors that underpin its recent successes. In addition to a literature review, RESPOND conducted in-depth interviews with 42 key informants, including senior government officials and representatives of donor agencies, nongovernmental organizations (NGOs), national-level civil society institutions, service providers at the district and community levels, and local leaders. Community group discussions were also held with FP clients at the village level. This brief synthesizes the findings from the review, highlighting key achievements, relaying the story behind the FP program's success, and looking to the future for sustaining and building on its remarkable progress.

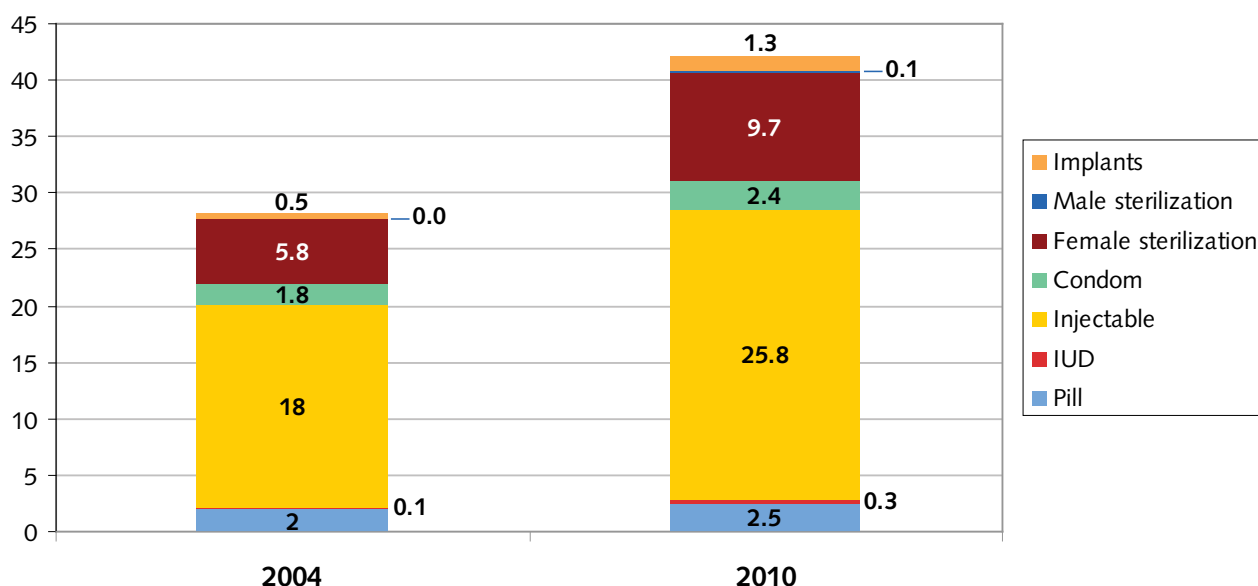
KEY ACHIEVEMENTS

Malawi has made notable strides in the provision and use of FP services and methods. The 2010 Malawi Demographic and Health Survey (MDHS) shows that the use of modern contraceptive methods among married women of reproductive age has increased dramatically, from 28% in 2004 to 42% in 2010 (Figure 1, page 2) (NSO & ICF Macro, 2011). Malawi has also seen strong and sustained use of injectable contraceptives and of long-acting and permanent methods of contraception (LA/PMs). Injectables (56% of current use) and female sterilization (21%) are the most commonly used FP methods in Malawi.

The overall number of FP users has almost doubled since 2004, with an estimated 611,000 new users of modern methods. In addition, access to modern FP methods has improved among disadvantaged subgroups: Between 2004 and 2010, contraceptive prevalence rose by 60% among women in the lowest wealth quintile (from 22% to 35%), by 60% among women with no education (from 23% to 37%), and by 51% among rural women (from 27% to 41%).

The demand for FP is high and growing; in 2010, almost three out of four married women reported having a demand for FP. The proportion of women with

FIGURE 1. CONTRACEPTIVE PREVALENCE RATE AND METHOD MIX IN MALAWI, 2004 AND 2010



Source: NSO and ICF Macro. 2011.

a demand to limit births (38%) now exceeds the proportion with a demand to space births (34%) (Figure 2), and a higher percentage of demand for limiting is being met by current contraceptive use (though often with short-acting methods) than is the demand for spacing. Though IUDs and implants are the most effective methods for women who want to space their births, these long-acting methods constitute a very small share of the method mix for both spacers and limiters in Malawi. Unlike many of its African counterparts, Malawi shows a significant level of sterilization use; almost one-quarter of the total demand for limiting is met by sterilization. This indicates potential for more robust programming focused on LA/PMs. Greater access to correct information and services, particularly for long-acting methods, would enable people to meet their changing needs as they progress through their reproductive lives.

THE STORY BEHIND THE SUCCESS

Malawi's achievements in rapidly expanding the use of modern FP methods reflect a set of broad-based and mutually reinforcing improvements in FP policy and program implementation. High-level political commitment, continued financing, expanded and innovative service delivery options,

and receptive communities and clients all combined to make FP more acceptable, accessible, and affordable to Malawian households.

Political commitment to FP

Core national policies reflect the commitment of the Government of Malawi to improve people's access to reproductive health services, including FP. This commitment was recently articulated in *RAPID Population and Development in Malawi*, a 2010 analysis of the impact of rapid population growth on socioeconomic development and poverty reduction, produced by the Population Unit of the Ministry of Development Planning and Cooperation and the Reproductive Health Unit (RHU) of the Ministry of Health (MoDPC, 2010).

Significantly improving sexual and reproductive health is central to attaining the Millennium Development Goals (MDGs). In 2006, the African Union endorsed a policy framework on sexual and reproductive health and rights at a meeting in Khartoum, and in September 2006, at a special session of the African Union Conference of Ministers of Health, the Maputo Plan of Action (MPoA) 2007–2010 was adopted to operationalize that framework. One of the six key strategies

of the MPoA is the “repositioning of [FP] as an essential part of the attainment” of the health-related MDGs (AUC, 2006, p. 4). The MPoA recognizes that high unmet need for FP can result in rapid population growth that may exceed both the growth of the economy and of basic social services.

The Government of Malawi ratified the plan in June 2007 and acted promptly to implement it (SAfAIDS & Ford Foundation, 2011). To do so, the RHU led the development of the Sexual and Reproductive Health and Rights Policy 2009, which provides guidance in implementing sexual and reproductive health services, with the assistance of the Sexual and Reproductive Health Technical Working Group.

Financing the health sector

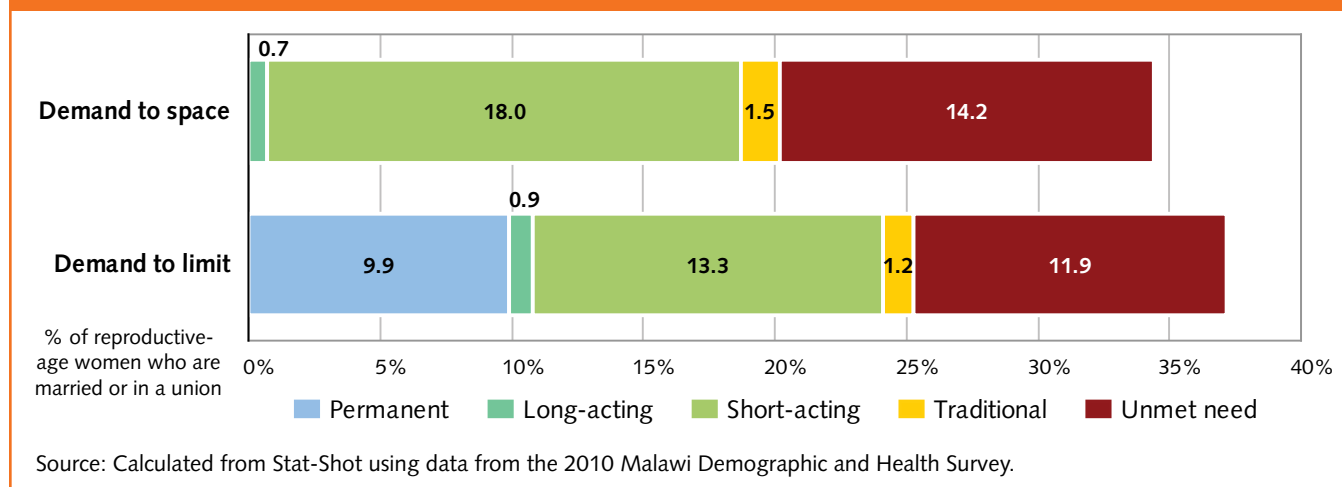
Malawi’s reproductive health program was part of a six-year Joint Program of Work for a Health Sector–Wide Approach (SWAp) (2004–2010), which was implemented by the government with the assistance of several development partners. The UK Department for International Development (DFID), the largest donor in Malawi, committed (and is on track in disbursing) approximately US\$175 million to the health SWAp over six years (Pearson, 2010).

The two main health-related objectives of the SWAp are to establish and deliver an essential health package (including FP), to be provided free of charge to all Malawians, and to address the severe shortages of workers in the health sector by improving the retention, training, and deployment of health care staff.¹ Immediate strategies included increasing salaries by 52% and deploying temporary, volunteer international personnel. For longer term sustainability, service delivery guidelines and job descriptions were revised in 2005 to reflect task-shifting and task-sharing.

An evaluation of the Emergency Human Resources Program found that across the program’s 11 priority cadres, the total number of health workers increased by 53% from 2004 to 2009 (MSH, 2010). Over this same period, the number of physicians in the country increased by more than 500%, the number of clinical officers by 61%, and the number of nurses by 39%. In addition, the number of community-based health surveillance assistants rose by 115%. Overall, the total number of health care providers per 1,000 population increased by 66% between 2004 and 2009, from 0.87 to 1.44 per 1,000.

Key informants credited the essential health package and the Emergency Human Resources Program as having had a significant impact in improving

FIGURE 2. MALAWI'S DEMAND FOR CONTRACEPTION (MET AND UNMET NEED)



¹ This was addressed through an Emergency Human Resources Program instituted by the Ministry of Health, with funding from DFID and technical assistance from Management Sciences for Health (MSH).

access to reproductive health services. However, the direct impact of the SWAp on FP service provision proved more difficult to assess. Much of the funding for the essential health package was channeled to support for HIV and AIDS services. Funding commitments to interventions not related to HIV and AIDS rose from 10% to 15% but varied considerably between years (Pearson, 2010). Support from many bilateral and multilateral donors supplemented the SWAp, especially for family planning program support in the public and private sectors.

An additional force in improving health services was the decentralization of decision making and financing in the health sector to the local level. For example, District Health Management Teams were enabled to design implementation plans for their districts that reflected local needs. Some informants suggested that because politicians are now in charge of budgets and plans, they must do their best to keep their constituents happy. The U.S. government's Millennium Challenge Corporation (MCC) initiative, which began in late 2007, is providing additional funding to strengthen the country's decentralized financial systems.

Transforming FP service delivery

Since 2004, Malawi's government has put different modes of service delivery into place to realize the goal of making FP accessible and affordable to all Malawian women and men. These have included:

- Investing in human resources and training

- Deploying lower cadres of health professionals (clinical officers, midwives, nurses, and health surveillance assistants) and volunteers to provide services at the community level
- Expanding outreach and mobile services through public-private partnerships

Investing in human resources and training

One of the major strategies under the Emergency Human Resources Program was to train and deploy lower-level cadres to provide clinical services in the public and private sectors. The policy regarding the provision of FP services currently allows clinical officers as well as physicians to perform female sterilization. The policy has allowed nurses to provide long-acting FP methods, including Jadelle® implants and intrauterine devices (IUDs), since 2005.

Because the vast majority of Malawians (81%) live in rural areas (NSO & ICF Macro, 2011), FP stakeholders in the government and private sector concurred that information and services need to be as close to the people as possible. A core component of efforts to establish culturally appropriate and effective modes of service delivery in Malawi has been training health surveillance assistants (the lowest-level cadre of full-time salaried workers in the Ministry of Health) and volunteer community-based distribution (CBD) agents to provide FP information and supply specific contraceptives at the community level. CBD agents are permitted to provide pills and condoms, and starting in 2008 the Ministry of Health allowed health surveillance assistants to provide injectables.

Deploying lower cadres of health professionals

Health surveillance assistants and CBD agents inform clients about the different FP methods' modes of action and potential side effects. They also inform clients that LA/PMs are available at the district hospital for a small fee (and many workers will accompany the clients to the facility). These community health workers also help schedule



BLM mobile outreach effort in rural Malawi

and announce visits by mobile outreach providers. Some key informants referred to this community-based approach as representing the “demedicalization” of FP. One CBD agent interviewed for this study remarked: “We can’t have a medical approach to a social need.” These significant shifts in policy and human resource deployment have dramatically improved access to a full range of FP methods.

A USAID-supported pilot test of community-based provision of the injectable provides strong evidence of the effectiveness of task-shifting (Nyirongo, Akhter, & Mtema, 2011). Between November 2008 and November 2009, the pilot program trained 545 health surveillance assistants and 100 supervisors in nine of Malawi’s 28 districts. The evaluation found that the number of clients accessing injectables per quarter rose from 3,210 in March 2009 to 101,885 in March 2011, a 31-fold rise.

Expanding outreach and mobile services through public-private partnerships

NGOs complement government health services in Malawi, especially in terms of mobile outreach services. In particular, Banja la Mtsogolo (BLM) addresses community and clinic-based needs nationwide. Starting with one clinic in 1987, BLM now operates 33 clinics in 22 of Malawi’s 28 districts. BLM also provides outreach FP services to rural areas in 27 districts, on a rotating basis and in collaboration with local communities. BLM offers a full array of methods, including LA/PMs. The mobile services are free, while services in the BLM static clinic sites cost a nominal fee. In a strong public-private partnership, BLM provides periodic mobile FP services at government health facilities that may not have the trained providers, medical equipment, instruments, and expendable supplies needed to offer LA/PMs routinely. Female sterilizations are performed by clinical officers in Malawi, rather than by doctors. BLM service statistics indicate that it has provided more than 170,000 female sterilizations over the past four years. In 2011, due to better supply and lower



A Malawian couple

price, BLM also provided more than 21,000 implants, up from 2,600 in 2010.

A second important public-private partnership involves the Christian Hospitals Association of Malawi (CHAM). CHAM provides FP services and has CBD programs tied to some of its facilities. Recent data showed that while one-third of all female sterilizations are provided by BLM, a further 10% are provided by CHAM (NSO & ICF Macro, 2011). This indicates that innovative public-private partnerships with strong, well-established NGOs can be critically important to expanding access to FP methods, especially LA/PMs. Nationally, one in 10 married women and one of every four users of modern contraception rely on female sterilization for their contraceptive protection. Also noteworthy is a 13-fold increase in implant use between 2004 and 2010.

A “culture of acceptance” for FP

Key informants noted that perhaps the greatest contribution to the growth in FP use is the culture of acceptance for FP at the community level. Close to three-quarters of married women reported having a demand for FP in 2010, which strongly suggests that FP use is increasingly becoming the social norm in Malawi. In explaining this shift, a senior Ministry of Health official said that in recent years, the Government of Malawi had made concerted efforts to disseminate information about the benefits of modern FP to all communities, with an emphasis on the idea that “modern

contraception can help mothers avoid pregnancies that may be too early, too frequent, too many, and too late.” The close collaboration of FP programs with community leaders, including Catholic and Muslim clerics, has also been vitally important to creating a supportive environment for contraceptive use. FP programs have held meetings to listen to the concerns of religious leaders and have agreed that natural family planning has a place in the method mix.

The 2010 MDHS shows that FP knowledge is universal in Malawi (over 99%). Furthermore, there is widespread knowledge of specific methods such as female sterilization (93%), injectables (99%), oral contraceptives (97%), and implants (86%). In general, Malawian women and men also know where to get different methods at community and/or district levels and when mobile services will be available. Radio is a major source of information about FP. The 2010 MDHS reported that 56% of women and 76% of men aged 15–49 had heard a radio program about FP (NSO & ICF Macro, 2011). Increased knowledge, greater acceptance, and more available providers, all of which led to increased access to a wider range of modern methods, have contributed to increasing the numbers of Malawians using modern contraception.

SUSTAINING AND BUILDING UPON ACHIEVEMENTS TO DATE

Malawi has demonstrated that despite severe shortages of health personnel, high rates of poverty, and many competing health and development priorities, rapid increases in FP use, including use of LA/PMs, can be achieved. Malawi’s positive environment (supportive government policies, strong donor support, and universal knowledge of FP) has enabled the use of four programmatic approaches:

- Bringing services closer to communities
- Task-shifting of service delivery to more cadres and sites
- Effective public-private partnerships with strong NGOs
- Creating a supportive environment where family planning use is an accepted norm

The experience in Malawi suggests that modern FP methods—even female sterilization and hormonal implants—can be provided widely and equitably in a Sub-Saharan African nation, despite the constraints. Critical for widespread LA/PM access and use to occur, however, are community-level provision of services and task-shifting. The not-for-profit private sector can contribute considerably to such efforts. However, rapid uptake and relatively high use of modern FP methods, including LA/PMs, does not necessarily result in immediate, sizable declines in fertility, as is evidenced by the slight decrease in the total fertility rate, from 6.7 lifetime births per woman in 1992 to 5.7 births in 2010. Current desired fertility among Malawian women is 4.5 births.

In its 2010 analysis of population and development (MoDPC, 2010, p. 22), the Government of Malawi noted that:

Even if fertility rates decline over the next decade, Malawi’s population will continue to grow substantially due to “momentum”—the built-in growth due to the large number of couples of childbearing age—an “echo” of past high fertility.

Sustained investment in FP will therefore be required to consolidate and expand the gains made so far. In analyzing the government’s achievements to date, the following four areas have been identified as important avenues to further increase contraceptive prevalence.

1. Reaching youth with FP

Malawi has a very young population; in 2010, 49% of Malawians were younger than 15. As these youth cohorts reach reproductive age, greater education about and access to modern methods of contraception will be critical if they are to delay, space, and limit births. At present, the teenage pregnancy rate is high: Twenty-six percent of all Malawian women aged 15–19 are currently pregnant or have delivered a child (NSO & ICF Macro, 2011). Younger married women are much less likely to practice FP than are older

married women (26% of 15–19-year-olds vs. 49% of 35–39-year-olds). Additionally, birth intervals are much greater for 35–39-year-olds (a median of 38 months) than for teenagers (a median of 26 months). Additionally, young women with no education are over 11 times more likely to have begun childbearing than are those with a secondary and higher education (45% compared with 4%). Thus, at a societal level, expanding educational and economic opportunities for girls and young women will likely have a significant impact on early childbearing—and, in turn, on national fertility rates and development.

2. Ensuring contraceptive security

An essential component of a comprehensive FP program is contraceptive security—i.e., when people have regular, reliable, and equitable access to a choice of high-quality FP methods to meet their reproductive health needs. Presently, in Malawi, FP services in both the public and the private sectors are either free or highly subsidized. As a result, contraception has become more affordable to poorer households. In addition, the expansion of CBD and mobile services is making FP more widely available and convenient. However, logistical problems in the supply of contraceptives have led to stock-outs of some methods, such as injectables. Without adequate and consistent supplies of contraceptives, couples are prevented from using FP effectively and may discontinue use completely. The ongoing efforts of the government, with the support of donors, to make structural changes to strengthen the Central Medical Store will be a cornerstone for future contraceptive and pharmaceutical security in the country.

3. Expanding use of LA/PMs

Over the last two decades, Malawi has shown that families will choose LA/PMs when these methods are available and affordable. In 2010, almost 10% of all currently married women aged 15–49 (more than one in five users of modern methods) had

opted for female sterilization. Although LA/PMs are more technically difficult to provide and their upfront costs are higher, they are the methods most clinically effective at preventing unintended pregnancy. Also, LA/PMs are highly cost-effective: Research has shown that IUDs, female and male sterilization, and the new Zarin implant (also known as Sino-implant (II)) all have lower service delivery costs per couple-year of protection than do oral contraceptives and injectables (Tumlinson et al., 2011). The significant increase in the use of LA/PMs in Malawi between 2004 and 2010 suggests that training efforts and task-shifting in the public sector and the development of public-private partnerships dedicated to providing LA/PMs have been successful. Scaling up these approaches has great potential to further expand access to these methods.

4. Reducing unmet need

More than one in four currently married women in Malawi still have an unmet need for FP. In recent years, differentials in contraceptive use by women's wealth and education status have fallen, but while contraceptive prevalence has grown rapidly, the rural-urban divide has stayed about the same. Overall, demand for FP among poorer, less educated, and rural women remains lower than in other subgroups, while at the same time unmet need in these groups is higher. Reaching underserved women and communities with FP methods will be a key to future substantial gains in FP use.



Community volunteers and health care managers reaching villages

Community health workers and volunteers backed by supportive supervision and strengthened contraceptive supply chains and outreach and mobile services provided through public-private partnerships will likely continue to play major roles in improving equity in service delivery. But to capitalize on recent progress, FP champions at all levels of the health system and the government will be needed.

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