



ECSA-HC

East, Central and Southern
Africa Health Community



EXPANDING ACCESS TO FAMILY PLANNING SERVICES AT THE COMMUNITY LEVEL:

MALAWI ASSESSMENT

**EAST, CENTRAL AND SOUTHERN AFRICAN
HEALTH COMMUNITY**

AND

MALAWI MINISTRY OF HEALTH

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LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
BLM	Banja la Mtsogolo
CBDA	Community Based Distributor on Agents
CBFP	Community Based Family Planning
CBHC	Community Based Health Care
CHAM	Christian Health Association of Malawi
CHW	Community Health Worker
DHMT	District Health Management Team
DHS	Demographic Health Survey
DMOH	District Medical Officer of Health
ECSA-HC	East, Central and South African Health Community
FP	Family Planning
GOM	Government of Malawi
HSA	Health Surveillance Assistant
MDGs	Millennium Development Goals
PHC	Primary Health Care
RH	Reproductive Health
SWAp	Sector-Wide Approach
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, participating countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs. This strategy resonates with earlier calls for action in the region, including the Maputo Plan of Action and the 2009 International Family Planning Conference held in Uganda.

The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states, including Malawi, to address issues related to expanding access to family planning. ECSA led this assessment, using a desk review, key informant assessments, and focus group discussions. Similar assessments were conducted in four other ECSA member states (Kenya, Lesotho, Uganda, and Zimbabwe).

In Malawi, the key informant interviews were conducted in February 2011 with 13 individuals and four groups (see Appendix 1). The interviews were conducted with Ministry of Health policy-makers and managers, professional health associations, regulatory boards, community-based FP (CBFP) implementing agencies, donors, members of Parliament, district level providers, and community health workers.

Four in every five people in Malawi live in rural areas, and most of them need services at the community level due to poor transportation systems and long distances to district and other lower health facilities. In recent years, Malawi has made a concerted effort to increase services to rural areas. Unmet need for family planning, while still high at 28%, has declined in recent years, even in rural areas, but the unintended pregnancy rate has not declined since 1992, remaining at about 40%.

Malawi guidelines have evolved such that in general they are supportive of community based access to family planning. However, access remains limited in part because FP services are often provided in the context of the “Essential Health Package” of primary healthcare services. In recent years, access has been expanded for injectable contraceptives through Health Surveillance Assistants (HSA), and to implants through medical assistants. Malawi has a two-tiered system of community health workers. The HSAs are considered the lowest cadre of the government health system, are attached to district health offices, and provide services in the community and sometimes the district outposts. The other tier is composed of volunteer community based distribution agents (CBDAs), who provide family planning information, as well as condoms and pills.

Section 3 of this report provides more information on recent pilot projects and decisions about community-based FP services and other policy issues. Section 4 synthesizes findings from the key informants and focus groups, and Section 5 provides first person

perspectives from the CHWs on key issues. This information combined with the desk review led to the seven recommendations discussed in Section 6 and listed below.

1. Implement the services allowed under the current policy environment.
2. Enhance motivation and retention of HSAs and CBDAs.
3. Focus on supervision.
4. Continue to strengthen community engagement, especially among men.
5. Increase access to injectable contraceptives.
6. Increase focus on youth.
7. Address the problems with the commodity procurement system.

Both key informants and the CHWs themselves expressed concern about the issues listed here and had ideas about addressing them. This assessment shows that CBFP has clear benefits in improving access to family planning information and services. Therefore CBFP is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health.

1.0 INTRODUCTION

1.1 Background

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, which emphasizes the universal access to reproductive health (RH), including FP services. Most of the populations in sub-Saharan Africa (SSA) live in rural communities, where the demographic determinants including health infrastructure, human resource, and financial support for health are very poor. The achievement of universal access to FP and RH services remains a major challenge. Expanding access of FP to the community has gained recognition as a promising practice for the majority of the populations in SSA, who live in the rural areas.

Expanding access to FP at the community level has been emphasized by resolutions from the East, Central and South African (ECSA) Health Minister's Conference of 2008 and 2009; from the 2010 FP conference in Kigali, Rwanda; the 2009 International FP Conference held in Kampala, Uganda; and the Maputo Plan of Action of 2006. The 12 African nations attending the 2010 Kigali meeting built a consensus to prioritize expanded FP access at the community level as a strategy for addressing the unmet need for FP and accelerating progress toward the MDGs.

Women in rural areas have a particularly high unmet need for FP services, especially during the postpartum period. A review of data from 27 Demographic and Health Surveys (DHS) found that 67 percent of women who gave birth within the previous year had an unmet need for family planning. One way to address this is by strengthening systems that can make FP services more available to the communities. Some approaches have worked successfully to address the critical shortage of medical professionals and to expand access to a range of health services, such as empowering cadres of health workers who have not undergone the regular medical training programmes to provide FP services at the community level. In this concept of skills transfer (known as task sharing or task shifting), which has been endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training.

The ECSA-Health Community has addressed issues related to expanding access to FP services at the community level. In 2008, the 46th ECSA Health Ministers Conference (HMC) adopted resolution HMC46/R4, which urged member states to allocate/increase financial resources for FP and to reduce unmet needs by 10% by 2010. The resolution also urged member states to develop and implement policies, guidelines, and training curricula on task shifting among health care providers by 2011 that allow mid-level cadres to carry out specifically identified activities that shift non/less technical duties from mid-level to lower-level cadre staff, such as community based distributors of contraceptives. In the same resolution the ECSA secretariat was directed to support countries to develop and implement policies and guidelines on task shifting among health care providers by 2010.

In 2009, the HMC in ECSA/HMC 48/R5 urged member states by December 2011 to advocate for increased political and financial commitment to FP, ensure the full integration of FP into national development plans and poverty reduction strategies, and develop costed implementation plans for sexual and reproductive health (SRH) services informed by the Maputo Plan of Action. It also called on the member states to develop country-specific policies and guidelines on task shifting by December 2012 for the delivery of SRH and FP services to ensure access to FP services for the poor, marginalized, and underserved communities. The resolution also directed the secretariat to support member states to develop and/or adopt advocacy, costing, and modeling tools; document and disseminate promising and best practices in FP with links to proven effective change practices; and assist member states to implement various international instruments such as the Maputo Plan of Action and the African charter on the rights of the woman. All signature countries to such documents are required to report against the indicators and targets in these documents.

To address these resolutions, ECSA-HC has conducted an assessment on policies, guidelines, and financing of expanding access to FP services at the community level in five member states (Kenya, Lesotho, Malawi, Uganda, and Zimbabwe) to determine the current status of these three areas, and to recommend the best way to implement a strategy to expand services. The assessments took place between November 2010 and April 2011. The Malawi assessment was conducted in February 2011.

1.2 Objectives

The objectives of the assessment were:

- To describe the degree to which national level policy and service delivery guidelines/standards facilitate the provision of quality FP at the community level.
- To determine the level and modalities of funding of FP services in the region.
- To describe the challenges and opportunities in current community-level FP service delivery systems and how they could be improved to better serve the FP needs of underserved populations.
- To synthesize commonalities with regional application and identify opportunities for improved approaches to FP services at the community level, in order to inform the development of recommendations on country and regional priorities for the improvement of expanded services to FP programs.

1.3 Methodology

The report of each country's assessment includes material from two primary sources:

- 1) Desk review of related literature, including DHS data, policy documents, national guidelines, research studies, and program reports; and
- 2) Qualitative input from key informant interviews and focus group discussions. The interviews and focus group discussions followed interview guides.

In Malawi, the key informant interviews were conducted in February 2011 with 13 individuals and four groups. The interviews were conducted with Ministry of Health policy-makers and managers, professional health associations, regulatory boards, community-based FP (CBFP) implementing agencies, donors, members of Parliament, district level providers, and community health workers (see Appendix 1).

2.0 RATIONALE

Why Expand Access to Family Planning at the Community Level

Four in every five people in Malawi live in rural areas, and most of them need services at the community level due to poor transportation systems and long distances to district and other lower health facilities. In addition, nearly half of the 15 million people in the country are under 15 years of age, which means that about 3.5 million females will soon be entering their reproductive years – about the same number of women currently aged 15 to 49.¹

In recent years, Malawi has made a concerted effort to increase services to rural areas. Unmet need for family planning, while still high at 28%, has declined in recent years, even in rural areas (see Figure 1). However, the unintended pregnancy rate has not declined since 1992, remaining at about 40% (see Figure 2).² An unintended pregnancy is a pregnancy reported as either wanted later or not at all.

Figure 1: Trends in Unmet Need for Family Planning

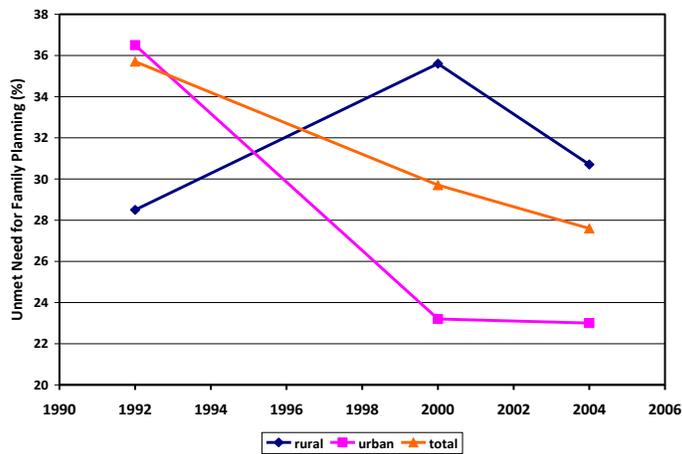
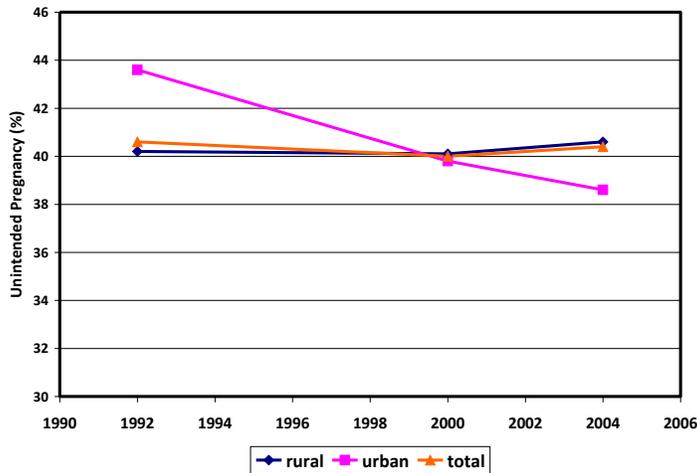


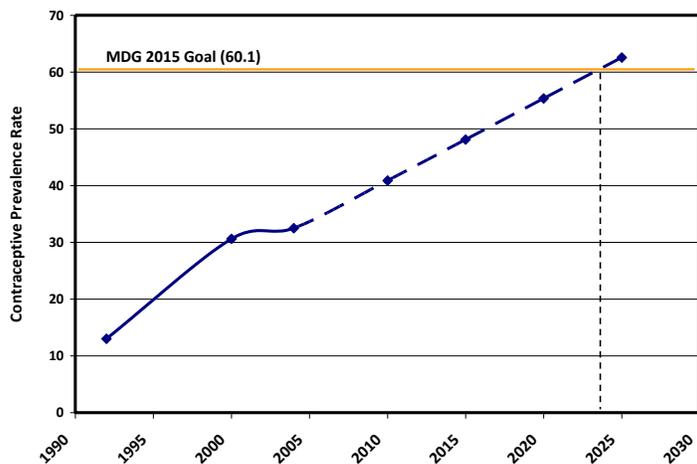
Figure 2: Unintended Pregnancy Trends in Malawi



If women who desired to space or limit births had access to FP, 25 to 35% of maternal deaths could be avoided, including abortion-related mortality. Though Malawi's maternal mortality rate (MMR) has declined by 44% since 1990, the rate is still high at 510 deaths per 100,000 live births.³ Increasing access to family planning services is a highly effective means of meeting the unmet need for family planning and thereby protecting the health and well-being of women and children.

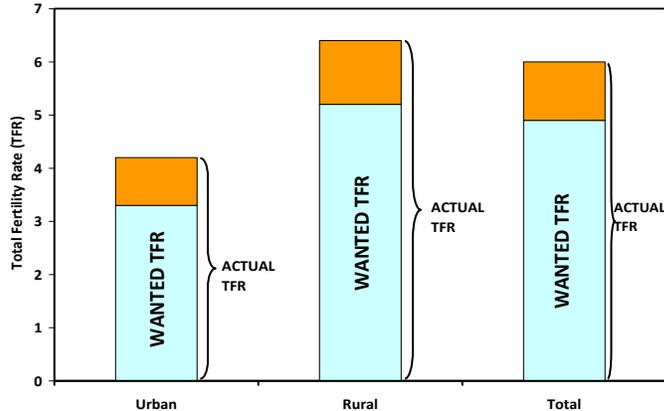
The latest Malawi DHS (2004) reports a 28% contraceptive prevalence rate (CPR) for modern methods among married women of reproductive age, with a much lower rate of 27% in rural areas compared to the urban areas rate of 35%. The use of modern contraception by married women in Malawi has increased dramatically since the government legalized the use of modern family planning methods in the early 1990s.⁴ To achieve the Millennium Development Goal (MDG) for family planning by 2015, Malawi's CPR needs to rise to 60% (see Figure 3). The CPR in Malawi would have to continue to rise at a steep rate to reach the MDG target, even by 2024.⁵

Figure 3: Trends in Contraceptive Prevalence Rate (Married Women, All Methods)



The recent Malawi DHS reports show a total fertility rate (TFR) decline from 6.7 in 1992 to 6.0 in 2004. While this decrease is promising, the divide between the urban TFR (4.2) and the rural TFR (6.4) is large and demonstrates the geographic inequities of access to services (see Figure 4).

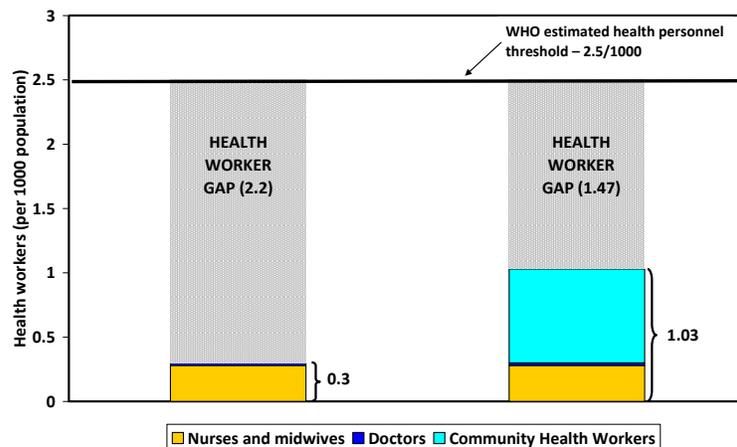
Figure 4: Total Fertility Rate, Wanted versus Actual, Malawi 2004



According to the DHS, about four in five women in Malawi report at least one problem accessing health care; the most common reasons are cost of transport, lack of money for treatment, and the distance to the health facility. Not surprisingly, rural women are more likely to report problems in accessing health care especially citing the same top three problems as key issues. The DHS shows that most women in Malawi access modern methods of FP from public sources (66%), though about a third of women access methods from a private source. The majority of women (85%) access contraception from hospitals and health centers, with only 3% of women accessing FP from fieldworkers or community based distributors.

The WHO recommends that the health workforce (doctors, nurses, and midwives) ratio be at least 2.5 health workers per 1000 population to make progress on global health goals like the MDGs. The ratio in Malawi is 0.3 health workers per 1000 population, well below the 2.5/1000 threshold. Adding in community health workers, the ratio is 1.03 health workers per 1000 population.⁶

Figure 5: Malawi Health Work Force



The health sector expenditure in Malawi for 2006 (latest data available) is 250 million US dollars (37.6 billion Malawi Kwacha). This amounts to approximately US \$25 per capita expenditure on health, which is below the WHO Commission on Macroeconomics and Health recommendation of US \$34 per capita.⁷

Malawi utilizes a Sector-Wide Approach (SWAp) and government basket financing for the health sector. For contraceptive procurement, the Government of Malawi (GOM) contributes funding from its national resources; however, approximately two-thirds of the funding comes from the basket funds which have a significant donor contribution.⁸ Additionally, although there is government funding for contraceptives, there is not a separate budget line item for contraceptive procurement.⁹

The government began decentralizing in 2005, and as a result, separate government funding was allocated to each district. This approach has allowed for positive reforms, but has caused some difficulty in contraceptive procurement. The SWAp approach bundles health funds, which causes districts to have to make health trade-off decisions. For instance, previously districts only had to pay a 5% handling fee for donated contraceptive commodities, but now, due to basket funding utilization, districts have to pay for the product plus a 12% handling fee. So, the district may choose to spend its funds on some other health commodity instead of contraceptives. This has caused critical shortages in contraceptive commodities, especially injectable contraceptives, the most popular method of contraception.¹⁰

With a large rural population, high unmet need for FP, and demographic bulge among young people entering their reproductive years, Malawi needs to seek ways to expand access to contraception. Approaches to greater access in rural areas in particular provide an important way to help women achieve their own pregnancy goals and to help the country meet its MDG goals.

3.0 FINDINGS: POLICIES, GUIDELINES, STRATEGIES

3.1 Introduction

In the early 1990s, guidelines in Malawi began to support an enabling environment that made FP more accessible. For example, a change in guidelines meant that a woman no longer had to have consent of her husband to initiate contraception. Later in the 1990s, the government adopted community based distribution (CBD) of contraceptives, which further improved access. In recent years, access has been expanded for injectable contraceptives through Health Surveillance Assistants (HSA), and to implants through medical assistants.

Malawi guidelines have evolved such that in general they are supportive of community based access to family planning. However, access remains limited in part because FP services are often provided in the context of the “Essential Health Package” of primary healthcare services. The government aims to provide this package of 11 essential services such as child vaccinations and malaria treatment free to all citizens. In 2009, the Malawi Ministry of Health (MOH) revised its *National Sexual and Reproductive Health and Rights (SRHR) Policy* in order to incorporate emerging issues related to obstetrics and neonatal care, youth services, antiretroviral therapy, and other issues. The revised policy includes among its key strategies to “strengthen the availability, access to, and utilization of family planning services at both the facility and community level.”¹¹

All respondents in the assessment noted that Malawi in general has good policies for FP. But the implementation of the services involves a number of challenges, which might be addressed by some changes in guidelines and service manuals. Three themes emerged in the assessment as the major areas needing attention: 1) the complicated commodity procurement system that effectively results in stock outs in many areas; 2) a vast shortage of providers in the lower cadres through the MOH system, especially HSAs and district level nurse/midwives (who supervise the HSAs); and 3) a training and supervision system that lacks coordination, funding, and attention.

3.2 Health-Care System

The Malawi health-care system has three tiers of service: four central hospitals, 22 district hospitals covering most of Malawi’s 28 districts, and about 400 health centers that are the base for outreach and community based services to villages. Not for profit or for-profit organizations including church groups and private practitioners operate another 140 or so health centers. The government health centers ideally would have five staff: a clinical officer, medical assistant, two nurse/midwives, and a health assistant. Many of the centers, however, do not have staff in all positions.

Even though about half of the population lives within five kilometers of a health center, rugged terrain and impassable routes in the rainy season make access difficult for many. A review in 2007 found that about one of every four health centers had the full staff recommended.¹² The HSAs work under the health centers to provide the Essential Health

Package of services at the village level. Until recent years, HSAs did not provide any FP services. HSAs began as cholera assistants, then were assigned other duties – childhood immunizations, HIV testing, and now FP information and injectable contraceptive provision.

“The HSAs are jugglers of all trades, master of none,” said Juliana Lunguzi, programme officer with UNFPA/Malawi. “The idea is good, to serve a population of 1,000, but we are moving away from their role of being a community health worker, as we move them into a health center. If you could leave them in the community and have them supervised, then they would be very effective – if well monitored. They should stay in the community and be supervised.”

To help bring FP services closer to the villages, Malawi has traditionally relied on community based distribution agents (CBDAs). The CBDAs are volunteers selected and based in their communities to provide FP counseling, oral contraceptives and condoms. Many of the CBDAs are supported with training and supervision through private implementing agencies such as the church-supported Adventists project (the Christian Health Association of Malawi or CHAM), the Family Planning Association of Malawi (the IPPF affiliate), Banja la Mtsogolo (the Marie Stopes International affiliate), or Management Sciences for Health (MSH), the international NGO supported by USAID. MSH implements a project in several provinces, working with Futures on policy issues and Population Services International on behavior change and communication, and with local collaborating partners on service delivery and other efforts: CHAM, the Muslim Association of Malawi, the Malawi College of Health Sciences, and the Peace Corps.

The range of services among the private implementing agencies varies extensively. One of the largest systems is through Banja la Mtsogolo or BLM, which has been providing FP services in Malawi since 1987. It works through 31 centers with a user fee model, and offers other services besides FP, including treatment for STIs and primary health care. It uses an outreach model to serve communities, working closely with the Government of Malawi (GOM) district clinics, as well as some CHAM clinics. The BLM outreach teams support more than 300 sites in the GOM system. BLM has a staff of 400 people at full time employment, plus 250 CHWs who operate on performance-based incentives. These CHWs have grown up with the HSA program in the country. The Reproductive Health Assistants in BLM have the same initial training as the HSAs and are supported by BLM.

3.3 HSAs Allowed to Provide Injectables

In 2006, Malawi policymakers expressed interest in expanding access to injectable contraceptives at the community level. Pilot studies in nearby Uganda and Madagascar had demonstrated that community health workers could provide this service safely and effectively, and the 2004 Malawi DHS had shown that 64% of currently married women using modern contraceptives were using injectables. In 2007, the MOH assessed the acceptability of using HSAs to provide these services, working with the Health Policy Initiative (a project led by Futures Group International). The assessment included interviews with 35 stakeholders at the national level and 40 focus group discussions with a

total of 152 participants. The study documented a strong desire for injectable contraception at the community level and reported that rural women prefer injectables because they are long-lasting, require fewer trips to the clinic, are convenient and private, and have few side effects.¹³ Providers favored HSAs to provide the injectable contraceptive because this cadre of community workers already provided child immunizations. In 2008, soon after the study concluded, a team from Malawi participated in a study tour of CHW provision of injectables in Madagascar, learning how the system worked there.

As a result of these activities, a pilot project was designed to improve access to DMPA services in rural communities. In nine pilot districts, focusing on hard-to-reach areas, HSAs were selected to participate in a six-day DMPA training program. The MOH worked with USAID, Futures Group International, and MSH to develop guidelines for provision at the community level, and provision of services began. The guidelines were issued in 2008, explaining, “Because of shortage of professional staff, the MOH has endorsed utilization of trained health surveillance assistants for the provision of injectable contraception.”¹⁴

In 2009, USAID asked FHI to evaluate the pilot project. The evaluation compiled information from observations of client-provider interactions and from structured interviews with HSAs, CBDAs, HSA supervisors, and HSA clients who had received DMPA. The evaluation found the provision to be acceptable and safe, and that the pilots had effectively expanded access to FP at the community level.¹⁵

Based on this evaluation, the MOH further supported HSAs to provide injectable contraception throughout the country. However, they decided that CBDAs could not provide this service because of their more limited training. This effectively has resulted in a two-tiered system of community health workers providing FP: HSAs are allowed to provide injectables but CBDAs provide pills and condoms. This has been a logical progression in the Malawi context, where HSAs have more training and were already allowed to provide child immunization. On the other hand, screening for pills is more challenging than for injectables regarding blood pressure in particular. So, the system in Malawi now has the more high trained HSAs referring women who want pills to a lower level cadre to screen for pill use.

4.0 ASSESSMENT SYNTHESIS

This section synthesizes information obtained during the key informant interviews and focus group discussions. The material is grouped according to general barriers to family planning that arose, general barriers specific to CBFP programs, operational barriers specific to CBFP programs, facilitating factors and opportunities, and need for improved financing strategies.

4.1 General Barriers to Family Planning

Most informants identified several key issues that limit access and use of family planning. The comments coalesced in three major themes: poverty and lack of knowledge, engaging youth, and engaging men.

Poverty and Lack of Knowledge. “Family planning is not achieving what it’s supposed to achieve,” said Honorable Paul Chibingu, chair of the Malawi Parliament Committee on Health, during a group session with six other Parliamentarians. “We have some cultural conflicts. Some believe having children is the only way the village can grow. Some religious teachings do not promote family planning.” At the same time, he noted, people have accepted FP in some areas and acquired services.

The Parliamentarians noted that high poverty levels and illiteracy in rural areas contribute to a lack of civic education. “People are not told what family planning is all about,” said one of the Parliamentarians. “The clinics are very far, and they only go when they are sick or when they are pregnant.”

Others mentioned specific issues, such as myths about pills going into the body. A poor understanding of a method leads to problems. The CBDAs interviewed in the Kasungu district said they often have to address misconceptions about pills, for example, that they can accumulate in the stomach or that they can cause cancer.

Engaging Youth. Many informants noted the demographic shift of the country to young people and the fact that providers of family planning are oriented to high parity women, both from patterns of service and the clinic structure. “Clinics are mainstream facilities without linkages to school structures and community services,” said Harriet Chanzah, the WHO/Malawi family planning and population officer. “Life skills education in schools are affected by teachers’ attitudes who are often not able to teach sex and sexuality issues.”

The WHO country representative, Dr. Zawaira, emphasized the challenges of addressing youth. “This society is in denial about youth sexuality. Definitely, we find children at age 14 are pregnant. Sexual debut can start at a very young age. But we are in denial about what is happening. We read every day about sexual abuse and being married off at a young age because of poverty, or pushed into sex at a young age. We need to understand why there has been sexual denial, while our dances are all sexual.”

The WHO team suggested that facilities be more youth friendly and the government and agencies address broad sensitization issues regarding socialization of the girl and boy child. WHO is supporting such a project in two districts.

Engaging Men. While the TFR is slowly declining, the economic issues are outstripping the pace of more children, said Dr. Zawaira of WHO. “You need to teach households to be sure they understand this. What are my responsibilities toward these children; can I afford to take care of them and how this affects the development of the country. To do this, you have to engage the men. Men need to be involved in family planning discussions. There needs to be discussion between men and women. And, we have to start socializing the boys as early as possible.”

In other cases, men have not accepted FP, so the women have at times chosen to get an injection behind the backs of their husbands. At times women give their health passports to HSAs to keep for them so that the husband does not see it and cause problems for her. There are reported cases of gender-based violence related to contraception. In such situations, there is need to protect women from violence and pregnancy. Providers also need to provide in-depth information to the clients to enable them to make an informed choice.

4.2 General Barriers to Community-based Family Planning

Informants discussed a number of important barriers to community-based family planning (CBFP), including: infrastructure, human resources, and regulatory resistance.

Infrastructure. The rural nature of the country and poor road network makes a CBFP delivery system challenging. “The government has made some progress in opening outreach clinics,” said Honorable Chibingu, the chair of the Parliament’s Health Committee. “But service centers are very far for many, and they cannot get the services they need.”

With travel to district clinics difficult and GOM outreach services limited, the private sector often has to be used. “In my region, the community is sensitized in some areas, but there are no government health facilities that provide family planning,” said a Parliamentarian on the Health Committee. “So, people only have BLM and other private clinics.” BLM charges a small fee for services, while GOM services are supposed to be free, where available.

At the Kasungu District Hospital, a focus group of the medical officers, nursing officers, FP coordinator, and field officer from MSH echoed these concerns, even in this area where MSH has USAID funds to provide services. There are long distances for clients to access services. The group noted that community hospitals do not provide a full range of services, and that faith based facilities charge user fees. Both issues contribute to a lack of access to FP services. The chief of party for the MSH CBFP project, noted that the poor road network means that HSAs cannot reach many people.

Human Resources. A number of informants discussed lack of human resources as a barrier. The Deputy Director of the National Organization of Nurses in Malawi, a professional association, emphasized the “critical shortage of nurses and midwives” in the country and noted, “Overall, family planning services are not fully supported by the MOH.” The regulatory Nurses and Midwives Council of Malawi echoed this view, citing their efforts to advocate for more nurses and midwives, training for community midwives, and lobbying for an increased package of funding to staff for motivation purpose and training.

Concerns from Regulatory Groups. Several regulatory groups discussed their concerns about both the CBDAs and HSAs delivering FP services. The Nurses and Midwives Council has been reluctant to embrace task shifting in general, but have decided to support the HSAs. “We understand the need for them. We don’t have the numbers of nurses/midwives to reach out to the remote areas. We support them but want them to be trained properly,” said the Council’s Registrar. Also, she said, “We need a regulatory framework” for HSAs and CBDAs.

4.3 Operational Barriers to Community-based Family Planning

Commodities System. Managing commodities for family planning is a challenge, especially for community programs. Malawi has an Essential Medical Practices system where the HSAs are supposed to provide a range of services including basic MNCH information; this system has not historically focused on family planning. The MOH gives a block amount of funds to Districts, which can allocate these funds to meet various commodity needs for the Essential Medical Practices – FP commodities are near the bottom of local priorities.

Around 2006 the USAID Mission began focusing more attention to FP and began to plan for the need for more commodities. Both USAID and Dfid joined the GOM SWAp program, which was not adequately funded – and local districts did not make FP a priority compared to essential drugs. Hence there were major stock outs. Meanwhile, USAID had started focusing more on FP through the “repositioning FP” project. Then, the GOM began allowing HSAs to provide injectables in nine provinces. “We knew we were going to create demand; so we increased our budget for commodities,” said Banda-Maliro. “Now, we are in the SWAp as a non-pooled party – so we provide commodities directly to our partners through the government mechanisms.”

Health Centers. Other barriers involve crowding and some requirements for initiating methods. For pills, for example, women are supposed to go for an examination at the health center. But the centers are too crowded and can’t give them full exams, explains Mexon of MSH. “But no operational system is perfect. Because of these issues, we need to initiate outreach.”

Policies. While informants felt the government has developed good policies and guidelines for the most part, some pointed out some gray areas that could be improved. For example, However, BLM has used CHWs for many years to provide services; they

have at least as much training as HSAs and in many cases far more experience. But the educational requirement for an HSA excludes some of these CHWs. This policy, identified during the assessment in February, has since received attention and may be changed.

CBDAs commented that due to myths about pills and dislike of condoms – the two methods they can provide – they often end of referring all the clients for DMPA. Policies in some countries allow CHWs with the level of training of CBDAs to provide DMPA.

Supervision. Supervision levels are not adequate, said many informants. “Government has to take the issue of that seriously,” said Zimba of Save the Children. “We really need to strengthen supervision. MOH staff are employed to do the job, not just to sit in the offices. The MOH has the mandate and need to fund/support it.”

Training and Compensation. A variety of respondents mentioned these two issues. The Nurses and Midwives Council recognized the need for HSAs, but they are concerned about the length of their training at 10 weeks and would like it to be increased and standardized among the various services that are added. The Malawi Medical Council feels that the training of both HSAs and CBDAs is very short and lacks input from the Council, including a regulatory framework. The Council believes basic training for HSAs to function effectively needs to take at least one year.

HSAs themselves in a focus group discussion in the Kasungu district, where they are providing injectables, said their training period is not adequate. They also noted that pay is inadequate and they lack good bicycles for transportation. They have too much work to cover, and they noted an inconsistent supply of resources like DMPA. One commented they had been out of stock for three months. The CBDAs in the focus group also were not satisfied with the training period and wished it could be several months.

4.4 Need for Improving Financial Strategies to Expand FP services

The MOH does not fully support program activities by CBDAs or HSAs because of the concerns about financial sustainability. Instead, the MOH relies on projects to support these community workers with training, supervision, and other supports. “The MOH should in future come out and state its plans and commitment to support HSAs. The key issue for CBDAs is sustainability,” says Lily Banda-Maliro, HPN officer for USAID/Malawi. “The Adventists have sustained this cadre for 20 years with supervision and support, but the government’s district health office cannot pick them up because there’s no GOM guidance on how to use them. That’s a gray area in the current guidelines.”

The key challenge, says the MOH leaders being interviewed is the implementation. Regarding the provision of DMPA by the HSAs, for example, the MOH started the pilots in nine districts with a target of training 450 HSAs in those areas. “The challenge is that we haven’t reached all of them,” said Fannie Kachale, Deputy Director of Reproductive Health. “We need to train more so they can reach out to their communities.”

Another financial issue is sustaining the CBDAs. The idea of the CBDAs is very good, respondents said, having them attached to a project and a village. But the incentives are not as good for them. “The CBDAs work role is preventive in nature. We need more health promotion in general, and family planning is like a vaccine for maternal health,” said Lunguzi, the programme officer with UNFPA/Malawi.

Many informants said the MOH should invest more in the HSAs and CBDAs. One key issue is sustainability. Key investment issues are training, supervision and the staff needed for that, remuneration, and incentives.

4.5 Facilitating Factors for Community-based Family Planning

Malawi has many good policies and standards, all informants agreed. A lot of work has gone into these in recent years. In the 1990s, the GOM adopted the CBD of contraceptives which improved access and allowed medical assistants to provide implants. Then, it initiated DMPA provision by HSAs. We should see in the next six to seven years that we have really improved access through HSAs, says Banda-Maliro, the USAID HPN officer.

During the group discussion with the MOH directors and managers of relevant departments, the officials pointed out that overall, policies for CBFP are adequate. They have extended DMPA to HSAs since nurses were being overwhelmed for services. The guidelines have also been put in place, together with the policy. Currently, CBDAs, however, are only allowed to give oral contraceptives (OCs) and condoms.

The MOH should in the future make a clear commitment on whether, it is ready to engage and utilize HSAs throughout the country. It should also clarify whether to invest in CBDAs or in HSAs. The key issue for CBDAs is sustainability and supervision. The district can't pick them up because there's no GOM guidance on how to use them. That's a gray area.

The community can be a valuable ally for CBFP and need to be nurtured. “Unless the community accepts it, it is very difficult to implement,” says Mexon of MSH. Their major role is to select the CBDAs. We give the community criteria – education, etc. We also train the community health workers. But the community role is to use them, so if the community doesn't accept them it will not use them. Community leaders give moral support and recognition. The MSH project involves the community leaders in community mobilization in recognizing FP and HIV services.

Providing FP information and services in the community will work better if we identify a person already in the community, says Dr. Kuchingale, chairman of the Malawi Medical Association of Doctors. However, he emphasized the importance of engaging communities in recruiting trainable persons as HSAs, so that they can provide the various services. He also emphasized the importance of supervision, including using the private sector to supplement the GOM's efforts to provide these services through the DHOs.

The CBFP work is largely a donor driven or private sector program, but these programs have begun to work with the GOM to see how they can sustain them after phasing out. “We have a role to provide more advocacies to the GOM, to engage them more with models that can lead to a greater understanding of the role of population,” said Dr. Kuchingale. Sustainability becomes more participatory from many angles, he said.

5.0 In Their Own Words: CHWs Speak

As part of the assessment, a focus group was held in Kasungu District with three HSAs, three CBDAs, and one nurse/midwife technician (NMT), their supervisor thru the Nkhota Health Centre. The summary below is based on their descriptions of their training, selection, and other aspects of their work.

How much training do they receive?

The training of the NMT is three years. The HSAs training takes 10 weeks, while some HSAs in other districts may get 12 weeks, depending on the additional information they get. The CBDAs received two weeks of training. The HSAs felt their training period is not adequate and suggested it should be for one year. The CBDAs were not satisfied with their training and felt it should be two to three months.

What roles do the HSAs play? What are the challenges?

They provide FP methods like condoms and DMPA after counselling. They give child immunizations. They conduct village clinics and provide growth monitoring for children under age five. They enjoy their work. They discuss warning signs of some contraceptive methods such as prolonged heavy bleeding and headaches. The pay is inadequate. They lack bicycles for transportation. They have too much work to cover. They have an inconsistent supply of resources, especially DMPA. They have been out of stock for three months.

What roles do CBDA play? What are the challenges?

They are selected by the community to undergo the training, which includes counselling about and administering of condoms and oral contraceptives. They are not paid any money, and they lack a communication system like phones. They use a pregnancy checklist to initiate a FP method. A woman should answer “no” to all the questions for a method to be initiated. If a “yes” is given, she is referred to the health facility for initiation. The women often do not choose the pills or condoms, so the CBDAs often end up referring many clients for DMPA. They also counsel youth on sexual and reproductive health, but most do not choose the pills. Youth tend to choose condoms. In this area, many girls become sexually active from age 13 and boys from age 15 to 16.

How does supervision work?

The CBDAs are supervised by the HSAs and thought it was adequate. The NMT supervises the HSAs and thought it was a lot of work. The pay is not enough. The medical assistant should also be at the DHO but is not. The DHO clinic is about 70 kilometres away and is used only in an emergency.

6.0 RECOMMENDATIONS

This assessment leads to seven key recommendations to expand access to FP through community based services.

6.1 *Implement the services allowed under the current policy environment.* The assessment found near unanimous agreement that Malawi has developed a generally positive policy environment for expanding community-based FP. However, the implementation of the services is lacking. More staff members are needed at the District Health Offices to support HSAs. Meanwhile, greater collaboration is needed by the GOM systems and existing private sector service delivery systems.

6.2 *Enhance motivation and retention of HSAs and CBDAs.* In general, respondents would like HSAs and CBDAs to be more sustainable systems, with some increased rewards including possible remuneration contributing to the motivation of these cadres and their retention rates. Most informants felt that the training for both groups was too short, and the HSAs themselves felt that way.

6.3 *Focus on supervision.* The nurse/midwives and doctors groups in particular felt that the HSAs and CBDAs needed more supervision. However, in the GOM system, this requires more fully functioning District Health Offices with a functioning supervision system.

6.4 *Continue to strengthen community engagement, especially among men.* A number of participants commented on the importance of strengthening community engagement. The more involved the community, the more acceptance that will grow for family planning services. Informants mentioned the importance of engaging men in particular, both to help change social norms in the village and to achieve sustained support for the CBDAs in particular.

6.5 *Increase access to injectable contraceptives.* All stakeholders (including professional regulatory groups, reluctantly) accept that the HSAs can provide injectables, per a recent change in MOH policy that supports this service nationwide. The policy change followed a pilot project in nine districts and an evaluation of that pilot completed by FHI in 2010. At the same time, most informants do not feel that the lower cadre of CBDAs should be able to provide injectables, even though the GOM policies allow them to provide pills. Despite this policy change and MOH desire to scale up this CBFP service, continued provision of the method is inconsistent even in the nine pilot provinces, due to commodity stock outs, lack of human resources, and limited supervision.

6.6 *Increase focus on youth.* Respondents agreed that providing contraceptives to sexually active youth in rural areas is an area that needs more attention. The Malawi Family Planning Association is beginning to work with youth as community-based peer educators. “We hope to support and evaluate it,” says Bando-Maliro of USAID. “Access to contraceptives for youth is a huge gap in the country.”

6.7 Address problems with the commodity procurement system. The current SWAp system combined with the Essential Medical Practices system and the expansion of access to injectables has effectively led to major stock outs in many areas, especially of injectables. This problem needs addressing, mentioned many informants.

Appendix 1.

Key Informant Interviews

Group Type	Data Collection Method	Number conducted
Professional Associations	Interview	3
Implementing agencies	Interview	5
Donors	Interview	3
Regulatory boards	Interview	2
Total		13

Focus Group Discussions

Group Type	Data Collection Method	Number conducted
Members of Parliament	Group discussion	1
Community Health Workers	Group discussion	1
District Health Management Team	Group discussion	1
Ministry of Health	Group discussion	1
Total		4

Endnotes

¹ CIA. *The World Factbook*. Malawi. Available from: <https://www.cia.gov/library/publications/the-world-factbook/geos/mi.html>; US Census Bureau. International Database. Available from:

<http://www.census.gov/ipc/www/idb/country.php>

² MEASURE DHS. STAT Compiler. Available from: <http://www.statcompiler.com/>

³ WHO, UNICEF, UNFPA, The World Bank. *Trends in Maternal Mortality: 1990-2008*. (Geneva, Switzerland, 2010). Available from http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf

⁴ Malawi 1992, 2000, 2004 data from: MEASURE DHS. STAT Compiler; Malawi 2006 data from: National Statistical Office and UNICEF. *Malawi Multiple Indicator Cluster Survey 2006, Final Report*. (Lilongwe, Malawi: National Statistical Office and UNICEF, 2008); Moreland S, Smith E, Sharma S. *World Population Prospects and Unmet Need for Family Planning*. (Washington, DC: Futures Group, 2010). Available from: <http://www.futuresgroup.com/wp-content/uploads/2010/04/World-Population-Prospects-and-Unmet-Need-for-Family-Planning.pdf>

⁵ The data from 1992, 2000, and 2004 come from the DHS, while the data from 2006 come from the 2006 Malawi Multiple Indicator Cluster Survey. The data on the dotted line comes from the modeling of the study by Moreland et al, which used two key assumptions to calculate the projected CPR for married women: 1. The total CPR and the CPR for married women will change at the same rate; 2. The proportion of married and unmarried women stays constant over time.

⁶ WHO. Global Atlas of the Health Workforce. Available from:

<http://apps.who.int/globalatlas/dataQuery/default.asp>

⁷ <http://www.who.int/nha/country/mwi/en/>

⁸ http://deliver.jsi.com/dhome/countries?p_persp=PERSP_DLVR_CNTRY_MW

⁹ http://deliver.jsi.com/dhome/newsdetail?p_item_id=22416247&p_token=E1B5872FFA8C96D737C640EE52C31AB7

¹⁰ http://deliver.jsi.com/dhome/countries?p_persp=PERSP_DLVR_CNTRY_MW

¹¹ *National Sexual and Reproductive Health and Rights (SRHR) Policy*. Lilongwe, Malawi: Republic of Malawi, Ministry of Health, August 2009, p. 8.

¹² Richardson F, Chirwa M. *Toward Community-based Distribution of Injectable Contraceptives in Malawi*. Washington, DC: Health Policy Institute, Futures Group International, 2007.

¹³ Richardson F, Chirwa M, Fahnestock et al. *Community-based Distribution of Injectable Contraceptives in Malawi*. Washington, DC: Health Policy Institute, Futures Group International, 2009.

¹⁴ Community Based Injectable Contraceptive Services Guidelines. Malawi Ministry of Health, 2008, page 2.

¹⁵ Katz K, Chikondi Ngalande R, Jackson E, et al. *Evaluation of Community-based Distribution of DMPA by Health Surveillance Assistants in Malawi*. Research Triangle Park, NC: FHI, 2010.

