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POLICY BRIEF

Beyond Access: Improving Service Utilization in Malawi

The Country Development Cooperation Strategy (CDCS) for USAID/Malawi, approved in 2013, strives to achieve better quality of life for all Malawians through programming aimed to expand access, use, and quality of public services. The Mission considers that Malawians do not have adequate supply of basic services and are not equipped to demand them. In this paper, we draw on data from a recent baseline study in Malawi to discuss access to and utilization of public services, focusing on health and education, in the study areas in order to identify programing implications for USAID/Malawi. We recommend that the Mission consider placing more emphasis on improving quality of services to increase usage as it implements the CDCS to achieve better quality of life for all Malawians.

Many development practitioners strive to achieve better development outcomes through both supply and demand-side interventions that address access, use, and quality of services. Access to services enables people to demand appropriate and quality services and use them to preserve or improve their quality of life. People can *have access* to services if they are available in adequate supply such that the opportunity to obtain them exists. While access is commonly defined and measured through proximity to a service facility, many people who live closer to a service facility may not always use it for variety of reasons. People *utilize* services effectively only if they are relevant, of good quality, and effective, and if their financial, organizational, social or cultural context allows. Only through effective utilization of relevant and quality services can impacts occur.

USAID, since mid-2014 under the CDCS, has been integrating its development activities across health, education, agriculture, environment, and democracy and governance sectors through a 3-C Approach: *co-location* of interventions, more effective *coordination* among USAID implementers and with other development partners (DPs), and *collaboration* between USAID and the Government of Malawi (GOM), district authorities, other DPs, civil society organizations (CSOs), and community based organizations (CBOs) to improve and sustain the results and institutions (USAID/Malawi 2013). An impact evaluation is being carried out to test the impacts of the integrated development approach used under the Mission's CDCS to improve quality of life of Malawians. As part of the evaluation, a recent baseline study was conducted by Social Impact in Malawi during November-December of 2014 to gather data through surveys of 4,610 households and focus group discussions (FGDs) in 18 communities within seven USAID/Malawi-supported districts (Social Impact, 2015a). Major results from the baseline are discussed in this brief.

While most households had access to basic health and education services in terms of proximity to service facilities, they were not effectively using all the services provided through them (Social Impact, 2015a).

Access to and Use of Public Services

Baseline data showed that utilization of public services varied by the type of service. Public schools and public hospitals and clinics were the most utilized services in over three quarters of sampled households; however, utilization of improved agricultural practices (18%), nutrition assistance programs (6%), and agricultural training programs (15%) were very low even though they were available and households reported being aware of them. In addition to low utilization of agricultural training, there were some gender differences noticed in the use, with a higher fraction of male-headed households (16%) relative to female-headed households (11%) reporting having participated in the program in the last 12 months. Future studies should explore which specific barriers or perceptions limit utilization of agricultural training, particularly by female-headed households, so that they can be addressed. While 75% of the households reported being aware of climate change, only 12% reported

adopting practices that might increase farm productivity in the face of climate change. The reasons for low adoption should be explored in future studies, as they could include limited knowledge about practices to improve resilience to climate change or limited capability to implement them.

Health and education services in particular are necessary for virtually all households, and adequate access and effective use of such services are important to improve quality of life. Survey data showed that while the reported utilization of public health centers and schools were high by the sampled households, certain health seeking behaviors and education outcomes were reported to be low. Therefore, access to and use of health and education services is examined in detail below.

Access to and Use of Health Services

Physical access, indicated by proximity to public health clinics or hospitals, was not a constraint for the study population since geographic proximity to a USAID-supported health facility within eight kilometers (through the Support for Service Delivery Integration project) was used as a criterion to select households surveyed for the baseline. Nationally, UN data (2013) showed that 85% of Malawian residents live within 10 kilometers of a health facility, over 50% live within 5 kilometers, and that the number of health workers in priority areas increased by 53% within a decade, implying that physical availability of basic health facilities may not be a major constraint in Malawi to obtain health services.

In terms of utilization of health services, survey data showed that over 80% of households have visited public clinics or hospitals in the past 12 months. Nearly 95% of households reported taking their children to a hospital or clinic when needed. Most respondents who received HIV counselling and testing reported receiving this service from public health centers and hospitals.

A closer look at certain health seeking behaviors, however, paints a less-than-satisfactory picture.

Survey data showed that HIV voluntary counseling and testing (VCT) services were used by 60% of respondents and the contraception prevalence rate was 62%, indicating that utilization has improved in recent years, although it remains below the targets set by many programs. The potential reasons for not reaching the targets could include incorrect perceptions about the availability of the services, as indicated in some FGDs, which revealed misconceptions about who should receive VCT and its voluntary nature. Some FGD participants perceived that VCT for HIV was compulsory if women needed antenatal care and nutritional support, although this is not the case. In one of the FGDs, a woman stated that *"…those who received this information (HIV testing and counseling) and accepted are women, and not many men. If man go for HIV testing, it means they have seen something is wrong in his body. But if you tell him about going for HIV testing while he is healthy he cannot accept. He says you can go for HIV testing but for me I am okay. I will go when I get sick."* This perception that men only seek treatment when they show signs of illness may indicate that the successful integration of VCT into routine antenatal care visits, a highly effective strategy to improve diagnosis and treatment of sexually transmitted infections for women, is not sufficiently addressing the needs of men in the community.

Perceived poor quality of care at the health facilities appears to be another barrier to full utilization of health services. Indeed, satisfaction with recent health facility visits was low due to the perception of low quality of services. Of the survey respondents who have recently utilized health facilities, 74% reported experiencing long waiting times and 66% reported a lack of medicine and supplies (Figure 1). A number of FGD participants also reported waiting for a long time to receive medical care, only to end up not being seen at all. If patients were able to see a health care provider, the appropriate medicines prescribed for treatment were not always available and the patients were sent to private pharmacies or private medical facilities to seek additional treatment or prescriptions.

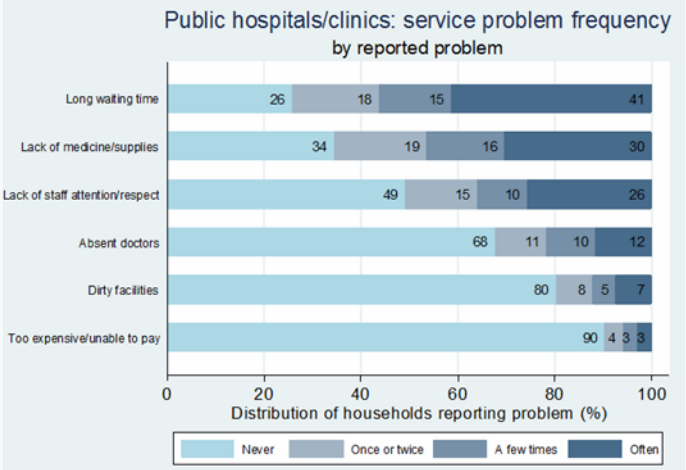

Figure 1. Satisfaction with local public hospitals/clinics – Frequency of service problems. Source: Household Baseline Survey, 2014

Affordability can be an important factor affecting health services usage. The study, however, showed that cost was not a substantial barrier to utilizing health services, as 90% of respondents did not report difficulty affording health care (Figure 1). However, in some cases, individuals' perceptions of the quality of care received may be related to wealth status of the patient. A participant in an FGD in Balaka said, "*It pains us when we go there (health facility). When a well-to-do patient comes to the hospital, they welcome them nicely. But not when a poor person comes there. Most of the times, they tell us that we should wait and they would come back. So they would be doing what they want to do and you would realize that you are not being helped.*" According to some studies, it is likely that the poor would willingly pay for perceived improvements in quality of health services, particularly for drugs (Cripps et al 1998, Franck, 1995, Wouters et al 1993), which would have an additional advantage of improving cost-recovery and financial sustainability of government services.

Access to and Use of Education Services

The baseline survey showed that 96% of children ages 6-12, both boys and girls, were enrolled in primary schools, with the nearest public primary school approximately a 27 minute walk away, on average. As described in an FGD, "*Here in Malawi it was very bad in the past for a person to get money to pay for primary education but nowadays we have free primary education; therefore, many people are able to go to school and are able to know the importance of school.*" Similar findings were reported in other studies in Malawi that showed nearly universal primary school enrollment in Malawi (Social Impact, 2015b; UN Data, 2013).

While most children were physically enrolled in primary schools most households surveyed did not appear to be utilizing the services effectively to realize the expected improved outcomes from these services. Only 3-15% of second graders in the study areas could read in Chichewa, as self-reported by survey respondents. This self-reported data could likely be biased, as a recent national Early Grade Reading Assessment using established reading assessment tools measured only 0.4% and 1.5% of first and third graders, respectively, achieving benchmarks for reading comprehension (Social Impact 2015b). Nonetheless, the low literacy among the primary school children is of concern and may derive from low quality of instruction that could pose barriers to effective utilization of education services.

Baseline survey data suggested that the quality of primary school infrastructure was low, as indicated in Figure 2. Availability of teaching materials and classroom space in primary schools were deemed inadequate. Nearly 65% of respondents said overcrowding was a problem, and 47% stated that they often encountered an overcrowded classroom. A lack of class room resources was close behind, with 37% of households reporting that there was "frequently" a lack of textbooks or supplies.

Quality of teachers and teacher absenteeism were also reported to be major issues affecting the quality of primary education services in schools. This may, in part, be explained by challenges in recruiting and retaining high quality teachers, as reported in several FGDs. The participants said that a lack of appropriate housing, as well as a lack of infrastructure developments, discouraged teachers from coming to and staying in their communities, as can be seen in this excerpt from a participant in Balaka: "*In schools we find that there are few teachers because teachers' houses have no electricity. Teachers don't stay long and they run away because they don't want to stay in the house without electricity, some have come from towns like Lilongwe, Blantyre.*"

Affordability, as indicated by cost of schooling, was not reported as a main barrier, with 68% of households reporting that it was never a problem and only 12% reporting the cost of education often posed a problem. While direct costs, such as school fees, may not be a major barrier, indirect costs such as clothing and books were, nonetheless, viewed by some participants in FGDs as rendering schooling prohibitive.

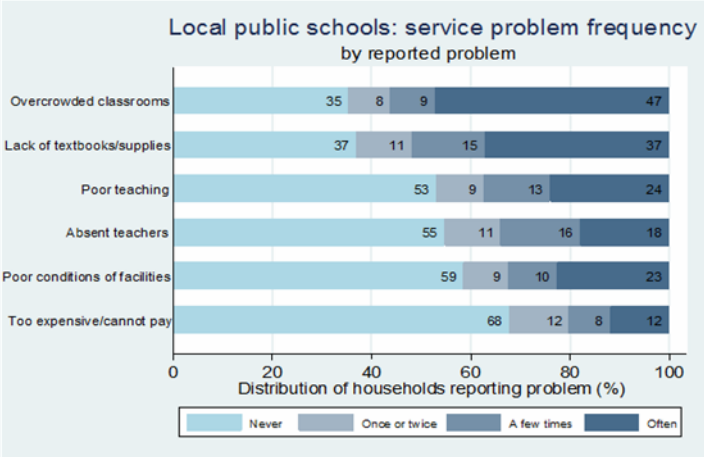

Figure 2. Satisfaction with local public schools – frequency of service problems

It is also important that children stay in school and progress to higher grades to realize the impact of education services. Survey data indicated that many children were not staying in school and progressing to secondary schools to effectively utilize education services, as shown by sharp increases in school drop-outs after the age of 15. The rate at which females of 15-17 years of age were enrolled in school was lower than for males, often due to pregnancy and the need to seek employment. There are additional challenges to secondary school enrollment since classroom space limited the admission in public schools for many qualifying students. Private secondary schools are sparse and prohibitively expensive for the majority of households. As one FGD participant observed: "*We don't have a secondary school in this community. And, the only secondary school we have is far from here.*" Since secondary school space is limited and students often have to apply to secondary institutions outside of their home communities, secondary education is an expense not all families can afford.

Recommendations for USAID

Low levels of effective utilization of services such as basic health care, education, and agricultural training, despite their physical availability has implications for USAID's CDCS programming and its efforts to increase health outcomes, literacy levels, and agricultural productivity to improve the quality of life of Malawians. Understanding and addressing barriers to effective utilization and building on the physical availability could lead to improvements in outcomes of all Malawians. Below, we outline recommendations to USAID/Malawi as it continues to implement the CDCS policy.

Focus on improving quality of services. USAID/Malawi should go beyond addressing physical availability of services and focus more on quality, relevance of services, and convenience in order to increase effective utilization of services to produce required impacts. For example, given common perceptions

about long waiting times at health facilities and drug stock-outs (Figure 1), increasing the supply of medical staff, equipment, and infrastructure, and improving supply chains for drugs and medical supplies could serve as valuable focal points for future programs. Given common perceptions about overcrowded classrooms and less qualified teachers (Figure 2), quality of services can be improved by increasing the supply of trained teachers and classroom space. In addition, availability, quality, and gender-related barriers to secondary school education need to be carefully assessed in order to improve literacy levels.

Address affordability while improving quality of services. While costs of basic services are not reported to be a major issue currently, services need to be affordable to all and costs should be kept low to maintain equity, even as quality and adequacy of services is improved. Studies focused on examining the willingness to pay for health services could help shed light on pricing the health services appropriately. Innovative service delivery mechanisms, such as collaborative arrangements to integrate various health services, should be encouraged to reduce costs and avoid inequities in access.

Identify and incorporate gender-specific features into programs. The barriers to utilization of public services by gender should be systematically examined to determine what actions can be taken to increase use of these services. For example, developing agricultural training programs based on needs assessments that also incorporate gender-specific needs by types of farming tasks, time requirements, mechanization needs, etc., could help to improve participation in agricultural training services and using the skills acquired from training programs.

USAID/Malawi's CDCS integration strategy could provide a valuable platform through which to bridge the gap between the various supply and demand-side interventions conducted by its implementing partners across education, health, and livelihoods projects (to mention a few). The colocation, coordination, and collaboration across sectors and partners have the potential to boost access, use, and quality of services; reduce duplication; and improve cost efficiency in service provision leading to better program outcomes and quality of life. USAID/Malawi's efforts need to be carefully studied so that lessons learned can help in improving development practices both in Malawi and in other countries with similar challenges related to delivery of public services to improve the wellbeing of all citizens.

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