

Integrating Family Planning into Primary Health Care in Malawi

A CASE STUDY

Andrea Rowan, Steve Gesuale, Rebecca Husband, and Kim Longfield

Acknowledgments

This paper was prepared by researchers at Databoom in partnership with Results for Development (R4D) and Population Services International (PSI). The authors would like to thank Michael Chaitkin, Nathan Blanchet, Yanfang Su, Pierre Moon, Candice Hwang, Paul Wilson, Ariana Childs Graham, Beth Tritter, and Olive Mtema for their comments on drafts of the paper. We would also like to thank the following individuals for participating in interviews and providing insight into the Malawian health system: Dr. Nelson Gitonga, Lucy Nkirete, Andrew Likaka, Olive Mtema, Dr. Owen Chikhwaza, Dr. Titha Dzewela, Carol Bakasa, and Beth Brogaard.

Ina Chang edited this paper.

The authors are grateful to the Bill & Melinda Gates Foundation for supporting this study, with special thanks to Katie Porter and all of the foundation staff members who participated in our Lunch and Learn session on September 18, 2018, in Seattle.

Databoom is a research and communications agency that believes powerful insights can shape the world. We provide research counsel for global health and development organizations that want to push boundaries and accelerate impact.

www.databoom.us

Population Services International (PSI) makes it easier for people in the developing world to lead healthier lives and plan the families they desire.

www.psi.org

Results for Development (R4D) works with change agents around the globe to create self-sustaining systems that support healthy, educated people.

www.R4D.org

Copyright © 2019
Results for Development
1111 19th Street NW, Suite 700
Washington, DC 20036

Suggested citation: Rowan, Andrea, Steve Gesuale, Rebecca Husband, and Kim Longfield. *Integrating Family Planning into Primary Health Care in Malawi: A Case Study*. Washington, DC: Results for Development, 2019.

Contents

Introduction	1
Methodology	2
Family Planning Policy and Integration Planning in Malawi.....	2
Using the PHC Framework to Understand the Vertical Program	5
Usefulness of the PHC Framework for Mapping Points of Integration	16
The Next Step: Considering Integration Options.....	16
Creating an Inclusive Process for Identifying Integration Priorities	16
Looking Ahead at Integration Priorities for Malawi	18
Annex: Malawi’s Integration Priorities	19
Endnotes	20
References	21

Introduction

This case study was produced as part of a project funded by the Bill & Melinda Gates Foundation called Integrating Vertical Programs into Primary Health Care Systems. The project tests a technical approach that policymakers can use to understand how a vertical, or health need–specific, program is structured and to what extent it is integrated with the larger primary health care (PHC) system.¹ In this case study, we examine key considerations related to integrating family planning services into Malawi’s PHC system.

We have combined a desk review of key documents with insights gained from interviews with health sector experts in Malawi to describe how family planning services are currently delivered in Malawi, the degree to which they are integrated with the PHC system, the actors involved, and their dynamics. The case study is intended to help policymakers in Malawi set priorities, identify where further integration would be beneficial, and select methods for increasing integration.

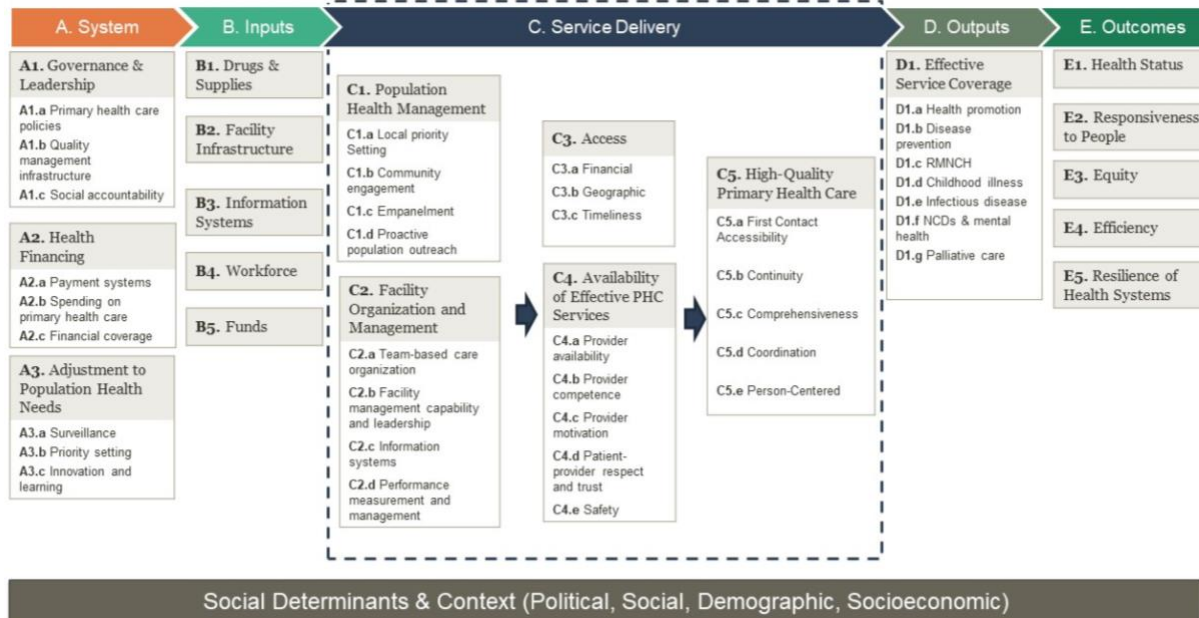
We define *integration* as the process by which a disease- or health need–specific program comes to share more of its components, or share them more fully, with the broader health system. Integration can be as simple as shifting from disease-specific facilities to multi-purpose facilities. Or it can be as complex as a thorough reorganization of financing, supply chains, and service delivery, especially in anticipation of the phasing out of donor funding.

Central to our project’s overall technical approach is the PHC Conceptual Framework created by the Primary Health Care Performance Initiative (PHCPI).² (See Figure 1.) This framework provides a way to identify and understand the components and functions of a PHC system and guide decision-making discussions between governments and donors.*

Our project hypothesizes that the PHC Conceptual Framework also applies to many, if not all, components and functions of vertical programs. We tested this hypothesis by examining the family planning program in Malawi. By doing so, we gained useful insights into where the vertical program is already integrated with PHC as well as areas that will require special attention if further integration is to occur without sacrificing quality of care.

* Even greater disaggregation may be desirable at times, such as when independently analyzing the three Financing functions—revenue mobilization, pooling, and purchasing (Blanchet et al., 2014).

Figure 1. The PHC Conceptual Framework



Note: This figure is reproduced from the PHCPI website. The dotted line surrounding Service Delivery is part of the original figure and has no specific meaning in this paper.

Methodology

To test the usefulness of the PHC Conceptual Framework in mapping the current level of integration of family planning and PHC in Malawi, we reviewed key documents—government strategies, survey reports, program reports, and scholarly articles—about the current level of integration and the future direction of the family planning program in Malawi. We also interviewed eight experts using a semi-structured discussion guide, which we continually adapted to reflect emergent areas of information and to better target questions to each interviewee’s area of expertise. We transcribed the interviews and coded the content using the subdomains of the PHC Conceptual Framework. Doing so helped us test the usefulness of the framework for categorizing and organizing insights revealed in the interviews.

Family Planning Policy and Integration Planning in Malawi

Malawi is one of the world’s poorest countries, with more than two-thirds of the population living below the poverty line.³ Despite resource limitations, the government of Malawi has expressed strong political commitment to improving the health and well-being of Malawians, including providing access to family planning services.⁴

It took the government some time to embrace family planning. In the 1960s and 1970s, modern contraceptive use was banned. The reasons for the ban are unclear, but some documents suggest that it was imposed in opposition to Western government policies and also reflected public distrust of contraception.⁵ A shift in ideology began in 1982 when the government released a policy advocating for child spacing using traditional family planning methods. In 1994, the government introduced a family planning program that promoted modern contraceptive methods. The National Population Policy, approved in 1994, provided a framework for addressing Malawi’s developmental challenges “through

structured management of its population dynamics, including rapid population growth, high levels of fertility and mortality.” The policy also established a formal family planning program.⁶

In 2012, the Ministry of Economic Planning and Development released an updated National Population Policy, which highlighted family planning as a key tool for socioeconomic development.⁷ The government has also identified family planning as crucial to its larger development agenda in policy and strategy documents, including the *Malawi Growth and Development Strategy (MGDS) III* and *Health Sector Strategic Plan II 2017-2022*.^{8,9} The current family planning strategy also proposes improved integration of family planning into other aspects of health care, especially PHC, to improve health coverage and meet strategic development goals.

The interviews confirmed that integration happens along a continuum: it is not an all-or-nothing or all-at-once shift. They also revealed that health policymakers do not always share a common working definition of integration.

The desk review and interviews revealed that some elements of the vertical program are critical to delivering high-quality family planning services and must be preserved, augmented, or improved as part of any integration effort. These include specific system requirements, inputs, and standards for service delivery. Figures 2 and 3 show some of the critical aspects of the family planning program that must be factored into decision-making about where and how to further integrate with PHC.

Figure 2. Important Considerations for Family Planning in the PHC System and Inputs Components

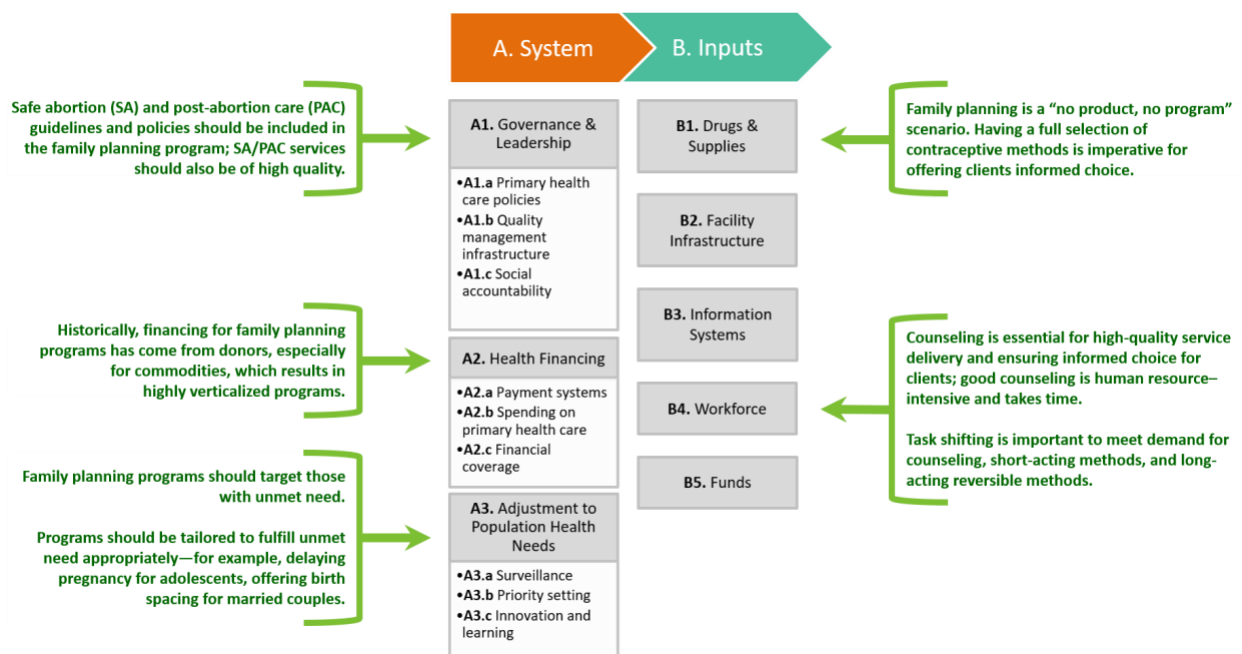
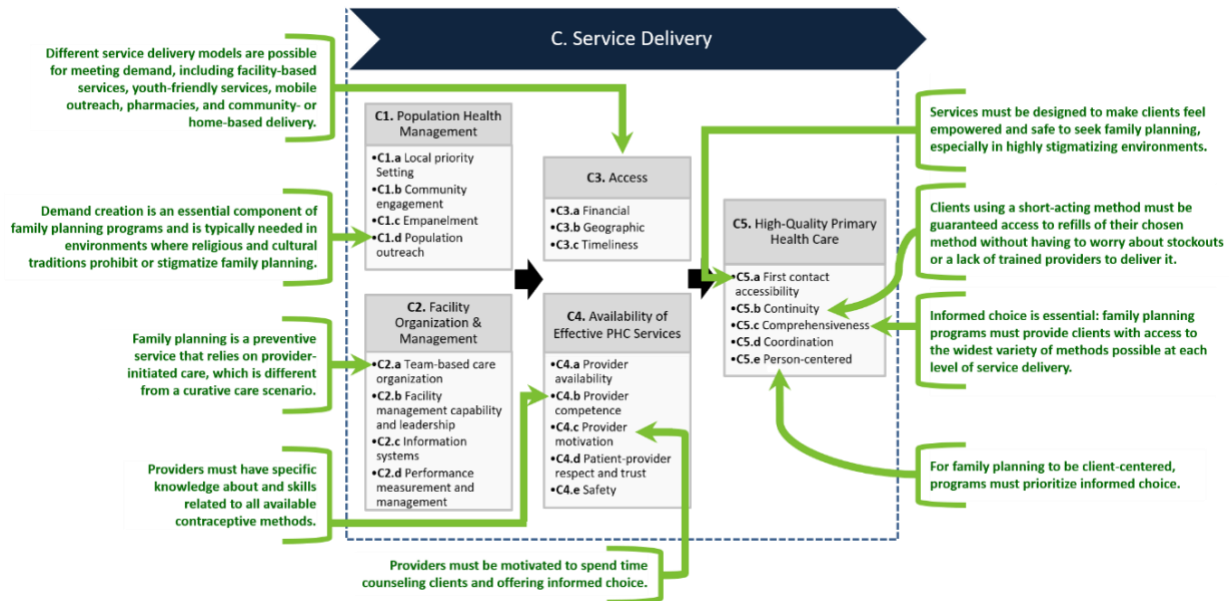


Figure 3. Important Considerations for Family Planning in the PHC Service Delivery Components

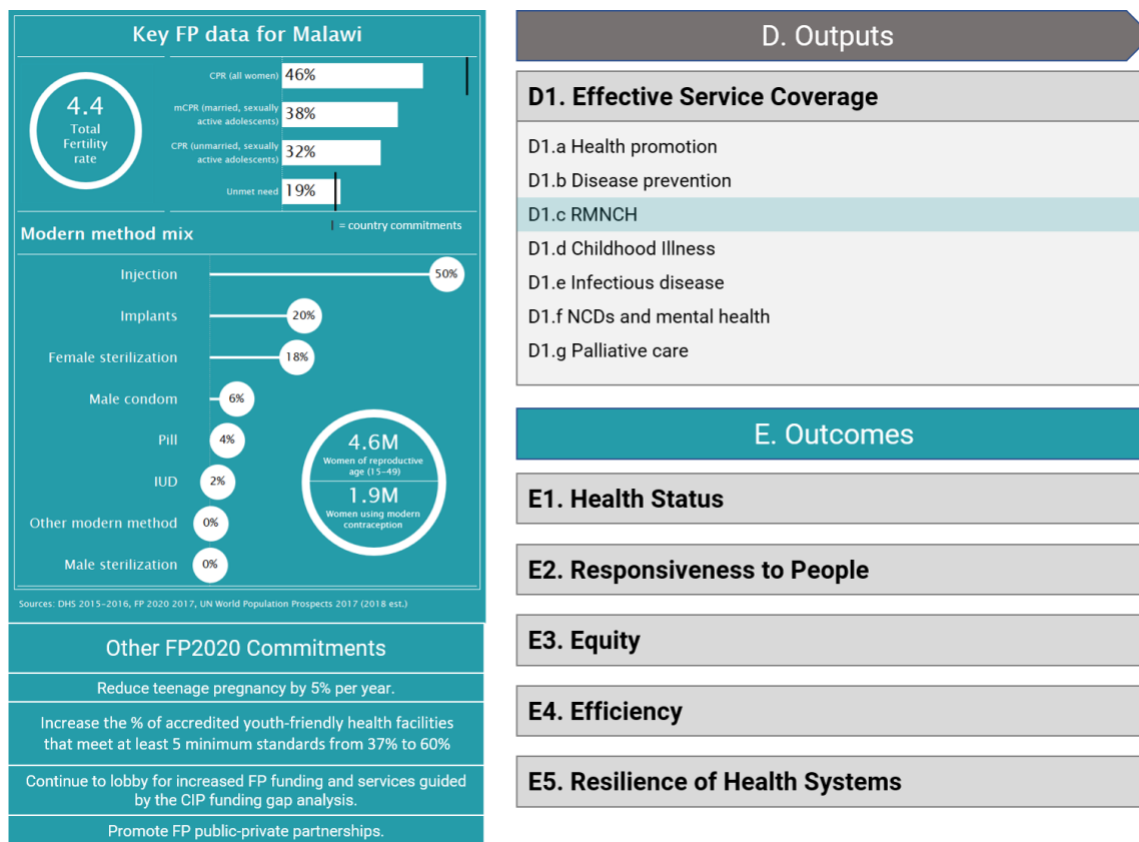


The government believes that integrating family planning with PHC will increase family planning coverage and improve overall population health.

Malawi has made progress in creating and meeting demand for family planning, but it has a long way to go.¹⁰ Since 2010, the total fertility rate (TFR) in Malawi has fallen from 6.7 to 4.4.¹¹ However, TFR is still high and the modern contraceptive prevalence rate (mCPR) is only 46% for all women and 32% to 38% for adolescents, depending on marital status. Unmet need for family planning is also high, at 19%. The government set ambitious commitments during the 2012 London Summit on Family Planning: increasing mCPR to 60% by 2020, reducing adolescent pregnancy by 5% per year, ending child marriage, and improving the quality of family planning services at accredited facilities.¹²

Figure 4 shows how Malawi’s current performance measures and FP2020 commitments for family planning map to the Outputs and Outcomes columns in the PHC Conceptual Framework.

Figure 4. Mapping FP2020 Commitments to the PHC Conceptual Framework



To help reach its FP2020 commitments, the government approved the *Malawi Costed Implementation Plan for Family Planning, 2016–2020* (FP-CIP) in 2015, which outlines six strategies that the government and its partners will undertake. One notable priority is to “promote multisectoral coordination at the national and district levels, and integrate FP policy, information, and services across sectors,” which acknowledges the importance of integrating family planning into other health areas, including PHC. However, Malawi currently lacks a unified vision for integration. As one interviewee noted, “Integration is happening at different levels and in different scenarios, [and] everyone looks at it differently.”

Using the PHC Framework to Understand the Vertical Program

The following sections apply the PHC Conceptual Framework in describing Malawi’s family planning program and its relationship to the PHC system.

A. System

A1. Governance & Leadership

All national and subnational family planning efforts in Malawi operate in a policy and legal environment in which provision of family planning services is legal. Married and unmarried adolescents and adults can access services without permission from a parent or a spouse. Induced abortion is legal only if the life of the mother is in danger, and most abortions that take place are unsafe.¹³ One interviewee noted that in the case of a life-threatening pregnancy, “even providers aren’t sure where to refer women.” In the latest strategic plan for the health sector, unsafe abortion is listed as the ninth-largest contributor to

disability-adjusted life years in Malawi. Post-abortion care is legal, however, and is covered under Malawi's Essential Health Package (EHP).

Despite a relatively favorable policy environment for family planning, several obstacles at the governance and leadership levels may prevent effective integration with PHC. They include poor coordination across agencies, the continued existence of vertical structures with vested interests in maintaining separate programs, and inefficient quality assurance systems. Such obstacles interfere with decision-making processes that could ultimately improve the quality of family planning services in Malawi.

The Ministry of Health owns the family planning program, which is housed within the Reproductive Health Directorate (RHD). As part of Malawi's FP2020 commitments, the reproductive health office was elevated to the status of a directorate, giving it more decision-making influence. However, the government noted that understaffing constrains the RHD's reach and cooperation is lacking within and between key government agencies.¹⁴

Malawi's health system is also decentralized, which makes coordination more complex. District health offices (DHOs) oversee health service provision and policy direction at the district level. The Ministry of Health supports district officers through zonal health support offices, which then provide technical support to DHOs. While the government technically owns the family planning program, international donors such as the United Nations Population Fund (UNFPA) and the United States Agency for International Development (USAID) have significant influence over the direction of family planning programs because of the commodities and funds they contribute for service delivery.

Interviewees underscored the coordination challenges and described how they affect decision-making. One said, "The health sectors are run in siloes; [for example], the director for child health doesn't sit with [the officers for] family planning and neonates, so they don't coordinate." Interviewees said the lack of coordination among government agencies results in duplicative efforts and a lack of consensus building: "You're always at four or five meetings discussing the same thing," one person said. "It's very inefficient." The FP-CIP also noted that the technical working groups for coordinating family planning and reproductive health issues meet on an irregular basis.

Another challenge to integration is skepticism among some Ministry of Health officials and concern that they will lose their jobs. As one interviewee said, "Unless you can make the case [that integration] promotes efficiency and you're not [trying to] replace anyone's job, then integration is a difficult sell."

The Ministry of Health wants to create a quality management framework that provides routine guidance and evidence that can be used for decision-making, but implementation has been a challenge. One interviewee said that the current supervision system is "expensive and inefficient" because each program area (such as child health, family planning, or reproductive health) has its own requirements and separate process. The current system also relies on a series of checklists with simple yes/no options that interviewees described as "tedious" and "time consuming to complete," precluding timely feedback to providers. One person described the results as "thin" and said decision-makers and facilities were not alerted to needed improvements: "Next quarter, there may not be any improvements because the facility was never briefed." Another interviewee said, "The current dashboard doesn't show what the facility did to warrant the score it received, so staff don't know how to improve."

Despite these challenges, the Ministry of Health has been pushing forward on many important integration objectives, including setting standards for reproductive health care. It is revising guidelines for provision of reproductive health services and has approved strategies for youth-friendly health services and essential health benefits. Enforcement will be critical. As one interviewee said, “Providers are guided by clinical guidelines,” and when guidelines aren’t implemented, “people do their own thing, [so] the MOH needs to reinforce them.”

A2. Health Financing

Malawi lacks sufficient financial resources for health spending and depends heavily on donor funding. That affects the Ministry of Health’s decision-making about integration priorities. From 2012 to 2015, 62% of health funding came from donors, 26% from the government, and approximately 13% from out-of-pocket costs paid by clients.¹⁵ Currently, donors directly provide 80% of contraceptive commodities, which are then imported into Malawi. Due to the predominance of external funding, the government must take into account donor priorities in its decision-making.¹⁶

Donor funds also come with restrictions on how they can be used, which can conflict with government priorities and opportunities for integration. For instance, donors may earmark money for vehicles and require that they be used only for family planning programs and not for any other high-priority health area. Some interviewees noted that while donor funding has been beneficial for promoting and supporting family planning, other health areas are ignored.

In terms of national health financing, some interviewees believe that the Ministry of Health is interested in efficiency gains that can accompany integration. One said that “there are overhead costs associated with vertical delivery and separate organizations delivering services” and that if health programs were grouped thematically into budgetary items, it would be easier to advocate for them as a bundle.

One major government initiative to finance improvements in overall population health is the Essential Health Package (EHP). The EHP was established in 2004 as a standard package of health services that would be offered for free through public facilities and in some facilities run by nongovernmental organizations (NGOs). Unfortunately, the EHP has been fraught with challenges. Most modern family planning methods (female sterilization, IUDs, implants, injectables, oral contraceptive pills, and male condoms) and post-abortion care are included in the package, but the cost of delivering the full package has far outstripped available resources. In addition, financial resources are not “explicitly allocated” to public health facilities,¹⁷ which means the government has been unable to fund them to provide services free of charge to clients. Theoretically, Christian Health Association of Malawi (CHAM) facilities are contracted to work within the EHP structure and are reimbursed for services provided on a fee-for-service basis; however, resource constraints mean that this arrangement does not always happen in practice.

Few providers and clients are familiar with the EHP, which limits use of the package. A survey in 2011 found that only 33% of surveyed providers knew about the EHP. Supervision is also lacking to ensure that providers do not charge clients for services that are covered under the package. The latest strategic plan for the health sector unveiled a revised EHP that emphasizes less costly preventive health care over more expensive curative services to make the EHP more financially sustainable and move closer to improving overall population health. In keeping with these goals, modern family planning services were

included in the revised EHP.¹⁸ As the government considers integration, it must ensure that key family planning services are adequately funded and are not compromised if EHP budget shortfalls occur.

A3. Adjustment to Population Health Needs

The government has made it a priority to reach those with unmet need for family planning, especially adolescents and young women ages 15 to 24.¹⁹ A number of its FP2020 commitments focus on improving access to family planning for youth and addressing cultural factors, such as child marriage, that contribute to unmet need for family planning. However, as one interviewee noted, “Few youth are really going to health centers.” Another added, “Adolescents want to come to facilities after school, but by that time [the facilities are] finished offering services for the day.” To address this issue, the government has approved a National Youth Friendly Health Services Strategy.²⁰

Reaching rural populations is also a priority, and the government has committed to investing in community-based family planning service delivery strategies. The latest strategy document emphasizes the importance of an integrated community health approach.²¹ Funding constraints have limited progress, however.

B. Inputs

B1. Drugs and Supplies

Commodity availability is critically important for family planning programs because clients cannot have true informed choice if some methods are not available. External donors fund most of the contraceptive commodity supply in Malawi. The system for ordering and delivering contraceptives is different than for other drugs and supplies, and sources of family planning commodities can vary. Forecasting takes place annually and is based on provision data submitted by public and NGO facilities, which receive donor-funded commodities. Private facility data are not included in the national quantification exercise,²² and private, for-profit facilities often procure commodities from the commercial market, at a much higher cost. This limits choice in private-sector facilities and interferes with accurate forecasting of overall contraceptive commodity needs for the country.

Stockouts at the facility level are a problem, but central-level stockouts do not appear to be the cause. Commodities purchased by donors are stored in multiple central-level warehouses, to be distributed at the district level. Parallel distribution chains and multiple storage facilities also exist because of different donor funding streams. The complexity of the system is compounded by poor-quality stock data and lack of a unified accountability system to monitor deliveries.²³ One interviewee described a reverse logistics exercise in which an NGO collected family planning methods from facilities that had overstock and then redistributed it to facilities that had no stock. The same person said some facilities had years’ worth of product (including “up to 11 years’ worth of IUDs”) while others were completely stocked out.

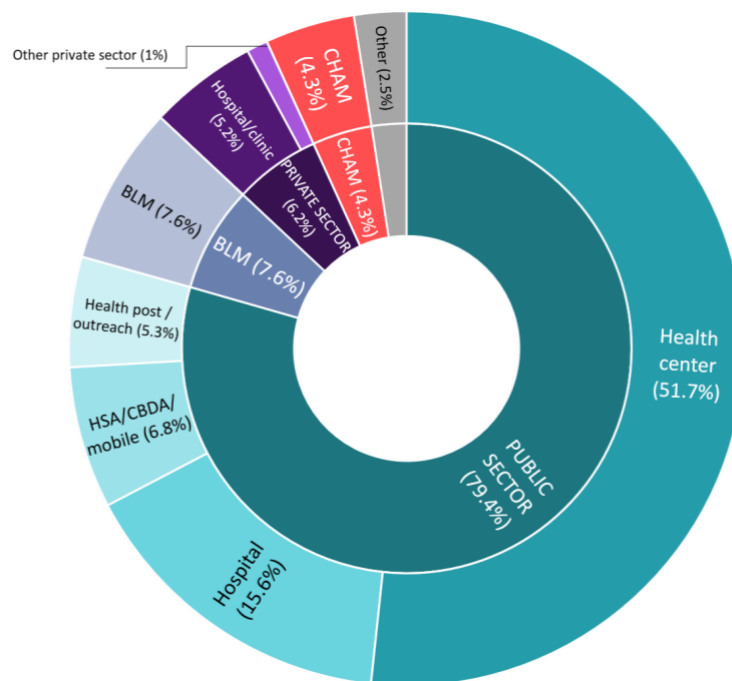
B2. Facility Infrastructure

A combination of public, NGO, and private facilities provide family planning services in Malawi. The government supports a network of public facilities, but it does not reach many rural populations. To supplement the public network, the government signed a memorandum of understanding with CHAM, which provides approximately 37% of the health services in Malawi.²⁴ The government reimburses CHAM for providing EHP services. Despite CHAM’s geographic coverage, the organization provides only 4% of the contraceptive services delivered in Malawi.²⁵ Approximately half of CHAM facilities are

affiliated with the Catholic Church and do not provide most modern family planning methods; this presents a major challenge for integrating family planning with PHC.

NGOs, such as the Marie Stopes International affiliate Banja La Mtsogolo (BLM) and Population Services International (PSI), offer standalone family planning services and use a “tent-based” outreach approach to fill the gaps in family planning services at Catholic CHAM facilities. This approach entails setting up an area at or near the facility grounds, often in a tent, to provide family planning services. While these outreach services help ensure access for clients, the partnerships between CHAM, BLM, and PSI to deliver family planning are not well coordinated. According to one interviewee, no formal agreements are in place detailing “what’s offered and where things are offered.”

Figure 5. Source of Most Recent Modern Contraception Method Among Women Ages 15 to 49



Notes: The “Other” category includes friends, relatives, shops, or unknown sources. CBDA = community-based distribution agent; HSA = health surveillance assistant. “Other private sources” include private pharmacy, private doctor, private mobile clinic, private CBDA, door to door, and other private medical sector.

Source: Malawi Demographic and Health Survey 2015-16

Most private facilities are located in urban or peri-urban areas.²⁶ Private-sector facilities provide 6% of family planning services in Malawi and are most likely to provide short-acting methods, such as injectables, pills, and condoms.²⁷

Table 1 provides a breakdown of family planning services delivered through Malawi’s public sector.

Table 1. Family Planning Services Delivered Through the Public Sector

	Care Level	Type of Service Delivery Point	Types of Family Planning Methods Offered	% of Family Planning Services Delivered Nationwide	# of Service Delivery Points
TOWARD THE COMMUNITY LEVEL	Tertiary Care Secondary Care Primary Care	Central hospital	Permanent methods* IUDs Implants Injectables Oral contraceptive pills Condoms	23%	4
	Secondary Care Primary Care	District hospital			24
		Rural/other hospital	*if appropriate cadre is available		57
	Primary Care Community Care	Health center	IUDs* Implants* Injectables Oral contraceptive pills Condoms	53.6%	328
		Dispensary		no data available	68
		Health post	*if appropriate cadre is available (usually through supplemental outreach for dispensaries or health posts)	5.3%	no data available
		Mobile outreach		2.8%	no data available
		Community/ home-based services	Injectables* Oral contraceptive pills Condoms *if appropriate cadre is available	4.8%	no data available

Sources: Devlin et al.; Malawi Costed Implementation Plan for Family Planning, 2016–2020; and Malawi Demographic and Health Survey 2015-16

B3. Information Systems

The tools for tracking family planning service delivery in Malawi are largely vertical because of the national supervision structure and donor reporting requirements.²⁸ As one interviewee said, “When you integrate services in the public sector, you need to have multiple registries because each service is treated as a separate visit and requires its own supervision.”

Reporting systems are of variable quality in both public and NGO facilities, which makes planning difficult. As one person noted, “CHAM [has] insufficient data collection capacity, so understanding how much family planning we should provide [through outreach] can be complicated.” In addition, reliance on an outreach model in CHAM facilities means that family planning data must be collected through third parties such as PSI and BLM.

To further complicate matters, reporting tools are often manual and inadequate at the facility level. One-third of public-sector facilities lack regular electricity or the equipment necessary for electronic data capture.²⁹ When public and private facilities fail to report their service delivery numbers, national-level figures remain incomplete.

B4. Workforce

One of the main challenges for health service provision in Malawi is a shortage of health providers—particularly mid-level health workers, such as nursing officers and midwives, who are the backbone of the health system. (See Table 2.) This chronic understaffing interferes with provision of needed services in a timely manner. It also makes integration difficult. As one person noted, “Providers find it difficult to offer integrated services due to work overload, [and] more time is required for things like family planning counseling.”

The government has identified task shifting as a key strategy for alleviating these staffing challenges. One interviewee described shifting tasks to health surveillance assistants, who can provide oral contraceptives and injectables, and to community-based distribution attendants, who can provide counseling, promote methods, and refer clients to a facility for long-acting reversible methods. Task shifting presents one of the most promising strategies for increasing family planning coverage and successfully integrating family planning into PHC.

Table 2. Family Planning Workforce and the Methods They Are Authorized to Provide

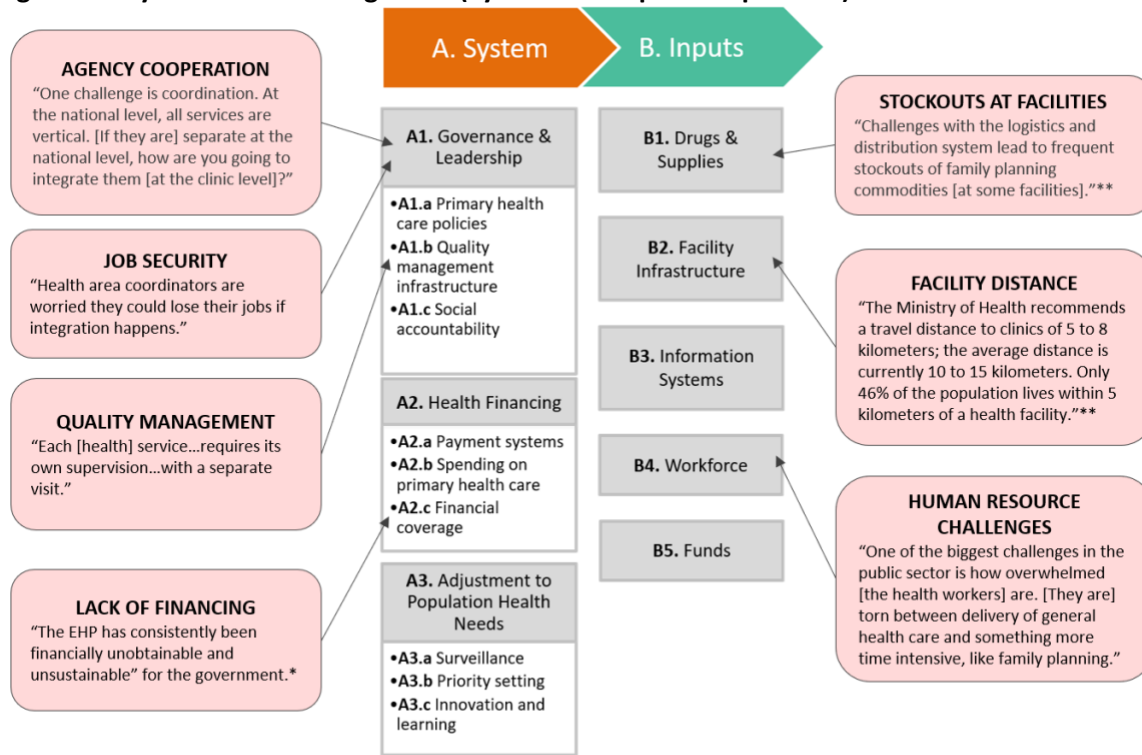
Cadre (public and CHAM facilities)	% of Positions Unfilled	Types of Family Planning					
		Permanent Methods	IUDs	Implants	Injectables	Oral Contraceptive Pills	Condoms
Medical officer	29%	Yes	Yes	Yes	Yes	Yes	Yes
Clinical officer	63%	Yes	Yes	Yes	Yes	Yes	Yes
Nursing officer	66%	No	Yes	Yes	Yes	Yes	Yes
Nurse midwife	60%	No	Yes	Yes	Yes	Yes	Yes
Medical assistant	20%	No	Yes	Yes	Yes	Yes	Yes
Health surveillance assistant	0%	No	No	No	Yes	Yes	Yes
Community-based distribution agent	No data	No	No	No	No	Yes	Yes
Community home-based care volunteer	No data	No	No	No	No	Yes	Yes

Sources: Devlin et al.; Malawi Costed Implementation Plan for Family Planning, 2016–2020; and Malawi Demographic and Health Survey 2015-16

Providers also need continuing education so they can provide informed choice and the full suite of current family planning methods. One interviewee said that most providers in the system “only received family planning training in medical school and no follow-up training.” When continuing education is offered, it is typically for public and NGO providers, which does not address capacity in the private sector and limits client choice.

Figures 6 and 7 summarize the key obstacles and enablers, respectively, for integration of family planning and PHC at the System and Input levels.

Figure 6. Key Obstacles to Integration (System and Input Components)

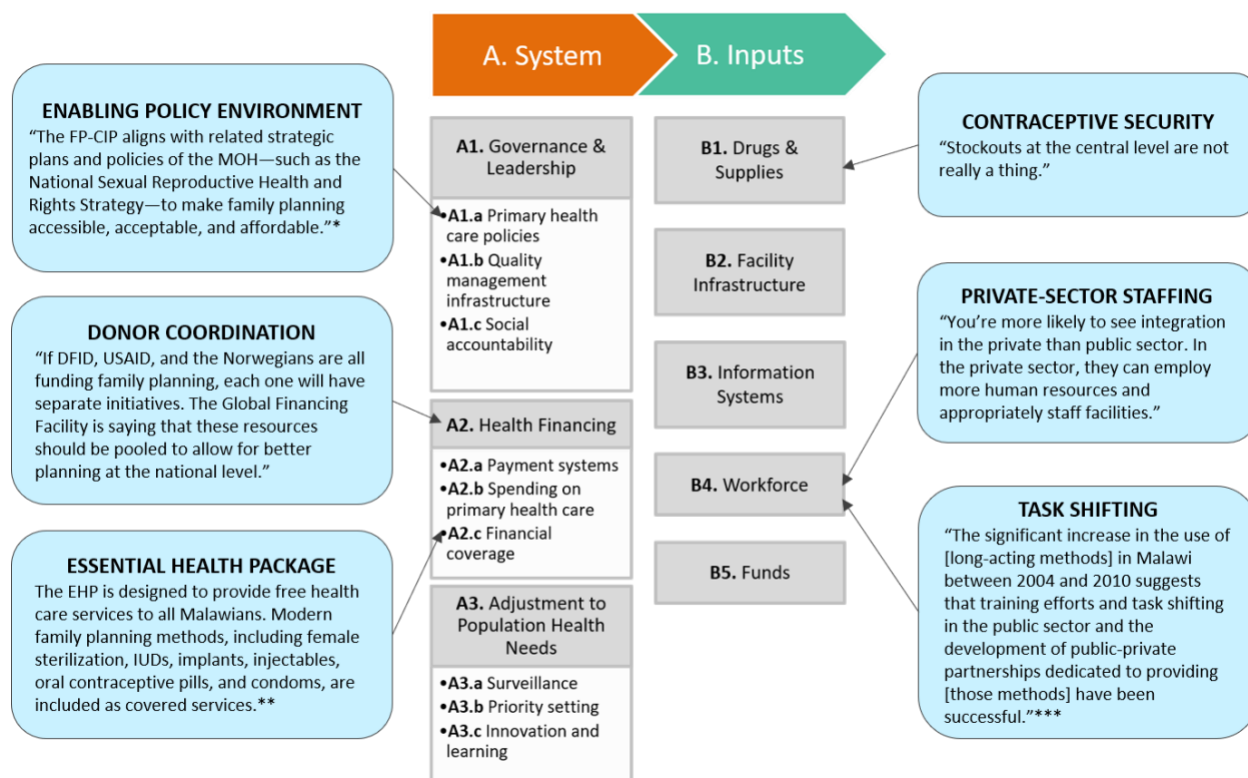


* Source: Health Sector Strategic Plan II 2017-2022

** Source: Malawi Costed Implementation Plan for Family Planning, 2016–2020

All other comments are from interviews with health sector stakeholders in Malawi.

Figure 7. Key Enablers of Integration (System and Input Components)



* Source: Malawi Costed Implementation Plan for Family Planning, 2016–2020

** Source: Health Sector Strategic Plan II 2017-2022

*** Source: USAID, Making Family Planning Acceptable, Accessible, and Affordable: The Experience of Malawi
All other comments are from interviews with health sector stakeholders in Malawi.

C. Service Delivery

C1. Population Health Management

The government has identified demand generation as a critical factor in achieving family planning program outputs and outcomes. Sociocultural factors, concern about side effects, and the perception that family planning is not “an immediate necessity” contribute to low demand among women. One strategy is to use the community health workforce (including health surveillance assistants and community-based distribution agents) to reach out to key populations to raise awareness, correct misconceptions, and increase demand at the community level. But this strategy has lacked coordination among partners on the ground. As noted in the FP-CIP, there is “no clear coordination mechanism for implementing partners and donors to track their efforts and limit a duplication of effort.”³⁰

C2. Facility Organization & Management

Strong organization and team-based care can facilitate integration of family planning into PHC. This is not being achieved in Malawi. Rather than offering a comprehensive array of services during all facility hours, with different staff for each area of service, “there are clinic days for each service [and] it’s the same people who deliver the services, but just on different days,” according to one interviewee. This results in inefficiencies and means that facilities do not offer a comprehensive suite of family planning

on any given day. One interviewee said that health workers believe that integrated models of service delivery will mean more work for them and “that’s not a welcome idea.”

C3. Access

Challenges at the System and Inputs levels mean limited access for clients at the Service level. Lack of facilities and insufficient workforce lead to crowding and long wait times. Even if services are “free,” clients must cover transportation and opportunity costs, which are barriers to access. In the *Malawi Demographic and Health Survey 2015-16*, 6% of women who discontinued a method cited difficulty of access as the reason.

C4. Availability of Effective Services

The same System and Inputs challenges mean that providers may not offer all family planning methods, which limits informed choice and can lead to method discontinuation. Multiple interviewees mentioned a lack of both provider motivation and provider competence as obstacles to integration. Providers prioritize the services they deem most necessary and most efficient. As one person said, “If family planning were truly integrated, you could have provider-initiated discussions around it, but family planning isn’t a priority for providers at the health center.” Another interviewee said, “Clinic information systems do not prioritize taking a ‘real client history,’ so no one asks the client what she needs.”

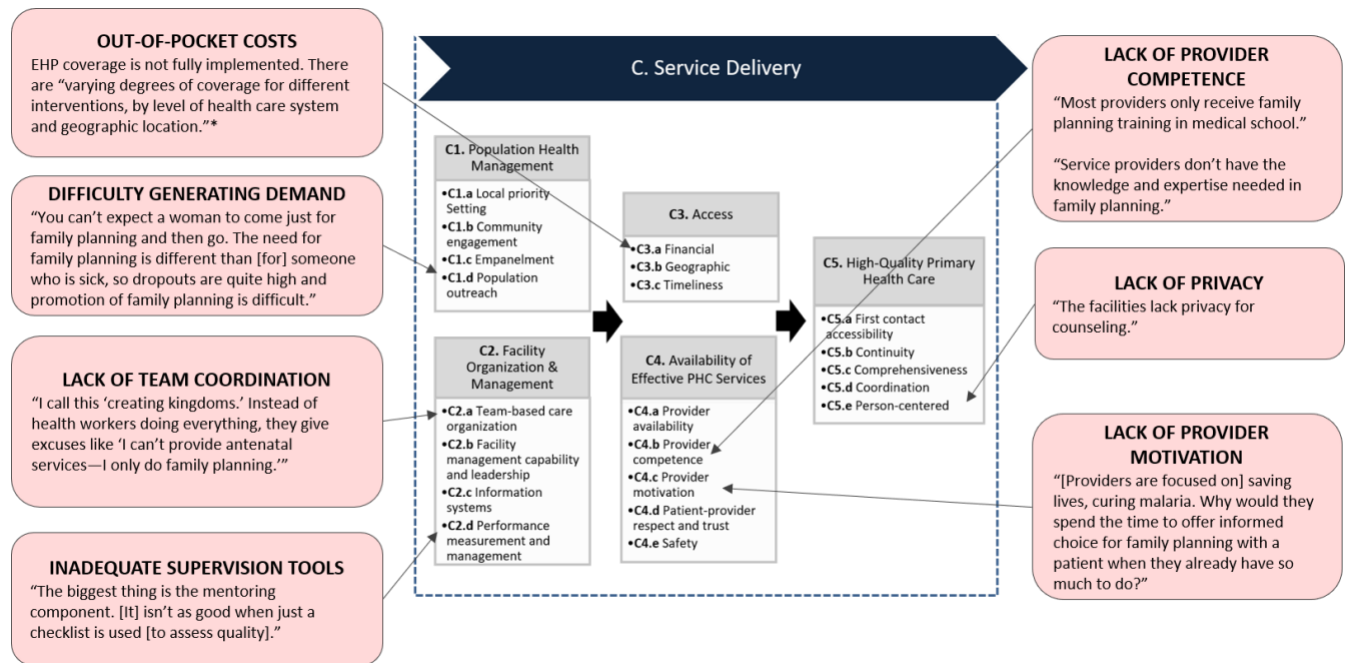
C5. High-Quality Primary Health Care

Informed choice is essential to high-quality family planning service delivery. Even when clients can access family planning at facilities, there is no guarantee that they can get the services they want on that day or without a long wait. Many clients must go to facilities on multiple days to receive the services they need. As one interviewee said, “If a mother goes to a facility to immunize her child and she wants family planning, she needs to come in twice—once for the vaccination and on a separate day for family planning.” Only half of public health facilities offer family planning services every day.³¹ Another operating model is to offer multiple services on the same day and under the same roof, but by different providers. But this means a woman must queue for the first service (e.g., vaccinating her child) and then queue again for family planning.

A rights-based approach is also crucial to high-quality family planning service delivery. Space can be a challenge at facilities, according to interviewees, which results in limited privacy for counseling. Likewise, provider bias can lead to directive counseling, especially if providers feel that certain clients, such as adolescents or women who have not been pregnant or had a live birth, should not use long-acting methods or some other method of their choice.

Figures 8 and 9 summarize the key obstacles and enablers, respectively, of integration of family planning and PHC at the Service Delivery level.

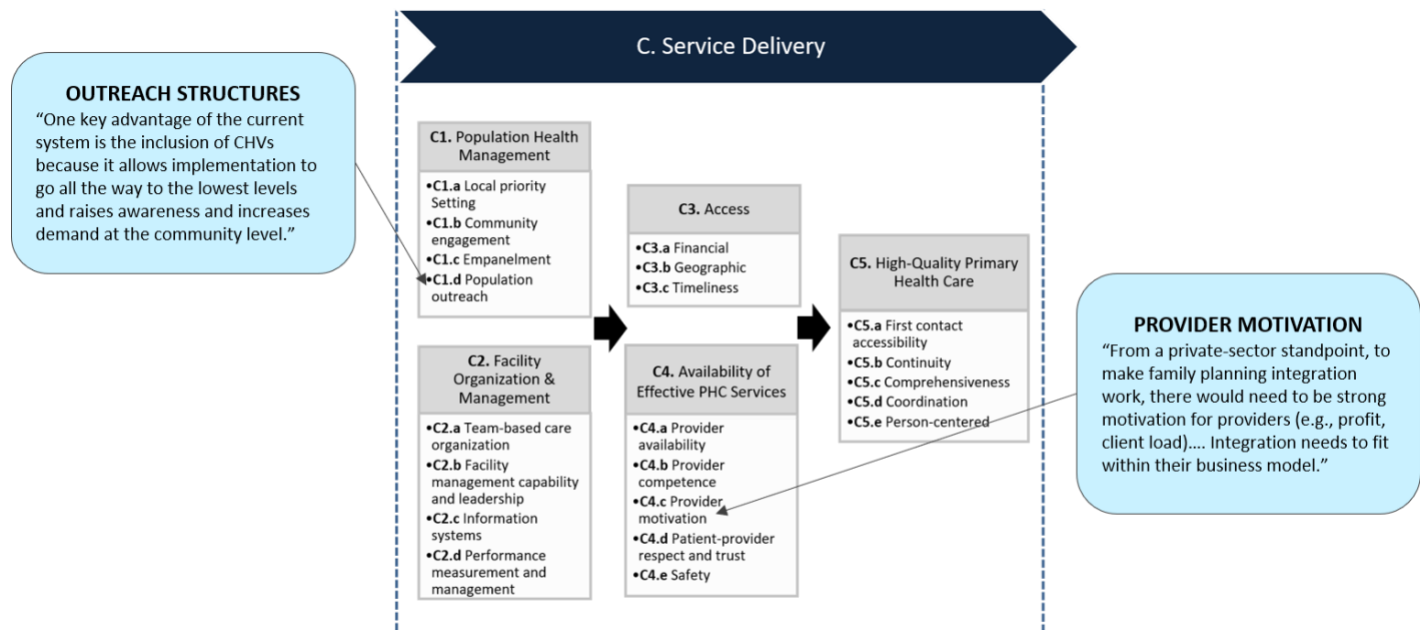
Figure 8. Key Obstacles to Integration (Service Delivery Components)



* Source: Health Sector Strategic Plan II 2017-2022

All other comments are from interviews with health sector stakeholders in Malawi.

Figure 9. Key Enablers of Integration (Service Delivery Components)



Comments are from interviews with health sector stakeholders in Malawi.

Usefulness of the PHC Framework for Mapping Points of Integration

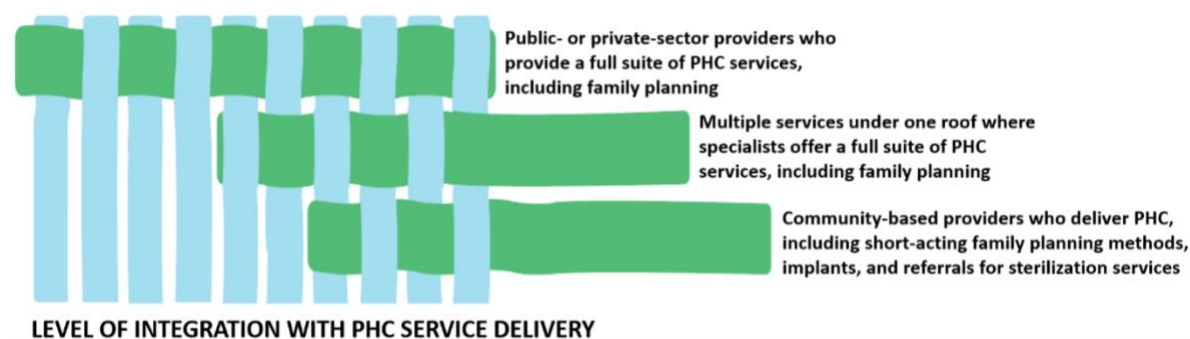
The PHC Conceptual Framework has been useful for mapping the points of integration between family planning and PHC programs in Malawi, by providing a way to organize and help identify patterns in the data sources we examined. However, many important data points relate to multiple components of the framework. For example, insufficient quality management structures (A1. Governance & Leadership) lead to a lack of useful and actionable feedback to facilities, thus affecting provider competence (C4. Availability of Effective Services). Due to the complexity of these chains of events, coding and organizing data according to the framework could lead to redundancies or prevent proper contextualization of how these processes work. Importantly, informed choice, which is central to quality family planning services, cannot be captured neatly by any one component of the framework.

While the framework is useful, it is important to use it with caution to avoid losing the nuance and interconnectedness of the components as well as the essential qualities of the service to be integrated with PHC.

The Next Step: Considering Integration Options

Mapping the family planning program in Malawi using the PHC Conceptual Framework is one way to identify discrete points where integration is more desirable or less desirable, depending on the goals of the vertical program and PHC program stakeholders. It also helps illuminate the continuum of integration. Figure 10 illustrates the degree to which family planning is already integrated into PHC in various service delivery settings in Malawi. In some settings, the PHC provider offers a full suite of family planning services. The least integrated model uses community-based providers to deliver PHC and short-acting family planning methods.

Figure 10. Continuum of Integration Across Malawian Health Services



Creating an Inclusive Process for Identifying Integration Priorities

Successful decisions about integration require stakeholders from different sectors and from different levels of the health system to agree on a set of priorities that reflect what is most feasible and desirable for the country context and will help the country reach its stated goals. Integration is never a full system overhaul, but it can better connect vertical programming and PHC.

We created a checklist-style tool for donors and policymakers to identify where integration goals are included in the national strategy and how much progress has been made. Policymakers can then determine where integration is desirable and chart progress over time.

The Malawi checklist was completed using information from interviews with health experts, strategy documents, and other background literature. Figure 11 shows a simplified version; the Annex provides a more complete version that includes comments to help policymakers understand the assigned status levels.

Figure 11. Malawi’s Integration Priorities

Malawi’s Integration Priorities					
		○ None ◐ Partial ● Full	Presence in National Strategy	Current Status	
PHC Conceptual Framework	Integration Pathway				
A. System	Alignment between government, donors, and partners on PHC/FP integration priorities	●	●	○	
	A1. Governance & Leadership	Guidelines developed and approved for PHC and FP, including counseling and informed choice	●	●	◐
		Integrated supportive supervision to assess service provision and quality for PHC and FP	○	○	○
		Agency structures that reflect shared priorities between PHC and FP	●	○	○
		Single mechanism at a national level to coordinate PHC/FP integration	●	○	○
		A2. Health Financing	Costed implementation plan that includes PHC/FP integration	●	●
	Covered benefits package/national insurance scheme that covers PHC and FP		●	○	○
	A3. Adjustment to Population Health Needs	Appropriate targeting to address unmet need	●	●	◐
	B. Inputs	B1. Drugs & Supplies	Unified supply chain, including appropriate forecasting mechanism	●	○
		B2. Facility Infrastructure	Private-sector facilities in PHC/FP network	●	◐
B3. Information Systems		Shared registers and reporting system for PHC and FP	○	○	
B4. Workforce		Task shifting to expand network for eligible providers for long-acting reversible contraceptives	●	◐	
C. Service Delivery	C3. Access	FP services offered during all service hours	●	○	
		Regular training for providers on FP	●	○	
	C4. Availability of Effective PHC Services	Sufficient staffing to provide both PHC and FP, including counseling on informed choice	●	○	
		C5. High-Quality Primary Health Care	Adequate facility space and equipment to provide integrated services	●	○
	Clients able to receive most appropriate method on site or through referral		●	○	

Looking Ahead at Integration Priorities for Malawi

As noted earlier, integration is not an all-or-nothing or all-at-once shift. The government of Malawi and its Ministry of Health have shown a clear commitment to scaling up family planning coverage and meeting the country's ambitious FP2020 commitments. However, Malawi has resource constraints and relies heavily on donor funding, which will limit integration options. Many interviewees mentioned lack of national-level coordination and lack of human resources at the service delivery level as impediments to progress in family planning service delivery and PHC, while also stating that integration at the national decision-making level could improve efficiency. They also noted a lack of sustainable funding streams to cover family planning under the EHP.

Given these factors, the following checklist items warrant the greatest attention:

- Single mechanism at a national level to coordinate PHC/FP integration (A1: Governance & Leadership)
- Improving reimbursements for FP under the EHP (A2: Health Financing)
- Task shifting to expand the network for eligible providers for long-acting reversible contraceptives (B4: Workforce)

Having a single coordinating mechanism at the national level would trickle down to improve coordination at the district and community levels and reduce redundancy in supportive supervision. Improving the reimbursement system under the EHP would remove up-front cost barriers for clients and motivate providers to offer family planning and include the full suite of services to ensure informed choice. Likewise, gains in task shifting would strengthen the family planning workforce and allow for more team-based delivery, further ensuring informed choice for clients.

Annex: Malawi's Integration Priorities

The following checklist was completed using information from interviews with health experts, strategy documents, and other background literature. This figure is a more complete version of the checklist shown in Figure 12 and includes comment comments to help policymakers understand the assigned status levels.

PHC Conceptual Framework		Integration Pathway	Legend		Presence in National Strategy	Current Status	Rationale for Status
			○ None	● Partial			
A. System	A1. Governance & Leadership	Alignment between government, donors, and partners on PHC/FP integration priorities	●	●	●	○	<p>Rationale for Status</p> <p>Talks are ongoing about how to better align donor funding for FP, according to interviewees. However, this has not yet been implemented.</p> <p>New FP clinical guidelines that are nearing completion will outline important task-sharing content.</p> <p>While FP-CIP emphasizes the importance of supervision, it does not detail how it should be integrated into other programs. Interviewees said that when supervision happens, it is siloed by program.</p> <p>FP-CIP highlights lack of multisectoral involvement in FP planning as a challenge. Interviewees said this has not improved significantly.</p> <p>FP-CIP tout the FP technical working group as a potential coordinating mechanism, but interviewees say the TWG is not functioning properly.</p> <p>Integration of PHC and FP services is a key strategy outlined in the current FP-CIP.</p> <p>While the revised EHP includes FP methods, lack of financing is still impeding implementation.</p> <p>FP-CIP outlines the importance of reaching populations with most unmet need, including youth. Progress is being made in using community-based models to extend the reach of FP efforts.</p> <p>FP-CIP emphasizes need for better supply chain coordination, but interviewees said maldistribution and lack of private-sector involvement persist.</p> <p>FP services covered by EHP are authorized to be offered at CHAM facilities. Ad hoc arrangements with private providers such as BUM and PSJ provide FP services at public facilities. FP services are not covered under EHP at private, for-profit providers.</p> <p>No mention of combining registers or data systems in FP-CIP. Interviewees said data collection tools are still vertical.</p> <p>Successful task shifting for HSA to provide injectables has happened, but more work must be done to expand the cadres authorized to provide injectables and implants.</p> <p>FP-CIP highlights lack of FP availability at all service hours as an important challenge. Interviewees said staffing shortages still impede FP availability during all service hours at many facilities.</p> <p>FP-CIP identifies expansion of provider training as a key goal. Interviewees said provider training has not significantly improved.</p> <p>FP-CIP says that staffing shortages are among the biggest obstacles faced by the FP program. Interviewees said these shortages have not been adequately addressed.</p> <p>Interviewees said facility-level stockouts are still a problem in many areas, despite adequate stock at the central level.</p> <p>Interviewees said that lack of equipment and inadequate space to provide private counseling have not been addressed.</p>
		Guidelines developed and approved for PHC and FP, including counseling and informed choice	●	●	●	○	
		Integrated supportive supervision to assess service provision and quality for PHC and FP	○	○	○	○	
		Agency structures that reflect shared priorities between PHC and FP	●	●	○	○	
		Single mechanism at a national level to coordinate PHC/FP integration	●	●	○	○	
		Costed implementation plan that includes PHC/FP integration	●	●	●	○	
		Covered benefits package/national insurance scheme that covers PHC and FP	●	●	○	○	
		Appropriate targeting to address unmet need	●	●	○	○	
		Unified supply chain, including appropriate forecasting mechanism	●	●	○	○	
		A2. Health Financing	Private-sector facilities in PHC/FP network	●	●	○	
B. Inputs	B1. Drugs & Supplies	Shared registers and reporting system for PHC and FP	○	○	○		
		Task shifting to expand network for eligible providers for long-acting reversible contraceptives	●	○	○		
		FP services offered during all service hours	●	○	○		
		Regular training for providers on FP	●	○	○		
		Sufficient staffing to provide both PHC and FP, including counseling on informed choice	●	○	○		
C. Service Delivery	C3. Access	Adequate facility space and equipment to provide integrated services	●	○	○		
		Clients able to receive most appropriate method on site or through referral	●	○	○		
		C4. Availability of Effective PHC Services	○	○	○		
		C5. High-Quality Primary Health Care	○	○	○		
			○	○	○		

Endnotes

- ¹ Chaitkin, Michael, Nathan Blanchet, Yanfang Su, Rebecca Husband, Pierre Moon, Andrea Rowan, Steve Gesuale, Candice Hwang, Paul Wilson, and Kim Longfield. 2019. *Integrating Vertical Programs into Primary Health Care: A Decision-Making Framework for Policymakers*. Washington, DC: Results for Development.
- ² Primary Health Care Performance Initiative. "Measuring PHC." <https://improvingphc.org/measuring-phc/>.
- ³ United Nations Development Programme. "Malawi: Human Development Indicators." <http://hdr.undp.org/en/countries/profiles/MWI>.
- ⁴ Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016–2020*. Lilongwe, Malawi: Government of Malawi. <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/Malawi-CIP-for-FP-2016-2020.pdf>.
- ⁵ Chimbwete, Chiweni, Susan Cotts Watkins, and Eliya Msiyaphazi Zulu. "The Evolution of Population Policies in Kenya and Malawi." *Population Research and Policy Review* 24, no. 1: 8.
- ⁶ Government of Malawi. 2012. *National Population Policy*. Lilongwe, Malawi: Government of Malawi. <http://populationmalawi.org/wp1/wp-content/uploads/2014/04/Malawi-National-Population-Policy-2012.pdf>.
- ⁷ Government of Malawi. 2012. *National Population Policy*.
- ⁸ Government of Malawi. 2017. *Malawi Growth and Development Strategy (MGDS) III (2017 - 2022)*. Lilongwe, Malawi: Government of Malawi. http://www.mw.undp.org/content/dam/malawi/docs/UNDP_Malawi_MGDS%20III.pdf.
- ⁹ Government of Malawi. 2017. *Health Sector Strategic Plan II 2017-2022*. Lilongwe, Malawi: Government of Malawi. <http://www.health.gov.mw/index.php/policies-strategies?download=47:hssp-ii-final>.
- ¹⁰ Family Planning 2020. "Malawi: Commitment Maker Since 2012." <http://www.familyplanning2020.org/node/2828>.
- ¹¹ National Statistical Office, Malawi; and ICF International. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi; and Rockville, Maryland: National Statistical Office, Malawi; and ICF International. <https://dhsprogram.com/pubs/pdf/FR319/FR319.pdf>.
- ¹² Family Planning 2020. "Malawi: Commitment Maker Since 2012."
- ¹³ Guttmacher Institute. 2017. "Abortion and Postabortion Care in Malawi." <https://www.guttmacher.org/fact-sheet/abortion-malawi>.
- ¹⁴ Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020*.
- ¹⁵ Government of Malawi. 2017. *Health Sector Strategic Plan II 2017-2022*.
- ¹⁶ Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020*.
- ¹⁷ Government of Malawi. 2017. *Health Sector Strategic Plan II 2017-2022*.
- ¹⁸ Government of Malawi. 2017. *Health Sector Strategic Plan II 2017-2022*.
- ¹⁹ Family Planning 2020. "Malawi: Commitment Maker Since 2012."
- ²⁰ Ministry of Health, Malawi. 2015. *National Youth Friendly Health Services Strategy, 2015–2020*. Lilongwe, Malawi: Government of Malawi. https://www.healthpolicyproject.com/pubs/673_YFHSStrategyFINALWEB.pdf.
- ²¹ Ministry of Health, Government of Malawi. 2017. *National Community Health Strategy 2017 - 2022*. Lilongwe, Malawi: Government of Malawi. https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf.
- ²² Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020*.
- ²³ Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020*.
- ²⁴ Christian Health Association of Malawi. "Our Impact." <http://www.cham.org.mw/our-impact.html>.
- ²⁵ National Statistical Office, Malawi; and ICF International. 2017. *Malawi Demographic and Health Survey 2015-16*.
- ²⁶ Carmona, Andrew. 2013. *Malawi Private Sector Health Mapping Report*. Washington, DC: Strengthening Health Outcomes through the Private Sector. <https://www.shopsplusproject.org/sites/default/files/resources/Malawi%20Provider%20Mapping%20Report.pdf>.
- ²⁷ National Statistical Office, Malawi; and ICF International. 2017. *Malawi Demographic and Health Survey 2015-16*.
- ²⁸ Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020*.
- ²⁹ Ministry of Health, Malawi; and ICF International. 2014. *Malawi Service Provision Assessment (MSPA) 2013-14*. Lilongwe, Malawi, and Rockville, MD: Ministry of Health, Malawi; and ICF International. <https://dhsprogram.com/pubs/pdf/SPA20/SPA20%5BOct-7-2015%5D.pdf>.
- ³⁰ Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016-2020*.
- ³¹ Ministry of Health, Malawi; and ICF International. 2014. *Malawi Service Provision Assessment (SPA) 2013-14*. Lilongwe, Malawi, and Rockville, MD: Ministry of Health, Malawi; and ICF International. <https://dhsprogram.com/pubs/pdf/SPA20/SPA20%5BOct-7-2015%5D.pdf>.

References

- Carmona, Andrew. 2013. *Malawi Private Sector Health Mapping Report*. Washington, DC: Strengthening Health Outcomes through the Private Sector.
<https://www.shopsplusproject.org/sites/default/files/resources/Malawi%20Provider%20Mapping%20Report.pdf>.
- Chaitkin, Michael, Nathan Blanchet, Yanfang Su, Rebecca Husband, Pierre Moon, Andrea Rowan, Steve Gesuale, Candice Hwang, Paul Wilson, and Kim Longfield. 2019. *Integrating Vertical Programs into Primary Health Care: A Decision-Making Approach for Policymakers*. Washington, DC: Results for Development.
- Chimbwete, Chiweni, Susan Cotts Watkins, and Eliya Msiyaphazi Zulu. "The evolution of population policies in Kenya and Malawi." *Population Research and Policy Review* 24, no. 1: 8.
- Christian Health Association of Malawi. "Our Impact." <http://www.cham.org.mw/our-impact.html>.
- Devlin, Kristen, Kimberly Farnham Egan, and Tanvi Pandit-Rajani. 2016. *Community Health Systems Catalog Country Profile: Malawi*. Arlington, VA: Advancing Partners & Communities.
https://www.advancingpartners.org/sites/default/files/catalog/profiles/malawi_chs_catalog_profile_0.pdf.
- Devlin, Kristen, Tanvi Pandit-Rajani, and Kimberly Farnham Egan. 2017. *Malawi's Community-based Health System Model: Structure, Strategies, and Learning*. Arlington, VA: Advancing Partners & Communities. https://www.advancingpartners.org/sites/default/files/technical-briefs/apc_malawi_brief_508.pdf.
- Family Planning 2020. "Malawi: Commitment Maker Since 2012."
<http://www.familyplanning2020.org/node/2828>.
- Government of Malawi. 2012. *National Population Policy*. Lilongwe, Malawi: Government of Malawi.
<http://populationmalawi.org/wp1/wp-content/uploads/2014/04/Malawi-National-Population-Policy-2012.pdf>.
- Government of Malawi. 2015. *Malawi Costed Implementation Plan for Family Planning, 2016–2020*. Lilongwe, Malawi: Government of Malawi. <http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2016/10/Malawi-CIP-for-FP-2016-2020.pdf>.
- Government of Malawi. 2017. *Health Sector Strategic Plan II 2017–2022*. Lilongwe, Malawi: Government of Malawi. <http://www.health.gov.mw/index.php/policies-strategies?download=47:hssp-ii-final>.
- Government of Malawi. 2017. *Malawi Growth and Development Strategy (MGDS) III (2017 – 2022)*. Lilongwe, Malawi: Government of Malawi.
http://www.mw.undp.org/content/dam/malawi/docs/UNDP_Malawi_MGDS%20III.pdf.
- Guttmacher Institute. 2017. "Abortion and Postabortion Care in Malawi."
<https://www.guttmacher.org/fact-sheet/abortion-malawi>.

- Ministry of Health, Malawi; and ICF International. 2014. *Malawi Service Provision Assessment (SPA) 2013-14*. Lilongwe, Malawi, and Rockville, Maryland: Ministry of Health, Malawi; and ICF International. <https://dhsprogram.com/pubs/pdf/SPA20/SPA20%5BOct-7-2015%5D.pdf>.
- Ministry of Health, Malawi. 2015. *National Youth Friendly Health Services Strategy 2015–2020*. Lilongwe, Malawi: Ministry of Health, Malawi. https://www.healthpolicyproject.com/pubs/673_YFHSSstrategyFINALWEB.pdf.
- Ministry of Health, Malawi. 2017. *National Community Health Strategy 2017 - 2022*. Lilongwe, Malawi: Ministry of Health, Malawi. https://www.healthynewbornnetwork.org/hnn-content/uploads/National_Community_Health_Strategy_2017-2022-FINAL.pdf.
- National Statistical Office, Malawi; and ICF International. 2017. *Malawi Demographic and Health Survey 2015-16*. Zomba, Malawi, and Rockville, MD: National Statistical Office, Malawi; and ICF International. <https://dhsprogram.com/pubs/pdf/FR319/FR319.pdf>.
- Primary Health Care Performance Initiative. “Measuring PHC.” <https://improvingphc.org/measuring-phc#/>.
- The RESPOND Project. 2012. “Making Family Planning Acceptable, Accessible, and Affordable: The Experience of Malawi.” *RESPOND Project Brief No. 6*. New York: The RESPOND Project/EngenderHealth. <http://www.respond-project.org/archive/files/1/1.1/1.1.1/Brief6-2012-Making-Family-Planning.pdf>.
- United Nations Development Programme. “Malawi: Human Development Indicators.” <http://hdr.undp.org/en/countries/profiles/MWI>.