

# Integrating Family Planning into Primary Health Care in Malawi



MALAWI

*Malawi is among the low- and middle-income countries that are taking steps to achieve universal health coverage (UHC). The performance of primary health care (PHC) systems in these countries and their ability to deliver quality essential health services contribute to this process. This fact sheet provides an overview of Malawi's progress in integrating one such service: family planning.*

Malawi is one of the world's poorest countries, with more than two-thirds of the population living below the poverty line. 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.

It took the government some time to embrace family planning. In the 1960s and 1970s, modern contraceptive use was banned. 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 current family planning strategy proposes improved integration of family planning into other aspects of health care, especially PHC, to improve overall population health and meet strategic development goals.

Malawi's total fertility rate has fallen from 6.7 to 4.4 children per woman since 2010. But that rate 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.

To make progress toward its FP2020 commitments, the government approved the *Malawi Costed Implementation Plan for Family Planning, 2016–2020*, which outlines six strategies that the government and its partners



## AT A GLANCE



Despite progress in recent decades, the total fertility rate in Malawi is high, at 4.4 children per woman.



Unmet need for family planning also remains high, at 19%.



Donors provide 80% of contraceptive commodities in Malawi and nearly two-thirds of all health funding.



The country's Essential Health Package calls for free contraceptive provision at public facilities, but the cost of delivering the package has far outstripped available resources.



Malawi has a shortage of health providers, particularly mid-level health workers such as nursing officers and midwives.



The government has set ambitious goals to increase the modern contraceptive rate, reduce adolescent pregnancy, and improve the quality of family planning services.



Integration of family planning into PHC is happening at various levels, but not in a coordinated or strategic way.

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.” However, Malawi still lacks a unified vision for integration.

## How Family Planning Fits into the Health Care System

The Ministry of Health oversees the family planning program, but Malawi’s overall health system is decentralized down to the district level. The ministry provides technical support for district health offices, which are responsible for health service provision and district-level policies. While the government is ultimately responsible for the family planning program, international donors such as the United Nations Population Fund and the United States Agency for International Development have significant influence over its direction because of the commodities and funds they contribute for service delivery.

Despite the structural complexities, the Ministry of Health has been pushing forward on many important integration objectives, including setting standards and revising guidelines for reproductive health care and approving strategies for youth-friendly health services and essential health benefits.

## Health Financing and Contraceptive Choice

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, 61.6% of health funding came from donors, 25.5% from the government, and 12.9% from out-of-pocket costs paid by clients. Donors currently provide 80% of contraceptive commodities, which are imported into Malawi. Due to the predominance of external funding, the government must consider donor priorities in its decision-making.

Donor funds also come with restrictions on how they can be used, which can conflict with government priorities and opportunities for integration. For example, 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.

One major government initiative to improve overall population health is the Essential Health Package (EHP). The EHP was established in 2004 as a standard set 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, which means the government has been unable to fund them to provide services free of charge to clients.

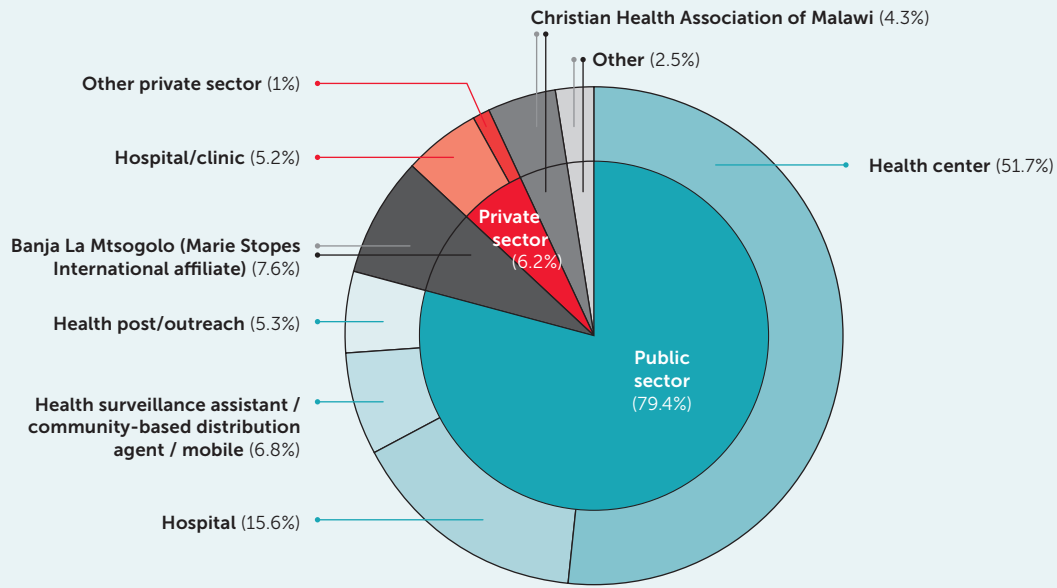
Few providers and clients are familiar with the EHP, which further limits use of the package. Supervision is also lacking to ensure that providers do not charge clients for services that are covered under the package. The latest strategic plan for the health sector unveiled a revised EHP that emphasizes less costly preventive health care over more expensive curative services to make the EHP more financially sustainable.

Commodity availability is critically important for family planning programs because clients cannot have true informed choice if some methods are unavailable. Because external donors fund most of the contraceptive supply in Malawi, the system for ordering and delivering is different than for other drugs, and sources of family planning commodities can vary. Forecasting is based on provisional data submitted by public and NGO facilities, which receive donor-funded commodities.

Private-sector facilities, which provide 6% of family planning services in Malawi, are more likely than public facilities to provide short-acting methods, such as injectables, pills, and condoms. Their data are not included in national forecasting. For-profit facilities often procure commodities from the commercial market, at much higher cost. This limits choice in private-sector facilities and interferes with accurate forecasting of overall contraceptive commodity needs for the country.

The following figure shows where Malawian women obtain modern contraceptive methods.

### Source of Most Recent Modern Contraception Method Among Women Ages 15 to 49



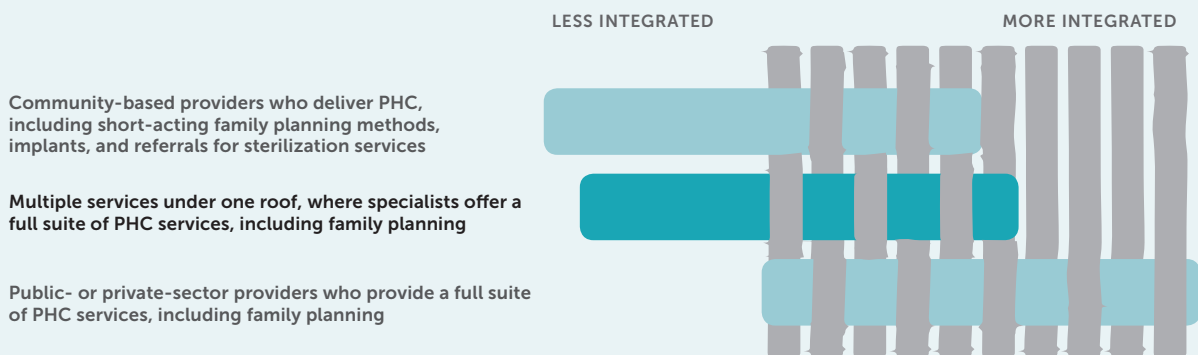
Source: Malawi Demographic and Health Survey 2015–16

### Current Level of Integration

The following figure 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.

### Continuum of Integration Across Malawian Health Services



## Obstacles to Integration

A number of obstacles stand in the way of fully integrating high-quality family planning services into PHC in Malawi:

- » Malawi has a shortage of health providers, particularly mid-level health workers such as nursing officers and midwives, who are the backbone of the health system.
- » Facilities offer clinic days for specific types of services on different days, which results in inefficiencies and means that facilities do not offer a comprehensive suite of family planning services on any given day. Many providers also prioritize the services they deem most necessary and most efficient.
- » The Christian Health Association of Malawi (CHAM) provides approximately 37% of the health services in Malawi, but about half of CHAM facilities are affiliated with the Catholic Church and do not provide most modern family planning methods.
- » The tools for tracking family planning service delivery are largely vertical because of the national supervision structure and donor reporting requirements.
- » Reporting systems are often manual and vary in quality, which makes planning difficult. One-third of public-sector facilities lack regular electricity or the equipment needed for electronic data capture. When facilities fail to report their service delivery numbers, national-level figures remain incomplete.
- » When continuing education is offered to providers, it is typically for public and NGO providers only, which does not address capacity in the private sector and limits client choice.
- » Cooperation is lacking within and between relevant government agencies.

- » Facility and workforce shortages lead to crowding and long wait times. Even if services are “free,” clients must cover transportation and opportunity costs, which creates an additional barrier to access.
- » Space constraints at facilities result 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.

## Next Steps

The government of Malawi has shown a clear commitment to scaling up family planning coverage and meeting the country’s ambitious FP2020 commitments. Feasible next steps would include:

- » Alleviating staffing challenges through task shifting to health surveillance assistants and community-based distribution attendants.
- » Providing continuing education for health care staff so they can provide informed choice and a more diverse suite of current family planning methods.
- » Ensuring better strategic coordination of outreach by community health workers to raise awareness, correct misconceptions, and increase demand for modern contraception among key populations.
- » Creating a single coordinating mechanism at the national level to improve coordination at the district and community levels and reduce redundancy in supportive supervision.
- » Improving the reimbursement system under the EHP to remove up-front cost barriers for clients and motivate providers to offer family planning and a broader suite of services.

**FOR A MORE DETAILED DISCUSSION,** see *Integrating Vertical Programs into Primary Health Care: A Decision-Making Approach for Policymakers* and the Ghana and Malawi case studies at [www.r4d.org/integrating-vertical-programs](http://www.r4d.org/integrating-vertical-programs).

