Programmatic Explanations for the Remarkable Increases in the Adoption of Modern Contraceptive Methods in Malawi[1]

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[1] Views and opinions expressed in this document are the author's. They do not necessarily reflect the views and opinions of the US Agency for International Development.

Introduction

Up to the early 1990s, the term "family planning" could not be used in official government documents in Malawi (Chimbwete et al., 2005; African Institute for Development Policy, 2012). Family planning services were provided to clients in the country before 1992 only for the purposes of child spacing or "Kulera". Thus, as of 1983, only two clinics were providing family planning (FP) services in Malawi. Political and social changes in the early 1990s led to a dramatic change in Malawi's family planning service environment and by 1995, the number of family planning clinics had increased to 210 – which represented only 28% of the 742 health facilities in the country. Within 24 years, Malawi's contraceptive prevalence rate for modern methods (mCPR) among currently married women of reproductive age increased eightfold – from 7.4% in 1992 to 58.1% in 2015/16 (see Figure 1). In other words, within so short a period, Malawi's contraceptive prevalence rates had surpassed what is observed in earlier African pace-setter countries such as Kenya, Botswana and Egypt. For example, in the 1980s, mCPR in Kenya was seventeen times that in Malawi, but by 2010, mCPR in Malawi already overtook that in Kenya – by five percentage points in 2015. This represents a remarkable family planning success story that is perhaps unprecedented anywhere in Africa.

More spectacularly, Malawi's contraceptive prevalence rate for modern methods (mCPR) is fairly equitable: mCPR differences between rural and urban areas, across educational levels, and among women in the lowest and highest wealth quintiles are minimal. Given these achievements, family planning program managers are keenly interested in understanding the factors that explain Malawi's spectacular mCPR progress. The questions that are asked include the following: What are the factors that explain the rapid increase in mCPR in Malawi? What explain the reduced growth mCPR in the early 2000s? How was Malawi able to resume the period of accelerated mCPR increase? FP program managers seek answers to these questions in efforts to isolate best practices (or Malawi's secrets of success) so that they can be implemented in similar settings where mCPR progress is slow or has stalled.

In answering the questions, we will focus mostly on programmatic factors that might have contributed to the rapid increase in mCPR. Although scholars have noticed the rapid increase in Malawi's mCPR (Dasgupta et al, 2015, Paramuleni, 2008, 2013, 2014, Solo et al., 2005), the focus of analysis by scholars tends to be on correlates and relationship with fertility levels. Little attention has been paid to FP program contents in the country. A major review on drivers of family planning in Sub-Saharan Africa was conducted by the African Institute for Development Policy (AFIDEP 2012) provides a comprehensive overview of major drivers of the program in selected sub-Saharan African countries, including Malawi (AFIDEP, 2012). The work also contains useful historical markers of family planning in the country.

The current review focuses largely on the work of the US Agency for International Development (USAID), which is by far the largest source of bilateral funding for family planning in the country. About a half of all donor funding for FP in Malawi between 2013 and 2015 came from USAID

(Kaiser, 2016). However, the role of Banja La Msogolo (BLM), UNFPA, DFID and other stakeholders is also acknowledged. Of course, none of the achievements would have been possible without the commitment and support of the Government of Malawi.

Sources of Data

Data sources for this largely descriptive paper include DHS reports for Malawi, DHS Statcompiler (www.statcompiler.com), available programmatic data, published and unpublished reports, and informal discussions with relevant stakeholders in Malawi. Malawi has implemented five standard DHS surveys: in 1992, 2000, 2004, 2010 and 2015-16 – and they are the main sources of information for mCPR trends and covariates in this paper. Other surveys implemented under the DHS program in Malawi, but that are not included in this analysis include the 1996 Knowledge, Attitudes and Practices Health Survey[2], and the 2012, 2014 and 2017 Malaria Indicator Surveys – which contain very limited family planning data. The DHS program also implemented a facility-based Service Provision Assessment (SPA) in Malawi in 2013/14. A SPA does not contain much information that can be used for the purposes of this paper. Information available on the DHS Statcompiler was used to obtain trends in mCPR and its covariates. This information was supplemented with data from USAID program reports and information from gray literature. The term CPR is used interchangeably with contraceptive prevalence rate for modern methods (or mCPR), which refers to the prevalence of modern contraceptive methods among married or in-union women age 15-49. CPR in Malawi is overwhelmingly modern methods – only about 1% of married women of reproductive age rely on traditional methods. Data and results are presented using simple bivariate charts, graphs and tables. Although the data presented in this paper date back to early 1990s, we are aware that family planning program existed in the country before 1992. Some historical timelines for FP in Malawi is presented in Appendix 1.

Trends and Phases in Contraceptive Prevalence Rates

As we trace the trends in mCPR in Malawi from 1992, three phases seem to emerge. They are described in fuller details as follows:

Phase 1: This is roughly period between 1992 and 2000, and it is characterized by the initial rapid increase in modern methods (mCPR) from 7% in 1992 to 26% in 2000 – an increase of more than 350%. If we put that progress in the parlance of the S-Curve stages (FP2020, 2016), it means that Malawi moved from stage 1 to stage 3 within 8 years. That was a remarkable achievement. The main USAID project in FP in Malawi at this period was the Support to AIDS and Family Health

[2] The 1996 KAP Health Survey reported an mCPR of 14.4% among married and in-union women age 15-49. However, its focus was mainly on malaria prevention, childhood immunization, management of childhood illnesses, sexually transmitted diseases, and HIV/AIDS (National Statistical Office and Macro International, 1997).

(STAFH) project. It had a funding ceiling of $45 million and was active between 1992 and 1998. The FP goal of the project was to work toward increasing voluntary family planning prevalence to about 20% by 1998 (USAID, 1992). The story of the initial success of this family planning program has been documented in a report by Solo and her colleagues (2005).

Some of the factors that contributed to that success are highlighted in Table 1 below. For example, the challenges facing the uptake of family planning in the country in the early 1990s included mainly supply-side issues such as insufficient number of service delivery points (SDP), stock-out of commodities at facilities, staffing shortages, restrictive service delivery policies, etc. To combat the challenge of insufficient SDP, the program introduced provided boosters such as giving bicycles to community-based distribution agents and worked with Banja La Msogolo (BLM) to undertake extensive outreaches through its 29 facilities. It also supported pre-service training of FP providers in order to combat FP staffing shortages.

Phase 2: This phase roughly covers the period between 2001 and 2010. It was an era of slow mCPR increase in Malawi and implementation of corrective programmatic actions. Shortly after the release of the Solo et al. (2005) report, the results of the 2004 Malawi Demographic and Health Surveys were released and they showed that the rapid increase in mCPR in Malawi had slowed or stalled – mCPR increased by just two percentage points (from 26.1% in 2000 to 28% in 2004). That led to some self-reflections among family planning program managers within USAID/Malawi as well as among other partners in the country. The conclusion of that introspection was that the slow-down in the pace of mCPR increase between 2000 and 2004 resulted from a combination of factors. First, the initial rapid increase in mCPR was helped by the availability of Depo Provera, which was approved for USAID FP program in 1992. In the 1990s, a large proportion of women with unmet need adopted modern methods (mainly Depo) as soon as they could access them. However, after the low-hanging fruits were reaped, there was a need to expand access to people in rural areas. Since Depo (a clinic-based method) was the mainstay of Malawi's FP method mix, and clinics were not easily accessible to rural residents, a logical solution was to allow Health Surveillance Assistants (HSAs) to dispense Depo in rural areas. For that to happen, Malawi Medical Association had to agree to allow non-medical staff to administer Depo injections. That required a major policy change, and USAID's Health Policy Project (HPP) was brought in to assist. HPP successfully negotiated that policy change in 2008, and HSAs began administering Depo. Consequently, by the time of the next DHS was conducted in 2010, HSAs had been administering Depo for almost 2 years. The results of the 2010 Malawi DHS showed that mCPR had increased to 42.2% - which was more in line with earlier rapid mCPR increase of the 1990s. The result placed Malawi firmly into Stage 4 within the 5-stage S-curve model (FP2020, 2016:17).

Phase 3: The third phase of Malawi's FP success story is the most recent increase in mCPR that occurred between 2010 and 2016 – it increased from 42.2% to 58.1% or about 40% increase within six years! In other words, Malawi moved from stage 4 of the S-curve to stage 5 within six years. That was marvelous. Discussions with family planning program managers at USAID/Malawi

suggest that the increase was related to effects of recent mobile clinic outreach efforts that made quality family planning/reproductive health services available to client in their communities. Within the period, rural mCPR moved 17 percentage points from 40.7% in 2010 to 57.5% in 2016. Thus, by 2016, rural-urban differential in mCPR is negligible (57.5% compared to 61.4%).

The role of funding for family planning: Perhaps funding trends have some role to play in the rapid rise or plateauing of mCPR in Malawi. Overall, it seems that three phases are also apparent in the FP funding trends in the country: the first the phase was characterized by a rapid increase; second was a phase of declining FP funding; and finally another phase of increasing funding levels. Between 1992 and 2000, USAID's average annual funding for family planning in Malawi was about $3.4 million (see Figure 2). Within the first five years, FP funding increased from a low of $1.3 million in 1992 to a peak of $6.5 million in 1996. After that peak funding level, FP funding declined consistently for the next five years, reaching a low of $2.3 million in 2001, where it plateaued for the next two years. In the period between 2001 and 2005, the average annual funding for FP in Malawi was $2.9 million. This was lower than the average of $3.4million/year between 1992 and 2000. Thus, if funding translated into availability of resources for programming, it was understandable if access to FP services slowed down and mCPR also rate of increase also slowed down as observed between 2000 and 2004 in Malawi. Between 2006 and 2010, the average annual funding level for FP in Malawi was $7.1 million – which was more than double the average annual funding between 2001 and 2005. Between 2011 and 2015, the average annual FP funding in Malawi was $21.5 million – which is over $5 million per year in funding above the funding in the period 2006-2010. Of course, there is result to show for it.

Of course, the number of women of reproductive age increased in Malawi from 2.2 million in 1992 to 4.2 million in 2015 (UN Population Division, 2017). The annual USAID funding in US$ for FP per woman of reproductive age (WRA) in Malawi is presented in Figure 3 and it shows a rapid increase in the early to mid-1990s – almost a fivefold increase between 1992 (60 cents per WRA) and 1996 ($2.90 per WRA). It then declined to about 80 cents per WRA in 2003 before increasing yearly again – reaching a peak of $3.40 per WRA in 2012. The shape of the graph in Figure 2 is somewhat similar to that of Figure 3 but the relative heights differ. Although a decline in funding does not automatically translate to a comparative decline in mCPR, a prolonged decline in funding tends to temper the increase in mCPR. Of course, we do not have yearly measures of contraceptive prevalence.

Overall, how much has USAID spent on family planning program in Malawi since 1992? The trends in FP funds spent on Malawi programs and activities are presented in Figure 2. It shows that USAID funding for FP increased from about $1.3 million in 1992 to $6.5 million in 1996. It then declined to about $2.3 million in 2001 and plateaued at that low level until 2003. It gradually increased from 2004 until it reached $12.7 million in 2011. It has stayed at that high level ever since. Altogether, USAID spent a total of about $168.2 million on family planning in the country

since 1992. Although USAID remains the lead donor for family planning in Malawi, it is obvious that results such as this cannot be attributed to the efforts of only one organization. Credits have to be shared key players in the family planning sector in Malawi – UNFPA, DFID, BLM, etcc. Of course, none of these achievements could have been possible without the leadership and support of the Government of Malawi.

Other elements of the success story

Success in achieving equitable access: Another aspect of the success in FP in Malawi is that the country has managed to provide equitable access to FP services to clients across various segments of the population (see Figure 4). In a sense, the FP program has made tremendous progress towards leaving no one behind. For example, in 1992, urban mCPR was almost three times that in rural areas (17.2% vs. 6%). By 2016, rural mCPR had increased to 57.5% - almost a tenfold increase in 24 years! A similar story could be told using the wealth quintile differentials in mCPR in the country. In 1992, mCPR among women in the richest (5^{th}) quintile was more than four times among the poorest (1^{st}) quintile (17.2% vs. 3.9%). Over the next 24 years, mCPR among the poorest quintile had increased almost fourteen-fold to 53.2% while the rate among the top quintile increased 3.5 times to 60.6%. A similar "closing-the-gap" story could be told by looking at mCPR differentials by women's educational attainment. This is an uncommon success indeed. The regional distribution in FP increase was fairly equitable as well (Figure 5). In 1992, Central Region had an mCPR of 8.2%, which increased eight-fold to 63.1% in 2015-16. Similarly, mCPR increased about eight-fold in Southern region (from 6.8% in 1992 to 54.4% in 2015-16). The gap between the region with the highest mCPR and one with the lowest mCPR remained almost constant at 20% in the 24 year period. This looks very good when you compare to a country such as Nigeria where the mCPR gap between the region with the highest (Southwest) and one with the lowest widened from 7.7:1 in 2003 to 9:1 in 2013.

Increased mCPR among adolescents: The program has also achieved great success in modern method adoption among currently married adolescents (Figure 6). Between 1992 and 2015/16, mCPR increased eleven-fold among this group. When one expands the denominator to all women age 15-19, mCPR still increased more than eight-fold (from 1.8% in 1992 to 15.2% in 2015/16). To appreciate how rapid the progress was in Malawi, let us compare it to what happened in Kenya: mCPR among all women age 15-19 increased four-fold in the country between 1993 and 2014 (from 2.4% to 9.3%) and it increased six-fold among married adolescents (from 6.1% in 1993 to 36.8% in 2014).

Long-Acting and Permanent Methods (LAPM) Uptake: Malawi has made tremendous progress in increased uptake of LAPM over the years – especially sterilization (see Figure 7). Discussions with the mission program managers suggest that this success was due in part to extensive outreach

programs that met the needs of women who would have otherwise had no access to safe implants and sterilization.

In summary, factors that have been important in explaining the meteoric rise in mCPR in Malawi include: political commitment and favorable policy changes by the government, task-shifting and expanded availability of contraceptives through community-focused initiatives. Such initiatives include the use of HSAs and community-based distribution of contraceptives. There is also the prolonged advocacy that linked FP to child spacing, maternal health, reproductive health, etc. This initial efforts enabled women to perceive injectables and other modern contraceptive methods as beneficial to maternal and child health. Fertility control was not the primary reason for use. That was probably a reason for the weak link between the meteoric increase in mCPR and fertility levels in Malawi.

Are there challenges that remain?

It is true that Malawi has made stellar progress in mCPR increase. However, many challenges remain, and the success that has been recorded still faces numerous vulnerabilities that need to be addressed.

- Malawi is a resource-poor setting and the country's health program relies heavily on donor support. The GDP per capita is only about $380, making Malawi one of the lowest income countries. Sustaining the success that has been achieved requires continued support until the country is able to do it all on its own. Moreover, past experience in the country shows that attempts to introduce user-fees would lead to a rapid decline in the number of FP users in the country. For example, when user-fees were increased in 2000 and BLM stopped subsidizing FP services, and the number of its clients dropped by 46% -- from 175,000 in 1999 to 94,000 in 2001. When BLM restored subsidy in 2002, the number of FP clients jumped to 370% about 350 in 2003.
- The country has a very high annual population growth rate (2.9%) and a huge momentum for future growth. This is because it has very large cohorts of children under age 15, and larger and larger cohorts will be entering the reproductive ages for decades to come. The median age is only about 17 years, which means that 50% of the population is below age 18. There is therefore an upcoming youth bulge challenge. Larger cohorts entering reproductive age means that the FP program will be serving larger cohorts every year -- even just to maintain the current level of mCPR.
- There continues to be a mismatch between mCPR and TFR. Although the country has witnessed a meteoric increase in mCPR, its TFR has not declined as rapidly as expected (see Figure 8 below). It used to be the rule of the thumb that for every 15/16 percentage point increase in mCPR, we expect a drop of 1 child in TFR. Thus, the more than 50 percentage point increase in mCPR in Malawi since 1992 should have led to a decline of more than 3 in

TFR. So, TFR should be below 4 by now. Many countries have achieved TFR below 3 with the same level of mCPR.

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Table 1: Some of the programmatic responses to problems facing the Malawi family planning program in the 1990s

Problem	What was done to address it
1. Insufficient number of Service Delivery Points	• BLM provided extensive outreach services through its 29 facilities • Expansion of and provision of incentives (e.g. bicycles) to Community-Based Distribution Agents
2. Lack of commodities at facilities	• Expansion of contraceptive commodity distribution through Contraceptive Distribution Logistics Management Info System
3. Staffing shortages	• Expansion of in-service and pre-service training of FP providers
4. Restrictive policies for accessing services	• Adoption of the 1992 Child Spacing and Contraceptive Guidelines - it removed restrictions on age and parity, and husband's consent for FP service • Expansion of FP service provision to 5 days per week
5. Knowledge barriers	• Extensive multiple channels of communication about FP and in multiple languages: radio jingles, posters, dramas, health talks, etc. Population education in schools.
6. Cost and poverty barriers	• FP services and commodities were provided free

Compiled from Solo et al. (2005) report, and USAID (1992)

Figure 1: Trends in contraceptive prevalence rates for modern methods: Malawi 1992-2015/16

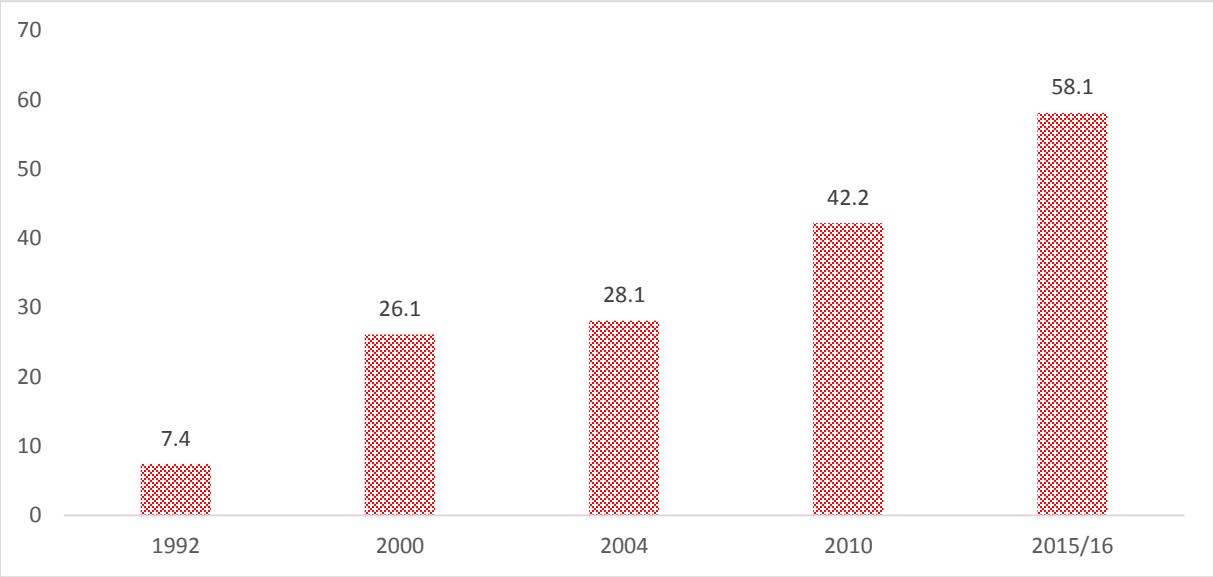


Figure 2: Trends in USAID Funding for Family Planning in Malawi ($millions, 1992-2017)

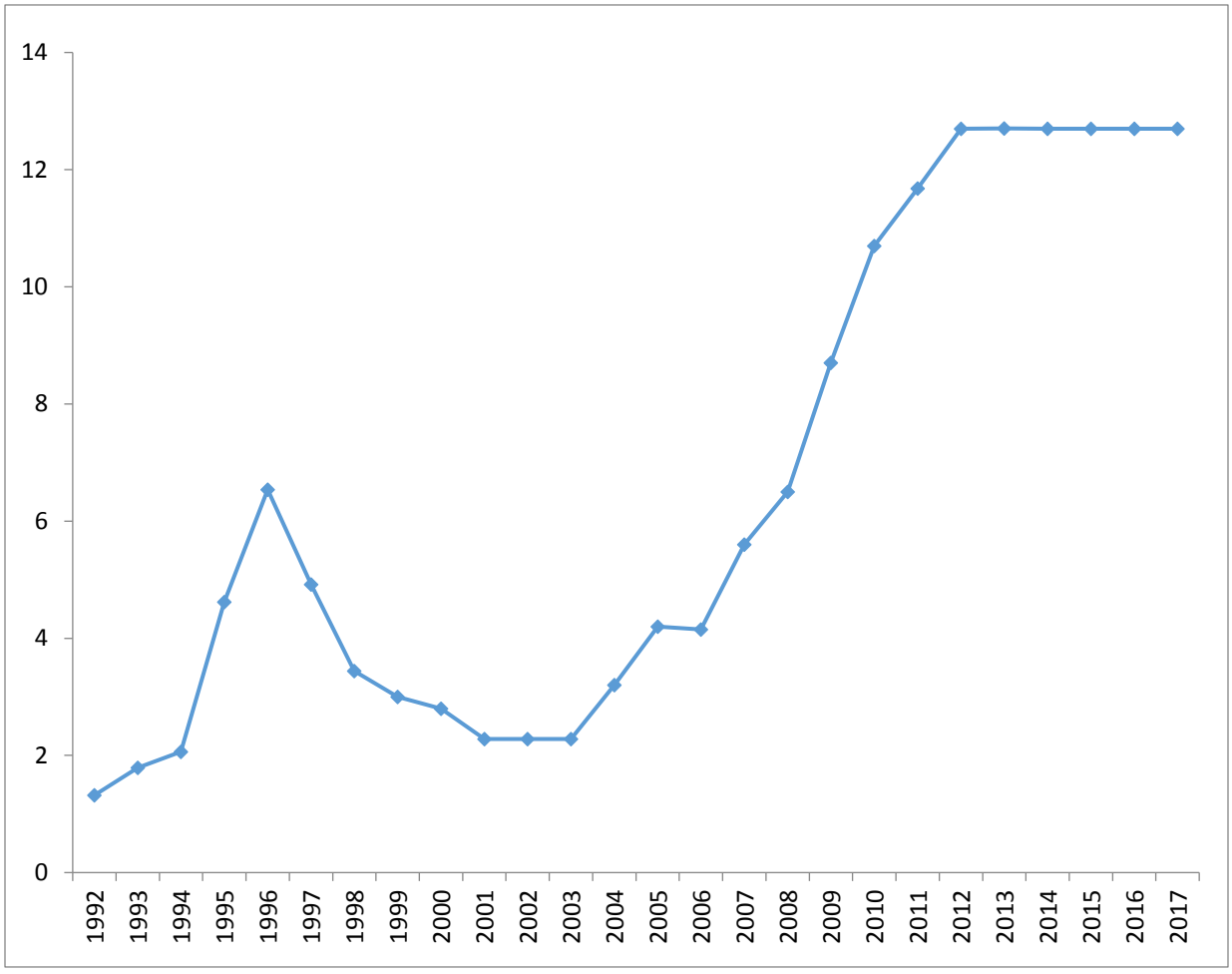


Figure 3: USAID Family Planning Funding (US$) per Woman Age 15-49 in Malawi (1992-2015)

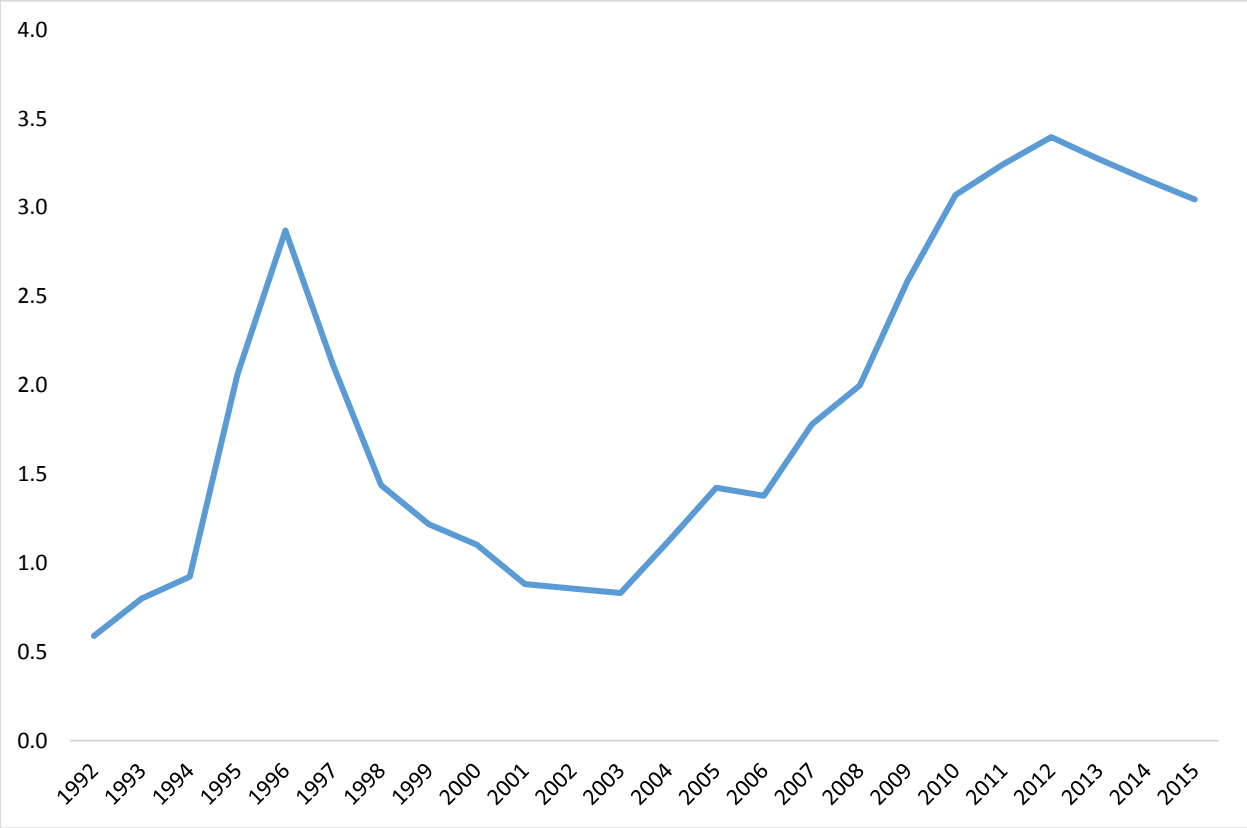


Figure 4: MCPR differentials between the rich and poor, educated and uneducated, and urban and rural women in Malawi (1992 compared to 2015/16)

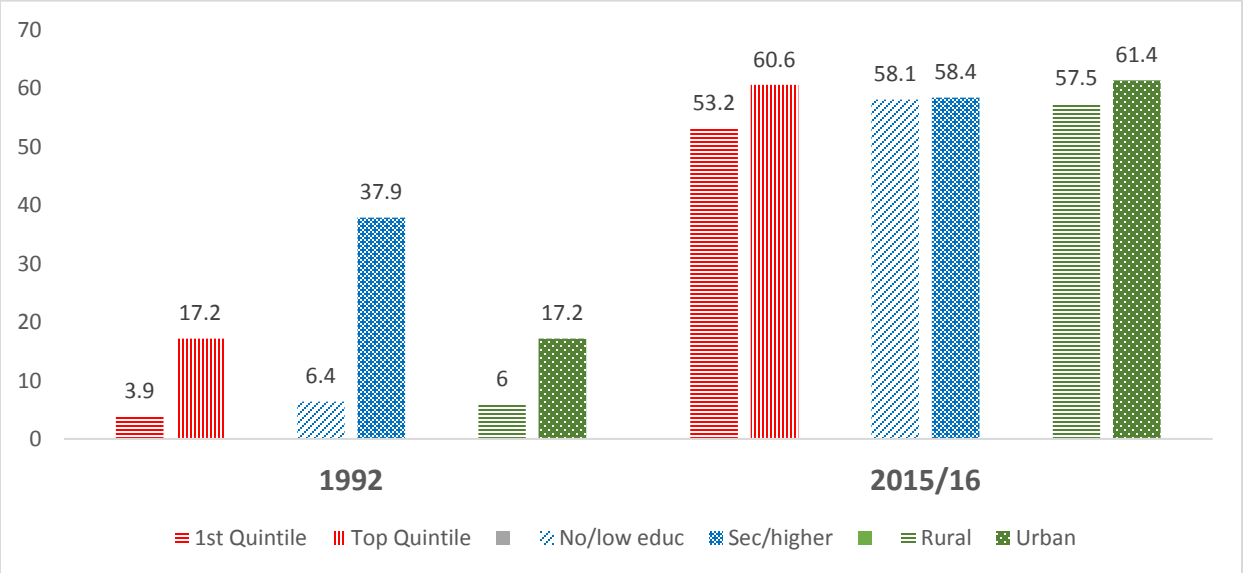


Figure 5: Trends in mCPR in Malawi Regions (1992-2015/16)

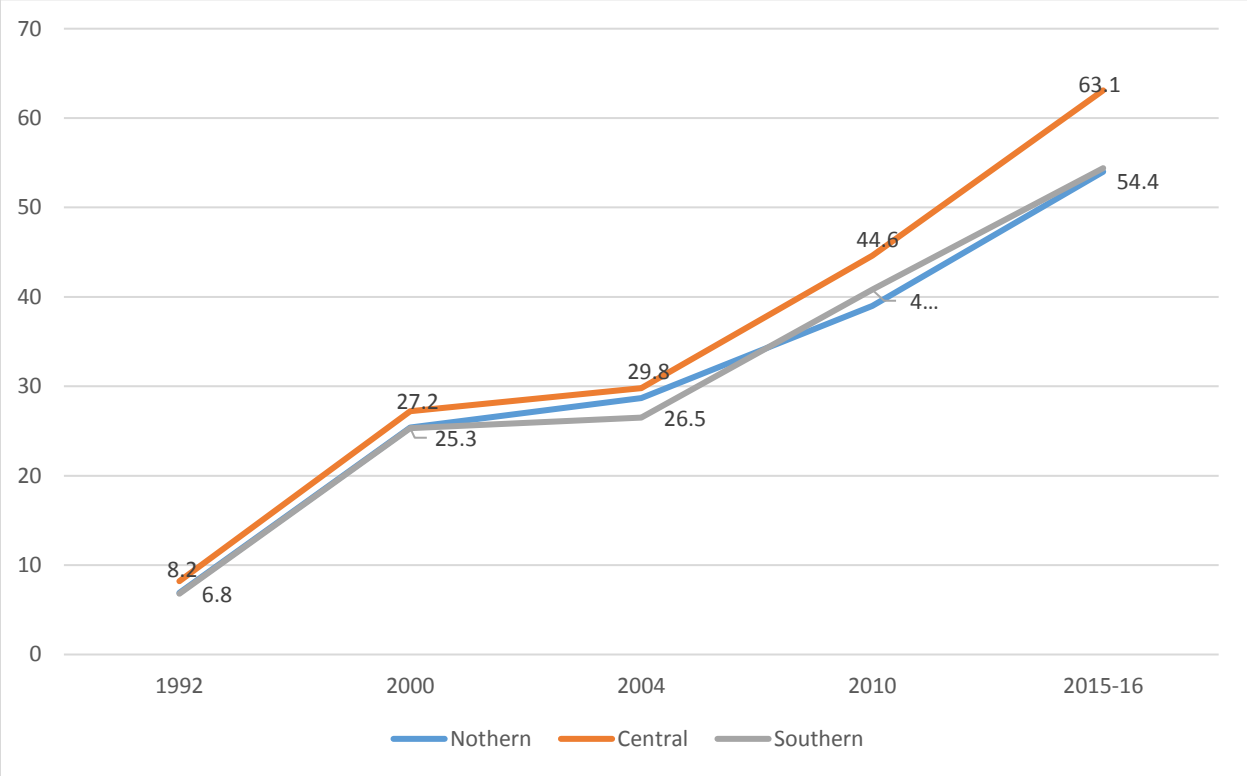


Figure 6: Trends in mCPR among married compared to all women age 15-19 in Malawi

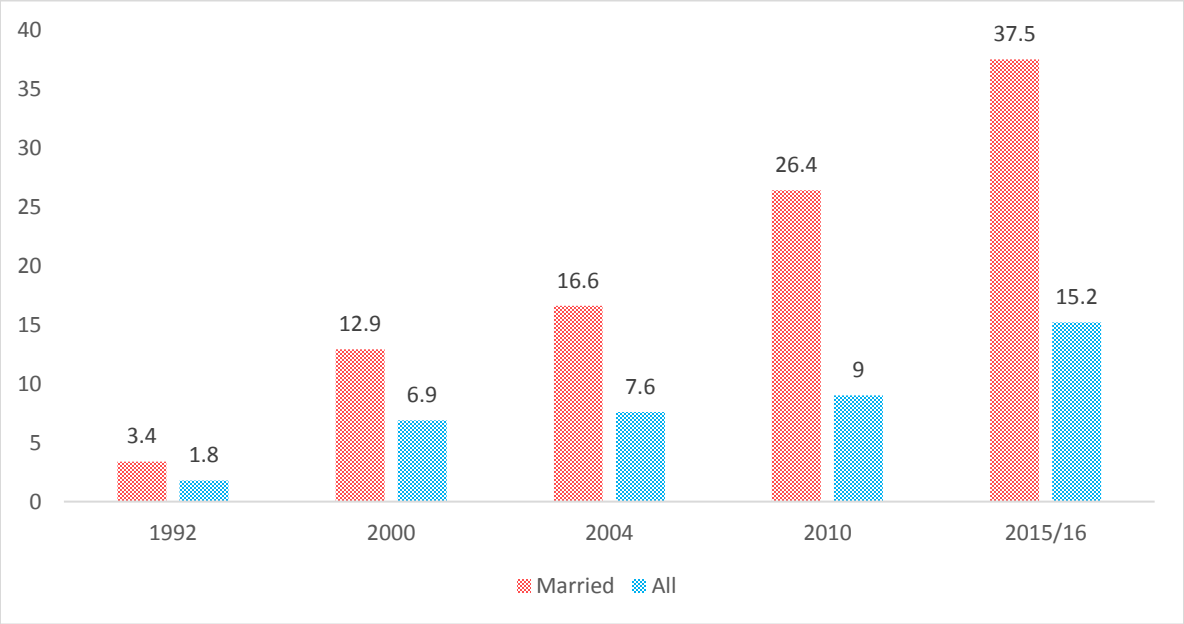
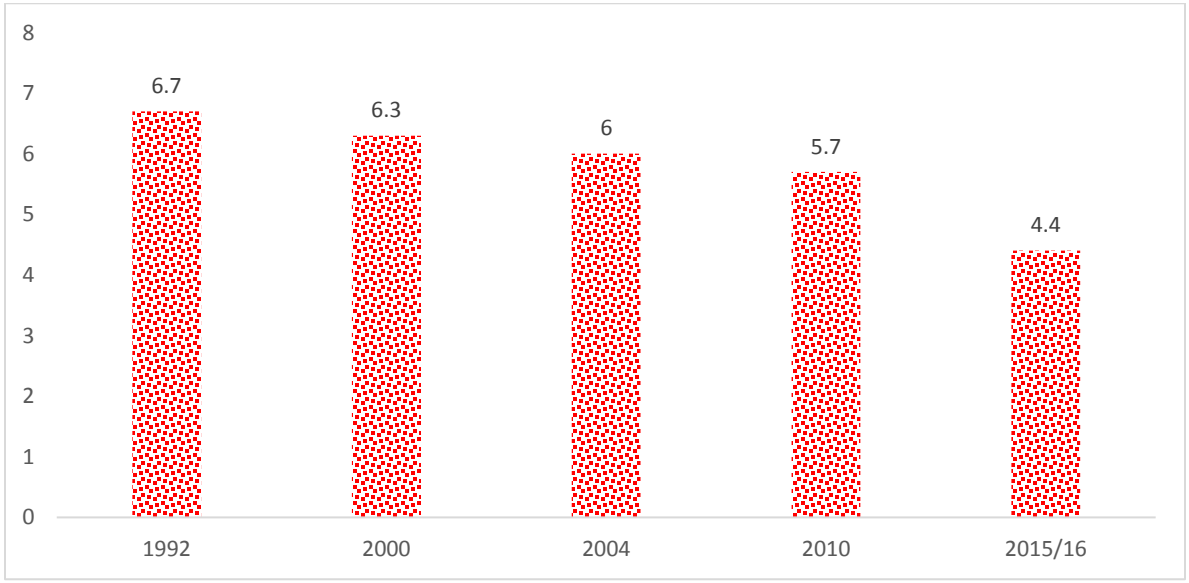


Figure 7: Trends in the Prevalence of Sterilization in Malawi

Figure 8: Trends in Total Fertility Rates, Malawi 1992-2015/16



APPENDIX I

Important Dates in Recent Family Planning History in Malawi

1982 Introduction of the Child Spacing Program as part of MCH. Modern child spacing (FP) methods became available in Malawi.

1983 TFR = 7.6 (the same TFR that was in the 1977 Census). Government's perception of fertility level is "Satisfactory".

1984 MCPR was 1.1% (with an estimated number of users at 3,000) obtained by the 1984 Family Formation Survey (USAID, 1992). The survey also found that 60% of non-pregnant women wanted to space or stop childbearing.

1987 Statement of Development Policies for 1987-1996 was released. It was the first official document in Malawi to recognize that the country's high population growth rate has a direct and immediate effect on the provision of economic and social service, and it mandated that an explicit population policy should be formulated before 1996.

- Malawi 1987 census is conducted. Its estimated TFR is 7.4.
- Banja la Mtsogolo (BLM) is established, with one clinic.

1989 Population and Human Resources Development Unit was created. Its mandate was to coordinate all population-related activities in the country and to integrate population variables into development planning.

1990 National Family Welfare Council of Malawi was established though and Act of Parliament with a mandate to advocate for, and provide support to the implementation of FP activities in the country. It was the first time that the government had supported such activities in the country.

1991 Principal Secretaries' Policy Recommendations were issued stating that the Malawi should develop its first explicit population policy and that Malawi should liberalize the delivery of and access to child spacing services

1991 The Christian Health Association of Malawi (CHAM) community-based distribution (CBD) projects begins.

- Social marketing of condoms begins
- MCPR increased to 3%

1992 *Child Spacing Policy and Contraceptive Guidelines* (1st edition) are published

- Child spacing policy and contraceptive guidelines were liberalized
- The 1st DHS in Malawi was completed and it puts MCPR at 7.4% with a TFR of 6.7

1992 USAID launched the Support to AIDS and Family Health (STAFH) project with a ceiling of $45 million.

1992 Food and Drug Administration (US) approved the use of DMPA. USAID began purchasing DMPA for programming in USAID-assisted countries – including Malawi.

1994 The first comprehensive population policy was adopted by the government with strategies for improving the quality of life through family planning and reproductive health programs and free universal education.

1994 A Presidential directive was issued to transfer the function of coordinating population activities from the Ministry of Economic Planning and Development to the Ministry of Health, and the name of MOH was changed to Ministry of Health and Population

1995 Advocacy workshop on population and sustainable development was held for parliamentarians and cabinet ministers.

1996 Second edition of *Family Planning Policy and Contraceptive Guidelines* is published.
- CPR: 14%. USAID funding for FP increased to $6.5m – a level that was not matched again until 2008.
- Injectables, which hitherto were available by prescription to women with at least four children became available to all women of reproductive age (AFIDEP, 2012)

1997 The Family Health Unit is reformed into the Reproductive Health Unit (RHU).
- STAFH Project is amended and extended until 2001.
- Contraceptive Distribution Logistics Management Information System (CDLMIS) is introduced.

1998 CBD agent training manuals and guidelines are developed.

2000 DHS results show that mCPR is 26%. TFR = 6.3

2004 Health Sector-wide Approach (SWAp) was initiated that pooled funding for the Essential Health Package, which promoted integrated programming that included FP. USAID and UN Agencies that did not participate in SWAp provided additional FP funding.

DHS results show that mCPR was 28%. TFR was 6.0.

2005 Emergency Human Resource Program was launched by DFID and focused on

2008 Malawi approved HSAs to give injectable contraceptives. Release of the Community Based Injectable Contraceptive Services Guidelines

2010 Malawi 2010 DHS found an mCPR of 42.2% among currently married women age 15-49. TFR was 5.7.

2011 Outreach to religious leaders, including in-depth and focus group discussions on health and child-spacing benefits of family planning among Muslim leaders in areas with low contraceptive prevalence (AFIDEP, 2012:60).

2012 USAID-funded Capacity-Plus Project worked with CHAM to strengthen human resource management.

2015-16 DHS results show mCPR is 58.1%, TFR declines to 4.4. FP demand satisfied with modern methods climbs to about 75% from 58% in 2010 and 15% in 1992.

APPENDIX

Figure 1A: MCPR Trends in Kenya and Malawi (1984-2015)