

# Findings

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## Population and Family Planning: Lessons from Malawi

*The objective of the Population and Family Planning (FP) Project, a Learning and Innovation Loan (LIL), was to test the feasibility of a comprehensive and district-wide Community Based Distribution (CBD) approach to Population and Family Planning Services in three districts, thereby increasing the Contraceptive Prevalence Rate (CPR) for modern methods.*

*Rigorous testing of the hypothesis was ensured in the design by selecting control districts and using the same instruments to collect both the baseline and end of project data. The three rural pilot districts – Chitipa, Ntchisi and Chiradzulu, represented the three main regions of North, South and Central Malawi and were adjacent to the control ones with which they shared comparable socio-demographic characteristics such as household composition (female headship and number of residents), environmental exposure (water sources, latrines) and backgrounds of respondents (age, education, marital status).*

### Impact on the ground

- The increases in CPR recorded by the project are quite unprecedented in Sub-Saharan Africa.. Also, the pilot districts recorded impressive gains in spite of their physical proximity to the control districts, which led to a significant spillover of benefits.
- The three ‘legs of the stool’ – IEC, Community-based distribution and Clinical support came together seamlessly to meet the objectives of the project.

### **Information, Education and Communication (IEC) was a major factor in the success of the project.**

- The project developed and distributed printed IEC materials to all communities in the pilot districts. The demand for IEC materials was much higher than anticipated.
- The project procured 172 radio cassettes for use by the community based district agents (CBDAs) - the messages were in local languages A popular twenty minute program on reproductive health (RH)/FP was also aired on the national radio twice every week. The end project survey confirmed that listenership was equally strong in the control districts which could have contributed to improvement in knowledge, attitudes and practices (KAP) recorded in those areas too.
- Youth clubs and training of peer educators targeted adolescents who formed their own drama groups (15 groups with a total of 150 members). District IEC fairs and campaigns were very useful for mass mobilization and youth sensitization and were well attended, especially by men and youth.

**Under the *community based distribution of contraceptives* component, a total of 172 CBDAs were recruited and 166 retained (retention rate of 97%). This exceeded the original target of 100 CBDAs and a retention rate of 80%.**

- The number of clients served ranged from 300 to 600 per CBDA. CPR increased by 12% in pilot districts and by only 6% in the controls. The increase was much higher (more than 100%) when total eligible female populations only in villages covered by CBDAs are considered.
- There is strong evidence that CBDAs made a significant contribution to change in the pilot districts. In 1999, the proportion of users who reported CBDAs as their source of contraception was only 1 per cent in both the pilot and control districts. The end project survey showed that while this percentage had remained the same in the control districts, it had increased to 24% in the pilot districts. This was accompanied by a significant shift from traditional to modern methods in the pilot districts. In addition, the proportion of young women aged 15-19 in pilot districts who had used contraception at zero parity almost doubled between 1999-2003 (from 11 to 21 per cent compared to a three per cent rise in the controls). The percentage of non-users who were not contacted by a CBDA and not counseled at a health facility declined from 67 to 57 per cent in pilot districts. In contrast, this proportion actually increased from 67 to 71 per cent in control districts, further confirming that CBDAs were important players in the pilot districts.
- Static health facilities continued to be the main source of FP services in both control and pilot districts. A significant divergence was, however, observed. While in control districts, the proportion of clients receiving FP services through static clinics increased ( from 92% to 95% ) , it dropped significantly in the pilot districts from 94% to 75%. This was because the CBDAs were effectively delivering the services in the pilot areas and thus reducing the workload of the static facilities
- A total of 99 health workers were trained in syndromic management and adequate quantities of STI drugs were supplied in two batches.
- Youth Friendly Health Services (YFHS) were established in several clinics with outreach services linked to several Youth Clubs. Staff from these clinics were trained in YFHS and backed the 65 peer educators and the 30 Youth CBDAs working in the community. The end project survey confirmed that the proportion of youth (15-19 years) using modern contraceptive methods had doubled from 11 to 21 per cent. The Ministry is using lessons from the LIL to reorganize adolescent reproductive health with support from DFID and UNFPA.

***Training courses covered both technical and management issues – IEC/mobilization, Logistics and health management information systems (HMIS), FP, infection control, post-abortion care (PAC), adolescent reproductive health (ARH)/peer education and transport management. They included:***

- (a) training of Project Implementation Team on management
- (b) training of 172 CBDAs (64 in Chitipa, 54 in Ntchisi and 54 in Chiradzulu)
- (c) 270 HSAs trained in FP/RH in preparation for new responsibilities in FP service provision and supervision of CBDAs
- (d) 78 health workers trained in Contraceptive Distribution Logistics and Management Information System (CDLMIS)
- (e) 320 traditional and religious leaders trained in leadership for RH
- (f) 65 peer educators trained to strengthen the youth component of the project

**The project invested heavily on *monitoring* and support supervision. The main outputs of the **Monitoring and Evaluation** component are:**

- (a) a baseline survey report

- (b) support supervision
- (c) field visit reports
- (d) Mid term review report
- (e) Computerized data collection system
- (f) End of project survey report.

Lessons from this project have already been assimilated by the MoHP and are leading to several policy changes. First, the ministry is putting greater emphasis on community level activities. Second, PAC services at the district hospital are being provided by clinical officers and discussions are going to decentralize the services further to the nurse or medical assistant at the health center. The MoHP has seen the benefits of working closely with the Social Action Fund (MASAF III) project to increase access while reducing the cost of the service to both clients and the government.

### **Lessons learned**

- Rapid increase in contraceptive prevalence is possible in rural Africa through community based distributors. Over a three year period, CPR grew to a level that according to MoHP projections, would have only been reached in 2012.
- The large unmet need for family planning can be addressed through innovative primary care approaches that expand access to quality services using community based workers. The study further confirms the importance of linking community based services with clinical back up that allows efficient referral of cases that are beyond the village health worker.
- Effective community mobilization through IEC and support supervision, rather than mere financial incentives, is the backbone of a successful CBD program. The messages were formulated with the full participation of communities and target groups and succeeded in raising the interest and level of participation of men and the youth in a culturally sensitive way. By doing this, the project did not arouse any opposition from cultural or religious groups. This is an important lesson for reproductive health programs and the healthcare sector.
- The strong support supervision process set by the project was another reason for its success and an important lesson to be noted. The process facilitated feedback between the project management team and the CBDAs which made each provider know that his/her contribution did matter.
- Sustainability of CBD is possible but requires careful planning. Most failed CBD projects have been characterized by big promises made by NGOs and the inability to discuss sustainability with the community at entry. Charting a realistic exit strategy allows informed community participation and preparation for eventual ownership.
- The important lesson is that the problem of sustainability is not insurmountable and has to be designed to fit the peculiarities of each community. Training, sustainable supply of commodities, data collection and support supervision are core responsibilities of the government. Additional support to CBDAs such as incentives can be delegated to communities, many of whom have traditional means of compensating communal work. Communities, when fully briefed and given room to decide, have the ability to design their own compensatory mechanisms.

*This Infobrief was excerpted by Siddhartha Prakash, Africa Region, World Bank, from Implementation Completion Report No. 27059. For more information, e-mail [rgovindaraj@worldbank.org](mailto:rgovindaraj@worldbank.org).*

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