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COMMUNITY-BASED DISTRIBUTION OF INJECTABLE CONTRACEPTIVES IN MALAWI

APRIL 2009

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.

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EXECUTIVE SUMMARY

Background

This report presents research findings on the potential for making contraceptives, and in particular injectable contraceptives, widely available through using a community-based distribution (CBD) approach. The USAID | Health Policy Initiative, Task Order 1, conducted the research, which in part influenced the Malawi Ministry of Health's (MOH) recent decision to allow paraprofessionals to provide injectable contraceptives. The research included the following key activities:

- Interviews with policymakers and other individuals at the national level regarding the feasibility of CBD of injectable contraceptives by paraprofessionals and the steps necessary for program implementation.
- Focus group discussions (FGDs) with district- and community-based stakeholders to understand provider and community member beliefs and opinions on the community-based provision of injectable contraceptives by paraprofessionals.
- A stakeholder meeting to disseminate the research findings and enable national family planning (FP) experts to build consensus for scaling up a CBD program in Malawi.

Throughout Africa, the popularity and demand for injectable contraceptives have increased dramatically over the past decade. According to the 2004 Malawi Demographic and Health Survey (DHS), three in five (64%) of currently married women using modern contraceptives had chosen injectable contraceptives. Yet, unmet need for FP services and injectable contraceptives persists, particularly in rural areas where women must travel long distances to reach health centers for these services. One of the fastest ways to increase access to family planning is to expand the cadre of providers authorized to provide contraceptives through CBD.

Despite Malawi's network of health centers at the community level, access to these centers is problematic for the predominantly rural population; there are often physical obstacles to overcome, such as the rugged terrain and impassable routes in the rainy season. Even when a community resident reaches a health center, the center is likely to be understaffed and lacking basic supplies and medicines. Ease in accessing health services must also be assessed in terms of time spent away from household duties, traveling to and waiting for health services, and of out-of-pocket expenses for healthcare and transportation.

To provide FP services at the community level, the government of Malawi could consider two potential cadres: health surveillance assistants (HSAs) and community-based distribution agents (CBDAs). HSAs can be either male or female and are the lowest level of civil servant in the public health system. They are based in communities and work in mobile or outreach clinics, village clinics, or health posts; and assist with implementing Malawi's Essential Health Package. CBDAs are male and female volunteers selected by and based in their communities to provide FP counseling, oral contraceptives, and condoms.

Feasibility Study Findings

The Health Policy Initiative research team interviewed 35 stakeholders at the national level, representing 16 public and private sector organizations. In general, when commenting on which cadre of health worker might provide injectable contraceptives at the community level, the stakeholders said that HSAs in Malawi perform well but they can be overloaded with tasks and inadequately supervised. Most stakeholders agreed on the need for in-service training, in addition to an implementation plan for the long-term development of HSAs, with provisions for their supervision and regulation.

The research team identified seven target groups of providers and community members for FGDs in six districts. The provider sample included (1) district health management teams (DHMTs); (2) district-level FP providers; and (3) health providers in health centers and communities (nurses, medical assistants, clinical officers, HSAs, and CBDAs). The community members included (1) district-level FP users; (2) adult males in the community; (3) adult females in the community; and (4) village leaders (chiefs, village health committee members, religious leaders, members of community-based organizations). The team conducted 40 FGDs with a total of 152 participants.

The following are key findings from the discussions:

- Only one of the 18 community participant focus groups reported having access to injectable contraceptives in its area through monthly outreach clinics; however, participants also said that the clinics were very unreliable.
- In two of the six districts, providers stated that the monthly outreach clinics were very or mostly reliable. In the other four districts, providers said that the outreach clinics were not reliable.
- Community participants mainly attributed unreliability of injectable contraceptive access to transport problems and a lack of FP nurses to cover both hospital and outreach clinics.
- Most community and provider participants agreed on the need to provide injectable contraceptives within communities.
- When the study team asked the focus group participants who should provide injectable contraceptives at village clinics, the majority of the DHMTs, district FP nurses, HSAs, FP user and women's participant groups stated HSAs.

Ministry of Health Decision to Allow HSAs to Provide Injectable Contraceptives

Although the research findings demonstrate that it is feasible for HSAs to provide injectable contraceptives in the community, the decision to allow them to do so has nevertheless met considerable opposition from the professional medical community. After years of debate, on March 14, 2008, the MOH's Senior Management Committee agreed by consensus to allow HSAs to administer injectable contraceptives at the community level, with the understanding that the ministry should first pilot the approach in several districts.

Following the ministry's decision, the MOH Reproductive Health Unit, in collaboration with the Health Policy Initiative, organized a stakeholders meeting around the theme "The Way Forward: Malawi's Road to Community-Based Distribution of Depot Medroxyprogesterone Acetate (DMPA)." Held July 15, 2008, the purpose of the meeting was to share findings of the Health Policy Initiative's research, disseminate the research, discuss insights from the ministry's study tour to Madagascar, and build consensus on how to implement the provision of injectable contraceptives by paraprofessionals.

After this meeting, the MOH Reproductive Health Unit began working with the USAID Community-Based Family Planning and HIV/AIDS Services Project to draft guidelines for HSA provision of injectable contraceptives at the community level. The guidelines focus on the core areas of training, integration of family planning and HIV, service delivery, monitoring and supervision, quality assurance, and logistics management.

Conclusion

An effective policymaking and implementation process is the foundation of scalable and sustainable health programs; Malawi's experience clearly demonstrates the importance of research, advocacy, high-level policy decisionmaking, and the development of operational policy and guidelines. The practical

experience in those districts that had allowed HSAs to provide injectable contraceptives at the community level was helpful in demonstrating the flexibility of this approach. The director of the MOH Reproductive Health Unit was a skillful advocate, using research and data to make a compelling case for persuading senior-level MOH decisionmakers to take action. By raising the issue and interviewing national-level stakeholders, the Health Policy Initiative served as a catalyst for discussions about CBD and raised the profile of the issue in the months leading up to the MOH's decision in March.

ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
BLM	Banjo La Mtsogolo (local NGO)
CBD	community-based distribution
CDA	community development agent
CBDA	Community-based Distribution Agent
CHN	Community Health Nurse
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DMPA	Depot Medroxyprogesterone Acetate (Depo-Provera)
FGD	focus group discussion
FP	family planning
HBC	home-based care
HIV	human immunodeficiency virus
HSA	Health Surveillance Assistant
IC	injectable contraceptive
IEC	information, education, and communication
MOH	Ministry of Health
OC	oral contraceptive
NGO	nongovernmental organization
NSO	National Statistical Office
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

I. INTRODUCTION

In 2007, at the request of the USAID Mission in Malawi, the Health Policy Initiative, Task Order 1, assessed the feasibility and acceptability of providing contraceptives—injectable contraceptives, in particular—at the community level in a non-medical setting. Malawi’s National Reproductive Health Strategy for 2006–2010 aims to decrease the total fertility rate from the 2004 estimate of 6.3 children per woman to 4.9 by 2010. The strategy also aims to increase modern contraception use from 28 percent of married women ages 15–49 in 2004 to 40.6 percent in 2010. To meet these goals, the Ministry of Health (MOH) seeks to expand access to family planning (FP) services and information, especially in rural areas.

This report summarizes research findings and policy dialogue regarding the feasibility of making contraceptives widely available through community-based distribution (CBD). The Health Policy Initiative conducted this research, which in part influenced the ministry’s decision in 2008 to allow paraprofessionals to provide injectable contraceptives at the community level. In collaboration with the project, the MOH Reproductive Health Unit organized a stakeholders meeting to disseminate the research findings and encourage dialogue among national FP experts to build consensus for paraprofessional provision of injectable contraceptives.

The following sections offer an in-depth understanding of the current preferences, opportunities, potential barriers, and next steps in implementing a national CBD program to provide injectable contraceptives in Malawi.

II. BACKGROUND

Malawi is one of the fastest growing countries in Africa, with an annual population growth rate of 3.2 percent (Haub and Kent, 2008). It also ranks among the poorest countries in the region, with a per capita gross national income in purchasing power parity of US\$750 (in 2007). Eighty-three percent of Malawi’s population lives in rural areas. Reflecting past population growth, almost half (46%) of Malawians are under the age of 15. Malnutrition is high, with 35 percent of all Malawians classified as malnourished as of 2000–2004. As of 2007, an estimated 12 percent of people ages 15–49 were living with HIV/AIDS. These factors all challenge efforts to raise the standard of living and improve the quality of life.

The government of Malawi is committed to making health services more accessible, especially to the rural poor. Most rural residents depend solely on community-level health centers for healthcare. However, because of Malawi’s severe shortage of health professionals, these health centers are often understaffed. Also, basic supplies and drugs may not be available. People living in rural areas may travel long distances to the health center and still not receive needed health services. Accordingly, more than half of primary healthcare in Malawi is provided by community-based paraprofessionals.

In this context, provision of reproductive health (RH) services in the community can help to improve women’s health and help couples to meet their reproductive needs. Many Malawian women would like to limit or space births but lack the necessary FP services and information.

Throughout Africa, the demand for injectable contraceptives has increased dramatically over the past decade. According to the 2004 Malawi Demographic and Health Survey (DHS), three in five (64%) of currently married women who were using modern contraceptives had chosen injectable contraceptives. Yet, unmet need for FP services persists, particularly in rural areas where women must travel long distances to reach health centers. One of the fastest ways to increase access to family planning, especially at the rural level, is to expand the cadre of providers authorized to provide contraceptives through CBD.

High Unmet Need for Family Planning Services

Contraceptive use appears to be rising in Malawi, based on a 2006 UNICEF-funded survey. The 2004 DHS reported that 28 percent of Malawian married women ages 15–49 were using a modern method of contraception—only slightly higher than the 26 percent modern method use found in the 2000 DHS (Malawi NSO and ORC Macro, 2005). Using different sampling methods, the 2006 Multiple Indicator Cluster Survey (MICS) reported modern method use at 38 percent (Malawi NSO and UNICEF, 2008). Paradoxically, the 2006 MICS reported higher fertility than the 2004 DHS, with a total fertility rate of 6.3 children per woman compared with 6.0. These differences will be clarified when the results of the 2009 DHS are available.

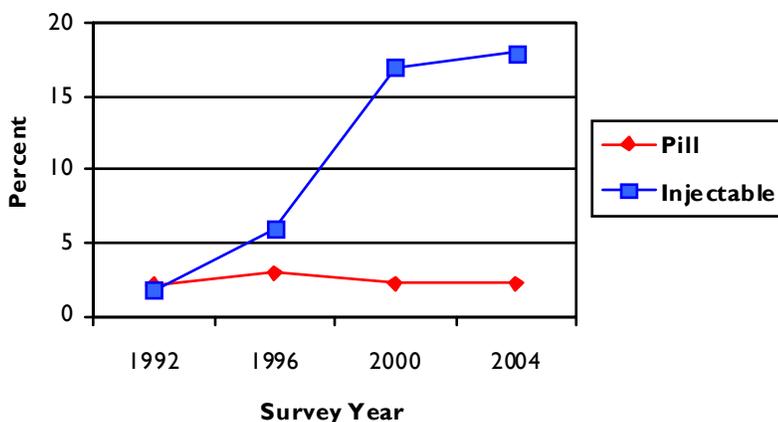
One key finding of the 2004 DHS is that more than one in four (28%) currently married women ages 15–49 has an unmet need for FP services. Women with an unmet need for family planning are those who do not want to have any more children or want to wait two or more years before having another child but are not currently using a contraceptive method. Unmet need is higher in rural areas (29% of currently married women ages 15–49) than in urban areas (23%). Unmet need is highest among poor women; 32 percent of women in the lowest economic quintile have an unmet need for family planning, compared with 22 percent of those in the highest economic quintile. Similarly, unmet need is greatest among women with no education and those who have completed four or fewer years of primary school (Malawi NSO and ORC Macro, 2005).

Popularity of Injectable Contraceptives

While increasing access to FP services is a key factor in addressing unmet need, it is also important to ensure that women have access to their preferred FP method. In Malawi, the popularity and demand for injectable contraceptives are high; as mentioned earlier, 64 percent of all married women using modern contraceptives use injectable contraceptives, according to the 2004 DHS. According to the same survey, injectable contraceptives are the most widely known method of contraception among women, as well as the most widely ever-used modern method of family planning; 41 percent of married women who have ever used modern contraception report using injectable contraceptives, followed by the pill (12%), male condoms (9%), and female condoms (6%) (Malawi NSO and ORC Macro, 2005). The 2006 MICS reported an even higher proportion of injectable contraceptive use, with 76 percent of current contraceptive users using this method (Malawi NSO and UNICEF, 2008).

During the past decade, use of injectable contraceptives has increased markedly, while use of oral contraceptives has leveled off (see Figure 1).

Figure 1. Trends in use of oral contraceptives and injectable contraceptives among married women in Malawi (DHS 2004)



Benefits of Community-based Distribution

Community-based distribution programs are unique because they deliver contraceptive methods and FP information to people where they live, rather than requiring people to visit clinics or other facilities for

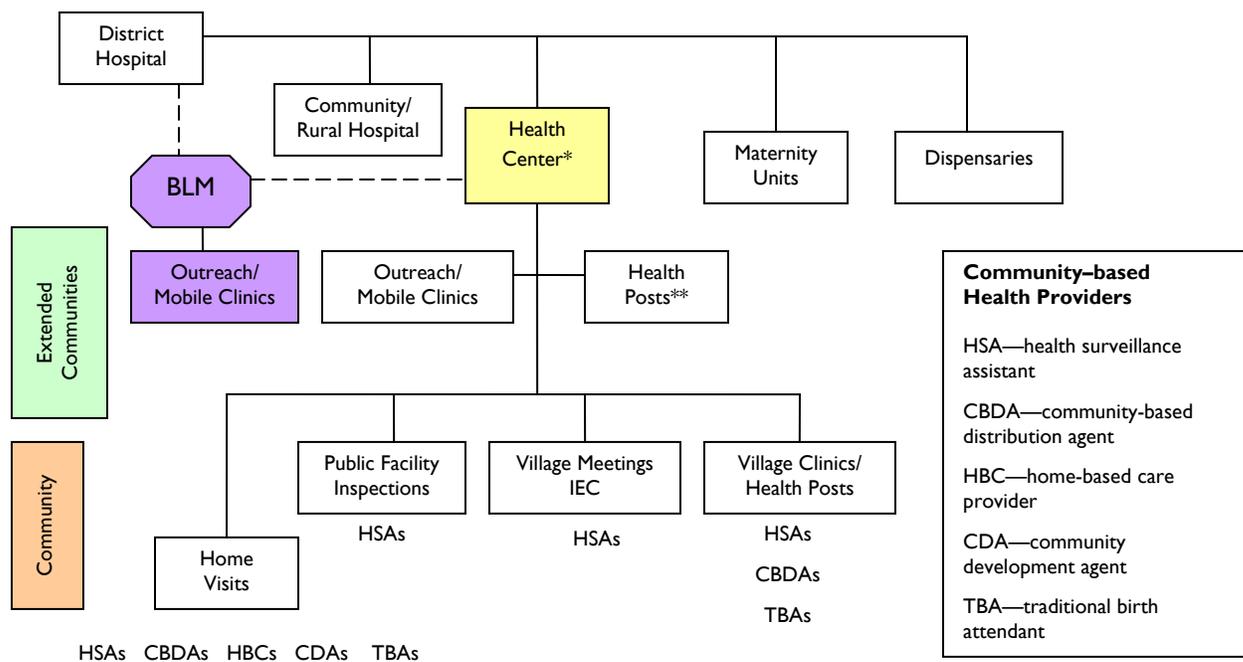
these services. These programs not only increase client access, especially for poor, rural women, but also increase knowledge about family planning and generate new users while helping couples to meet their reproductive goals. Family planning contributes to improved health of women and children. Provision of FP information and services in the community benefits health programs by reducing the workload of skilled medical staff, compensating for the shortage of health providers, and reducing service delivery costs. Countries that have CBD programs that distribute injectable contraceptives include Bangladesh, Bolivia, Guatemala, Madagascar, Mexico, Peru, Rwanda, and Uganda. Rwanda intends to implement a national program in 2009.

Malawi's Healthcare Delivery System

The Malawian healthcare system aims to provide access and free basic health services to the country's 14 million citizens, including access to FP/RH services. Yet, with its predominantly rural population, rugged terrain, and high proportion of people in their prime childbearing years, the challenge of meeting the demand for these services is formidable. There are two main obstacles: access to health services and a severe shortage of medical personnel.

The public healthcare system in Malawi has a three-tiered service delivery model. At the top tier, there are four central hospitals or tertiary hospitals. At the second tier, there are 22 government-run district hospitals, covering the majority of Malawi's 28 districts. Below the district level, in the bottom tier of the public sector system, Malawi has approximately 414 government-run health centers that provide primary care and FP services (see Figure 2). An additional 138 health centers are run by non-profit or for-profit organizations. The public and private community-level health centers are the providers of healthcare services for most Malawians. The health center is often the only medical facility that rural residents will visit in their lifetimes.

Figure 2. Subdistrict model of health service delivery (unofficial)



* Ideal health center staffing (5): clinical officer (1), medical asst., (1), nurses (2 total—1 midwife), health asst. (1)

** May be same as dispensaries.

Source: Richardson and Chirwa, 2007.

Limited access to health services. Although more than half (54%) of the rural population live within five kilometers of the nearest health center, access to health centers is not always easy (Richardson and Chirwa, 2007). There are often physical obstacles to contend with, including the rugged terrain and impassable routes in the rainy season. Ease in accessing health services must also be assessed in terms of time spent away from household duties, traveling to and waiting for health services, and out-of-pocket expenses for healthcare and transportation.

Shortage of medical personnel. Even when a community resident reaches a health center, the center is likely to be understaffed. Malawi is experiencing a critical shortage of medical personnel; only 25 percent of health centers have the required minimum staff of one clinical officer, one medical assistant, two nurses, and one health assistant (Richardson and Chirwa, 2007). Nurses generally provide the majority of FP services, but there are only 25.5 nurses per 100,000 people, and an estimated 65 percent of nursing posts remain vacant (Palmer, 2006).

To expand the cadre of personnel providing FP services at the community level, Malawi could consider two potential groups of healthcare providers: health surveillance assistants (HSAs) and community-based distribution agents (CBDAs).

Health surveillance assistants. HSAs can be either male or female and are the lowest level of civil servant in the public health system. They are paid employees of the MOH and based in communities; they work in mobile or outreach clinics, village clinics, or health posts and assist with implementing Malawi's Essential Health Package. The package is a set of health services within 11 "pillars" or health topic areas, such as acute respiratory infection and malaria, which are provided free to all Malawians in public sector facilities. HSAs receive a 10-week training course to provide crucial primary care services in villages, such as inspecting public facilities, keeping village health registers up-to-date, and providing vaccinations to children under five. Several programs within the MOH use HSAs to implement the community-based portions of their programs. Ministry officials estimate that HSAs currently provide 60 percent of all primary care services in the country. HSAs work in all 28 districts in Malawi, typically in two to three villages. HSAs have provided vaccinations to children and tetanus toxoid shots to pregnant women routinely in Malawi since the 1950s—although not all HSAs are able to administer injections properly and require further supervision and on-the-job training until they are competent. There are currently approximately 5,000 HSAs in Malawi, and the Global Fund for AIDS, Tuberculosis and Malaria has just provided funding to hire an additional 5,000 HSAs. The target ratio for HSAs is set at one HSA per 1,000 people; the current ratio is approximately 1:2,000.

Community-based distribution agents. CBDAs are male and female volunteers selected by and based in their communities to provide FP counseling, oral contraceptives, and condoms. The agents can refer women desiring other FP methods or who need more counseling on side effects to health centers or outreach clinics. CBDAs are recruited, trained, and managed by nongovernmental organizations (NGOs), such as the Christian Health Association of Malawi and *Banja la Mtsogolo* (the local Marie Stopes affiliate). These NGOs continue to train CBDAs and provide refresher courses. Although these agents are volunteers, some NGOs provide the CBDAs some form of compensation or reward (e.g., bags and umbrellas). *Banja la Mtsogolo*, for example, provides a monthly transport reimbursement allowance to all CBDAs and pays commissions for some referrals for FP services, but this policy is currently being re-evaluated.

Although some HSAs currently provide vaccination injections, the MOH has not authorized them to provide injectable contraceptives. However, over the past decade, HSAs have been allowed to provide injectable contraceptives at the community level through a series of informal programs in up to eight districts—although the exact number of districts that allow HSAs to provide injectable contraceptives is unknown. Several communities allow HSAs to provide injectable contraceptives because of the high

demand for this contraceptive method and the small number of medical personnel at the health center level. Other districts, such as Zomba in the South, chose to allow particular trained HSAs to provide injectable contraceptives in those areas where the only health center is run by Roman Catholics and does not provide FP services.

III. FEASIBILITY STUDY

To address the MOH's interest in implementing a national CBD program for injectable contraceptives, the Health Policy Initiative first conducted a feasibility study to assess the need for injectable contraceptives in communities and to gauge the acceptability of using HSAs to provide this service. The study was based on stakeholder interviews at the national level and focus group discussions (FGDs) with healthcare providers, community members, and FP users.

Study Methodology

The Health Policy Initiative engaged two local researchers to compile information on local conditions and conduct the interviews and FGDs from September–December 2007. At the national level, the research team interviewed 35 stakeholders from 16 public and private organizations, including several MOH officials and program directors, international and national NGOs (e.g., the Malawi Red Cross Society), development partners, representatives from professional regulatory bodies and associations, and other nongovernmental FP providers (e.g., the Christian Health Association of Malawi). Appendix A includes the full list of stakeholders interviewed. The research team developed a questionnaire to use as an interview guide.

For the FGDs at the district and community levels, the researchers engaged two additional consultants to assist with conducting the discussions in the local language, if necessary. The discussions were held from December 13–20, 2007, in the districts of Karonga, Kasungu, Nkhosvota, Mangochi, Phalombe, and Chikwawa. The study team selected these six districts because of their low contraceptive prevalence rates, high infant and child mortality rates, geographic representation, and ethnic and religious diversity (see Appendix B for more details).

The research team identified seven target groups for FGDs: (1) district health management teams (DHMTs); (2) district-level FP providers; (3) district-level FP users; (4) adult males in the community; (5) adult females; (6) village leaders (chiefs, village health committee members, religious leaders, members of community-based organizations); and (7) health providers in health centers and communities (nurses, medical assistants, clinical officers, HSAs, and CBDAs). The research team prepared a discussion guide for each target group.

The team sought to conduct a minimum of four FGDs in each district (two at the district level and two at the community level) and to recruit between five and 10 participants per focus group. When there were insufficient participants for a focus group, the team conducted individual interviews. In total, the team held 40 focus group discussions (18 at the district level and 22 at the community level) with 152 participants (see Table 1). Of the total participants, 61 percent were female and 39 percent were male. The team conducted the FGDs in either English or the appropriate local language and recorded and transcribed the discussions verbatim.

Table I. Focus Group Discussion Participants by District and Target Group

District	DHMT	District FP Providers	HSA	Health Center Nurses	CBDAs	District-level FP Users	Women	Village Leaders	Men	Total Participants	Total Groups
Chikwawa	4	2	3	0	5	6	3	4	0	27	7
Phalombe	6	0	6	1	0	6	6	0	1	26	6
Karonga	4	2		1	0	6	0	4	1	18	6
Kasungu	4	1	2	0	0	6	5	5	6	29	7
Nkhotakota	4	3	3	2	5	7	5	5	5	39	9
Mangochi	4	1	4	1	0	3	0	0	0	13	5
Number of groups	6	5	5	4	2	6	4	4	4	--	40
Number of participants	26	9	18	5	10	34	19	18	13	152	--

Findings from National-level Stakeholder Interviews

For the stakeholder interviews at the national level, the research team sought to

- Learn the stakeholders' views and ideas for expanding access to injectable contraceptives to communities;
- Discuss with stakeholders the ways in which the health system can ensure the safe and competent administration of injectable contraceptives in the community, specifically by HSAs.
- Identify areas in the health system that need change or support to implement a community-based intervention for the distribution of injectable contraceptives.

In general, when commenting on which cadre of health worker might provide injectable contraceptives at the community level, the stakeholders said that HSAs in Malawi perform well but they can be overloaded with tasks and inadequately supervised. Most stakeholders agreed that HSAs need in-service training, in addition to an implementation plan for their long-term professional growth, with provisions for their supervision and regulation. Stakeholders believe the following 10 issues must be addressed before HSAs can qualify to administer injectable contraceptives in communities.

1. Clarification of role and job description

The MOH needs a formal policy provision that describes the relationship between community-based workers providing health services (HSAs, CBDAs, traditional birth attendants, etc.) and health centers. Stakeholders suggested that the upcoming revision of the Nursing Act would be a good opportunity to add a section describing all paraprofessional cadres that perform service delivery functions in Malawi (CBDAs, patient attendants, home-based care attendants, etc.), their roles and responsibilities, and their relationship with nurses and midwives in their education, delegation of duties, and supervision of their work. With regard to the HSAs, the MOH wants them to remain generalists in the provision of essential health services rather than become specialists or work for specific programs.

2. Curriculum and basic training

HSA training must address the critical components of the Essential Health Package, and training should be both theoretical and clinical. An assessment should be conducted with HSAs to determine priority areas to be included in district in-service training plans. Stakeholders suggested that the training curriculum be integrated with regular in-service Essential Health Package training from existing program

modules for all HSAs, but that these modules first be revised to include supportive supervision and team building and HSA tutors (nursing, medical, and environmental officers).

Suggested curriculum components include

- A comprehensive module on FP counseling and injectable contraceptive administration with practical experience under tutor supervision;
- Community health management—how to track supplies, do logistics reporting, and coordinate and plan with communities to build capacity in addressing health issues; and
- CBDA training (3 weeks) to understand what FP services CBDAs are providing at the community level, as some HSAs may be asked to supervise CBDAs.

Stakeholders also emphasized that continued in-service training is vital to scaling up the provision of injectable contraceptives.

3. Recruitment, deployment, and retention

Short- and medium-term plans for recruiting, selecting, and training HSAs to administer injectable contraceptives should consider gender, interest, performance, and deployment to areas with low access to FP services. Recruitment efforts should also account for the ratio of male to female HSAs, as many HSAs are males and some women and husbands of women may be uncomfortable with a male HSA administering injectable contraceptives to a woman other than his wife. Other professional cadres should be deployed to hospitals to facilitate the re-assignment of HSAs to rural areas. Furthermore, once trained, HSAs should not be transferred out of their rural communities.

To retain HSAs, their workloads should be evaluated and managed. In addition, benefits and salaries should be standardized; currently, benefits and incentives are not standard across HSAs, even though they are all civil servants. For example, some assistants receive a housing allowance and duty allowance (in areas where NGOs provide additional support); other HSAs have access to customary land for farming, while others may receive bicycles for transport to the villages in their catchment area.

4. Career development

HSAs now have opportunities to move into professional groups, if motivated. The MOH should screen current assistants to assess who might be qualified and interested to go on to other basic technical training. The ministry should also develop a clear plan and career path for HSAs, leading to technical upgrade. Training could be offered through distance education or a continuing or in-service education credit program. The MOH and the Ministry of Education should explore the potential to develop distance education courses for HSAs.

5. Regulation

Regulating HSAs will require a long-term intervention. With only 10 weeks of training before they are deployed to communities, assistants require intensive supervision to ensure that they carry out only the procedures and practices for which they have been trained. HSAs need to be recognized as health workers and thus should be trained and regulated by professional councils. Furthermore, regulatory boards (nursing, medical, and pharmacy) need to be involved in developing and supporting a final MOH policy on task shifting to community-based health workers.

As the HSA's role expands, the MOH may decide that it is more appropriate for community health nurses (CHNs) to supervise this cadre. However, with only one training institution in the country for CHNs, their supervision of all HSAs cannot be achieved quickly, especially with the planned scale-up of HSAs to achieve the 1:1,000 people target ratio. One alternative suggested by the stakeholders interviewed was that nurse-midwife technicians in health centers could assume the role of the CHNs (assuming the nurse-

midwife technician's training is sufficient). In addition, stakeholders pointed out that because HSAs already give immunization injections to children and tetanus shots to pregnant women, contraceptive injections would be in line with current practice.

Stakeholders stated that if CHNs were the best technical supervisors for HSAs and the link needed to connect HSAs with health centers, Malawi must train more community health nurses or specially trained nurse-midwife technicians to fulfill that role. In addition, to allow for adequate supervision, health centers should be staffed with one community health nurse, one midwife, and one other nurse to provide continuity of community-based health services and supervision.

6. Supportive supervision

The MOH and health professionals should consider developing formal, integrated, and supportive supervisory systems for community-based health providers regardless of sector, with clear lines of supervision and authority. The designation of supervisors should depend on the technical nature of the work.

The ministry should sustain formal, integrated, and supportive supervision guidelines for community-based health providers (CBDAs, HSAs, traditional birth attendants, etc.) and establish and maintain provisions (i.e., transport, budget) for regular supportive supervision and quality assurance mechanisms. The ministry should also provide resources for conducting and supervising community clinics and community-based health workers to ensure continuity and coordination by those with proper technical expertise (such as CHNs).

Stakeholders suggested that the next steps should also integrate CBD of injectable contraceptives into the supervision model from Malawi's National Strategy for Accelerated Child Survival, which includes

- Monthly supervision of HSAs (by community health nurses) from the health center with involvement of community leaders;
- Bi-monthly supervisory meetings of all community health workers within a given village as a peer supervisory mechanism;
- Bi-monthly supervisory visit to each health facility by DHMT members (members of the Health Center Management Team should also be involved in the supervisory visit);
- Monthly quality of care audit meeting for all health center staff to identify bottlenecks, performance standards, and other quality of care issues and propose immediate remedial actions.

7. Procurement and logistics

Malawi's Central Medical Stores is responsible for the procurement and distribution of drugs and other commodities. Stakeholders stated that the Central Medical Stores system is well-established and that increasing the amount of injectable contraceptives managed by the Central Medical Stores should not create a strain on the system. However, procurement of injectable contraceptives will require more diligence in monitoring and forecasting to prevent stockouts. Therefore, forecasting projections should be changed to consider HSA contraceptive needs in procurement. In addition, provision of supplies to distant and remote areas needs to be planned for, particularly during the rainy season. As a back-up to stockouts of injectable contraceptives, communities should consider creating a community revolving drug fund to purchase them from private sector providers. Reporting systems will also need to be standardized with the current CBDA reporting system.

The distribution of injectable contraceptives would not differ from commodities currently delivered to health centers and does not require a cold chain to preserve the drug. However, injectable contraceptives must remain in an upright position, which may be difficult to ensure as they are carried from the health center to the community. The MOH needs to clarify the conditions required to maintain and store

injectable contraceptives. If HSAs collect injectable contraceptives directly from health centers, this will solve the storage and security issues.

8. Operational policies

Long-standing practices by lower-level paraprofessional health workers—accepted and supported by the MOH—are not formalized in existing operational policies or regulations. For the protection of the public as well as the health workers, the ministry needs a long-term plan for integrating community-based healthcare delivery systems. Stakeholders stated that the MOH’s decision to explore provision of injectable contraceptives at the community level by paraprofessional health workers provides a stimulus to resolve some long-standing operational policy issues for all community-based health workers who operate outside of their job descriptions. Through negotiations, decisions, and revisions in strategies, policies, and systems, high-quality community-based healthcare can be provided safely by qualified health workers.

Stakeholders also suggested that the following be considered in developing operational guidelines:

- All options should be pursued to satisfy the demand for FP methods, including injectable contraceptives. For example, door-to-door distribution of FP methods has proven to be effective in increasing access. Some stakeholders believe that nurse-midwife technicians, CBDAs, and HSAs should be able to administer injectable contraceptives.
- Cases needing further management due to complications, side effects, or lack of availability of other FP methods should be identified and referred to the appropriate level of care.
- FP counseling and injectable contraceptive services should be integrated into entry points such as maternal and neonatal care and HIV/AIDS interventions. For example, during a woman’s three antenatal visits and three postnatal visits for maternal and newborn care, HSAs could discuss FP options. Providers can also discuss FP options during prevention of mother-to-child transmission therapy and antiretroviral adherence counseling.

9. Community involvement

Stakeholders also discussed the need to involve the community in finding ways to overcome barriers to FP method use, including injectable contraceptives, based on traditional or cultural beliefs or customs. The importance of using existing community structures and systems that will enhance FP acceptance and promote unity of purpose was also emphasized. Community members should be included in a participatory process to identify weaknesses and strengths in the health service delivery of Essential Health Package interventions. HSAs could also work with communities in developing funding mechanisms to build or maintain health posts, provide transport to and from health centers, and purchase back-up FP supplies.

10. Human resources

Due to staffing shortages at health centers and the high expectations for services to be delivered, nurses and HSAs provide services beyond their training or job descriptions, possibly compromising quality of service and affecting morale. The existing human resources strategies do not address HSAs and therefore do not offer plans for retaining, advancing, and regulating HSAs. Accordingly, little is known about HSAs’ qualifications, training, actual scope of work, or the quality of services they provide, despite that they are the largest cadre employed by the MOH and provide up to 60 percent of all primary care services.

Stakeholders recommended that the MOH’s Human Resources Department focus on filling the positions of two nurses in health centers instead of placing them in the community, as the role of outreach falls under the position of HSAs rather than the nurses. Additional CHNs could be trained after health centers are fully staffed with nurses.

In addition, respondents recommended that human resources policies, strategies, and plans be revised to include long-term goals for lower level cadres (HSAs, attendants) with a means for professional development (continuing education/distance learning). Stakeholders emphasized the importance of obtaining direct input from HSAs and liaising with policymakers while developing medium- to long-term human resources plans for HSAs for optimal resolution and the finalization of policy.

Findings from Focus Group Discussions

The FGDs focused primarily on provider and community member beliefs and opinions about community-based provision of injectable contraceptives. For the focus group discussions, the study team sought to

- Assess current preference and access to FP methods, including, but not limited to, injectable contraceptives at the community level;
- Gather opinions from community members and various provider groups about contraceptive provision at the community level;
- Identify commonly held beliefs and opinions about injectable contraceptives; and
- Determine acceptable strategies for distributing preferred FP methods in communities.

The following summarizes respondents' views by *community groups* (FP users, women's groups, men's groups, community leaders) and *provider groups* (DHMTs, district FP providers, nurses, medical assistants, clinical officers, HSAs, and CBDAs). Primarily, community group views were expressed at the community level and provider group views were expressed at the district level, but this is not always the case.

Preference for injectable contraceptives

The FGD findings corroborated DHS data indicating that injectable contraceptives are the preferred FP method in Malawi, as they were almost unanimously cited as the preferred FP method among the participants.

Community groups. All of the women's groups agreed that injectable contraceptives are the FP method most preferred and used, citing reasons such as convenience and few side effects. Almost all participants of the men's and village leaders' groups also supported the use of injectable contraceptives, with the exception of one participant, who preferred condoms for family planning. The main reasons cited for the preference for injectable contraceptives included the duration of effectiveness (three months) and thus fewer trips to health facilities, convenience, few side effects, and concern that other methods have serious side effects.

“Injection is an easy method; you stay a long time before going to the health center for another dose and it is not easily forgotten like the pill.”
– Member of a woman's focus group

Provider groups. All health providers in the FGDs said injectable contraceptives were the most popular and preferred FP method for reasons such as convenience, privacy (a woman's husband does not always know about the injections), and the difficulty in remembering to take other methods, such as the contraceptive pill. The provider participants estimated that between 60 percent and 90 percent of women coming to FP clinics receive injectable contraceptives.

Difficulties in accessing family planning services

Both community groups and provider groups acknowledged the problems with accessing FP services and obtaining injectable contraceptives.

Community groups. In five of the six FGDs with women, participants spoke about the difficulties in getting to health facilities to access FP services, including long distances, rugged terrain (hills, rivers, impassable roads), and high transport costs. One women's group also noted that once women arrive at health facilities, it is not uncommon to spend the day waiting for FP services, particularly at district hospital FP clinics.

“Others [women] just stay at home; they don't go to the hospital [for FP] because it's far from their homes and difficult to travel, and the health center is always overcrowded.”
– *Member of a woman's focus group*

Only one of the 18 community groups reported that injectable contraceptives were available in their area through monthly outreach clinics. However, this group also stated that the mobile clinics were very unreliable because they sometimes did not arrive for the monthly scheduled visits; when they did arrive, the clinics sometimes did not have all the FP methods available. Members of the remaining community groups reported that injectable contraceptives could be obtained at health centers, district hospitals, or *Banja la Mtsogolo* (Marie Stopes) clinics.

Provider groups. Provider participants from five of the six study districts reported scheduling between two and 10 monthly FP outreach or mobile clinics conducted by FP nurses from district hospitals. The remaining district relied on *Banja la Mtsogolo's* mobile clinic to provide injectable contraceptives in designated areas. In the Phalombe and Kasungu districts, monthly outreach clinics were very or mostly reliable according to district providers, while participants reported clinics in the other four districts as not being very reliable. District hospital-level FP providers from four districts stated that obtaining reliable transport to conduct monthly outreach clinics and supervision activities was the biggest obstacle in providing FP services. Provider participants also cited the shortage of FP clinic nursing staff. CBDA participants specifically mentioned referring women to health clinics for FP services, but that these women often return without a contraceptive method because of stockouts or lack of an available health provider.

Need for community-based provision of injectable contraceptives

Community and provider groups almost unanimously agreed that there is a need to provide injectable contraceptives in communities.

Community groups. Among community groups, the main reason cited is that it would save time and money by shortening the distance that women travel to obtain FP services. Engaging men in the FP process was also cited as an important benefit of community-level provision by most participants. A dissenting view, from participants in a male group, was that because women and men could already obtain condoms and oral contraceptives from a nearby health clinic, community-based provision of injectable contraceptives was unnecessary.

Provider groups. Among provider groups, the main reasons cited are that it will improve access for women and shorten the distance women have to travel to obtain FP services. However, the group of district health nurses do not believe there is a need for community-based provision of injectable contraceptives, stating that many of their clients come to town for other reasons (such as shopping or socializing) and obtaining injectable contraceptives gave them a reason to do so.

Where in communities to deliver injectable contraceptives

When asked how injectable contraceptives could be administered, the community and provider participants cited the use of mobile outreach clinics, weekly village clinics, and, to a lesser degree, home visits.

Community groups. Community group participants unanimously agreed that one solution is to increase the number of mobile or outreach clinics to reach more communities. Most of these participants also said that injectable contraceptives could be provided by weekly village clinics. A few community groups also cited providing injectable contraceptives through home visits.

Provider groups. The majority of provider participants preferred the use of weekly village clinics—although a few also agreed with using more mobile/outreach clinics or home visits.

Who should provide injectable contraceptives in communities

In both the community and provider groups, most participants proposed that HSAs administer injectable contraceptives in communities—although there was still some dissension, especially among nurses.

Community groups. When asked who should provide injectable contraceptives in communities, the majority of female participants favored HSAs—although some women also cited nurses or any trained health worker. Some participants of the men’s and village leaders’ groups thought nurses should provide injectable contraceptives through village clinics, while other participants would also consider trained CBDAs, HSAs working in conjunction with nurses, or any other trained health worker.

“...the ones giving these methods [injectable contraceptives] need to be well-trained, not everyone. The most suitable provider is the nurse, although we appreciate what HSAs are doing.”
– Member of a women’s focus group

Provider groups. The majority of DHMTs, district FP nurses and HSAs stated that HSAs should provide injectable contraceptives in communities—as HSAs are already providing vaccinations; a capable pool of HSAs already exists; HSAs are known and trusted in their communities; and, with training, HSAs can manage injectable contraceptive problems. However, respondents proposed that HSAs receive a screening checklist similar to the one used for screening clients for oral contraceptive use. The provider participants also suggested that the government recruit more female HSAs.

Participants in the nurses’ groups disagreed with allowing HSAs to provide injectable contraceptives, arguing that HSAs are not competent or able to handle injections. However, most nurse participants thought that HSAs could provide injectable contraceptives if they worked in conjunction with nurses at village clinics. In this scenario, nurses would conduct the initial assessment (including a pelvic exam) and administer the first injection, and then HSAs would provide subsequent injections at three-month intervals. Alternatively, HSAs could do the initial injectable screening and counseling, provide the first injection, and refer the client for a physical exam at the health center or arrange a time for a nurse to perform exams at a village clinic before the next injectable dose.

Current work performance of HSAs

Provider groups (these questions were not asked of the community groups). With most providers citing HSAs as their first choice to administer injectable contraceptives in the community, the research team sought their opinions on and concerns about HSA work performance. Most of the provider participants had no concerns about HSAs’ practical abilities in providing basic, essential healthcare. Specifically, all district FP nurse participants commended them for doing good work. However, a DHMT group expressed concern about HSAs’ heavy workload.

In all six districts in which the FGDs were conducted, HSAs currently administer injections to pregnant women for tetanus toxoid and immunizations to children under five years old. The majority of provider participants said HSAs’ skills were adequate for giving injections—provided they have good supervision and on-the-job training. However, most provider participants stated that the HSAs’ current 10-week pre-service training program is inadequate, particularly in essential areas such as injection technique and safety, infection precautions, and practical experience.

Implementing community-based provision of injectable contraceptives

Provider groups (these questions were not asked of the community groups). The research team asked providers for their suggestions on implementing the provision of injectable contraceptives at the community level. They offered recommendations in the areas of training and supervision.

Supervision of community-level health workers

All FP provider participants reported that the current system of supervision of community health workers (of HSAs and CBDAs, in particular) is inadequate if injectable contraceptives are to be provided at the community level. All provider participants agreed that community health workers should be supervised primarily by the nearest health center but differed on which cadre at the health center should supervise. Most participants preferred a combination of nurses and senior HSAs to jointly supervise the full scope of HSA and CBDA work. Health center nurses' groups recommended CHNs as supervisors because they are qualified to provide back-up for FP services, supervise other health workers, and work with communities. However, the nurses added that senior HSAs are still needed to continue community supervision of all public health and village registry activities. Provider participants mentioned several potential benefits to joint supervision, such as more involvement of health center staff in community healthcare, shared responsibility, and better communication between health centers.

Training of community-level health workers

The research team asked provider participants to comment on the necessary training for effective provision of injectable contraceptives at the community level. Participants cited extensive training in FP counseling; all FP methods; injectable contraceptives (i.e., using screening checklists, administering injectables skillfully, managing complications, and adhering to infection prevention measures); and effective approaches for raising people's awareness of FP services and ways to introduce injectable contraceptive services into the community.

Several participants mentioned including supervisors in the training sessions (CHNs, health center nurses, and senior HSAs) to provide adequate supportive supervision for new providers of injectable contraceptives. All training curricula for supervisors (whether CHNs or health center nurses) should include a course in supportive supervision of injectable contraceptive providers. Providing refresher courses in FP methods for supervisors would also be beneficial, particularly in FP counseling and managing side effects.

IV. MINISTRY OF HEALTH'S DECISION TO ALLOW HSAs TO PROVIDE INJECTABLE CONTRACEPTIVES

Although the research findings indicate that it is feasible for HSAs to provide injectable contraceptives in the community, the decision to allow them to do so has nevertheless met considerable opposition from the professional medical community over the last several years. As previously mentioned, several districts had already decided to allow particular HSAs to provide injectable contraceptives, but the district health offices did not have the MOH's official support or endorsement.

After years of debate, on March 14, 2008, the MOH Senior Management Committee agreed by consensus to allow HSAs to administer injectable contraceptives at the community level, with the understanding that the ministry would first pilot the approach in several districts. Although the Health Policy Initiative's research did not directly inform the ministry's decision, the national-level stakeholder interviews and FGDs in several districts helped to spotlight the issue in the months leading up to the decision.

Dr. Chisale Mhango, director of the MOH's Reproductive Health Unit, played a key role in helping the ministry make its decision. The Health Policy Initiative had worked closely with Dr. Mhango to identify

study participants at the national and district levels. In early 2008, Dr. Mhango met with key members of the research team to explain his rationale for proposing that HSAs be allowed to administer injectable contraceptives at the community level. At the March meeting, according to interviews and the Senior Management Committee meeting minutes, Dr. Mhango distributed a literature review summary of various countries' experiences in CBD of injectable contraceptives. He then gave a PowerPoint presentation explaining the demand for injectable contraceptives in the country and the ministry's policy to offer women their preferred FP method. He explained that injectable contraceptives have been safely administered by paraprofessionals in many countries, including Uganda and Madagascar, by using a screening checklist to determine whether a prospective user has any health conditions that would rule out use of injectable contraceptives. Dr. Mhango proposed that HSAs provide injectable contraceptives to women in their coverage area.

Some Senior Management Committee members strongly opposed allowing HSAs to provide injectable contraceptives. They voiced concerns about HSAs' ability to safely administer the contraceptives; providing these contraceptives, unlike immunizations, requires providers to counsel women on potential side effects. Some members were also concerned about the additional burden on HSAs' workload.

Rebuttals to these arguments cited the good work that HSAs are currently doing, particularly in providing immunizations without incident. These proponents agreed that the additional service's impact on the current HSA workload is yet to be determined, but the MOH could integrate the service into the services at child health, immunization, and outreach clinics. To address concerns about the side effects of injectable contraceptives, proponents suggested that HSAs counsel on the common problems and refer clients to nurses in health centers for further management. Regarding the safety of injectable contraceptives, proponents stated that the Malawian government had already approved injectable contraceptives and therefore the MOH Senior Management Committee did not need to consider this issue.

At the end of the March meeting, the group reached a consensus in favor of allowing HSAs to start administering injectable contraceptives, with strong guidelines and provisions for training and supervision. The group agreed that implementation should not happen all at once but rather begin with eight pilot districts.

V. JULY 2008 DISSEMINATION MEETING WITH STAKEHOLDERS

In early 2008, the Health Policy Initiative's research team concluded its research and began compiling its findings. Around the same time, the USAID Mission agreed to fund a study tour for Malawi's key FP stakeholders to visit a USAID-funded CBD initiative in Madagascar. The tour became more urgent after the ministry's decision in March, as the MOH representatives could benefit from learning how Madagascar's program operates and what lessons could be applied to Malawi's case. Instead of disseminating the Health Policy Initiative's research findings before the study tour, the ministry and USAID Mission asked the team to wait until after the tour had finished so that the findings could be discussed in conjunction with the insights of the study tour participants.

The one-week study tour (June 15–21, 2008) in Antananarivo, Madagascar, included 12 key FP stakeholders representing the MOH, Christian Health Association of Malawi, the USAID Mission, USAID partner organizations, and the United Nations Population Fund.

After the study tour participants returned, the MOH Reproductive Health Unit, in collaboration with the Health Policy Initiative, held a stakeholders' meeting on July 15, 2008, called "The Way Forward:

Malawi’s Road to Community-Based Distribution of Depot Medroxyprogesterone Acetate (DMPA).” The meeting objectives were to

- Disseminate findings of project’s research on national- and community-level views about CBD of injectable contraceptives;
- Share lessons learned from the Madagascar study tour on CBD of injectable contraceptives; and
- Build consensus on the provision of injectable contraceptives by paraprofessionals.

The facilitator of the meeting, Fannie Kachale, Deputy Director of the Reproductive Health Unit, encouraged participants to identify the necessary steps for CBD provision of injectable contraceptives by HSAs; build consensus on a phased approach strategy and evaluation plan; and make and submit recommendations on service provision and training guidelines to the Reproductive Health Technical Working Group.

Overview of Presentations

At the meeting, Dr. Mhango gave the first presentation, titled “The Current Status of Family Planning in Malawi and the Way Forward.” He briefly discussed Malawi’s high unmet need for FP services and the high percentage of the population living in rural areas unable to access FP services.

Dr. Maureen Chirwa, a consultant for the Health Policy Initiative, gave the second presentation, titled “Malawi’s Road to Community-Based Distribution of Injectable Contraceptives.” She gave an overview of the project’s research findings, emphasizing the major steps of preparing for CBD of injectable contraceptives by HSAs—such as conducting in-service HSA training for injectable contraceptives, developing supervision systems for the regulation and policies governing HSAs, drafting plans for the selection and retention of HSAs, and developing CBD management systems (human resources, referrals, logistics, and injectable contraceptive procurement). Dr. Chirwa outlined the following priority actions:

- Developing standards and guidelines
- Training HSAs
- Ensuring the provision of HSAs to community areas
- Determining the frequency and location of outreach services to ensure access to services
- Securing supplies for coverage expansion
- Preparing a plan for national scale-up

Meeting participants recommended disseminating the research findings at the community level and having the MOH update FP providers on this new information. They also suggested reviewing the current guidelines to remove those that restrict HSAs from providing injectable contraceptives.

Fannie Kachale, deputy director of the Reproductive Health Unit, made the third presentation, sharing the lessons learned from the study tour to Madagascar. The lessons were grouped into six main areas:

1. **Selection and training of CBDAs.** Madagascar uses selected volunteer CBDAs to provide injectable contraceptives. Stakeholders from the community and health centers choose the CBDAs based on their high performance levels. These CBDAs then receive a four-day training on the provision of injectables.
2. **Role of injectable contraceptive providers at the community level.** In Madagascar, the role of injectable contraceptive providers at the community level is to assess client eligibility, conduct community mobilization and awareness campaigns on the benefits of family planning, refer clients requiring further clinical management, and follow up on clients who discontinue use.

3. **Supervision.** Health center and NGO staff supervise the CBDAs. They must report to medical professionals and replenish stock during monthly meetings at the nearest facility. CBDAs receive written feedback from supervisors at all levels. The study tour participants cited this feedback as a key motivator for volunteer CBDAs.
4. **Supply chain logistics.** The CBD program has integrated logistics reporting systems into its recordkeeping. There is good coordination at all levels on supply chain products.
5. **Waste disposal.** The CBD program supplies sharps containers (for syringe disposal) and waste disposal boxes to every CBDA. When the boxes are full, CBDAs dispose of the contents at health centers.
6. **Challenges.** The CBD program still faces some challenges, including inadequate storage of FP products, too many reporting forms for CBDAs, and the limited use of logistics data for resupply.

VI. NEXT STEPS

Following the July 2008 dissemination meeting, the MOH Reproductive Health Unit began working with USAID, Futures Group International, and Management Sciences for Health to draft guidelines for HSA provision of injectable contraceptives at the community level. The guidelines focus on the following core areas:

1. **Training.** Community-based workers should gain the requisite knowledge, skills, and attitudes to advocate for and provide high-quality injectable contraceptive services at the community level.
2. **Integrate FP and HIV services.** Integrating injectable contraceptives into FP and HIV services at the community level has the potential to be more efficient and effective than providing them solely through clinical services. Integration enhances not only the sharing of existing infrastructure or facilities and personnel but also maximizes the management of service delivery and simplifies logistics.
3. **Service delivery.** The program should promote, advocate use of, and ensure availability of injectable contraceptives in the community.
4. **Monitoring and supervision.** Monitoring and supervision of injectable contraceptive services should be strengthened within the existing systems.
5. **Quality assurance.** Injectable contraceptive services should be integrated into the Quality Management Plan. The performance of community-based workers should promote professionalism and attract and retain clientele. The clinical performance should assure clients' safety at all times.
6. **Logistics management.** The program should institute a well-run logistics system that will ensure that supplies are in good condition and delivered in a timely manner. The system should control costs by eliminating overstock, spoilage, pilferage, and other kinds of waste.

The guidelines were drafted following a workshop held August 18–22, 2008, with stakeholders from public, private, and nongovernmental organizations. The MOH officially approved the guidelines in December 2008.

Futures Group International and the MOH Reproductive Health Unit—through the USAID-funded Community-Based Family Planning and HIV/AIDS Services project—will distribute the guidelines to the appropriate providers. Management Sciences for Health and the Reproductive Health Unit have developed manuals to train HSAs in the eight project districts in the provision of injectable

contraceptives. These districts are the same ones targeted under the Community-Based Family Planning and HIV/AIDS Services project: Salima, Nkhoskhota, Phalombe, Kasungu, Karonga, Mangochi, Balaka, and Chikwawa. The Zomba District will be added as the ninth pilot district because of its experience during the last decade in allowing HSAs to provide injectable contraceptives at the community level. Training of the HSAs is expected to begin in early 2009.

Although the newly approved guidelines offer necessary direction for those working with and supporting HSAs, they are only the first step toward ensuring the successful provision of injectable contraceptives. As the Health Policy Initiative's research findings and July 2008 stakeholder recommendations indicate, many more issues must be addressed to fully and successfully implement the new program.

Over the next year, Futures Group International will work with the MOH Reproductive Health Unit—again through the Community-Based Family Planning and HIV/AIDS Services project—to develop training modules, supervisory guidelines, management systems, and further policy guidance. Remaining policy issues to resolve include the regulation of oral and injectable contraceptives by Malawi's Pharmacy, Medicines, and Poisons Board and the regulation of paraprofessional cadres such as HSAs by Malawi's medical and nursing councils. Until these regulations are established, the initiative to allow HSAs to provide injectable contraceptives could be vulnerable to criticism and puts the burden of protecting the HSA cadre squarely on the MOH's shoulders—not an ideal situation if the program is going to be nationally successful and sustainable.

VII. CONCLUSION

Despite the popularity and demand for injectable contraceptives in Malawi, limited access to injectable contraceptives—particularly in rural areas—continues to contribute to Malawi's high fertility rate, low contraceptive prevalence rate, and persistent unmet need for FP services. With its decision to implement a national program for CBD of injectable contraceptives, the government of Malawi has signaled its commitment to address these problems. Although many implementation issues must be addressed, ultimately, the use of HSAs in the provision of injectable contraceptives should reduce unmet need for FP, improve maternal and child mortality, and help to slow Malawi's rapid population growth.

An effective policymaking process is the foundation of scalable and sustainable health programs; Malawi's experience clearly demonstrates the importance of research, advocacy, high-level policy decisionmaking, and the development of operational policy and guidelines. The country's practical experience in those districts that allowed HSAs to provide injectable contraceptives at the community level was helpful in demonstrating the feasibility of this approach. The Director of the MOH Reproductive Health Unit was a skillful advocate, using research and data to make a compelling case for policy change that persuaded senior-level MOH decisionmakers to take action. By raising the issue and interviewing national-level stakeholders, the Health Policy Initiative served as a catalyst for discussions about CBD and raised the profile of the issue in the months leading up to the MOH's decision in March. HPI's research helped to inform the development of countrywide operational guidelines for the new CBD program.

APPENDIX A: NATIONAL-LEVEL STAKEHOLDERS INTERVIEWED

Name	Position	Organization
Hon. Marjorie Ngaunje	Minister	Ministry of Health
Chris Kang'ombe	Secretary for Health	Ministry of Health
Dorothy Ngoma	President (1 st Director, Banja la Mtsogolo)	National Association of Nurses of Malawi
Sheila Bandazi Felisitas Kanthiti	Acting Director Acting Chief Nursing Officer	Nursing Services Ministry of Health
Edwin Nkhono	Director	MOH HSA Program
Martha Mondywa Chrissy Chiromo Jacinta Mtengezo	Acting Registrar Registrar Officer Nursing Education & Services	Nurses and Midwives Council of Malawi
Veronica C. Chirwa Lisa Hare	Out-going Logistics Advisor Interim Logistics Advisor	John Snow International/DELIVER Project
Dr. Kelita Kamoto	Director (previous Reproductive Health Unit Director)	MOH HIV/AIDS Program
Dr. Anna Phoya	Director (previous nursing director)	Sector-wide Approach (SWAp) and Technical Working Group for Reproductive Health, Ministry of Health
Dr. Chisale Mhuhango Fanny Kachele	Director Deputy Director	MOH Reproductive Health Unit
Ragnhild Seip	2 nd Secretary—Development	Norwegian Agency for Development Cooperation
Pongolani Msakambewa Kondwani Mkandawire	Acting Registrar Assistant Registrar (Technical)	Medical Council of Malawi
Dr. A. Somanje	Director	MOH Preventive Services
Dorothy Lazaro	National Program Officer	United Nations Population Fund
Abigail Kyei Tambudzai Rashidi	Country Director Deputy Country Director	ACCESS (formerly JHPIEGO)
Dr. Matias Joshua	Director	MOH Clinical Services
Evelyn Zimba	Newborn Health Program Manager	Save the Children/U.S.
Lawson Kasamale	Secretary General	Malawi Red Cross Society
Grace Banda	Nursing Education	Christian Health Association of Malawi

Name	Position	Organization
Florence Chipungu Peter Kambalame Joseph Mwandina	Director FP Coordinator Project Manager	Adventist Health Services
George Macheka	Director of Operations	<i>Banja la Mtsogolo</i>
Eliana Gutierrez-Amo John Justino	Program Manager Resident Director	Population Services International
Jane Namasuma	Student <i>(former Reproductive Health Unit Deputy Director)</i>	
Lenny Kamwendo	President President	White Ribbon Alliance Malawi Midwifery Association
Lilly Banda-Maliro	Reproductive Health Specialist	USAID

APPENDIX B: METHODOLOGY FOR DISTRICT- AND COMMUNITY-LEVEL FOCUS GROUP DISCUSSIONS

District selection. Eight districts were initially identified based on their low contraceptive prevalence rates, high infant and child mortality rates, geographic representation, and sampling of ethnic and religious diversity (see Table B1). However, due to time constraints, research was conducted in only the six districts of Karonga, Kasungu, Nkhonkhotakota, Phalombe, Chikwawa, and Mangochi.

Table B1. Characteristics of Study Districts

District	Characteristics
Karonga	Northern region. Close to Tanzanian border. Culturally, it is different from the rest of the districts outlined. Hilly district with few health facilities. Polygamy is widely practiced.
Kasungu	Central region. Most of the district is underserved. Literacy level is low for both men and women. Tobacco growing industry dominates.
Salima	Central region district along the lake. Has a mixture of Christians and Muslims. Functional literacy is relatively good. Has Christian Health Association of Malawi private and public facilities.
Nkhonkhotakota	Central region district along the lake with a mixture of Christians and Muslims. Border district between northern region and central region. Literacy is relatively good.
Balaka	Southern region district. Large number of Christian Health Association of Malawi facilities. Mixture of Christian and Muslim communities. Literacy is low generally.
Mangochi	Southern region district along the lake. Functional literacy is very good. Most men leave for South Africa for employment. Men have great authority over women. Mixture of Christians and Muslims.
Phalombe	Southern region district. Hilly, mostly underserved rural areas with low literacy generally. Relatively new district.
Chikwawa	Southern region district. Low literacy for both men and women. Polygamy widely practiced. Has a number of oppressive cultural practices in favor of men.

The seven target groups for the research included the following:

Providers

1. DHMTs
2. FP clinic providers
3. Health providers (from health centers and communities)
 - Nurses (CHNs and enrolled nurse-midwives)
 - Medical assistants
 - Clinical officers
 - HSAs
 - CBDAs

Community

4. FP users
5. Adult males
6. Adult females
7. Village leaders (chiefs and leaders of village health committees and religious and community-based organizations)

Discussion guides. Two consultants of the Health Policy Initiative prepared an FGD guide for each target group. The guides contained some questions common to all target groups, covering people’s awareness and concerns about family planning, the most preferred FP method, and how the method might be easier to access (see Box B1). Specific questions for community members (village leaders, men, women, and FP users) focused on soliciting ideas for improving and promoting FP and injectable contraceptive services and making them happen. For FP providers (nurses, HSAs, CBDAs, and DHMTs), specific questions focused on determining current FP and injectable contraceptive use and hindrances to its operations or management; as well as determining the level of awareness of emergency contraception services among health workers and the public, as emergency contraception is another intervention available to avoid pregnancy.

Conducting focus groups. The Health Policy Initiative research team (two consultants and two researchers) conducted the FGDs and interviews with various health providers and community members in six underserved districts in Malawi from December 13–20, 2007. The aim was to conduct a minimum of four FGDs in each district (two each at the district and community levels) and to cover as many target groups as possible. Two teams, including one consultant and one researcher, simultaneously conducted the FGDs and interviews at the district hospital and health center/community levels. While one team met with the DHMTs, FP providers, and FP users awaiting services at the district hospital, the other team conducted focus groups in a community selected by the DHMT and district FP coordinator, who also identified community participants through a “snowball” process initiated with the local chief. Each focus group had five to 10 members. When there were insufficient participants for a focus group, respondents were interviewed individually. The research team conducted focus groups and interviews in either English or the appropriate local language. All FGDs were recorded and transcribed verbatim.

The research team began by introducing themselves, reviewing the purpose of the meeting, and requesting members’ participation. Once consent was obtained from each group member, the discussion leader (usually the consultant) followed the appropriate discussion guide with some deviation based on the participants’ responses. The discussion leader improvised follow-up and probing questions to seek or clarify responses. All community member participants were provided transportation compensation in the amount of 500 Malawi Kwacha (approximately US\$3) at the end of the discussion. The researchers assisted the consultants by taking notes, ensuring that the sessions were recorded and that proper protocol was followed, and in some instances, facilitating the group sessions.

Box B1. Questions for All Focus Group Discussions

FP experience and views

- What is known about family planning; the methods, the benefits?
- What hinders people from accessing FP?
- What are people’s concerns about using FP?

Preferred FP method and its accessibility

- What are the FP methods being used or preferred by women? Why?
- Is the preferred FP method available in the community? If so, how and who provides it?
- What are people’s concerns/worries about injectable contraceptives?
- Is there need to provide injectable contraceptives in communities? If so, why?

Options for CBD of injectable contraceptives

- How can injectable contraceptives be provided in communities (how, when, where, who provides)?
- What is necessary for this to happen (resources, training, supervision, etc.)?

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