Malawi Case Study: Choice, Not Chance

A Repositioning Family Planning Case Study

September 2005

USAID
FROM THE AMERICAN PEOPLE

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ACQUIRE Report

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Executive Summary

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well documented, the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though need remains high. This is particularly true for Sub-Saharan Africa; for the region as a whole, only 14% of women are using modern methods of contraception (PRB, 2004). To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. Case studies were undertaken in three countries that have been successful in increasing contraceptive use and reducing fertility—Ghana, Malawi, and Zambia—so that lessons learned can be used to guide strategy development and identify key investments. A three-person team conducted interviews and site visits in Malawi from January 31 to February 10, 2005, interviewing 42 key informants, visiting health facilities, and holding group discussions with community-based distribution agents and family planning clients.

Family planning has been remarkably successful in Malawi, particularly considering the constraints faced in the country. Malawi's contraceptive prevalence rate (CPR) for modern methods increased from 7.4% to 26.1% between 1992 and 2000, despite high rates of poverty, low rates of literacy, a predominately rural population (86%), and an HIV/AIDS prevalence rate of 14% in its adult population. It is particularly impressive to note that gains in CPR cut across the economic spectrum.

Although family planning had essentially been banned under President Hastings Kamuzu Banda (1964–1994), "child-spacing" had been adopted as an integral part of the maternal and child health program in the 1980s, emphasizing the health problems that women faced when pregnancies were too early, too many, too late, and too frequent. The change in the political system from an essentially totalitarian government to multi-party democracy meant that the words "family planning" could be used and that more intensive policy and programmatic activities could be undertaken.

As a result, the number of facilities providing family planning increased from two clinics in 1983 to 210 out of 742 sites in 1995; now, family planning is almost universally available. A 1994 study identified a number of factors that limited access, including the fact that only 28% of facilities offered family planning services on a daily basis (Tavrow et al., 1995). After this, access was improved by ensuring that services were offered five days a week and for free. Malawi has had a good mix of both public and private services and both clinic and community-based services. In particular, Banja la Mtsogolo (BLM), a nongovernmental organization (NGO) with a network of 29 clinics and extensive outreach efforts, has played a significant role in expanding access to reproductive health services. BLM's subsidy fund helps to keep services affordable for poorer clients. When this was removed in 2000, utilization of family planning services dropped dramatically, but when the subsidy fund was restored in 2002, the number of family planning clients increased significantly.

Supply-side interventions focused on improving the contraceptive logistics and supplies through the introduction in 1997 of the Contraceptive Distribution Logistics Management Information System (CDLMIS), the training of providers, and the development and dissemination of service-delivery policies and guidelines. These 1992 guidelines removed barriers of spousal consent, age, and parity and allowed a wider range of cadres to offer various services.

On the demand side, multiple channels of communication in multiple languages were effectively used, including radio jingles, posters, dramas, health talks, and community-based distribution (CBD) activities, so that Malawi was "flooded with IEC messages." One reason for the effectiveness of these messages is that they were developed through consultation with communities, "asking them to analyze the situation. They talked about all these problems they had because of too many children," problems that included land disputes and disputes between husbands and wives.

Community-based distribution agents (CBDAs) began in Malawi in the late 1980s and have been a key contributor to the success of family planning in the country: "If we didn't have CBDAs, we wouldn't have made the headway that we managed." In a country where the majority of the population lives in rural areas, often far from health facilities, CBD has been essential to making services more convenient: "We need the CBDAs—people would rather have a child than queue for hours." In addition to directly providing pills and condoms, CBDAs also help to raise awareness and normalize the idea of family planning and serve as referral agents, in many cases even escorting women to clinics for services. Focus-group discussions in 2002 found that CBDAs were highly praised for giving clear explanations and for helping to overcome difficulties with hospital providers (Opportunities and Choices, no date-a). CBDAs talk about the satisfaction of helping their communities, but they need more of an incentive than this to continue with their work. A 1999–2003 project that implemented district-wide CBD programs in three districts led to an increase in contraceptive prevalence from 24% to 36%, and project staff believed that "the incentives are what made the project successful." The provision of bicycles was a particularly effective incentive, as well as refresher courses.

Some of the key lessons learned from Malawi's family planning story are:

- Rapid uptake of modern family planning can occur in poor and largely rural settings.
- Family planning services must be affordable and available routinely and regularly, with trained staff and a reliable supply of contraceptives.
- A close partnership between government facilities and a strong NGO can be very effective.
- Removal of unjustified barriers (such as spousal consent, age, parity, and marital status) is essential to improving access.
- Knowledge and demand can be increased even in low-literacy settings, through information, education, and communications (IEC) that are properly developed with community input.

- Bringing services to the doorstep via CBD is important for increasing access for rural populations, and incentives—particularly bicycles—are important for facilitating CBD agents' work.

Introduction

Family planning saves lives and has long been considered a key aspect to socioeconomic development. Although this is widely acknowledged and well documented, in recent years the attention and resources directed toward improving family planning programs in developing countries have been decreasing, even though the need remains high. By one estimate, satisfying the unmet need for contraceptive services in developing countries would avert 52 million unintended pregnancies a year, thereby saving 1.5 million lives and preventing 505,000 children from losing their mothers (Singh et al., 2003).

To address this need, the U.S. Agency for International Development (USAID) has identified Repositioning Family Planning as a priority for its work in Africa. In the face of scarce resources, weak infrastructure, and a growing focus on HIV/AIDS, it is extremely difficult for African country programs to make significant gains in strengthening their family planning programs and thereby raising contraceptive prevalence. USAID has committed itself to providing incremental assistance to a selected number of focus countries at the very early stages of program development. To help guide these investments, lessons learned by countries in the region that have made significant progress will be very useful.

Therefore, USAID has undertaken a project to document the success of the family planning programs in three countries in Sub-Saharan Africa over the past 10–20 years and to identify which program interventions led to that success. The three countries selected for analysis are Ghana, Malawi, and Zambia, all of which have shown considerable growth in contraceptive prevalence and significant fertility decline, despite a challenging environment and limited resources. Their success can provide guidance for other Sub-Saharan African countries. The case studies will be used by USAID to guide strategy development for Repositioning Family Planning and to inform efforts to identify key investments for the region. In addition, a synthesis paper will pull out key lessons from the three case studies.

Methodology

This report documents the achievements, the process, and the keys to success from the family planning program in Malawi. The sources of data for this case study included in-depth interviews with key informants (Appendix 1) and a document review (Appendix 2). A team of three people, including two from the United States and one from Malawi, conducted interviews and site visits in Malawi from January 31 to February 10, 2005. In addition, the team interviewed a number of individuals at USAID/Washington, as well as other knowledgeable informants who had worked in Malawi. In total, 42 individuals were interviewed. Quotations from these interviews appear throughout the report. The following were the main questions addressed in these interviews:

1. What do you feel have been the main achievements and successes of the family planning program in Malawi in the past 10 years?
2. What were the main reasons for these achievements and successes (including program factors, policies, and societal/cultural factors)?
3. What were the main challenges or constraints encountered in implementing the family planning program?
4. How were these challenges addressed?
5. Have any regions of the country or segments of the population been more challenging to effectively provide services to? If so, what has been done to meet their needs?
6. What are the current priorities for the family planning program in Malawi?
7. What do you see as the main lessons learned from the work on family planning in Malawi?
8. What do you see as the challenges currently confronting the program, threatening past achievements to date? What should be done about them?

The information presented in this report gives a picture of the family planning program in Malawi; based on the data and on the opinions of key informants, general lessons learned are identified. However, these findings have some limitations. First, we are considering the program over the past 20 years, and sometimes getting accurate information about past conditions and actions can be difficult. This is due both to staff turnover and to the fact that people are generally more conversant about their current programs. Often, inadequate documentation and evaluation of projects has made determining exactly what was achieved difficult. In addition, directly attributing particular outcomes—e.g., increases in the contraceptive prevalence rate (CPR)—to specific interventions is difficult. However, based on the wide range of information gathered, it is possible to make general conclusions about effective aspects of the program that contributed to the country's success. Finally, the field work for the Demographic and Health Survey (DHS) was completed just at the time of the case study, so no preliminary results were yet available. This information could have proved very helpful, by showing trends over the past five years.

Findings

Timeline

Year	Key Policy and Program Activities	Impact	Context
1960s ⇒			• Family planning is banned.
1970s ⇒			• One-party rule is instituted.
1982–1983 ⇒	• National Child Spacing Programme is introduced as an integral part of the Ministry of Health's (MOH's) maternal and child health (MCH) programme. • The Health Institutional Development project begins to train providers in child spacing.		
1984–1986 ⇒	• Family Formation Survey is conducted.		• First case of HIV is identified.
1987–1989 ⇒	• Banja la Mtsogolo (BLM) is established, with one clinic. • Seven training sites for child spacing are set up.		
1990 ⇒	• Population and Human Resources Development Unit (PHRDU) is established in the Department of Economic Planning and Development.		
1991 ⇒	• The Christian Health Association of Malawi (CHAM) community-based distribution (CBD) projects begin. • Social marketing of condoms begins.		
1992 ⇒	• *Child Spacing Policy and Contraceptive Guidelines* (1st edition) are published. • Support to AIDS and Family Health (STAFH) Project begins as a six-year, $45 million dollar project. • National Family Welfare Council is set up to coordinate child spacing activities.	TFR: 6.7 CPR: 7.4%	
1993 ⇒			
1994 ⇒	• Population policy is launched.		• Multiparty democracy is instituted. • Primary education is made free. • International Conference on Population and Develop-ment takes place in Cairo.
1995 ⇒			• Beijing conference is held.
1996 ⇒	• Second edition of *Family Planning Policy and Contraceptive Guidelines* is published.	CPR: 14%	
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.		

(cont.)

Timeline (cont.)

Year	Key Policy and Program Activities	Impact	Context
1999 ⇒	• Population and Family Planning Project (PopFP) tests district-wide CBD of family planning (1999–2003). • Family Planning Association of Malawi is launched.		
2000 ⇒		TFR: 6.3 CPR: 26.1%	
2001 ⇒	• BLM expands to 29 clinics.		• Adult HIV prevalence: 15%
2002 ⇒	• The UK Department for International Development (DFID) provides funding to BLM, including support of its subsidy fund.		
2003 ⇒			
2004 ⇒			

What Was Achieved?

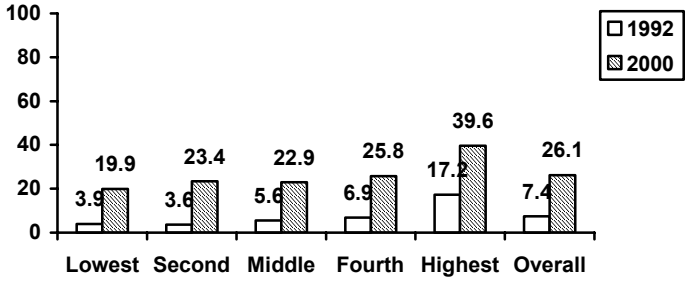
Malawi has made tremendous progress in increasing the use of modern contraceptive methods. The contraceptive prevalence rate (CPR) among married women aged 15–49 rose from 7.4% in 1992 to 26.1% in 2000, well on the way to meeting the goal set forth in the 1994 National Population Policy to increase the CPR to 28% by 2002. However, less progress has been made in meeting the goal of reducing the total fertility rate (TFR)[1] to 5.0 lifetime births per woman by 2002. The TFR was 6.7 births per woman in 1992 and decreased only to 6.3 per woman in 2000, making this rate one of the highest in eastern Africa, where the regional average TFR is 5.7 per woman (PRB, 2004). The authors of a review of the contraception-fertility link concluded that the weakness of this correlation in many countries in Sub-Saharan Africa has to do with these countries' being at the early stage of the fertility transition and that this link will likely become stronger with time (Westoff & Bankole, 2001).

How equally distributed across the population have these gains been? Most of the fertility decline has occurred among women aged 30 and older, with no decline among women younger than 30. In addition, much of the fertility decline has occurred among women in urban areas; the TFR among rural women is 6.7 births per woman, compared with a rate of 4.5 among urban women. Similarly, the CPR is higher among women in urban areas (38%) than among those in rural areas (24%). Nonetheless, the increase in CPR has been particularly striking in rural areas, where it rose from 6% to 24% between 1992 and 2000; in contrast, in urban areas it rose from 17% to 38%. Education also has a strong effect on fertility: Women with no formal education average more than seven births, compared with only three births per woman among those who attended secondary school or higher. While regional variation is minimal, fertility at the district level ranges from 4.3 lifetime births per woman in Blantyre to 7.0 in Kasungu, Machinga, and Mangochi districts.

[1] Total fertility rates are calculated for women aged 15–49 and are based on births in the three-year period preceding the survey. Rates may differ slightly from those published in 1988, 1993, and 1998, as these were based on births in the five years preceding the survey.

It is particularly impressive that the gains in contraceptive use cut across the economic spectrum. Although women in the wealthiest quintile still have a higher CPR than other groups, dramatic increases occurred from 1992 to 2000 among all groups (Figure 1). This

Figure 1. Prevalence of modern contraceptive use, by wealth quintile, 1992 and 2000



is probably due in part to the intensive effort in Malawi to bring services to the mostly rural population in the country (discussed in detail in the following section of this report). The TFR changed minimally in the lower wealth quintiles, and only the highest quintile showed a large decline, from 6.1 births in 1992 to 4.8 in 2000.

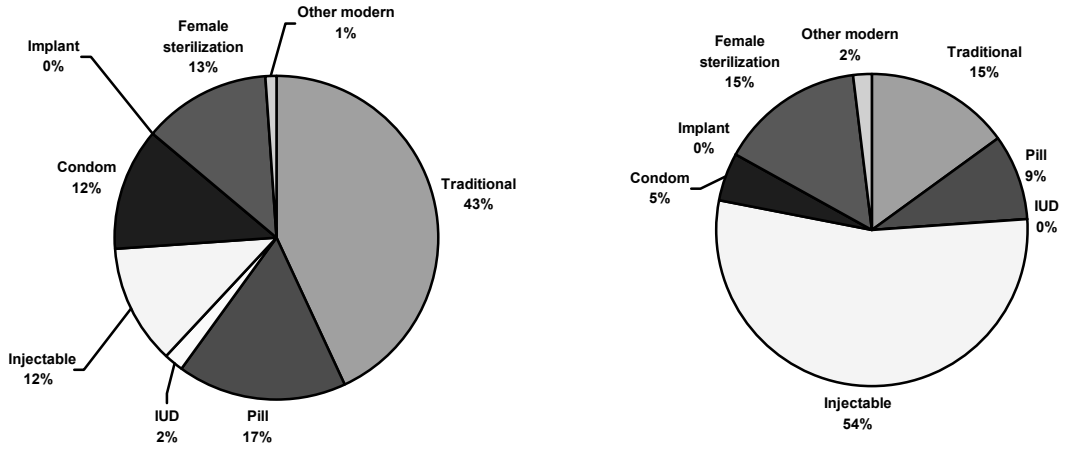
Despite relatively low literacy, knowledge of family planning methods has become almost universal in Malawi, with 98% of women and more than 99% of men knowing at least one method of contraception. More than 90% of currently married women are aware of pills, injectables, and condoms. Among currently married women, knowledge increased between 1992 and 2000 for all modern methods (Table 1). For example, knowledge of injectables rose from 68% to 96%, while knowledge of female sterilization climbed from 63% in 1992 to 88% in 2000.

Table 1. Percentage of currently married women knowing of selected modern contraceptive methods, 1992 and 2000

Year	Any modern method	Pill	IUD	Injectable	Condom	Female sterilization	Vasectomy	Implant
1992	91.8	82.9	46.3	68.3	73.2	63.1	18.8	--
2000	98.4	94.9	70.4	95.5	92.2	87.5	60.2	52.4

While women know about a number of modern contraceptive methods, the method mix has become increasingly skewed toward a strong preference for the injectable Depo Provera (Figure 2, page 8).

Figure 2. Percentage distribution of contraceptive method use among currently married women, 1992 and 2000



The percentage of currently married women using the pill or the condom changed little from 1992 to 2000 (from 2% to 3% for the pill and 2% each year for the condom). However, use of injectables rose from only 2% in 1992 to 6% in 1996 and to 16% in 2000. Reliance on female sterilization also increased significantly, from only 2% of currently married women in 1992 to 5% in 2000. IUD use remains extremely uncommon.[2]

Data from the team's site visit to Kamuzu Central Hospital in Lilongwe give an indication of the continued popularity of Depo Provera. From July to December 2004, an average of 1,185 clients per month chose the injectable, as compared with 62 per month choosing the pill, five selecting Norplant, and only two receiving the condom as their family planning method.

Malawi has made significant progress in expanding access and use of family planning. However, much remains to be done, and as one respondent explained, "do we celebrate when we have only a fraction?" According to the 2000 DHS, almost one-third of women (30%) still have an unmet need for family planning, with 12% having an unmet need for limiting births and 17% an unmet need for spacing. In urban areas, almost two-thirds (64%) of demand is being met, but this proportion falls to just under half (48%) in rural areas. Some respondents

Figure 3. Map of Malawi

[2] As an interesting indication of this, the Health Education Unit explained that when they were recently developing a poster of available family planning methods, they could not find an IUD to photograph.

discussed the challenges in increasing family planning in rural areas: "People have no entertainment except for sex. People don't have blankets because of poverty, so the only warmth they have is their partner."

What Was Done?

Context

The achievements of the family planning program in Malawi are particularly impressive, given the constraints faced in the country. These include:

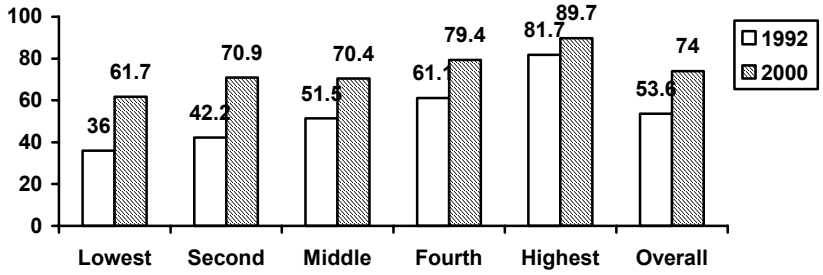
- **Poverty**. Almost two-thirds (65.3%) of Malawi's 11.9 million people live below the poverty line (World Bank, 2004).
- **High maternal and infant mortality.** The 2000 DHS estimated the maternal mortality ratio (MMR) to be 1,120 deaths per 100,000 live births, the third highest in the world. A maternal mortality audit at the Queen Elizabeth Central Hospital in Blantyre found an MMR of 1,140 per 100,000 (MOHP et al., 2003). The infant mortality rate (IMR) was estimated to be 103.8 per 1,000 births in 2000, a reduction from the 1992 rate of 134.6 per 1,000.
- **A predominantly rural population.** Eighty-six percent of the population lives in rural areas, creating significant challenges to increasing access to health services.
- **Cultural and religious barriers to family planning use**. This includes the desire for large families and the opposition of the Catholic Church.
- **Drought**
- **Low literacy**
- **Severe shortages of health personnel**. The Malawi Ministry of Health (MOH) has fewer than 100 doctors and 400 registered nurses in its system (to serve a population of 11 million citizens). This human resources crisis is exacerbated by HIV/AIDS, as more and more health care providers die while still in their productive years die.
- **HIV/AIDS**

The national adult prevalence of HIV was estimated at 15% in 2001. AIDS is the leading cause of death in adults, and more than 70% of hospital beds on medical wards are occupied by patients with HIV/AIDS-related conditions (USAID, 2001). In large part due to AIDS, life expectancy has dropped from 48 years in 1990 to 39 years in 2000. As stated in the 2003 National HIV/AIDS Policy, "HIV/AIDS is the greatest development threat and challenge Malawi is facing today" (NAC, 2003). Since the first case in Malawi was diagnosed in 1985, HIV prevalence among antenatal care clients in Blantyre increased from 2.6% in 1986 to more than 30% in 1998 and then decreased slightly, to 28.5%, in 2001 (NAC, 2003).

One of the major constraints faced by Malawi is also cited as one of the leading forces behind the fertility decline. Almost all respondents highlighted the idea that poverty and increasing economic hardships are among the strongest motivations for people wanting smaller families. In particular, land issues and the desire to educate children drive couples to choose to have fewer children and to invest more of their scarce resources in these children.

Increased access to education, particularly for girls, also has a strong impact on fertility and contraceptive use. There have been impressive improvements in providing education to the population, as shown in the changes between the 1992 and 2000 DHS surveys. For example, in 1992, almost one-half of women (47%) had no formal education, but this proportion had decreased to 27% in 2000. In addition, the proportion of girls aged 6–10 who were currently in school increased from 54% in 1992 to 74% in 2000, with a similar increase for boys in the same age range (from 51% to 71%). As with contraceptive use, these improvements occurred for all wealth quintiles (Figure 3).

Figure 4. Percentage of girls aged 6–10 currently attending school, by wealth quintile, 1992 and 2000



Linked with these improvements in education, the proportion of women who are literate has also increased over time. The 2000 DHS found that only 25% of women aged 45–49 are literate, compared with 67% of women aged 15–19. Projects such as Girls' Access to Basic Literacy and Education (GABLE), which has fertility reduction as one of its goals, have contributed to these achievements.

Policy and Government and Donor Commitment

From the time of its independence in 1964 until 1994, Malawi had an essentially totalitarian government under President-for-Life Hastings Kamuzu Banda. Child spacing was first introduced in the 1960s, but, as the 1992 Malawi Population Policy states, "the services' scope and objectives were not clearly presented to the public so that many misconceptions [which arose] led to the services being terminated," and family planning was essentially banned in Malawi. With the change to a multiparty democracy in 1994, a new freedom and openness in the country provided new opportunities: "Once those obstacles were removed, you can make a lot of difference. The public was being protected by a few who said they knew what the public wanted, but the opposite was true." Another respondent pointed out that the "change of government meant we could talk about things publicly, but the program started earlier." Child spacing (*kulera*) had been adopted as an integral part of the MCH program in the 1980s, emphasizing the health problems women faced when pregnancies were too early, too many, too late, and too frequent. But with the change in the political system, in addition to changing the name of the program to family planning, more intensive policy and programmatic activities have been undertaken.

Over the past 10 years, the Government of Malawi has demonstrated a clear and consistent political and programmatic commitment to the importance of ensuring

widespread access to modern family planning services, to improve the welfare of the country and its citizens. The rationale has sometimes primarily been related to economic and/or demographic considerations and has sometimes been health-related. The political support of the government was shown by national policies and actions, such as the Population Policy, which was launched in 1994. Such policies provided a "conducive environment" for program implementation.

Family planning was implemented as a vertical program, which ensured focus. For example, family planning coordinators in each district were seen as important in pushing the program: "The focal person in each district did wonders." There was some shift over the years in terms of which group coordinated family planning activities. In 1992, the National Family Welfare Council (NFWC), a parastatal under the Ministry of Women, Youth, and Community Services, was set up to coordinate child spacing activities. In 1997, the NFWC was reorganized as the National Family Planning Council (NFPC) and moved under the auspices of the MOH. At the same time, the Family Health Unit was reformed into the Reproductive Health Unit (RHU), and this group then took the lead in terms of implementing family planning services. By 1999, NFPC was dissolved.

There has been a good relationship between the donors and the MOH and sustained resources from a number of donors over time**.** "Without [the] commitment of donors, we would have low CPR," one respondent explained. Key donors in family planning have included USAID, the Department for International Development (DFID), the United Nations Population Fund (UNFPA), the European Union (EU), the United Nations Children's Fund (UNICEF), the United Nations Development Programme (UNDP), the World Bank, and the World Health Organization (WHO).

In 1992, USAID funded the Support to AIDS and Family Health (STAFH) Project as a six-year, $45-million-dollar project. The STAFH Project was then extended for three years, with a number of changes. Instead of a standard evaluation, an innovative participatory process was undertaken to determine the way forward. More than 250 key stakeholders were involved in discussions about which issues had been fully addressed, which needed additional support, and what gaps existed. Results were compiled and presented at a two-day workshop, which was followed by a series of meetings with government counterparts to agree on what activities would receive USAID support. The process not only provided input to amend the project and identify the most appropriate interventions (e.g., contracting with JHPIEGO to provide assistance with preservice training and with AVSC International [now EngenderHealth] to help improve services for long-term and permanent methods), but also provided a solid base for future dialogue between the stakeholders. For example, it led to specific examples of increased coordination between donors: USAID and UNFPA met with the RHU and NFPC to coordinate training efforts, and USAID met with the RHU, NFPC, National AIDS Secretariat, and DFID to discuss syndromic management and the need for STD drugs and HIV test kits. The latter resulted in DFID's agreement to finance the procurement of drugs for treating sexually transmitted infections and HIV test kits (USAID, 1998).

Another important change in the amended project was enhancing ownership by the MOH. According to the amendment of the STAFH project document, "due to strong criticisms of the project management approach in the first six years of STAFH, a new approach will be attempted that will be more participatory and will begin the process of putting 'ownership' for family planning and AIDS reforms into the hands of Malawians" (USAID, 1998). In the initial phase of the STAFH project, it "looked like a stand-alone project." After the project was amended in 1998, the agencies that provided technical assistance worked through the MOH and in many cases were based within the RHU: "That creates a camaraderie and team spirit. It was a very good group working together toward the same goal."

Program

The number of facilities providing family planning services in Malawi has increased significantly. In 1983, only two clinics offered child spacing services. By 1995, this increased to 210 out of 742 sites, and now family planning is almost universally available.

In addition to more facilities offering family planning, access has also been improved by ensuring that services are available five days a week: "Having reliable services was a key factor because rural people don't have a lot of time to spend to wait in line." A 1994 study that looked at the quality of care of family planning services had identified several factors that limited access (Tavrow et al., 1995):

- Only 28% of facilities offered family planning services on a daily basis.
- The average waiting time for family planning services was three hours, as compared to one hour for outpatient services.
- Stock-outs of contraceptives were common.

Although there has not been a systematic study to determine how much these factors have changed, respondents emphasized that these factors had been effectively addressed and this had made a significant difference in service utilization.

The provision of family planning services for free is also an important factor in the increase in access. The experience of Banja La Mtsogolo (BLM), a nongovernmental organization (NGO) based in Malawi, illustrates the importance of having affordable services. When BLM increased its fees and stopped subsidizing services in 2000, service utilization declined dramatically, from 174,548 family planning clients in 1999 to 112,142 in 2000 and as few as 94,257 in 2001 (Opportunities and Choices Programme, no date-d). When DFID provided support to restore the subsidy fund in 2002, the number of clients immediately increased to 136,373 and then practically tripled in 2003 to 349,829, at which time BLM also intensified outreach efforts. Based on this experience, it is clear that any cost-recovery initiatives in Malawi—where almost two-thirds of the population lives below the poverty line—must be very cautious and designed to avoid a similar sharp fall-off in service utilization.

Figure 5. Family planning client in Lilongwe

There has also been a good mix between public and private services and between clinic- and community-based services. The 2000 DHS found that the public sector provided 68% of family planning services. NGOs are an important complement to the public sector, because they can often meet needs that government services might not (such as providing youth-friendly services more easily and conducting more aggressive outreach). In particular, BLM has played a significant role in expanding access to reproductive health services. Starting with one clinic when it was established in 1987, BLM now operates 29 clinics throughout the country. Each clinic also undertakes extensive outreach efforts, including operating community mobile clinics with 102 government health centers (roughly four per BLM clinic) at which BLM staff provide services on certain days each month.

There had been some tension between the government and BLM, in part because the BLM logo formerly stated "leaders in family planning," which the government saw as their role. In 2000, BLM changed its logo to read "providing reproductive healthcare countrywide," and both sides now say that the relationship is greatly improved. As an example of collaboration, many of the clients for female sterilization at Queen Elizabeth Hospital in Blantyre go to BLM for services so they do not have to wait a long time. A number of facilities under the Christian Hospitals Association of Malawi (CHAM) also provide family planning services and have community-based distribution (CBD) programs. Social marketing of condoms, which began in 1992, has also contributed to the increase in family planning usage.

A number of key actions at the service-delivery nexus were taken to ensure that, as much as possible, an appropriate constellation of family planning information, commodities, and services would be regularly, reliably, and routinely available in Malawi. The actions taken for each of the key system components are described below.

Contraceptive logistics and supplies

For the last 6–8 years, the Government of Malawi and its donors of family planning and reproductive health commodities have "walked the talk" with respect to the well-known,

incontrovertible maxim, "No product, no program." The logistics system for family planning commodities and supplies has been maintained, with dedicated staff at MOH headquarters, the 1997 introduction of the Contraceptive Distribution Logistics Management Information System (CDLMIS), more attention to reporting and feedback, better storage capacity, and a significant complement of JSI/Deliver staff. (The latter were closely integrated with the MOH/RHU apparatus, so that the MOH/RHU had "ownership" of the system and effort.) Respondents highlighted the central importance of the improved logistics system, as before that there was "no system of knowing how much we needed in the country, it was simply guesswork. And you have to make sure the commodities are available—that was the greatest thing that we did." The primary donors in this area—USAID, DFID, and UNFPA—evinced a steady and ongoing commitment to the importance of family planning logistics and supplies. The result was that the supply of commodities became more reliable (since around 1997), with stockouts since then the exception rather than the rule.

Training

Training in family planning in Malawi has a long history, dating back at least to initial "child spacing" activities in the early 1980s. Early efforts under the USAID-funded Health Institutional Development (HID) project sent providers to the United States to be trained as trainers; in the following years, seven training centers were set up around the country. Malawi and its donor and implementing partners invested regularly in preservice didactic and clinical education to ensure that curricula for clinical officers and nurses were up to date with respect to family planning and that family planning received adequate attention. In particular, efforts were made to improve the practical side of preservice training for nurses, although this remains a continuing challenge. As one nurse explained about nurses trained recently, "they haven't even seen the cervix." In-service training was a frequent intervention, to provide needed knowledge and skills (e.g., method provision, infection prevention, side effects management, counseling, and supervision) to staff at the front lines of providing services. Training addressed the importance of full-site orientation, ensuring that the first people who met women at a facility—whether guards or cleaning staff or others—were sensitized about family planning and did not spread misinformation: "Gossip goes around like wildfire and it's really hard to extinguish that."

The past few years also saw more specific and intensive attention given to long-term and permanent methods (LTPMs) and to postabortion care (PAC), with training and technical assistance for increased service delivery in these keys areas provided by JHPIEGO and EngenderHealth.

Notwithstanding all of the investments in training, high rates of emigration, retirement, departure from government service for the private sector, and early death (mainly due to HIV/AIDS) have thinned the complement of health care staff available to serve Malawi's 12 million citizens. For example, in 2002, there were estimated to be fewer than 20 medical specialists, 70 medical officers, and 4500–5000 health surveillance assistants (HSAs) in the MOH system. In 2001, the MOH calculated that it had 323 clinical officers, 350 medical assistants, 374 registered nurses, and 1,268 enrolled nurse-

midwives deployed.[3] Overall, Malawi has approximately one physician for every 90,000–100,000 population.

Figure 6. Filled posts and vacancies of nursing personnel in government health facilities, 2005

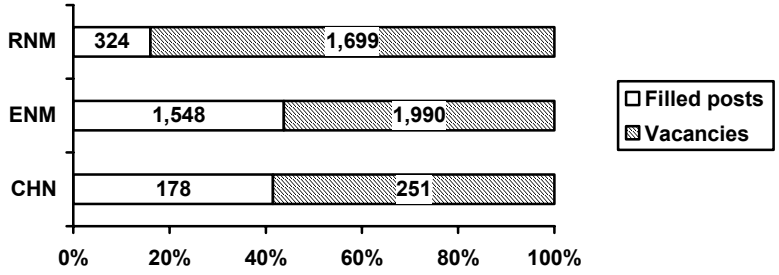


Figure 5 shows the extent of understaffing for nursing personnel in government facilities in the country. For example, only 16% of posts for registered nurse-midwives (RNMs) are currently filled. In CHAM's network, only 33% of its clinical (nursing) positions and 50% of its medical posts are filled—and even should these posts be filled, the provider-to-client ratio would be very low. For a project-level example, JHPIEGO trained 20–25 master trainers in the late 1990s, so that these trainers would be present at each Malawian teaching institution, as well as at key service institutions; by 2005, only four master trainers remain, the others lost to retirement, relocation, and death.

Service delivery policies and guidelines

An important set of activities, closely related to the education and training efforts, was the updating and dissemination of (and training in) the latest clinical/service-delivery policies and guidelines, with a view to removing any unnecessary policy and practice barriers to family planning service delivery. Specifically, these guidelines removed barriers of spousal consent, age, and parity, and allowed a wider range of cadres to offer various services. Perhaps the most dramatic example of the impact of removing unjustified medical barriers is that before 1992, a Malawian woman had to be married and have four children to be allowed to use Depo-Provera; since then, there have been no marital status, parity, or other (e.g., age, spousal consent) barriers to accessing Depo-Provera, and this has facilitated its widespread adoption and use. However it is still difficult in practice for most youths, especially unmarried youths, to access family planning and reproductive health services. A 1994 study found that more than two-fifths of providers would not be comfortable with providing services to young, unmarried women without children (Tavrow et al., 1995). Although there has been training in youth-friendly services, these attitudes likely still present a barrier to access for young people.

[3]These numbers do not include the additional personnel in the private sector (25 clinical officers, 30 registered nurse-midwivess, 110 enrolled nurse-midwives, and 60 medical assistants), in CHAM (81 clinical officers, 84 registered nurse-midwives, 657 enrolled nurse-midwives, and 123 medical assistants), and BLM (27 clinical officers, 30 registered nurse-midwives, 41 enrolled nurse-midwives, and four medical assistants) (McGrath, Schenck-Yglesias, & Lacoste, 2004; Schenck-Yglesias, 2004).

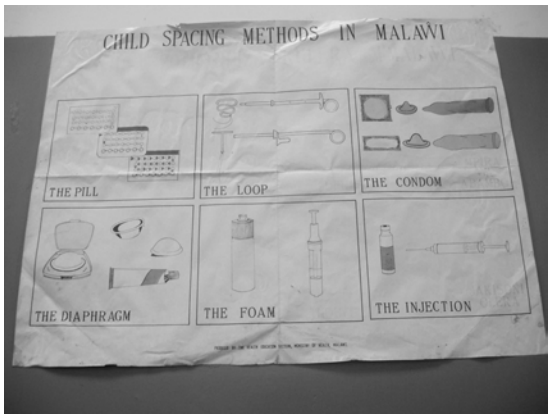
Investments and interventions in education, training, and rationalized, updated service guidelines and policies have been one of the most important reasons for the system's ability to provide wider access to quality family planning and reproductive health services, since the size of the complement of providers able to provide—and providing—quality services is clearly a "rate-limiting step" within a service system.

IEC/behavior change communication/demand creation

Over the period of time that Malawi prepared the way for, and then enjoyed, the rapid uptake of modern family planning, investments in the "demand" side also took place and were important. Multiple channels of communication in multiple languages were effectively used, including radio jingles, posters, folk dramas, health talks at clinics and in communities, and the activities of CBD agents (CBDAs), so that Malawi was "flooded with IEC messages." According to the 2000 DHS, while only 27% of women had heard a radio or television message about family planning in 1992, this increased to almost two-thirds (63%) in 2000. This increase occurred among people living in both rural areas (from 24% to 62%) and urban areas (from 48% to 71%). Community leaders were engaged, and satisfied clients (both formally and informally) spread information as well. All of these dynamics led to almost universal knowledge of family planning and to relatively fast and widespread adoption of modern contraception, showing that IEC can be effective even in populations with low literacy rates.

The early messages for family planning were developed through consultation with communities, "asking them to analyze the situation. They talked about all these problems that they had because of too many children." Problems such as land disputes or disputes between husbands and wives were seen as occurring because of too many children, and there were too many children because people were not using family planning. Respondents highlighted the need for developing messages properly and ensuring that the right message is conveyed. Initially, "the approach we had was wrong. We said you should have four children. That is wrong. You can't dictate to people. We should be saying there should be spacing, there should be a period of resting [between births]."

Figure 7. Family planning poster in a Malawi hospital



The family planning IEC materials have not been revised since 1995. The Health Education Unit is now looking at updating these materials, in part because their work in promoting emergency contraception has brought up the need to repackage family planning so as to encourage users of emergency contraception to then use regular family planning methods.

Community-based distribution

CBDAs began in Malawi in the late 1980s and have been a key contributor to the success of family planning in the country: "If we didn't have CBDAs, we wouldn't have made the headway that we managed." Such services are particularly important in a country with a mostly rural population: "We didn't want people to walk for miles to get services." Just over half (54%) of the rural population has access to formal health services within a five-kilometer radius, as compared with 84% of the urban population. A recent study found that access to reproductive health services did not explain use of modern contraception in Malawi, and the authors concluded that one explanation was that community-based health workers and mobile clinics might account for providing access to those who live far from facility-based services (Heard et al., 2004). CBDAs are an important way to make services more convenient: "We need the CBDAs—people would rather have a child than queue for hours." Programs effectively used existing social structures for the CBDA programs. For example, chiefs were involved in choosing who would be a CBDA: "They select the people they trust and those people don't want to disappoint their leaders."

In 1999, with World Bank funding, the MOH began the Population and Family Planning Project (PopFP) to test the feasibility of district-wide CBD of family planning and reproductive health services. Implemented in three districts (Chitipa, Ntchisi, and Chiradzulu) between 1999 and 2003, the project led to significant increases in contraceptive use between the baseline and end-of-project surveys, as well as in comparison to three control districts. Use of modern methods increased from 24% to 36% in the pilot districts, while it only increased from 25% to 30% in the control districts. In addition, the proportion of women reporting CBDAs as their source of contraception increased from 1% to 24% in the pilot districts (PopFP et al., 2003). The idea was to replicate the project if it was successful, but this did not happen: "If replicated, [it] would have seen even more success, but there was no proper handover."

BLM undertakes a range of community-based activities. They have two agents per clinic (for a total of 58) who receive a salary and are called reproductive health agents. Referral agents, who are typically satisfied clients, are also recruited by BLM in their outreach efforts. In addition, since 1987, BLM has employed male motivators, after having realized that few people were coming for services in part because male opposition to family planning acted as a barrier. Encouraging male involvement has been important in Malawi; an analysis of the 2000 DHS data found that discussion of family planning with a partner and his approval of family planning were the single most important factors in the use of modern methods of contraception (Opportunities and Choices Programme, no date-c). It is encouraging to note that the proportion of couples who discussed family planning at least once increased from 57% in 1992 to 72% in 2000.

Figure 8. What do the community-based distribution agents say?

Male CBDA, Ntchisi	Female CBDA, Chiradzulu
Although the PopFP project has stopped, he has continued working as a CBDA because he feels that it is part of his responsibility. "When I see a pregnant woman with a small child, I feel that this was my responsibility and I have failed in my duty." It is difficult for him to leave the job, because people who are using family planning methods are always coming to his home and he feels that if he leaves the job, all of these people will suffer. The work has changed his life a lot, including his attitude towards having children. He used to think it was good to have many children, but now he has only four. It has taught him to empathize with women and how important it is to space births. The work has also brought a tremendous change to the community. People had been telling women how dangerous it is to have pregnancies close together. Then while he was going around counseling, a woman with many children died in childbirth, and people saw what could happen and they thought "I don't want that to happen to me" and they saw the importance of birth spacing. There have been no maternal deaths since the program started.	When asked whether she is still working as a CBDA since the project ended, she responded, "Of course!" She is still doing the work because of humanitarian reasons. "I was chosen by the people, so I must continue to help them." The work has changed her life. Before, she didn't know about family planning, but with her new knowledge she was able to plan with her husband to have only three children and then she chose tubal ligation at age 27. Because they were able to plan, now they can send their children to school and feed them. In addition, they have a better understanding of HIV/AIDS. There were also changes in the community. At first, when counseling women, they had problems, because the women thought they were telling them to not have children. But then they appreciated that they would have an interval between births. There had been high levels of malnutrition and high infant mortality, and many women would have five births but only one living child. And so they saw that women who space children had good health and so they could do more work. "So now it is easier to talk about family planning."

The widespread use of CBDAs has not only led to wider availability of family planning methods such as oral contraceptives and condoms, but it has also helped to normalize the use of contraception and the idea of planning the size and timing of one's family. In addition, the CBDAs frequently served as effective referral agents to clinical facilities, even accompanying or transporting clients to those facilities to receive longer-lasting, more effective contraceptive methods such as Depo-Provera and female sterilization. Focus-group discussions conducted in 2002 found that CBDAs were highly praised for giving clear explanations and for helping to overcome difficulties with hospital providers (Opportunities and Choices Programme, no date-b). The training and the work also had a strong impact on the individual agents, in many cases transforming them into advocates and champions at the community level.

CBDAs talk about the satisfaction of helping their communities. But they need more of an incentive than this to continue with their work. Staff from the PopFP project explained that "the incentives are what made the project successful." Another explained that "you can't expect someone to provide a service for free." Effective incentives included refresher courses, which were important in terms of maintaining morale, and, most importantly, the provision of bicycles. In one CBD program, with support from the

UMOYO Network, program managers noted that the provision of bags and umbrellas made little difference in the uptake of family planning, but that when the agents were given bicycles, there was an immediate and significant increase: "There is a reluctance to pay for things like that, but you have to—you have to get people around. It makes such a huge difference." According to the 2004 CBD guidelines, "anyone setting up a CBD program should consider some of the following incentives: community support; recognition and acknowledgment of CBDAs efforts by influential leaders and community members (e.g., during church/political meeting, she could be asked to say something); promotion to CBDA supervisor; performance-based awards; and money for an IGA activity appropriate to the community" (MOHP, 2004).

Lessons Learned

Malawi's experience has demonstrated that:

1. Rapid uptake and sustained use of modern family planning methods can occur in even the most poor, resource-strapped, and largely rural settings.
2. It is important that family planning services be available routinely and regularly, with trained staff and a reliable supply of commodities.
3. Consistent and meaningful commitment of government and donor attention and resources over time is essential to this (still-unfolding and potentially fragile) "family planning success story."
4. The cost to clients of family planning and reproductive health commodities and services is a significant and highly elastic variable. Governments and donors working in highly impoverished settings should be focused on programmatic sustainability, (i.e., sustainability of demand for, and availability of, modern family planning services). While an emphasis on financial sustainability in these settings is unrealistic and inadvisable, this does not diminish the need for implementers and donors to be strategic and wise with respect to costs.
5. A close working partnership between governmental facilities and strong NGO service-delivery organizations—in Malawi's case, Banja Lo Mtsogolo—can be very effective in increasing the availability and use of family planning and reproductive health services, especially clinical services.
6. Even in resource-constrained settings, careful attention and commitment to maintaining a contraceptive logistics and supply system can ensure that stockouts are the exception rather than the rule. Having personnel dedicated to contraceptive logistics supplies is very helpful in reducing or eliminating stockouts. A system whereby staff providing technical assistance in managing family planning commodities logistics are housed with their MOH counterparts who are also dedicated to family planning logistics is also very useful.
7. Because a system's complement of trained providers is a key "rate-limiting" step in the extent to which quality family planning and reproductive health services can be provided, and because this complement will experience ongoing losses through migration and mortality, training of all types and at all levels (both didactic and clinical, preservice and in-service) will continue to be a necessary and important intervention.
8. Removal of service policy and practice barriers that prevent wider access to services (e.g., age and parity barriers to receiving family planning, or barriers to which level of trained provider can provide a given service) can result in much wider availability and use of modern methods.
9. Malawi's openness to using trained "lower level" cadres to provide some types of services (once they have demonstrated their capability to do so) has had an important effect on access, without compromising quality. Thus, clinical officers as well as physicians can and do provide female sterilization, Norplant and vasectomy; registered nurses and enrolled nurse-midwives can and do provide Depo-Provera and IUDs, etc.

10. Knowledge and demand can be increased, even in low literacy settings, through the use of multiple communication channels and local languages. Attention to IEC, BCC, and demand creation is a necessary part of holistic programming; neglecting it will diminish programmatic impact.
11. Demand for services will increase when it becomes known that the services are available and that others have found the quality of those services to be acceptable.
12. Bringing services to the doorstep via CBDAs is important for increasing access for rural populations (and for "legitimating" family planning). The contribution of CBDAs is not limited to their ability to widen availability of oral contraceptives and condoms; they also help foster a norm of family planning in their communities and serve as effective referral agents to clinical settings. However, even when CBDAs are unpaid volunteers, such programs are expensive and difficult to sustain.
13. Female sterilization services can still comprise a significant share of modern method use and meet the needs of women who desire no more children, even in a setting severely constrained by the lack of clinically skilled providers.

Challenges

As identified in the preceding sections, Malawi faces an array of daunting challenges that threaten the remarkable, yet fragile, gains that have been made there in family planning. Among the greatest of these challenges are the following:

The HIV-AIDS pandemic in Malawi is siphoning away available human and financial resources. The funding and service emphasis on HIV/AIDS is understandable, important, and overdue. However, the separate contribution that family planning makes, and can increasingly make, especially to the health of Malawi's women—who face one of the highest maternal mortality rates in the world—is in jeopardy. The important contribution that effective contraception can increasingly make to the prevention of mother-to-child transmission of HIV is also in jeopardy. Modeling shows that contraception offers greater potential for preventing vertical transmission than does nevirapine, albeit in a different subset of the population (i.e., among women who want to space or limit their next birth, rather than among women who desire a birth at present). Similarly, effective contraception provides greater reduction in the national burden of AIDS orphans than does nevirapine.

Malawi also faces a **major human resources crisis**, in the face of rising demand and greater workloads due to increasing disease burdens. Trained providers are being lost to emigration, to higher-paying jobs in Malawi (e.g., with NGOs[4]), and to HIV/AIDS. In addition, the demands of coping at the facility level with HIV/AIDS and its related conditions reduces the time and resources available personnel have for providing family planning.

There is also a discernable **lack of champions** for family planning. The Reproductive Health Unit of the MOH—the locus for Malawi's family planning and reproductive health program effort—is now markedly understaffed. In such a situation, it is difficult to maintain the existence of a "champion" or "champions" to ensure continued focus on family planning.

The HIV/AIDS and family planning and reproductive health communities, and the public health community at large, are grappling with the complex and multifaceted issue of the **integration of HIV/AIDS and family planning**. However integration is conceived, its demands are obvious, even if the way forward is obscure. There are logical areas of connection and potential synergy between these two areas, but also many theoretical and practical difficulties in effecting meaningful integration. Typically, an "integrated" effort diminishes the performance of any given intervention (as the same worker or system is asked to "do more with no more"—if not with less). In addition, often when a public health community organizes to address a given problem, it does so in a vertical manner,

[4] For example, the evaluation team was told about the following contrasts: Whereas an enrolled nurse in the MOH would receive 7,000 kwacha per month and a registered nurse 14,000, people working for an international NGO in Malawi could earn 25,000 and 45,000 kwacha per month in the same positions, respectively.

because that is often a more effective way to address a given problem. To a large extent, this is happening now with HIV/AIDS,[5] putting an added strain on the provision of family planning commodities and services. Thus, whether the HIV/AIDS focus is a (yet to be fully defined) "integrated" one or a vertical one, attention to the inputs and programs needed to continue Malawi's remarkable family planning performance is in jeopardy.

The **structure and financing of health services** also poses challenges. The twin movements of decentralization of responsibility for service provision and the adoption of the Sector-Wide Approach (SWAp), while understandable and defensible, pose another set of challenges to Malawi's ability to maintain a dynamic, high-performing family planning effort. This is because many more separate decisions will now be needed, as well as much greater "coordination" between various units and organizations and individuals, to continue a focus on family planning and reproductive health care, and all of this in an environment where funding is less certain and where program responsibility is more fragmented.

The **contraceptive logistics system's relative reliability** over the past few years is in jeopardy, as evidenced by the recent move of the JSI/Deliver technical assistance staff from the RHU to the larger MOH and the absence of a person dedicated to family planning and reproductive health logistics in the RHU. Yet the truism "No product, no program" must be heeded, or the overall upward trends in family planning use will surely slow markedly, if not even reverse course.

Malawi's **large young population**—there are 3.4 million Malawians aged 5–15, compared with 4.3 million aged 15–44—will soon be entering their reproductive years. Yet young Malawians, especially unmarried ones, still have limited access to family planning and reproductive health services. Furthermore, these services are inherently more challenging to provide effectively, even without the discomfort and denial that many adults evince, which further impedes effective service provision to younger clients.

Ongoing **needs for various types of training**—preservice and in-service, didactic and clinical—**are and will continue to be large**, especially given the threats from migration and mortality. Failure to invest in this area will compromise the always-fragile availability and quality of services. Maintaining a capacity to provide safe and good-quality female sterilization services, as well as enlarging the program's ability to increase the availability of relatively neglected and "underutilized" contraceptive methods such as the IUD (and even vasectomy), also has significant training (and cost) implications. Similarly, revitalizing the CBD system—one that might be integrated with community-based HIV/AIDS work—also has cost and training implications.

[5]For example, whereas family planning commodities have now been "integrated" within the larger MOH system, without a dedicated staff person, as opposed to the function (and dedicated staff person) residing in the MOH/RHU, antiretroviral logistics will be handled in a dedicated fashion (as was formerly the case with family planning commodities).

Programmatic sustainability in Malawi—as manifested by widespread and regular availability of commodities and of trained providers, and effective access to services by clients—is thus gravely threatened (with "financial sustainability" an unrealistic goal in the short to medium term[6]).

Perhaps the greatest challenge of all is **maintaining government and donor commitment** (of both attention and funds) **to the provision of family planning and reproductive health services,** which is important both in itself (for the economic health of Malawi and the physical health of its women and children) and as an important weapon in the battle against the devastating HIV/AIDS pandemic.

[6]Indeed, given the salary differentials between the MOH and various NGOs, donors may need to reconsider the truism that they should never pay recurrent costs; otherwise, the loss of human resources will (predictably) continue. Indeed, given the flood of money devoted to all aspects of HIV/AIDS—from clinical research to provision of antiretrovirals—the hemorrhage is likely to worsen.

Recommendations

Overall, the team recommends be continued support to ensure that the impressive gains made by the Malawi family planning program are not lost: "Things have improved, but we have to be careful that what we have achieved in the past seven years will not be lost." In light of the challenges discussed above, there is a need to reemphasize the importance of family planning, in part through filling key MOH positions and ensuring continuing advocacy for family planning. In addition, it will be essential to avoid missed opportunities—for example, by enhancing integration with HIV/AIDS services, building on the existing cohorts of CBDAs, and exploring the reintroduction or revitalization of underutilized contraceptive methods.

Some specific recommendations follow:

1. Donors need to **stay the course** and ensure continued support for key program components (e.g., logistics), while at the same time working with the government to plan for sustainability.
2. The MOH needs to **remain committed to family planning**, including filling staff positions at RHU and having a staff person dedicated to family planning.
3. There is an overall need to **improve staffing and supplies** at health facilities throughout the country.
4. The Malawi MOH and its donors must **ensure the effectiveness of the contraceptive logistics system** and that regular availability of contraceptives remains strong and reliable after the system becomes fully integrated into the MOH.
5. **Integration of family planning and HIV/AIDS** is essential**.** Family planning should be considered to be a vital component of HIV prevention or mitigation so that it is part and parcel of it: "Family planning is fading away slowly, and yet we should have utilized HIV/AIDS as an opportunity." In addition, donors can "be more lenient with HIV/AIDS funding," to avoid creating unnecessary barriers to integration. As one respondent explained, by not talking to a couple about family planning when counseling them about HIV, "we are doing a disservice to that couple."
6. **CBDAs are an important resource**. As one respondent explained, "if family planning wants to go forward, given the serious human resource problem which won't go away any time soon, we will need CBDAs." It would be helpful if a national assessment of the different CBDA programs looked at where are they available, where are they needed, and how can they be sustained.
7. **Test the feasibility of expanding the cadres** able to provide various family planning methods (e.g., allowing lower-level cadres to provide Depo-Provera), as this will be needed to meet the continuing growth in demand for these method. For example, health service assistants (HSAs) currently can vaccinate children but cannot give Depo-Provera to the children's mothers, even though the clinical skills involved are largely the same.
8. Explore ways to **broaden the method mix**, particularly for longer term methods such as the IUD. There is currently not a great deal of interest in, or accurate knowledge about, the IUD in Malawi. This situation will not be easy to change; however, it could

be worth the effort, given new findings that are relevant to the Malawi context.[7] Pilot projects could test the feasibility of reintroduction.

9. **Get services to youth.** Youth-friendly services should continue to be a focus of NGOs. The MOH could also test the feasibility of offering youth services in afternoons at its facilities: "You look at services on the ground and it's mostly BLM and FPAM. In government, we have trained staff to be youth friendly, but there are human resource problems, and the structures are not favorable." Cost-effective and replicable models of youth-friendly services are clearly needed. Realism and honesty among adult decision makers, program managers, and providers is also necessary.
10. **Improving the clinical skills of providers,** both through in-service and preservice training, will be particularly important for expanding access to long-term methods.

[7] In 2003, WHO endorsed the IUD as safe for HIV-positive women and women with AIDS. As Malawi experiences greater availability and correct use of antiretroviral drugs and this leads to longer periods of healthy living, women with HIV/AIDS are likely to be more concerned about contraception in the future. The fears that are widely prevalent among providers and clients with respect to the IUD's causing pelvic inflammatory disease (PID) or infertility are known to be highly overestimated: The IUD presents very little risk of increased PID (from one in 333 to one in 666 in high-STI settings), and this risk is limited to the first few weeks after insertion. The risk of infertility due to PID is markedly smaller than that. For these reasons, efforts to "revitalize" the IUD are underway in several countries neighboring Malawi (Kenya, Tanzania, and Uganda).

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Appendix 1: List of Contacts

Name	Title	Organization
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Mexon Nyirongo Cheryl Kamin Lilly Banda Maliro	HPN Team Leader HPN Deputy Team Leader RH Specialist	USAID/Malawi
Robert Ngaiyaye	HIV/AIDS & Education Technical Advisor	Ministry of Education & Human Resources (formerly PHRDU IEC Officer)
Dr. Ann Phoya	Director	Nursing Services, MOH (formerly Manager of Population and Family Planning Project)
Paul Dielemans	SRH Programme Officer	Reproductive Health Unit, MOH
Antony Mhango Y. Kwauma Charles Phiri	Senior Clinical Officer Supervisor CBDA	Ntchisi District Hospital Formerly with PopFP Formerly with PopFP
Jane Banda	Tutor	Formerly CBDA Officer with Project HOPE
George Mandele		Demographic Unit
Alister Munthali	Medical Anthropologist	Centre for Social Research, University of Malawi
Agnes Chimbiri	Director	Centre for Reproductive Health, University of Malawi
Florence Chipungu Joseph Mwandira Daniel Munthali Ellen Jamba	Director Programme Manager, HIV/STI Coordinator, HIV/AIDS PMTCT Officer	Adventist Health Services
Mrs. Mpinganjira Mrs. Perpetual Msindo Mrs. Lizy Missi	District FP Coordinator CBDA CBDA	Chiradzulu District Hospital Formerly with PopFP Formerly with PopFP
Clement Naunje Limbika Tauzi Edward Mponda	Outreach Officer Health Services Manager Marketing	Banja La Mtsogolo
Jones Katangwe	Deputy Director	PSI
Juliana Lunguzi	SRH, HIV/AIDS Consultant	Formerly with PopFP project
Maryjane Lacoste	Country Director	JHPIEGO
Veronica Chipeta John Zingeni	Acting Resident Advisor Management Assistant	JSI DELIVER
Effie F. Pelekamoyo	Executive Director	FPAM
Dorothy Lazaro	Programme Officer	UNFPA
Lilian Ng'oma	Director	Health Technical Support Services, MOH
Desiree Mhango	Nursing and Training Officer	Christian Health Association of Malawi
Aubrey Chibwana	Programme Officer (Research and Evaluation)	National Youth Council of Malawi
Ms. Chirwa	In-charge for MCH	Bottom Hospital (Kamuzu Central

Mrs. Potani Three FP clients	FP provider	Hospital)
Mr. Chibwana Mr. E. Mphande	Deputy Director	Population and Human Resources Development Unit (PHRDU)
Rita Chilongozi	Resident Advisor	Policy Project
Hector Kamkwamba Beth Deutsch	IEC Officer SRH Programme Officer	Health Education Unit, MOH
Chris Moyo	Director	Health Information Management Systems, MOH (formerly Director of PHRDU)
Joan LaRosa		USAID/Mozambique (formerly Malawi)
Susan Watkins		University of Pennsylvania
Michelle Folsom		PATH/Kenya

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