DEMOGRAPHIC PROFILE

• Population:
  – 13 Million (NSO, Malawi 2008 Preliminary Results)
  – 32% increase from 1998
  – 42.2% in the reproductive age range of 15-49 years
  – 85% of population lives in rural areas (MGDS 2004).
DISEASE BURDEN IN WOMEN OF MALAWI

• 18% Burden of disease in women of reproductive age is due to maternal causes (TFR 6.3)

• Additional 16% of disease due to HIV & AIDS (HIV prevalence 14%)

Ref. World Development Report 1993
Context and environment

• Family planning faces several obstacles
  – FP prohibited in Malawi until the 90s
  – Inadequate, understaffed and underequipped health facilities
  – Uneven distribution of health services
  – Total Fertility Rate remains high
  – Unmet need remains high
  – Maternal care services are limited due to shortage of midwives

• As a result Family planning method use has leveled off
The number of women of reproductive age is large and growing.

Projected women of reproductive age in Malawi

Source: SPECTRUM 2.41 Projections
The number of pregnancies continues to increase each year.

Pregnancies in Malawi

Source: SPECTRUM 2.41 Projections
A significant percentage of these pregnancies are unintended or mistimed.

Source: DHS

17. Source: DHS

Malawi
STRATEGY FOR MATERNAL HEALTH IMPROVEMENT IN MALAWI

1. Increase infrastructure for MNH
   i. Train more health workers (6-yr Emergency RH Plan being implemented)
   ii. Create more BEmOC site in rural areas (Now at 70% WHO criteria of 1BEmOC/125,000 pop.)

2. Reduce frequency at which women are exposed to risk of pregnancy. (*Increase access to FP to reduce # maternities*)
   i. Scale up community MNCH services including FP
   ii. Provide broad range of methods even at community level, including condoms
Policy Development Process for Community FP Services

- Decision to include DMPA in CBD delivery system met considerable opposition from medical community
- In March 2008 MOH’s senior management agreed by consensus to allow HSA's to administer ICs at community level
- Madagascar study tour conducted in June 2008
- Stakeholder’s dissemination meeting July 2008
Health Surveillance Assistants: Who are they?

- Lowest cadre of health workers on government pay roll based in communities; work in mobile or outreach clinics, village clinics, or health posts in all districts.
- Have 4 years of secondary school education
- Receive a 10-week training in health
- Estimate that HSAs currently provide 60% of all PHC, including administration of injectable EPI vaccines.
- Approximately 11,000 HSAs in Malawi,
- Official target ratio is one HSA/1,000 population; the current ratio is 1:1300.
RATIONALE FOR COMMUNITY-BASED DMPA IN MALAWI

• Human resource crisis - Clinic staff not coping with demand for FP services
• Limited access to services for rural undeserved communities. ~ 85% of population rural

• High demand for depo provera - the most preferred method of FP
• RH Strategy to meet Malawi Growth & Development Strategy (MGDS) targets (CPR, Annual Pop. Growth Rate).

• Taking MNH services to community shown to increase service coverage
Policy Development Process cont.

• 2007 study revealed that HSAs have been administering ICs for many years in pockets of some districts:
  – For more than 5 years in 3 districts,
  – For more than 18 years in 1 district,
  – For more than 15 years in 2 districts, and
  – In 2 districts, HSAs cover CHAM facility areas through an outreach clinic.

• NO ADVERSE REACTIONS reported.
CONTINUATION RATES SAME AS UGANDA (% Returning for Second Injection)

- CRHW Clients: 88%
- Clinic Clients: 85%

Percentage

[Graph showing the comparison between CRHW Clients and Clinic Clients with bars for 88% and 85%]
Client Satisfaction Same as Uganda
CBDA vs Clinic

Satisfaction with Care

Satisfaction with Depo Provera

CRHW Clients | Clinic Clients
---|---
Satisfied | Very Satisfied

CRHW Clients | Clinic Clients
---|---
Satisfied | Very Satisfied
THE MNCH SCALE-UP MODEL IN MALAWI

Preliminary impact model

**Model level**

1) **Inputs**
Policy, human resources, logistics/supplies, financing

2) **Outputs**
Information to families
Service availability
Quality of services

3) **Outcomes**
Population behaviours
Targeted population receiving the intervention

4) **Health status**
Mortality, morbidity
Nutritional status

District implementation plans

- Community mobilization
- Training of HSAs & supervisors
- Supplies, equipment & essential drugs
- Training of providers in health facilities

Outreach

- Increased training & supervision coverage
- Essential commodities available; monitoring established

Utilization

- Improved availability and quality of care at community level
- Improved availability and quality of care in health facilities

- Increased coverage for curative & preventive interventions

- Improved household compliance/care
- Improved careseeking utilization
- Improved preventive practices

- Improved nutritional status, Reduced mortality

**Monitoring, review, replanning**
Process of Introducing Community Delivery of DMPA

- Stakeholders meeting to build consensus on implementation approach and action plan
- Developed operational guidelines and adapted training manuals; job aids & clinical guidelines - August 2008
- Established CBD DMPA Logistics system August 2008
- Trained 30 trainers of trainers (TOT)
- Pretested training manuals - November 2008
- Scale up to be gradual and sustainable
Geographic Focus

10 intervention districts for MNCH rapid scale up
Progress to date

• MoH endorsed the guidelines and training materials in October 2008
• Trainings conducted in 9 districts as pilot sites.
• To date 426 HSAs trained and 80 supervisors/Nurses).
• Incorporation of CBD of DMPA in the Revised SRH policy using trained HSAs.
Input for assumptions

• Choice of goals to be reached by certain year:
  – Reducing unmet need for family planning
  – Reducing total fertility rate
  – Increase contraceptive prevalence rate
  – Increase birth interval
Facility data calibrated with community data

- Assess and improve health facility data on births and deaths
- Assess and improve community data collection
- Compare data from health facility to community data and assess possibility of calibration
Impact of Providing FP Through CBD Delivery System in Malawi

National CPR Trends in Malawi

- 1992: 7\%
- 2000: 26\%
- 2004: 28\%
- 2006: 41\%
Trends in U5MR (upper) and IMR (lower) in Malawi
Countdown to 2015 - MMR
CHALLENGES

• Availability of DMPA to meet the high demand

• Weak supervisory system for HSAs

• Waste management at community level

• HSAs multiple roles.

FIELD VISITS
Lessons Learned

• CBD service increased demand for DMPA

• Delivery of integrated MNH services (family planning/reproductive health and HIV/AIDS) has increased demand for HIV testing services.

• Increased contraceptive use at health centre level has required substantially-increased orders for contraceptives.
Conclusion

• FP has been recognised as key strategy for socioeconomic development & especial maternal and child health

• Taskshifting of DMPA delivery to nonmedical personnel has been shown to be safe and effective in Malawi

• Inclusion of DMPA in CBD programme has increased CPR in rural areas
Thank You