Success Story - Towards Universal Access to Comprehensive Sexual & Reproductive Health Services

Malawi’s Implementation of the Maputo Plan of Action (MPoA) - The Milestones Achieved

Summarised Report
Acknowledgements

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Acronyms

AIDS  Acquired Immune Deficiency Syndrome
ART  Anti-Retroviral Therapy
CHAM  Christian Health Association of Malawi
CBDAs  Community Based Distribution Agents
HIV  Human Immunodeficiency Virus
HSAS  Health Surveillance Assistants
HTC  HIV Testing and Counselling
ICPD  International Conference on Population and Development
IEC  Information, Education and Communication
MDHS  Malawi Demographic and Health Survey
MDGs  Millennium Development Goals
MMR  Maternal Mortality Ratio
MNH  Maternal and Neonatal Health
MoH  Ministry of Health
NGO  Non-Governmental Organisation
PMTCT  Prevention of Mother-to-Child Transmission
RH  Reproductive Health
RHU  Reproductive Health Unit
SRH  Sexual and Reproductive Health
SRHR  Sexual and Reproductive Health and Rights
STI  Sexually Transmitted Infections
TBA  Traditional Birth Attendant
UNFPA  United Nations Population Fund
YFHS  Youth Friendly Health Services
WHO  World Health Organization
Malawi’s Implementation of the Maputo Plan of Action (MPoA)

The Maputo Plan of Action (MPoA) states that African leaders have a civic responsibility to respond to the sexual and reproductive health (SRH) needs of their people. It is intended to be a demonstration of leaders’ commitment to this aim.

1.0 The Maputo Plan of Action

The Maputo Plan of Action (MPoA, 2006) is a short term Plan of Action which aims to assist African countries in achieving the goal of universal access to comprehensive sexual and reproductive health (SRH) information and services by 2015. The Plan of Action was developed following the realisation that African countries probably would not achieve the Millennium Development Goals (MDGs) by 2015 if significant improvements in the SRH information and services available to citizens were not achieved. The MPoA was designed and is tied to the achievement of health-related MDGs 4, 5 and 6, which it was designed to complement and accelerate.

The MPoA recognises that an efficient health system and sufficient financial and human resources are critical for the success of national SRH interventions. It highlights the need to mobilise domestic resources to support health programmes, including complying with the Abuja 2001 commitment to increase allocation of resources to the health sector to at least 15% of the national budget.

The Plan, which had been ratified by at least 21 African countries by 2010, is built on nine pillars:

1. HIV, STI and SRH services integrated into primary health care
2. Strengthen and increase community-based STI/HIV/AIDS and SRH services
3. Family planning repositioned as a key strategy for attainment of the MDGs
4. Youth-friendly SRHR services positioned as a key strategy for youth empowerment
5. Access to good quality safe motherhood and child survival services increased
6. Incidence of unsafe abortion reduced
7. Resources for SRH
8. SRH commodity security strategies for all SRH components achieved
9. Monitoring and evaluation coordination mechanism for Plan of Action established

The ultimate goal of the MPoA is for African governments, civil society, the private sector and all development partners to join forces and redouble efforts so that effective implementation of the continental policy, including universal access to sexual and reproductive health by 2015 in all countries in Africa could be achieved.
1.1 Scope of Success Story: Malawi

Why Document Malawi?
This report aims to articulate the positive lessons that are emerging from Malawi as Government operationalizes the Maputo Plan of Action which it domesticated in 2007. The report discusses lessons learnt from Government’s programmes and interventions that are aimed at achieving the SRH related targets that it has set for itself in the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi (2007).

Content in this booklet provides information on successful initiatives and strategies that African governments can emulate in their efforts to achieve universal access to comprehensive sexual and reproductive health services in their own countries. It is hoped that the lessons discussed in this report will:

- Help propel the efforts and progress of Member States towards the achievement of the MDGs as the set deadline, 2015, approaches
- Support countries to identify bottlenecks, share lessons and define national actions for accelerating and monitoring progress towards the achievement of universal access to comprehensive sexual and reproductive health as outlined in the MPoA.

The decision to document the progress made by Malawi is in part due to the fact that at the African Union Summit held in Kampala Uganda in July 2010 it emerged that Malawi was one of the few countries that has made substantial strides in implementing some of the nine action areas upon which the MPoA is based. This was particularly so with regards to the development of and implementation of national policies and programmes, and the engagement of strategic key stakeholders. SAfAIDS thus considered it important and timely to document the lessons emerging from Malawi’s success story so that Member State could learn from them and enhance their efforts towards meeting the 2015 targets.

1.2 Documentation Methodology
This report was compiled using information collected through interviews and focus group discussions using a qualitative research methodology and tools. A desk review of regional instruments, policy documents, policy frameworks, guidelines, national standards, strategy documents, legislation and other relevant literature on sexual and reproductive health issues was also conducted.

Data collection tools were developed to capture both qualitative and quantitative information from key stakeholders who are working around SRHR issues in Malawi. Key informants interviewed were divided into stakeholder groups comprising policy makers, implementers, and development partners. Stakeholders interviewed include
officials from Ministry of Health Reproductive Health Unit and HIV Department, Ministry of Youth, Central Monitoring and Evaluation and Research Division, Mchinji District Hospital, WHO, UNFPA, young men and women from Chiwamba, youth club and representatives from civic organisation (the list of respondents is annexed).

Data collection tools used for this report were standardised by matching them with the Southern Africa Development Community’s (SADC) and other international Good/Best Practice criteria to ensure validation of the Good Practice within and beyond SADC. The tools were adjusted accordingly on realising that the Malawi case was still emerging and that it was premature to assess it using the Good/Best Practice criteria. The exercise was therefore confined to documenting lessons emerging as Malawi implements the MPoA.

1.3 Contextualising Malawi
Malawi is a landlocked country in south-eastern Africa. It is one of the least developed countries of the world with an estimated population of between 13 and 15 million. Of Malawi’s total population, 49% are male and 51% are female. The country’s population is young, with 45% of all citizens aged below 15 years. Malawi has a largely rural population with 85% of all Malawian’s living in rural areas (UNGASS Country Progress Report, 2009).

Malawi is hard hit by the HIV epidemic. While national incidence peaked at 26% in 1998; encouragingly, it has been steadily declining since then (USAID 2010). This decline has been attributed in part to Government’s ability to engage with and coordinate the activities of multiple stakeholders through the development of policies and programmes. An example of effective collaboration is the Government’s May 2010 development of public service HIV workplace policies and programmes in partnership with private companies.

The guidelines provide standards of care and protection for workers living with HIV in the public service.

Furthermore, national policies and guidelines for voluntary counselling and testing, and sexual and reproductive health (SRH) areas such as prevention of mother-to-child transmission of HIV, ARV equity, and treatment of sexually transmitted infections (STIs) have also been developed and are being implemented.

These interventions are supported by impressive and rapid scale-up of provision of free ARVs that has been seen in Malawi since 2004, effectively contributing to reductions in mortality from HIV-related complications.

Through implementation of the MPoA, Malawi has enhanced access to quality, relevant, safe and friendly health services. The country is working to address the following SRH challenges through prioritising the implementation of the Maputo Plan of Action:

- **Limited knowledge and access to family planning options**, among young people, and young women in particular.

- Limited knowledge and access to family planning options **among married women, especially those in the rural areas.**

- **High incidence of unsafe abortion**. In Malawi induced abortion is illegal, unless the pregnancy threatens the mother’s life. Notwithstanding this, Malawi has the highest abortion rate in southern Africa at 35/1,000 for women aged 15 to 44 years. The majority of complications from unsafe abortions occur in young women below the age of 25 years.

- **Malawi’s maternal mortality rate in 2009 was at 807/100,000; the second highest in Africa** (Ibid 2009).

- **The early age of sexual debut and marriage** (15 years) also contributes to high incidence of early and unwanted pregnancies, to the high abortion rate, to maternal and infant mortality, and to incidences of STIs and HIV in young people.

In line with the MPoA, Malawi has a Roadmap in place for accelerating the reduction of maternal and new-born morbidity and mortality. Through the Safe Motherhood Project several interventions, including the incorporation of Emergency Obstetric Care in pre-service training; the use of cheaper, cost-saving but effective transport options (like bicycle-ambulances); and the use of traditional birth attendants have been successfully implemented. Further, Malawi uses Health Surveillance Attendance, whose contribution led to an 80% increase in immunisation.

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1. Malawi Reproductive Health Unit, 2009
2. Measuring the magnitude and consequences of unsafe abortions in Malawi, 2010
3. Second only to Sierra Leone
Malawi’s Domestication of the Maputo Plan of Action

2.0 Process of Domestication

In Malawi, the Maputo Plan of Action was domesticated through insertion of some of its components into national policies, strategic frameworks, standards and guidelines, processes and instruments. As will be discussed in this report, political will at all levels was crucial to the successful domestication and implementation of this and other international instruments.

The major national instrument that contextualises the MPoA in Malawi is the SRHR Policy (2009) which was developed to provide direction for decision-makers and programme managers for effective implementation of SRHR services that respond to Malawi’s specific needs. The policy was developed in collaboration with various stakeholders under the leadership of the Reproductive Health Unit of the Ministry of Health, in collaboration with the Christian Health Association of Malawi (CHAM), United Nations (UN) agencies, development partners, civic organisations implementing reproductive services, regulatory bodies, training institutions, Government implementers drawn from various sectors, as well as individual health experts.

2.1 Implementation Through Frameworks and Strategies

Malawi has developed a well-articulated institutional framework that coordinates the domestication and implementation of the MPoA. The Reproductive Health Unit (RHU) in the Ministry of Health is responsible for the formulation, dissemination, implementation and review of SRHR policies, guidelines and strategies.

The RHU operates under the guidance of an SRH Technical Working Group whose main purpose is to provide technical support, advice and coordination for SRH services. The Technical Working Group is comprised of members from line ministries, development partners and the private sector. The Director of Reproductive Health chairs the working group, which works with SRH sub-committees and reports to the Health Sector Review Group and the Senior Management Committee (SMC).

As is the case with other countries, including Uganda, Zambia and Zimbabwe, Malawi already had a National Sexual and Reproductive Health Strategy and a Roadmap for Maternal and Neonatal Health in place prior to domesticating the MPoA.
The setting up of institutional and legal frameworks for the implementation of health services served to further enhance the effective implementation and coordination of efforts and interventions around the MPoA after 2006, with Government naturally taking the lead role through its various institutions and mechanisms.

Below is a summary of the main legal and institutional framework and strategies, the particular issues they address and the interventions and activities they support.

<table>
<thead>
<tr>
<th>Year Developed</th>
<th>Policy/Legal Framework/Strategy</th>
<th>Key Issues and Areas Addressed</th>
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| 2006           | National Reproductive Health Strategy 2006-2010 | -Facilitated the formulation of the National Reproductive Health Programme  
-Provides direction and guides implementation of the national RH programme |
| 2009           | Sexual and Reproductive Health Rights Policy | -Principal plan on SRHR issues which integrates various emerging SRHR issues (also integrates Malaria, STIs and HIV and AIDS), assigns roles and articulates a framework for providing comprehensive services to all  
-Synchronises all SRHR initiatives; makes the RHU responsible for coordinating the implementation of the SRHR programme; identifies responsible units and partners and elucidates institutional strategies for implementation of the instrument. |
|                | Guidelines for Community Initiatives for Reproductive Health | Utilised to empower communities to partner with SRH and HIV and STI service delivery points for better community-based responses.  
-Complement the SRHR Policy by providing a standard method of implementing SRH community interventions  
Utilised to empower communities to partner with SRH and HIV and STI service delivery points for better community-based responses.  
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<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
<th>Description</th>
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<tbody>
<tr>
<td>2007</td>
<td>Roadmap To Accelerated Cuts In Maternal And Child Deaths And Illness In Malawi</td>
<td>Came out of a RHU-commissioned Emergency Obstetric and Neonatal Care assessment to determine the capacity of the healthcare delivery system to reduce maternal and neonatal mortality. Guides policy makers, development partners, training institutions and service providers in supporting Government.</td>
</tr>
<tr>
<td>2006</td>
<td>Youth-Friendly Health Service National Standards</td>
<td>Supports the development of a supportive environment to address the SRHR needs of young people. Also directs the coordination of health service provision for young people; enhances community and young people’s participation in health services and provides relevant services that meet the health needs of young people in a way that is accessible and acceptable to them.</td>
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<tr>
<td>2007</td>
<td>National Plan of Action for Scaling up SRH and HIV Prevention for Young People 2008-2012</td>
<td>Harmonises, consolidate and aligns all major existing policies, plans and strategies from various sectors on young people’s HIV and SRHR issues. Provides for the training of YFHS service providers; for pre-service training and creates a coordination mechanism that should help all national players to scale-up and accelerate HIV and SRHR programmes for young people.</td>
</tr>
<tr>
<td>2005</td>
<td>National Condom Strategy</td>
<td>Aims to ensure access to quality condoms of choice, free or at affordable prices; and to promote effective condom use to prevent unwanted pregnancy, STIs and HIV. Provides for the private sector to play a role, including giving technical assistance to industries to enable them to formulate HIV workplace programmes and strategies for condom distribution.</td>
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<tr>
<th>Event</th>
<th>Description</th>
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<tbody>
<tr>
<td>National Post-Abortion Care Strategy and National Post-Abortion Care Programme.</td>
<td>Contributes to the reduction of maternal mortality and morbidity related to complications of incomplete abortion and to break the cycle of repeat abortion through the provision of post-abortion family planning.</td>
</tr>
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Figure 2: Key legal and institutional frameworks and strategies guiding the implementation of projects.
Figure 3: Some of the guidelines and policies that govern SRHR issues in Malawi
Implementation

In implementing the MPoA, the Reproductive Health Unit in the Ministry of Health in Malawi works in collaboration with other key stakeholders, among them health departments, community based organisations and individuals, faith based organisations, civil society and private sector organisations, which are implementing interventions that address components of the MPoA.

Also in line with the MPoA, Malawi has integrated SRHR, HIV and STI issues into key national health policy documents and plans. Furthermore, Government, in collaboration with UNFPA, USAID and UNICEF, is integrating provision of family planning and HIV and malaria services into primary care at district and community level. One such hospital offering integrated services in Mchinji District Hospital.

Figure 4: Billboard at Mchinji District Hospital explaining the integrated SRHR services offered

Services that are available at Mchinji include antenatal and neonatal care, both long-term and short-term family planning methods, PMTCT, voluntary counselling and testing for HIV, including treatment, STI prevention and management, and cervical cancer services. Other services include post-abortion care, outpatient treatment, radiology and cans for pregnant women with minor and major complications. All women who access the antenatal clinic at Mchinji are screened and treated for STIs early to curb related complications and to prevent STIs from passing on to the unborn child. All these are referral services.

In order to provide the very best services, the infrastructure at Mchinji has been redesigned, and departments are laid out differently.

Mchinji Hospital is not without its challenges however. The major ones mentioned were insufficient equipment, low number of trained staff and over-subscription of services, meaning that the centre is constantly struggling to service all clients on the waiting list. A strategy devised by staff to deal with patients on the waiting list is to create waiting rooms for expectant mothers at community level. The waiting rooms are manned by specially trained community health surveillance attendants, some of whom formerly acted as Traditional Birth Attendants (TBAs).

“Integration is an approach that focuses on providing services during the same visit by the same provider and at the same facility as well as linking the client to other services within the same physical location.”

- Sister Ennie Chagunda, Mchinji Hospital
• **Family Planning Repositioning Key To Attainment of the MDGs**

Malawi’s unmet need for family planning services currently stands at 28%. Several innovative initiatives are being implemented to address this. Family planning is listed as an essential service, accessible free of charge in CHAM and public health facilities. The service is integrated as a component of a maternal, new-born and child health care service package; services include free female and male condoms, oral pills, Depo-Provera, Norplant, intra-uterine contraceptive device and sterilisation.

Other innovative interventions aimed at increasing family planning coverage are the Community-Based Distribution Models in which **Community Based Distribution Agents have been trained to address gaps in knowledge** in access to and utilisation of the wide range of available family planning services at community level. The intervention was piloted in 10 districts and was scheduled to be rolled out to the remaining 18 in 2010 (Reproductive Health Unit, 2010). The engagement of Community Based Distribution Agents is important in relieving the severe human resources shortages that Malawi faces; in all intervention areas they now carry out family planning-related information, education and communication (IEC) activities.

The Government of Malawi continues to support SRHR initiatives by making practical concessions that aim to address staff shortages. It recently formulated a policy that authorises Health Surveillance Assistants (HSAs) to provide Depo-Provera at community level. The empowerment of HSAs has contributed to an increase in family planning coverage, which in turn reduces pressure on health facilities.

The innovative interventions discussed above have increased the number of women reached with family planning information and methods, and in particular with Depo-Provera which, between 2008 and 2009, was the most preferred family planning method (Health Management Information Bulletin, 2009).

With technical and financial support from Management Sciences for Health, 1,400 Health Surveillance Assistants have been trained and now provide injectables at community level in eight of the 28 districts.

• **Improving and Expanding Youth-Friendly SRHR Service Provision**

Malawi has in place a coherent policy framework for the provision of SRH services for young people, although these are not yet as widely available in the majority of health facilities. The **implementation of the Youth Friendly Health Services Standards is helping to promote provision of SRH services to young people.**

The Youth Friendly Health Services provided at community level include oral contraceptives, condoms, HIV counselling and testing and referral to other service delivery points. Health promotion and counselling is offered during service delivery at all levels. Issues covered include STIs, HIV, contraceptives, nutrition, maternal and neonatal healthcare and adolescent growth and development.
In 2010 there were 1,609 health facilities providing YFHS, an increase from 8% in 2004 to 85% in 2010 (Reproductive Health Unit, 2010). The number of young people accessing services was also rising. Young people interviewed explained that through the various interventions and programmes they were more aware of their sexual and reproductive rights and that they had gained the confidence to seek SRH services at health facilities.

- **Reducing Incidences of Unsafe Abortion**
  Although Malawi criminalises abortion, the country does provide post abortion care (PAC), in adherence to the ICPD, which recommends that all women experiencing complications from abortion should have access to quality services. Through the Post Abortion Care Strategy, Malawi offers post-abortion care services which are provided by trained clinical officers at district and CHAM hospitals. In 2010 there were about 166 facilities providing PAC and the country was working towards expanding PAC into rural areas.

Furthermore, in line with the MPoA and in efforts to reduce unsafe abortions, the Government of Malawi undertook three research studies and disseminated data on the magnitude and consequences of unsafe abortion in 2009. The research was conducted by the Reproductive Health Unit in collaboration with the WHO, UNFPA and DfID. According to the findings, women, especially the poor and young do not have adequate information on contraception and safe abortion, yet availability of modern contraceptive methods has more than tripled since 1992. Furthermore, the studies revealed that SRH services such as post abortion care, family planning, youth essential services and education do not adequately serve the targeted clients because women are not empowered to make informed reproductive health choices on their own.

Malawi sensitised key stakeholders on the findings and formulated a plan for transforming the results into action. Further plans were formulated with the aim of engaging policy makers in undertaking legal reform in line with the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa.

Women, especially the economically disadvantaged and young do not have adequate information on contraception and safe abortion, yet availability of modern contraceptive methods has more than tripled since 1992.
Service delivery concerns will be addressed through expansion of the infrastructure to facilitate management of complications of abortion using affordable skills that can be imparted to health workers in rural health facilities. Attention will also be placed on eliminating the need for abortion by providing communities with adequate information and appropriate family planning methods to all women of reproductive age, especially those in rural areas.

Although Malawi has a high abortion rate that threatens its attainment of MDG5, current interventions testify to a continued commitment to addressing the challenges the country is facing, a lesson other countries can learn from.

- **Increasing Access to Safe Motherhood and Child Survival Services**

  The implementation of several interventions is helping Malawi reduce its maternal mortality rate, albeit this is slow. Malawi’s current maternal mortality rate at 807/100,000 is the second highest in Sub-Saharan Africa, second only to Sierra Leone. Furthermore, Malawi’s 2010 National Assessment of Emergency Obstetric and Neonatal Care depicted a gloomy picture of available services as poor, as evidenced by the high fatality rate of 2.5%; compared to the UN recommended rate of less that 1%. It must be noted here that the rate was even higher, at 3.4%, in 2005. Indications are high that Malawi is unlikely to meet MDG4 which seeks to reduce child and maternal mortality rates by 2015.

![Figure 6: Local PMTCT Data on display at Mchinji District Hospital](image)

Guided by the MPoA and in collaboration with relevant stakeholders, Malawi is working towards addressing its challenges through creation of an enabling policy environment to facilitate the use localised low cost and low technology strategies. The strategies are articulated in the Roadmap and include capacity development of health personnel. Towards this end, in 2007 Malawi developed the Basic Emergency Obstetric Care on-the-job training manual to increase availability of emergency and obstetric care and skilled attendants at birth.
The **focus on community based neonatal and motherhood care interventions** in the country has significantly increased demand for delivery at health centres. Government recommends that all pregnant women receive antenatal care services at least four times, and that all births should be delivered by trained health personnel (HM Information Bulletin 2009). Notwithstanding this, in 2009, even though the number of women accessing antenatal was low (only 9% of the total number of expectant mothers attended antenatal care in the first trimester (HM Information Bulletin 2009)), there has been an increase in the number of babies delivered in health facilities by skilled health personnel in the districts.

In universal solidarity with the goal of eradicating maternal and child mortality, Malawi was one of the first countries to launch the Campaign to Accelerate the Reduction of Maternal Mortality in Africa (CARMMA) in August 2009. The campaign, supported by UNFPA, UNICEF and WHO, seeks to increase political leadership and commitment at national level to reduce maternal and child deaths. **This is to be achieved through working with national champions who should drive the campaign to leverage local resources to mobilise action.**

Malawi implemented innovative and inexpensive strategies to reduce the under-five mortality by two-thirds by 2015. Some of the innovations include **encouraging community and family involvement and participation in child care.** This is enhanced by use of door-to-door community behaviour change communication and community mobilisation strategies that result in improved child care and increased demand for under-five immunisation. **Under-five services, including treatment for Malaria are also being provided at community level.**

Another low cost strategy that is being used and is **effective in reducing infant mortality and morbidity is Kangaroo Mother Care (KMC).** This is a simple and inexpensive method of caring for low birth weight infants (it is also useful for normal weight babies). The process involves carrying the baby on the front with skin to skin contact and mitigates the medical system’s inability to provided electronic incubators. Intermittent KMC is also used by mothers recovering from surgery or on babies receiving intravenous fluids.

Lessons drawn from the pilot of KMC in Zomba Central Hospital were used to roll out KMC to 20 out of 28 districts with support from the Saving New-Newborn Lives Initiative that is funded by Save the Children (Save the Children interviewee Evelyn Zimba, 2010). The success of the initiatives is attributed to Government’s political will in endorsing the use of KMC as well as effective engagement with community members.
Evidence of Success
Case Study of Pitala-Mchinji Family and Reproductive Health Project

Pitala is located in the Mchinji District in the Central region of Malawi which is 140km west of Lilongwe. The total population of the district is 456,789 (2008 Population and Housing Census). There are slightly more women than men in the area which has 1,356 villages and 97,200 households. Villages are located not less than 20km to Mbeaba, the nearest health facility.

Pitala village is implementing a highly successful and effective community reproductive health project which was initiated by the MoH with technical assistance from UNFPA; the Pitala initiative was a pilot site. The initiative has been rolled out to the whole district but the projects are at different stages of development. So successful is the intervention that the RHU is promoting study tours by traditional and community leaders to model villages to learn from the case and to replicate it in other villages.

![Figure 7: Health Surveillance Attendant Alex Mpasala (standing) explains the links between youth clubs and traditional initiators during the site visit](image)

High community stakeholder engagement and participation

The main objective of the project is:
- to reduce occurrence of maternal mortality by actively involving the community in the provision of health care services.

According to an interview with Ennie Chagunda, a health worker, the project started 1999. The first step in the project was the sensitisation of zonal officers, the District
Health Management Team, and health centre staff. The latter, and representatives from Mchinji District Hospital introduced the programme to the community through the traditional authority who then facilitated a sensitisation meeting to be held between the Mkeaba Health Centre staff and the Area Development Committee, comprised of the group village head and representatives of religious sectors, youth, and politicians. The Village Head, Mrs Margret Pitala, and the health surveillance assistants were highly instrumental in mobilising the community to support the project.

**A community centred approach**

One of the first actions by the community was the setting up of a Village Health Committee comprised of 10 community volunteers who were chosen by the community under the leadership of the village headman. The community organised task teams focusing on safe motherhood, family planning, youth-friendly services, HIV and hygiene and sanitation.

“It is commonly accepted in the village that men will ensure that their pregnant partners access waiting facilities three weeks before the expected date of delivery.

*—Alex Mpasala, Health Surveillance Attendant, Pitala*

The Safe Motherhood Task Team is led by the Village Head Mrs Margret Pitala, who is a champion in promoting and supporting maternal and child health initiatives in the village.

*Figure 8: Village Head Margret Pitala with some members of the Pitala Village Health Committee*
Communities as the first line of care

The initiative provides integrated SRHR services for the first line of care at community level. Members of the various task teams have been trained to provide components of the essential health package services at home. Services provided include advocacy for early antenatal care, voluntary counselling and testing and prevention of mother to child transmission counselling, breast feeding support, IPT door-to-door advocacy for use and distribution of oral contraceptives, including condoms, and home-based care (HBC) for chronically ill patients. Other services include advice on disease prevention and good hygiene in the home and community; growth monitoring for children under five years old, treatment for dehydrated children under five years old, child immunisation and treatment for Malaria.

The initiative has nurtured acceptance and ownership by involving all stakeholders and affording them opportunities to contribute. For instance, traditional initiators who in the past were responsible for introducing youth to adulthood maintained their titles, but are now attached to the youth clubs. They have received training on how to teach young people about responsible behaviour, and to discourage bad cultural practices. Former traditional initiator Renia Chiwanga from Pitala plays a prominent role in encouraging teenage mothers to go to school and mediates between parents of teenage mothers and the schools to facilitate the girls’ re-admission post-delivery.

Traditional Birth Attendants too have had their roles integrated into the initiative. They are the main link for pregnant women with the health facility and for referring pregnant women and new-borns with complications to health facilities. Traditional Birth Attendants in Pitala have also been trained in, and offer birth preparedness education to couples, encouraging them to practice family planning and advising against harmful socio-cultural beliefs.

Figure 9: A bicycle-ambulance under the shade where it is kept by the traditional birth attendant
and practices. They are also in the forefront of recommending kangaroo mother care for new-born infants. One Traditional Birth Attendant is the custodian of the community bicycle-ambulance which is used to ferry pregnant women, and those who are too weak or ill to walk, to the nearest health facility.

**Monitoring service delivery**

Each member of a committee or anyone who is involved in implementing the project in Pitala, including traditional birth attendants, has been trained to keep records of all patients they attend to. They produce monthly reports of their work which are submitted to Mkeaba Health Centre; the data and information is then incorporated into the reports which are submitted to the Health Management System by the corresponding facility.

Community health service providers have been trained in data collection and in how to use health information to make decisions at community level. Traditional leaders and community members have also been empowered to initiate community-based campaigns to improve maternal and child health. Ownership of the project is so high that community members write campaign messages on the walls of their huts.

![Figure 10: Campaign message on safe motherhood painted onto a hut](image)

The community has also instituted policies that encourage male participation in reproductive health issues. The policies include penalties for non-compliance; for instance, a pregnant woman’s partner will be fined should his wife give birth at home, die while delivering at home, or lose a baby.
The Traditional birth attendant who attended to her, as well as the village head in whose village this happens is also fined. The fines, which are often in the form of livestock, are kept by the village head on behalf of the community, and ploughed back into the project.

**Evidence of effectiveness**

The case of Pitala-Mchinji is a good example of the integration of basic SRH services at community level. The villagers receive family planning and STI services, ante-natal and post-natal care and care for the under-fives at community level. **The initiative is shortening the distance between the community and the nearest health care facility** by bringing the services to people. Those in need of secondary care get timely referral from the community to the health facility. Furthermore, Government’s deficiency in transport infrastructure is complimented by innovative mechanisms like bicycle-ambulances that are used to transport the critically ill to the nearest health facilities. The efforts of community based distribution agents also help to alleviate the strain on the weak human resources base that is widespread in the district. The immense contribution of these agents results in increased awareness of health care delivery and the ultimate increase in utilization of life-saving interventions.

The initiative has succeeded in cutting maternal and neonatal deaths; **no woman has died since the introduction of the project in 1998.** During this time, **only one baby** was born at home. Before this initiative, it was not unusual to hear that a pregnant woman or a new-born baby had died.
Lessons Learnt

There are some lessons that were learnt during the documentation of this success story. It is hoped that by sharing these key lessons which are outlined below, Governments and relevant stakeholders in southern Africa and beyond might be galvanised to adopt strategies that have been shown to work in efforts to achieve universal access to SRH information and services for all on the African continent.

**Key Lessons learnt**

**Lesson 1: Political commitment that is led by clear champions is important**

Malawi’s political commitment to providing comprehensive and integrated sexual and reproductive health and rights (SRHR) for its citizens is demonstrated by the presence of political champions at all levels of leadership who promote and motivate for SRHR interventions. The President himself sets a good precedent that permeates all leadership levels. Furthermore, the country’s Vice-President, Honourable Banda was actively involved in championing the reduction of maternal mortality as Malawi’s Goodwill Ambassador for Safe Motherhood; this was before the post was taken over by the First Lady. Traditional leaders also play a central role in community-based SRHR interventions as points of entry of programmes into communities. In addition, Malawi is benefiting immensely from identifying and appointing champions to lead in government processes around SRH. The process even involves inviting influential Malawians with the necessary expertise from wherever they may be in the world to come back home and be champions. An example of this is that of Dr. Chisale Mhango who was called back from Addis Ababa to head the Reproductive Health Unit.

**Lesson 2: An enabling policy environment makes a good foundation for effective interventions**

In line with the Maputo Plan of Action Malawi developed an important policy which nationalises the MPoA and integrates SRH components and issues into health delivery systems. The policy environment created by Malawi led to the creation of a single national reproductive health programme that is supported by all stakeholders under the leadership of the MoH and spearheaded by the RHU. The national programme is the only entry point for any SRHR interventions. The importance of an enabling policy environment for facilitating the integration of SRH services in public healthcare cannot be overemphasised.

**Lesson 3: Institutional frameworks and mechanisms are important for coordination and implementation of health services**

The existence of government-developed and coordinated institutional frameworks and mechanisms for implementation of health services are important for the successful implementation of SRH provisions by multiple stakeholders in any country.
Lesson 4: Coordinated funding and management of financial resources ensures efficiency
In Malawi, funding from Government and development partners is well-coordinated through the Sector Wide Approach; this has had the impact of encouraging the increase of resources allocated to the health sector in the country. Both Government and donors increased their contributions. It is not expected over the last five years (2006-2010). The Sector Wide Approach is also credited with fulfilling the Abuja Declaration’s commitment to allocate 15% of the total government budget to the health sector. Although Malawi is among the poorest countries in the world, its commitment to financing health issues is impressive. However, although the Sector Wide Approach is credited with accelerating funding to health issues, available resources are still not sufficient enough to achieve the MDGs.

Malawi continues to honour its commitments by increasing its financial allocation to the health sector. In 2010, it allocated 15.5% to health; an increase from below 10% in the late 1990s and early 2000s. The allocation is in line with the commitments of Heads of State under the Abuja Declaration. In 2010 Government contributed 12% of the total budget to SRH issues. Government continues to advocate for increased support for SRH issues and services from donors and development partners.

Lesson 5: Link economic growth to social sectors - particularly health
Committed and sustained efforts to enhance the SRHR of all in Malawi are an indication of the country’s appreciation that meeting people’s needs for reproductive health, is crucial for both individual and national development. This appreciation is concretised in the Malawi Growth and Development Strategy 2006-2011 where SRHR issues, with particular focus on the prevention and management of nutrition and HIV is identified as a key priority area for the government in terms of resource allocation. Addressing SRHR issues was thus identified as a critical component for enabling Malawi to achieve economic growth, thus transforming it from relative poverty to a middle income industrial nation.
Conclusion

Political commitment plays an integral role in attracting support for SRHR interventions. Such commitment at all levels of leadership ensures community buy-in and appropriation of support from policy to implementation from all players. Furthermore, an enabling SRHR policy environment creates an atmosphere that is conducive to the formulation and implementation of interventions that are tailor-made to suit local contexts and realities. Although progress has been made, human resources and infrastructure still need to be addressed.

Success of SRHR interventions to a large extent depends on adequate funding. However, even with increased finances, it’s not sufficient for Malawi to realise the MDGs in time. The country has made some notable achievements which have primarily been made possible due to the high level commitment shown to SRHR issues shown by the leadership, and the operationalisation of the MPoA.
Recommendations

- Countries should foreground the importance of developing an enabling SRHR policy environment for the creation of an atmosphere that is conducive to the formulation and implementation of interventions that are tailor-made to best suit local contexts and realities.

- Once the policy environment is enabling, governments should support the provision of adequate human resources and infrastructure for the implementation of policies.

- Many countries in the region have nationals with expertise in SRHR who are dispersed globally. National programmes can benefit immensely from employing such experts to come back home and be champions. A good case in point in Malawi is that of Dr. Chisale Mhango who was recalled from Addis Ababa to head Malawi’s Reproductive Health Unit.

- The success story of Malawi demonstrates that an enabling SRHR policy environment creates an atmosphere that is conducive to the development and implementation of interventions that are tailor-made to suit local contexts and realities. Although progress has been made, challenges related to human resources and infrastructure still need to be addressed. Human resources challenges can be addressed by identifying and employing nationals with expertise in SRHR who are dispersed globally to contribute to national programmes and interventions as already stated.

- The success of SRHR interventions to a large extent depends on adequate funding, both from governments and development partners. However, even with increased funding, there is a need for countries to ensure an enabling policy environment which supports the creation of a single coordinated national reproductive health programme that is supported by all stakeholders under the leadership of a central body. In this way, the national programme becomes the only entry point for any SRHR interventions, ensuring that available funding is utilised in the most effective manner.


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