

Assessment of the Acceptability and Feasibility of Two Interventions to Improve Family Planning Access

ABOUT THIS BRIEF

In 2016–2017 FANTA conducted qualitative formative research in with the USAID Office of Food for Peace (FFP)-funded Njira development food security activity implemented by Project Concern International and Emmanuel International in Balaka and Machinga districts in Malawi.

The study was conducted to inform the strategic design of the family planning activities within Njira. It was also intended to serve as a proof of concept to generate learning more broadly on a process to help understand how to best integrate FP into development food security activities.

This brief is one of a series of four and presents findings from two of three research objectives. Additional findings, an overview of the study and methods used are available at www.fantaproject.org/FPintegration.

Introduction

Although Malawi has made great strides in increasing voluntary contraceptive use, the unmet need for family planning (FP) is 18.7 percent among married women and 39.8 percent among sexually active unmarried women (National Statistical Office & ICF 2017). This brief presents qualitative formative research findings from the Njira activity (hereinafter referred to as Njira) on: 1) community perceptions of the current FP services; and 2) acceptability and feasibility of two proposed interventions aimed at improving access to FP services among adult women with young children and adolescent girls and young women (AGYW) in Balaka and Machinga districts in Malawi (see box). The two proposed interventions, which were designed to be integrated into Njira's existing

nutrition and food security interventions, are: 1) FP referrals from activity platforms (Care Groups and youth groups) to government health providers, including adult and youth community-based distribution agents (CBDAs), health surveillance assistants (HSAs), and facility-based providers; and 2) FP service provision by government health providers at a community resource center (Ubwino center), which is already being leveraged for Njira activities.

Although there is some overlap in their coverage, this brief focuses on the supply side factors affecting FP use in these communities while [Brief 2](#) focuses on the demand side factors. The data sources for findings discussed in this brief are 12 focus group discussions (FGDs) and 46 semi-structured interviews (SSIs) conducted with a range of respondents including adult women with young children who are members of activity Care Groups, AGYW 18–24 years of age who belong to youth groups, adult men who are husbands/partners of Care Group members and/or members of activity Father Groups; and government health providers, community leaders, and activity informants. Additional information on the study methods can be found in Research [Brief 1](#).

Key Findings

Perceptions of Current Family Planning Services

Perceptions of current FP services available to adult women and AGYW were sought from government health providers delivering services and the community members accessing these services.

Provider Perspectives on Delivering Services

The 14 government health providers interviewed included two facility-based and 12 community-based providers (four from each of HSAs, adult CBDAs, and youth CBDAs).



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Provider roles and populations served. Both facility providers were midwives and one was also a nurse technician. They reported having a discrete scope of work dictated by facility service schedules. The CBDAs described their role as volunteers providing FP methods door to door in the community. The youth CBDAs had relatively little experience, ranging from three months to a year, compared to the other providers who had been in their role for at least two years, but most often over five years.

All providers were engaged in other activities besides providing FP services. For example, HSA job duties included activities such as HIV testing and counseling; community case management; antenatal care; vaccinations; referrals of malnourished children to the health center; TB treatment; and water, sanitation, and hygiene. The CBDAs were engaged in subsistence farming, reforestation, women's empowerment groups, sexually transmitted infection (STI) prevention and counseling, and providing referrals for fistula services.

Neither of the facility providers was engaged in conducting community-based outreach services nor did either work directly with Care Groups or youth groups. However, all but two community-based providers reported working with Care Groups and youth groups in some capacity (training of lead mothers or youth leaders, educational talks about health topics, FP counseling, method provision, or referrals).

The HSAs appeared to be responsible for relatively large catchment areas covering multiple villages. With the exception of one HSA, all providers said they served adults and youth (married and unmarried) with some variations in who their primary clients were. There was wide variation in the age range providers described as their youth clients (e.g., 10–8, 14–21, 18–25, 17–30, 15–35 years). Both facility providers acknowledged that there were Youth Friendly Services at their facilities and other providers referred to these services. For example, a youth CBDA in Machinga said: *“This [youth friendly services] was organized by two Traditional Authorities [names] to make sure that the youths from these areas meet at the health center whereby they can discuss their issues with the nurse or the doctors about issues that they are not comfortable to talk about among themselves. There is sport and other activities like drama on that particular day...The members of the*

“I am a CBDA. I do this work as volunteer and do not get any payment in cash or in kind. I go to people's homes and ask for the opportunity to chat with the occupants of that particular house. If they accept, we enlighten them about family planning methods and tell them the methods that I provide which are condoms and pills. If the person wants a method that I do not have, I write a letter referring the person to the health center.”

SSI with adult CBDA, Balaka

“I meet the Care Groups when they are meeting and teach them about how they can take care of their homes, how they can have gardens in their homes, and how they can feed the children properly. I also teach them about the benefits of family planning by showing them our manuals, I also teach them about the benefits of starting under five clinics early too.”

SSI with HSA, Balaka

youth clubs are engaged in social activities like I said. While these activities are in progress, people go to the nurse individually to have their issues addressed.”

Locations and schedule of services. At the health facility, FP services were usually offered on one designated day per week. The HSAs primarily provided FP services at the health facility and at village outreach clinics, specifically under-5 clinics. The CBDAs primarily offered door-to-door services, and in the case of the youth CBDA, services were also provided at youth groups and community events. Offering services in their own homes was less commonly reported by HSAs and CBDAs, but was mentioned more commonly by clients.

Most of the HSAs seemed to operate on a set schedule (i.e., clinic days versus outreach days). The adult CBDAs discussed setting schedules to guide which villages to visit each day. The number of days and hours a week they reported offering door-to-door services ranged from six to 18 hours over the course of one to three days. Youth CBDA schedules were primarily influenced by the number of youth meetings they attended per week and, compared to adult CBDAs, appeared to provide a more limited community outreach schedule (for example, one hour three times a week).

Contraceptive methods provided. Facility providers offered short- and long-acting reversible contraceptive (LARC) methods, emergency contraception, and long-acting permanent methods (LAPM), such as male and female sterilization, which were usually offered by facilities in collaboration with Banja La Mtsogolo mobile clinics. While trained to provide injections, pills, and condoms, most HSAs said the injection was the most common method they provided and they relied on CBDAs to provide other methods, such as pills and condoms. Although the youth CBDAs interviewed were also trained to provide the same methods as adult CBDAs, their activities were largely limited to counseling, condom distribution, and referrals at the time of data collection. This is because two of the four youth CBDAs had not been provided with pills and one reported only having received training on counseling.

Referral relationships. The most common type of FP referrals described by community-based providers were those made to a health facility provider if the client wanted to use a method they were not trained to offer. Other reasons for health facility referrals included check-ups for first-time pill users and if the client was experiencing negative side effects with a method, wanted to switch methods, or had a health condition such as hypertension. The facility providers also said they received referrals for emergency contraception, for injectables when HSAs ran out of stock, and when CBDAs were unable to explain the details of the methods to the client. In some cases, CBDAs discussed that they refer clients first to HSAs instead of to the facility. Likewise, HSAs discussed referring clients who were interested in pills or condoms to CBDAs. As one HSA said *“I refer them to my colleagues who were trained to administer pills and condoms. I was trained to provide the injection method and that is what I keep.”*

All providers mentioned the use of letters to send information about referrals; this is distinguished from those who specifically mentioned a referral form. While only three of the 12 providers said they are currently using referral forms, two said they had used forms in the past, but had run out of them. Most of the HSAs said their referrals are informal.

Challenges to delivering FP services. Providers noted several challenges to delivering FP services: Occasional contraceptive stock-outs (especially condoms and injectables) was noted

“Sometimes we run out of resources like injectables or even condoms.”

SSI with facility provider, Machinga

“We meet a lot of challenges. Married young men stop their wives from using FP methods. People believe that the method that a woman is using makes a man weak to the extent that he does not perform in bed. This belief is rooted in culture I think. Whenever they come here, we enlighten them that the methods will not change anything in their bodies.”

SSI with HSA, Machinga

“We have a challenge of transportation which makes it difficult for us to reach out to many people in the communities.”

SSI with youth CBDA, Machinga

by all providers. Demand side barriers was the second most common challenge, and included fear of negative side effects of contraceptives and resistance by husbands and/or parents to using FP (discussed in more detail in [Brief 2](#)). Husbands were most often concerned about negative effects on their libido and sexual performance and some parents believed that contraceptive use among young people resulted in infertility and barrenness. A few CBDAs appeared to reinforce the strong community preference to limit contraceptive method use among AGYW before the birth of the first child to non-hormonal methods (discussed in [Brief 2](#)). For example, an adult CBDA said, *“Because as I said earlier, we only serve people who are married and are bearing children. The risk with young women is that they may never give birth to children if they start using pills at a young age.”* Some CBDAs also believed that their youth clients often accepted the offer of condoms and pills out of respect to them, but did not actually use the methods.

Both adult and youth CBDAs said they have transportation challenges since they have to travel long distances to provide door-to-door services. In addition, they noted that while CBDAs are accessible within communities, they are not trained to offer methods clients prefer, such as injectables and implants. Some CBDAs and HSAs also reported a lack of supplies, such as registers and bags, for

carrying the contraceptives. One health facility provider said that facility providers can sometimes face language barriers with clients who only speak Yao.

Community Perspectives on Accessing Services

Community perspectives on current FP services were obtained from 12 FGDs, four each conducted with mothers, AGYW, and fathers; 18 SSIs with mothers and AGYW; four SSIs with community leaders/members of village civil protection committees and ten SSIs with activity informants.

Overall, there was high awareness among community members of where adult women and AGYW could access FP services, which was consistent with the locations providers described, including health facilities, including hospitals and health centers; community-based venues, such as under-5 clinics; door-to-door services; HSA and CBDA's homes, and youth club meetings. Their knowledge of the types of methods available from the various providers corroborated the information shared by providers.

Perceptions of availability of community-based services varied among community members. For example, two Care Group lead mothers in Machinga shared that there were no active CBDAs in their communities. According to the community leaders interviewed in Balaka, in one community, under-5 clinics, and thus FP access at the community level, had stopped; and in another, only CBDAs offered FP services in the community because the HSAs primarily stayed at the health center. In the 18 SSIs with mothers and AGYW, the perceptions and experiences of FP access as well as provider and method preferences varied between users and non-users and also between adult women and AGYW.

Current FP users considered their access to be fairly convenient. The mothers reported being able to obtain the method they were using (injectables, implant, and standard days method) either at the health facility or from the HSA. Some described wait times ranging from 30 minutes to four hours and noted long distances to access their method, for example a two-hour walk or 250–300 kwacha bicycle ride each way. Most also said they did not have trouble obtaining childcare or completing household duties on days when they accessed FP. Notably, all AGYW using FP were condom users who largely relied on their boyfriend to obtain the condoms. Only one girl had personally obtained condoms.

Mothers and AGYW who were not using FP were asked about future use, including which method they would choose and from where they would want to access services. All the mothers said they would prefer a long acting or permanent method (LAPM) and would access it at the hospital; none mentioned CBDAs or HSAs. Most mothers said they would not want to get service locally via a mobile clinic because of fear of others gossiping or “cursing” them and added that distance to the facility was not a problem. The AGYW who said they may use a method in the future were aware of multiple options of places to receive services, but ultimately said they would be likely to choose the local health center (for implants) or HSA (for injections), with distance to the services being the driver of their choice. The AGYW said no one would impede their going to the provider to access a method if they chose to do so and they believed that young women do not face more challenges accessing methods compared to adults.

Factors influencing provider choice. Community member preferences for where or from which provider (facility, HSA, or CBDA) to access FP services was influenced by three factors: perceived ease of access; perceived quality of services with a focus on provider skills, attitudes, and methods provided; and the perceived ability to access services secretly. Table 1 summarizes the perceived benefits and concerns that emerged regarding each provider.

More AGYW, mothers, and fathers indicated a preference for accessing services at the health facilities because they trusted them, thought they provided high quality services, and preferred the convenience of receiving multiple services during one visit (i.e., integrated care). However, some participants described barriers to accessing FP at the health facilities, including long distances to travel, long wait times, rude providers, especially toward AGYW, and occasional stock-outs.

For some participants, while the ease of accessing services from HSAs within the community was a benefit, others considered their high client load as a potential barrier. Some participants were concerned that providers—particularly facility-based providers and HSAs—may provide preferential treatment to clients who come with their husband, or pay bribes. Several respondents did not trust HSAs or CBDAs because of concerns they made sexual advances toward clients, did not maintain client confidentiality, or were not as

Table 1. Factors influencing provider choice

Provider	Perceived Ease of Access	Perceived Level of Skill/ Quality of Services or Methods Provided	Perceived Ability to Access Secretly
Facility-based providers	<i>"They [women] will receive good counselling [at health facility] because these that move around, the HSAs, don't have enough time to counsel. But at the hospital, those people have all the time and they are even many of them."</i> FGD with fathers, Machinga		
Benefits	<ul style="list-style-type: none"> Highly trained/ qualified 	<ul style="list-style-type: none"> All methods available 	<ul style="list-style-type: none"> Can combine FP visit with antenatal care or other services
Concerns	<ul style="list-style-type: none"> Long distances Long wait times Preferential treatments to higher status clients 	<ul style="list-style-type: none"> Rude, particularly toward AGYW Stock-outs 	<ul style="list-style-type: none"> Hard for AGYW to access secretly
HSA	<i>"Some HSA's wives doesn't keep the secret when you go she is the one telling people that she came to get, to my house to get FP."</i> FGD with mothers, Balaka		
Benefits	<ul style="list-style-type: none"> Available in community 	<ul style="list-style-type: none"> Provide injectables, but not implants 	<ul style="list-style-type: none"> Can combine FP visit with under-5 clinic or meet at a mutually agreed upon discrete location
Concerns	<ul style="list-style-type: none"> High client load Preferential treatment to higher status clients 	<ul style="list-style-type: none"> Stock-outs Lack of trust/make sexual advances 	<ul style="list-style-type: none"> Concern over HSA and HSA wives maintaining secrecy
CBDA	<i>"Most of the youths are worried that when they go aside to get the methods from CBDAs they end up asking for sexual relationships and they even make sexual advances. That is why they prefer the clinic even if people see them."</i> SSI with youth leader, Machinga		
Benefits	<ul style="list-style-type: none"> Available in community. Convenient door-to-door services 	<ul style="list-style-type: none"> Comfortable with peers (lead mothers and youth leader) 	<ul style="list-style-type: none"> Can meet at community events and in youth groups
Concerns	<ul style="list-style-type: none"> Not active in all communities 	<ul style="list-style-type: none"> Less qualified to provide counseling or handle side effects Provides less desirable methods Stock-outs Lack of trust/make sexual advances 	<ul style="list-style-type: none"> Concerns about confidentiality of door to door visits

skilled at handling side effects from contraceptive use. Fear of being seen accessing services was also mentioned often, particularly in relation to AGYW in facilities and CBDAs who provide door-to-door services. These supply side constraints were reiterated during discussions on the proposed FP integration interventions the study assessed (described below).

Feedback on Proposed Family Planning Integration Interventions

This section describes findings on the feedback received on the feasibility and acceptability of two proposed interventions or designs for improving

access to FP services among mothers with young children and AGYW in Njira communities, namely:

- 1) Referrals from project group platforms to government FP providers:
 - Care Group referrals from lead mothers to health facility or HSA or CBDA
 - Youth group referrals from youth leaders to health facility or HSA or CBDA
- 2) Provision of FP services by a government provider at a community resource center (Ubwino center)

Feasibility was assessed among those who would be engaged in delivering the proposed interventions, such as project informants including health promoters, lead mothers, and youth leaders (10 SSIs) and government FP providers (14 SSIs). Acceptability was examined primarily from the perspective of members of activity groups engaged in health programming, including mothers who were Care Group members (4 FGDs—two providing feedback on Care Group referrals and two on service provision at resource center); AGYW who belonged to youth groups (4 FGDs—two for youth group referrals and two for service provision at Ubwino center); and fathers belonging to Father Groups or partners of women in Care Groups (4 FGDs). These perspectives are referred to as client perspectives in the findings below.

The FGDs with mothers and AGYW utilized a form of directed storytelling with fictitious characters to explore the acceptability of the FP integration options. Fathers, providers, and activity informants were asked for feedback on each integration option without the vignettes. For each proposed intervention, information was sought to assess interest and/or concerns about the option, elicit recommendations related to operationalizing the intervention, probe and pursue issues related to accessing FP services in the context of the stories where relevant, and invite other ideas or suggestions participants might have.

Overall, both FP integration options under consideration by Njira were received favorably by the target groups they were designed to serve—mothers with young children and AGYW, as well as by fathers, providers and activity informants. The key perceived benefits and concerns that emerged from the findings for each proposed option are discussed below.

Perceived Benefits

Care group and youth group referrals. Referrals were acceptable to clients, providers, and activity informants for multiple reasons. Across all respondent types, the two most common perceived benefits of referrals were: clients would receive quicker service from providers and referrals would increase FP access. An added perceived benefit according to some fathers was that women who were referred by leader mothers in Care Groups would be more respected at the health facility. Providers also believed youth referrals can help improve young people's health and lives by

reducing STI/HIV transmission and by keeping girls in school longer.

With respect to benefits to providers, CBDAs saw referrals as a way for them to save time going door to door because more clients would come directly to them. Some providers believed that referrals would simplify the process of connecting with clients for two reasons: lead mothers and youth leaders had a better understanding of the lives of women and AGYW in their communities and clients would trust referrals from their peers. A few activity informants and providers also liked referrals because they viewed them as a way to work “in unity” or “hand-in-hand” with each other and to better be able to monitor FP use in their communities.

“It can be different with someone who has a referral letter and someone who hasn't a referral letter, then one with a letter can be helped fast.”

FGD with AGYW, Balaka

“I think this arrangement is a good one. It will even free us as men because someone assumes a responsibility of referring them and telling them where they should go. And when they go there after being sent, they are well respected.”

FGD with fathers, Machinga

“That [referrals] would be helpful because the women are open to each other. Since we are always busy, it is possible for the lead mothers to identify someone who wants FP methods and they can refer them to us. If we cannot administer the method the woman wants, we will refer her to the nurse.”

SSI with HSA, Machinga

Service provision at the community resource center. The overarching benefit of this option to clients and providers was convenience. Clients found the resource center intervention convenient because they would not have to travel long distances to a health facility. Some clients also believed the quality of services at the resource center may be better than the facility, including perceptions of fewer people to be served, shorter wait times, or better provider attitudes. Several providers and project informants thought receiving multiple services or attending multiple

“Yes, another advantage is that the health center treats a lot of people unlike the Ubwino center which may have few people. They go in the morning at the health center and come back at around 3PM, but maybe at the Ubwino center, they may be back around 10AM.”

FGD with fathers, Machinga

“It would be easy because I volunteered to help the people in my community. Instead of going door to door every day, I will also be serving them at the Ubwino center. It would be easy because many people will come to us instead of us going to their homes.”

SSI with youth CBDA, Machinga

“But it might also be in this way, that [a care group member] would go to the neighbor women group and would tell the lead mother that ‘my husband doesn’t want me to get contraceptives.’ And when she comes here at [resource] center as if she is coming with the child to the clinic, then she will get the contraceptives without the husband knowing it.”

FGD with mothers, Machinga

INTERVIEWER: “IS IT POSSIBLE FOR YOUNG WOMEN TO GET CONTRACEPTIVES FROM HSA OR FROM CBDA IN THIS COMMUNITY?”

“Participant: No, it is not possible for someone who doesn’t have children. That’s how people say, that someone without a child cannot line up on a contraceptive line to get them”.

FGD with AGYW, Machinga

“Participant 1: Some male HSAs propose love to you when you go for family planning.

Participant 2: When you refuse their proposal the things will no longer get well for you.”

FGD with mothers, Balaka

INTERVIEWER: “WHAT IF A YOUTH GROUP MEMBER HAS BEEN ESCORTED WITH THE YOUTH LEADER TO THE HSA?”

“Participant 1: It can be helpful to [the youth group member] because those who were thinking that [she] is in a relationship with the HSA will stop doing that because she is with a youth leader.

Participant 2: But it will be still a problem, those who has been saying that [the youth group member is in a relationship with the HSA will now say that the youth leader is a go between of [her] and the HSA.”

FGD with AGYW, Balaka

types of meetings in one location would be more convenient for clients, and this was also mentioned in relation to fewer concerns over privacy and confidentiality for women and AGYW who did not want their partner or other community members to know they were using a FP method. However, as discussed below, several mothers and AGYW were concerned about being seen accessing FP services at the community resource center.

As in the case of referrals, community-based providers also found this option convenient because instead of visiting client homes, they could access many potential clients in one place especially if women and AGYW were coming to the resource center for other services or activities.

Perceived Concerns

Because the respective respondent group concerns were shared across the two proposed interventions, the findings are summarized below by respondent group.

Client perspectives. For both types of referrals as well as the resource center option, when mothers and AGYW expressed concerns, they were primarily related to privacy and confidentiality of accessing FP services and/or distrust of community-based providers. For Care Group referrals, some mothers were worried that HSAs might not protect their privacy, that home visits from CBDAs would reveal their contraceptive use, and that husbands could find referral letters. A few respondents mentioned concerns about HSAs initiating relationships with clients and the possibility of stock-outs of methods. For youth group referrals, in addition to concerns about AGYW using contraceptives before they had children (see [Brief 2](#)), AGYW were mainly concerned about how community members perceive the relationship between the provider (mainly the HSA) and the AGYW who is being referred, including concerns that people would think the youth leader was facilitating a relationship between the two. For the resource center option, the primary concern was being seen by other community members accessing services.

Overall, although fathers did not have concerns about care group or youth referrals, there was consensus among them that men should know their wives have been referred. These discussions further supported findings discussed in [Brief 2](#) that men want to be involved in and often control

FP decisions. Although only one father in one FGD expressed concerns about AGYW using contraceptives when discussing youth referrals, this was a common concern among community members, including fathers and some providers that emerged in other sections of the interviews (see [Brief 2](#)).

“It’s important for the man to know about this as a family. If she just goes and maybe come back later in the evening, what would the husband think of where she was and what she was doing? He has to know where his wife has gone and what she has gone there for as a family.”

FGD with fathers, Machinga

Provider and activity informant perspectives.

From a feasibility perspective, the primary concerns providers and project informants expressed for both interventions were related to logistics of implementing them. All three types of providers were concerned about having adequate contraceptive commodities and other supplies (e.g., forms, registers) to meet the increased demand resulting from either of these interventions. For the resource center option, the added concern for providers was related to storing and transporting FP supplies. They were worried about the possibility of theft, the difficulty in transporting supplies from the health facility to the resource center, or the difficulty in storing the supplies at the community resource center. Providers and project informants also shared concerns that the physical structure of the resource center might be inadequate and make it more challenging to maintain client confidentiality. Although not as common, a few providers expressed infrastructure concerns, such as inadequate electricity at the resource center.

Providers and activity informants overall had more concerns about youth referrals than adult referrals. They were mainly concerned about potential backlash against them from parents who might blame them for promoting promiscuity or “introducing their children to bad behaviors.” Similarly, for adult referrals, a few lead mothers and community-based providers worried that they may be seen as meddling in a woman’s life or face resentment if a woman faced negative side effects or had trouble conceiving children after using contraceptives. Less than a handful of community-

“If the Ubwino center will have more clients, it means the orders will change and we would need more materials. So the few materials from the government cannot help, we may need different stakeholders.”

SSI with facility provider, Machinga

“The only difficulty would be that everyone in the community would see us carrying the contraceptives and they would know that people who are going to the Ubwino center on that day are going to receive contraceptives.”

SSI with youth CBDA, Machinga

“The problems are that when you refer a woman to the hospital to get family planning method, people start talking bad things like ‘why is she listening to the lead mother? Will the lead mother bare children for her?’ People talk a lot of things but we don’t care what matters is what the women wants.”

SSI with lead mother, Machinga

based providers expressed concern about the potential for increased workload as a result of referrals.

Method and Provider Preferences

When discussing method preferences for referrals, AGYW chose injectables and pills; mothers chose injectables, pills, implants, and IUDs. Mothers, AGYW, providers, and activity informants were also asked what methods should be offered at the resource center. Injectables, condoms, pills, and implants were most commonly mentioned; tubal ligation, cycle beads, LAM, and IUDs were less frequently mentioned across respondents. Method-related preferences and concerns were driven by one or more of the following four factors: perceived risk of side effects, perceived ease of use, perceived effectiveness, and perceived ability to use secretly (discussed in [Brief 2](#)).

Provider preferences for both interventions varied based on whether the client was accessing the method secretly, her preferred method, distance to or trust in the provider, further corroborating the three factors influencing provider preferences discussed in Table 1, above: perceived ease of access, perceived quality of services, and perceived ability to access services confidentially. Participants

were often reluctant to choose one provider and a few respondents suggested having different types of providers visit the resource center, rather than only one type.

Mothers and AGYW primarily chose HSAs because they were already in the community and because of perceptions that clients could access services from them secretly. However, they were still wary of HSAs wanting to have relationships with them. For providers and activity informants, the preferred providers were split almost equally between the three provider types. Providers often chose themselves. Among activity informants, youth leaders and lead mothers primarily chose the facility provider and health promoters chose CBDAs. In addition to ease of access since they are already in the community, many providers believed that HSAs and CBDAs can be the first point of contact and can refer up the chain as needed. Several respondents, including providers, noted that task shifting or additional training may be required for CBDAs and/or HSAs to meet client method preferences. Those who chose health facility providers cited availability of more methods and perceptions of improved skills and training, especially for first-time users and those experiencing side effects.

Preferred Option

Since fathers, providers, and activity informants had the opportunity to provide feedback on both FP interventions, they were asked which of the options program managers should prioritize if only one could be pursued. Almost all chose the resource center over referrals, with the primary reason being convenience of having access within the community; a few noted that clients could access FP while coming to the center for other activities. Only three CBDAs chose the referral scenario, citing issues of privacy and confidentiality, including that the resource center may not be feasible for women who wish to use a method secretly.

Mothers and AGYW who discussed only one of the proposed interventions within each FGD, were asked what the best option was for accessing services. Those who discussed the resource center intervention chose it as the preferred option if the client didn't need to access services secretly. For all others, including those who discussed the referral option, the HSA or the health facility were the provider of choice for the same reasons described above.

"It's good for [the care group member] to get it from the HSA because she is doing it secretly. If the CBDA come to her house then her husband can know it through other people. Sometimes it may also happen that other women are interested in your husband and they may be the first to reveal that the wife is using FP, I saw the CBDA at your house so that the husband can chase you out and they get a chance of hooking with your husband."

FGD with mothers, Machinga

"Because they [AGYW] are relatively new to using contraceptives so they would need to be checked by professionals [in health facility] to determine the method that best suits them through a medical examination."

SSI with adult CBDA, Balaka

"If you are many, should share the work and everybody can be in a room offering a different method. A local person from Ubwino [CBDA] can be offering condoms, and the HSAs injectables, and if there is a person from the health center, they can offer methods like implants."

SSI with facility provider, Balaka

"I think they should get them from the Ubwino center because it's nearby".

FGD with fathers, Machinga

INTERVIEWER: "WHY SHOULD THIS APPROACH [referrals] BE PRIORITIZED?"

Participant: Because if the lead mother and youth leaders make referrals, we can decide to meet the clients where they are comfortable including the Ubwino center."

SSI with youth CBDA, Machinga

Preferred Logistics and Organization of Interventions

Clients, providers, and activity informants were asked for their recommendations on how the two intervention options should be operationalized.

Referrals. Mothers, providers, and activity informants wanted Care Group and youth group referrals to be organized in a similar way where lead mothers and youth leaders could do one of the following:

- Send clients to providers with referral letters or forms. Key components of the document would include information about the client (name, age, where she is from, number of current children), the lead mother/youth leader referring, which care/youth group client is coming from, which method she wants, any methods she is currently using.
- Call or send a text message to providers about referrals with the same information as in the forms.
- Set up meetings between lead mothers and providers to discuss referrals

In addition to needing adequate contraceptive supplies, community-based providers and activity informants said they would need additional supplies like registers, forms, pens, bags to carry commodities and/or supplies, and airtime for phones. Facility providers, CBDAs, and youth leaders said that they would request additional training on how to serve young women. The CBDAs and HSAs requested support for transportation including bicycles.

Almost all the providers believed it important to send feedback to the lead mother or youth leader so he/she would feel valued, supported, and encouraged to refer more clients. Respondents also suggested days and times that would work better for the referrals at the health facility (e.g., FP or youth-friendly days) or in the community (e.g., antenatal clinics held by HSAs). Other suggestions for youth referrals was to have a soccer ball at the facility to help young people feel more comfortable; have a private space to meet the client; and have special days when the HSA talk about FP and provide methods.

"If she has a mobile phone, she [youth leader] should write a text message or make a phone call and sometimes writing a letter would be ideal."

SSI with youth CBDA, Machinga

"I would need a good mode of transport because the areas are very far apart so that I can meet the women where they stay easily if the lead mother has identified people who want my services."

SSI with HSA, Balaka

Community Resource Center. Most respondents said FP services should be provided at the resource center at least twice a week with convenient times. Many suggested morning hours and weekdays because women have more free time earlier in the day, there would be greater provider availability, and weather would be cooler. Weekday FP services would also give women the opportunity to combine accessing FP with other activities or health services, such as under-5 clinics. Some respondents mentioned the weekends, to better accommodate youth group referrals that sometimes meet on Saturdays. A few participants, including AGYW, expressed a preference for afternoon or evening hours as being easier for those who wanted to access FP secretly. Others noted the importance of working with community members to design services for sustainability. For example, an HSA in Balaka said *"That [logistics] should depend on what the people from the community want. This is called community empowerment and it leads to sustainability of interventions. If people from the community are comfortable with the arrangement of receiving contraceptives from the Ubwino center, then it will be okay."*

Participants made several recommendations to address privacy and confidentiality concerns at the resource center, including providing services individually in private rooms, ensuring the provider does not disclose FP use to others, integrating FP services with under-5 clinics or other services, and storing files and registers securely.

Providers said they would need new drug boxes and transportation assistance to transport and store supplies. Other supplies needed included gloves, pails, table and chairs, soap, and handwashing facilities. A few providers also said they would like to have an allowance/incentive, for example, an HSA and facility provider suggested a lunch allowance and a CBDA suggested an allowance to buy basic needs like soap.

“The times should be arranged in such a way that the provision of contraceptives should be embedded in another activity so that people do not know that the women are going to the Ubwino center purely for contraceptives. For example, the days could be during those days when women from care groups meet. Likewise, earlier I suggested that girls should also form their own groups so that they can access contraceptives attending to some of their group activities.”

SSI with youth CBDA, Machinga

“If there can be pails, because we inject a lot of people and we need to wash hands. And during the demonstration of the usage of condoms, we also touch the oils, so we need to be washing the hand.”

SSI with HSA, Balaka

Conclusions and Program Recommendations

The formative research study findings discussed in this brief provide important insights to the FP service delivery context and supply side factors influencing FP access in Balaka and Machinga districts of Malawi. The findings confirmed partner support is a gateway factor for married women, while community stigma remains a potential barrier for AGYW seeking contraceptives, corroborating the need to address both demand and supply side factors concurrently.

The two FP integration interventions explored in this study were perceived as addressing two significant service delivery constraints, namely long distances and long wait times at facilities. Clients and providers alike believed referrals would result in shorter wait times at facilities, because of perceptions that referred clients would receive quicker service from providers, and reduced travel time because the community resource center option would bring services closer to the community. Despite general enthusiasm for these interventions, clients and providers expressed several concerns related to privacy and confidentiality of FP services for both options. If either or both intervention(s) are implemented by Njira, careful attention to ensuring client confidentiality would be needed, in addition to addressing other logistical needs highlighted by respondents, such as the supplies (forms, registers, gloves), transportation, and additional training to meet client needs. Although referrals from Care Groups and youth groups appear to be happening more informally, the findings could help further operationalize and formalize the efforts. Recommendations to address some of the supply side constraints for consideration by Njira and other programs working to improve unmet need for FP in Malawi include:

- Train facility- and community-based health providers and relevant project staff (e.g., youth leaders and lead mothers) to provide voluntary client-centered information and counseling on the range of available contraceptive methods to ensure informed choice and expand method choice.
- Improve provider skills in ensuring client privacy and confidentiality.

- Address provider biases, especially about contraceptive use among AGYW and beliefs that FP should only be used by those who are married and/or have a child.
- Raise awareness about the safety and effectiveness of hormonal and long-acting reversible and permanent methods, including among AGYWs (Family Planning 2020 2015).
- Equip providers, especially community-based providers who make home visits, with couples counseling training.
- Improve perceptions of provider trustworthiness and skills, particularly for CBDAs, who may be best positioned to expand services and are well placed to overcome youth-specific barriers like age gaps between providers and youth clients and negative provider attitudes toward providing methods to unmarried women.

- Coordinate with the Ministry of Health and other relevant USAID implementing partners working on reproductive health commodity security to ensure a regular supply of contraceptives in facilities and through community-based distribution systems to accommodate potential increased demand.

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This brief is made possible by the generous support of the American people through the support of the Office of Food for Peace, Bureau for Democracy, Conflict and Humanitarian Assistance, and the Office of Maternal and Health and Nutrition, Bureau for Global Health, U.S. Agency for International Development (USAID), under terms of Cooperative Agreement No. AID-OAA-A-12-00005, through the Food and Nutrition Technical Assistance III Project (FANTA), managed by FHI 360.

The contents are the responsibility of FHI 360 and do not necessarily reflect the views of USAID or the United States Government.

June 2018

Recommended Citation

Food and Nutrition Technical Assistance III Project (FANTA). 2018. *Integrating Family Planning in Development Food Security Activities: Formative Research in Malawi Research Brief 3: Assessment of the Acceptability and Feasibility of Two Interventions to Improve Family Planning Access*. Washington, DC: FANTA, FHI 360.

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