HP+ POLICY *Brief*

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Advancing Family Planning Policy Priorities: Matching Funds Scheme in Malawi

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Introduction

In Malawi, decentralization reforms have transferred important responsibilities for family planning and other health programming from the central government to districts. The ability of districts to deliver on family planning policy priorities will be critical to meet the country's rising demand for high-quality services. An important policy framework in Malawi is the costed implementation plan (CIP) for family planning, which guides activities and investments. The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), developed a matching funds scheme to strengthen the capacity of districts to fund and implement family planning CIP priorities. For each district, HP+ provided up to US$10,000 per fiscal year to match domestic resources allocated by district health offices. In line with HP+ rules, project support covered qualified expenses with no direct support given to the government. The project's aim in Malawi, through this activity and complementary stewardship strengthening and policy dialogue efforts, was to heighten program sustainability. The five districts that participated successfully tapped HP+ support to deliver on family planning priorities, reaching almost 6,000 clients and strengthening their policy implementation capacities in the process.

Participating Districts

In 2021 and 2022, HP+ invited five districts—Lilongwe and Mchinji in the country's Central region, Machinga and Zomba in the Southern region, and Nkhata Bay in the Northern region—to apply for matching funds to defray costs for implementing family planning activities. The scheme began with two districts (Machinga and Nkhata Bay), which started implementing in January 2022, then expanded to three others (Lilongwe, Mchinji, and Zomba) that initiated work in April and May 2022. Four of these districts (excluding Mchinji) had been highlighted by the government in its CIP Addendum as "acceleration districts"— locales where additional funds were likely to boost family planning progress and where significant unmet need existed among a large youth population. With a relatively short implementation period due to the project's end in September 2022, HP+ also targeted districts where it had previous experience and existing relationships.

Capacity Strengthening

Each phase of the matching funds scheme, from application to implementation and reporting, facilitated "learning by doing" in translating policy priorities into concrete action. Participating districts were required to submit an application and detailed budget to secure the funds. The application and budget required district teams, led by the district health officer and the district nursing officer, to identify priority activities as outlined in the CIP Addendum and provide evidence substantiating their priorities, based on DHIS2 data and programmatic reports.

Most districts have historically relied on donor partners for family planning support and have not had to prepare funding applications. Thus, application preparation was a capacity strengthening effort. Among the application

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requirements, districts had to provide a description of the following:

- Family planning context and rationale behind proposed interventions
- Activities, along with an amount districts proposed to contribute from "other recurrent transactions" (ORT)/domestic funding and the amount of funds requested from HP+
- How the district would engage with the District Health Management Team
- Major anticipated barriers for implementation and how to mitigate them
- How they would define and measure success

Because districts were requesting support from HP+ to defray specific expenses, these charges had to be elaborated in detail. For each activity, for example, planners had to include the duration and associated costs, including for items such as fuel and transport, refreshments for trainers and mobilizers, fees for venue rental and communications, materials such as notepads, pens, and flipcharts, and allowances for drivers, supervisors, master trainers, and others, such as drama performers if relevant. Districts also had to commit to specific funds they would put forward as their share—which could not be less than 20 percent of the support requested from HP+. These district applications were incorporated into a memorandum of understanding with HP+.

During the application process, HP+ reached out to district staff to answer questions and provide clarifications. For the first two districts (Machinga and Nkhata Bay), HP+ staff provided limited support in engaging decisionmakers about the scheme and writing and revising the applications. After these initial experiences, HP+ became more involved in providing high-level support to expedite the next three applications. HP+ held a policy dialogue session to secure support for family planning investment from key national and district decisionmakers before proceeding with working sessions with personnel from the other three districts (Lilongwe, Mchinji, and Zomba). Overall, HP+ believes that this approach, when feasible, worked well for gaining "buy-in" and facilitating application preparation and approval.

Once matching funds were approved and after each activity, districts submitted a report to HP+ before receiving funds for the next undertaking. HP+ provided a template for activity monitoring and reporting and district officers submitted reports on all planned activities. Overall, HP+'s technical support included guidance through occasional field visits and project review of quarterly monitoring reports, fund disbursement, and finance checks.

Results

Drawing on support from the matching funds scheme, districts were able to implement or expand their implementation of key family planning activities (see Table 1). These efforts, aligned with CIP policy priorities, included service provision; supportive supervision and monitoring; capacity strengthening of providers, such as community-based distribution agents; community outreach; and family planning review and district health management team meetings. Many activities focused on youth, a priority family planning population group for Malawi. Overall, in a matter of months, districts reached almost 6,000 clients with modern family planning services, including 3,777 youth (63 percent), who are a harder-to-reach population segment. More than 400 providers received family planning training among other outcomes (see Box 1).

Beyond the coverage numbers, participating districts achieved other important results. In Machinga, for example, the scheme enabled district personnel to provide outreach for family planning and sexual and reproductive health services in hard-to-reach areas such as Mpiri and Mkwinda. In these areas, no such services had been provided for a year since the Organized Network of Services for Everyone's Health project scaled down. Health workers in these two places resumed the family planning program and data review meetings after a three-year gap. With matching funds, Machinga also trained providers from five health facilities on the family planning reference manual and participants learned that some of their approaches were outdated, such as offering family planning methods to women

Table 1. District Activities and Outcomes

District	*Activities*	*Number of events and people oriented or trained*	*Number of clients reached with modern contraception*
Lilongwe	• Nurse and data clerk orientation on family planning reporting tools • Youth-focused family planning outreach clinics • Cluster-based orientation of youth community-based distribution agents and youth club chairs/ leaders on a new strategy for emergency contraception and on modern family planning methods in general • Health surveillance assistant training in family planning and youth-friendly health services • Supportive supervision for youth community-based distribution agents and youth "corners" in health facilities • Supportive supervision and data verification in health facilities and youth clubs	• 10 youth outreach clinics conducted • 38 youth community-based distribution agents trained • 19 youth club leaders trained on emergency contraception and family planning • 15 health surveillance assistants trained on family planning • 29 nurses and 29 data clerks oriented on family planning reporting tools for DHIS2 entry and report analysis	659 clients (including 450 youth)
Machinga	• Youth sexual and reproductive health outreach clinics • Supportive supervision and mentorship in family planning • District health management team meeting • Family planning sensitization campaigns • Family planning data review meeting • Soccer "bonanzas"	• 12 community-based distribution agents trained • 5 facilities oriented in immediate postpartum family planning services • 14 facilities supervised and monitored • 4 outreach clinics conducted • 2 family planning sensitization campaigns conducted	685 clients accessed modern contraceptive methods (including 535 youth)
Mchinji	• Mobile outreach clinics • Quarterly commodity spot-checks and redistribution of family planning commodities and family planning service supervision • Family planning open days and community engagement sessions • Orientation and mentorship on new family planning methods to providers • Data clerk and provider training on updated family planning data collection tools • Youth community-based distribution agents supported with refresher training and data collection tools such as registers, tally sheets, and reporting booklets	• 46 community-based distribution agents trained • 17 data clerks and 12 providers (nurses and health surveillance assistants) oriented on family planning reporting tools for DHIS2 entry and report analysis • 40 providers trained on immediate postpartum family planning • 12 outreach clinics conducted	751 clients (including 472 youth)
Nkhata Bay	• Mentorship of family planning providers in integration of family planning into other health services • Integrated outreach clinics • Community dialogues • Cluster-based engagement dialogues • Logistics management and information system supervision and mentorship • Immediate postpartum mentorships and supervision	• 70 providers trained in immediate postpartum family planning • 7 outreach clinics conducted • 70 providers mentored on using the open logistics management and information system (real-time database on stock status) • 7 community dialogues on family planning conducted	2,911 clients (including 1,847 youth)

District	*Activities*	*Number of events and people oriented or trained*	*Number of clients reached with modern contraception*
Zomba	• Community dialogues on family planning and sexual and reproductive health • Community mobilization on family planning targeting youth • Family planning outreach clinic • Immediate postpartum family planning mentorships	• 174 workers trained on immediate postpartum family planning • 21 outreach clinics conducted • 7 community dialogue sessions conducted	973 clients (473 youth)

Box 1. Totals for All Districts

- 54 outreach clinics conducted
- 414 people trained
- 70 people mentored on the open (real-time) logistics and management information system
- 87 people oriented on family planning reporting tools for DHIS2 entry and report analysis
- 14 community dialogues and 2 communication campaigns conducted
- 5,979 clients reached with modern contraception (3,777 or 63 percent of youth 10–24 years of age)

six weeks after delivery. Now, these providers, who will train other providers, know they should discuss family planning method choice even before women deliver, integrating these discussions into antenatal care.

Three other participating districts (Mchinji, Nkhata Bay, and Zomba) used matching funds to train providers and promote practices aligned with Malawi's guidance on immediate postpartum family planning, described in the latest family planning reference manual. These districts had been using old guidelines similar to Machinga's practice. Healthcare workers were waiting for the first postnatal check-up to introduce family planning; the matching funds support introduced them to the new guidelines. In one district, the visiting management team noted that contraceptive implant insertion was being done incorrectly. Using the reference manual, the team provided district staff with supportive supervision on the correct insertion method.

All districts were able to commit small amounts of government funding from their other recurrent transactions (ORT) budget lines to contribute to the expenses supported by HP+, up to US$10,000 maximum per district application in any given fiscal year. Districts also contributed human and infrastructural resources as well as fuel, vehicles, personnel, and community structures. In total, districts contributed about US$9,780 from their ORT budget lines and HP+ covered about US$46,350 in expenses associated with the family planning activities. HP+ requested districts to specify in their applications that they would put in at least 20 percent of their own funds to support activity costs. The overall ratio of district-to-HP+ contributions across the five sites—1 to 4.7—is on par with the 20 percent commitment but only because of especially strong funding levels from two districts. The other districts were unable to make contributions in line with the levels they committed to in their applications.

Lessons and Ways Forward

The project elicited feedback on the matching funds scheme from districts, both directly and through monitoring efforts. Additionally, the project gained a sharper understanding of family planning funding issues through a national advocacy meeting in Lilongwe and four zonal policy dialogue meetings (in Blantyre, Mangochi, Mzuzu, and Salima) with representatives from

the 12 acceleration districts named in the CIP Addendum and Mchinji. The national family planning focal point and a policy officer from the Reproductive Health Directorate attended these meetings, during which districts identified resource bottlenecks and opportunities and agreed on action items to advance family planning efforts in their localities.

The participating districts were successful in applying for matching funds and implementing their plans. This process required coordination and collaboration among the district health officers, family planning coordinators, and community-based cadres. Planning for the activity required districts to review high-impact interventions in the family planning CIP Addendum and assess the status of their own districts based on program and service delivery data. Districts had to select activities targeting the areas most in need and monitor implementation progress in each of them. Notably, the scheme illustrated an alternative way for districts to partner with stakeholders. The Lilongwe District Health Office, for example, is using this model with another funding partner to expand family planning efforts to wider catchment areas.

Through these efforts, a number of resourcing challenges related to domestic funding for family planning also became evident (see Table 2). District actors noted that they receive too little in ORT funds to invest in family planning after they satisfy utility, personnel, and other costs. Delayed release of ORT funds also posed challenges and stakeholders noted the need for the matching funds scheme to better align with district budget cycles. Domestic resourcing for family planning may be constrained by perceptions among district decisionmakers that this programming is a "soft"

Table 2. Resource Issues and Ways Forward

Resource Issue	*Ways Forward*
Inadequate ORT funding. District representatives noted that ORT allocations were often too small to cover the usual costs (e.g., electrical, vehicle maintenance, and personnel) and family planning activities. Some district representatives noted that the program-based budget guidelines on health budget resource allocations have no specific guidance on family planning allocations.	At the district level, ORT advocacy can target the full district council to explain family planning benefits and resourcing, generating support for district health offices to allocate and disburse funds for family planning. At the central level, family planning stakeholders can engage the National Local Government Finance Committee to issue a directive for a percentage of the district budget to be used for family planning activities, similar to advisories for other health programs.
Delayed ORT funding. Districts reported that delays in ORT funding affected their ability to contribute to the matching funds effort.	HP+ found that district health officers, working alone, faced barriers in securing the release of ORT funds. Upon engagement of the full District Health Management Team and the District Council, funds could be "unlocked" for family planning activities. Stakeholders also noted the need for HP+ to align disbursement of funds to that of district budget timelines.
Mindset regarding family planning. Some district decisionmakers may perceive that ORT and other potential development funds should be for "hard development" investments in areas such as infrastructure, vehicles, and utilities. Family planning may be perceived as a "soft" investment and thus a lower priority.	To help shift this mindset, the policy dialogue meetings presented an evidence-informed case for the contributions family planning makes to both health and economic development objectives. Districts participating in the matching funds scheme also gained experience increasing support for family planning activities from ORT funding. Going forward, family planning stakeholders should engage district councils and other high-level management on the importance of funding for family planning activities.
Limited guidance. Even in a devolved setting, districts may look to the program-based budget guidelines, developed by the Ministry of Health planning department and the National Local Government Finance Committee, for direction on family planning funding allocations.	The Ministry of Health's Reproductive Health Directorate has taken up this issue for further advocacy with the relevant decisionmakers to incorporate specific guidance to districts on family planning funding.

investment and not an important contributor to economic development. Even though Malawi has decentralized many health functions, district decisionmakers said they look to the central level for policy guidance on family planning and budgetary advice on which programs have required funding levels set—called "ringfencing." Family planning is not among programs that have protected budgets. Improved planning and further policy advocacy and dialogue can help address many of these issues.

The matching funds scheme encountered some planning and administrative issues. Devaluation of the Malawian kwacha led to a rise in fuel costs that affected budgets and district health officers had to find extra funds to bridge the gaps. In planning, managers need to consider contingencies (where allowable) to absorb shocks. These strategies could include paring back the number of activities, integrating family planning activities with other programs, and cost-sharing collaborations with other partners. On the administrative side, HP+ tried to disburse relatively small amounts of money efficiently and effectively, without incurring outsized costs in staff time and travel. The project streamlined processes and disbursements to the extent allowable. Still, with some participants lacking devices for mobile payments, efficient disbursement posed challenges.

Conclusion

Even with an implementation period measured in months rather than years, districts participating in the HP+ matching funds scheme achieved a great deal. They were able to train and update providers on the latest family planning policies and practices, including important guidance on immediate postpartum family planning; improve outreach to remote communities; improve understanding of data quality and reporting; and deliver services to hard-to-reach young people and women. Notably, at least one participating district is using the "matching funds" model as an alternative way to work with other funding entities. All participating district actors followed a process that required them to engage in policy and data review, coordination and collaboration, and monitoring and reporting. They gained experience prioritizing activities and areas most in need. In the process, they turned policy priorities into on-the-ground action to improve the health and well-being of women and young people.

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