



Government of Malawi

Guidelines for Family Planning Communication

April 2011

**Ministry of Health,
Health Education Unit**



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Acronyms

ART	Antiretroviral therapy
BLM	Banja la Mtsogolo
BCC	Behaviour change communication
CBDA	Community-based distribution agent
CHAM	Christian Hospitals Association of Malawi
CBO	Community-based organization
CPR	Contraceptive prevalence rate
DHMT	District Health Management Team
DHO	District Health Officer
EHP	Essential Healthcare Package
FP	Family planning
HCT	HIV counseling and testing
HEU	Health Education Unit
HSA	Health surveillance assistant
IEC	Information, education, and communication
IUD	Intrauterine device
LAM	Lactation amenorrhea method
MDHS	Malawi Demographic and Health Survey
M&E	Monitoring and evaluation
MICS	Multiple Indicator Cluster Survey
NSO	National Statistics Office
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PHAM	Private Hospitals Association of Malawi
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PSI	Population Services International
SBCC	Social and behaviour change communication
TA	Traditional Authority
TFR	Total fertility rate

Preface

Family planning (FP) is a key development issue that impacts the quality of lives of families, communities, and broader society. Increased use of FP leads to large improvements in the health of mothers and children, the status of women, and economic development. The recent publication from the Government of Malawi, *Rapid Population and Development, Malawi*, states that if current trends in fertility continue, “the population of Malawi will reach approximately 40.6 million by 2040.” This growth will have far-reaching consequences for the future health and development of the country.

FP ensures that women are able to delay their first pregnancy until they are physically and mentally ready to have children. They can also space their children so they have a chance to recover and build their own strength. Each child can also receive adequate nutrition and attention. FP also helps couples to avoid unwanted pregnancies. .

It is also imperative to strengthen the integration of FP and HIV services in order to prevent mother-to-child transmission (PMTCT) of HIV and to address the FP needs of people living with HIV (PLHIV). Given that over 50,000 HIV-positive pregnant women will be identified in Malawi’s PMTCT programme each year, efforts need to be made to enroll as many of them as possible within the new national pre-antiretroviral treatment (ART) programme and then ensure that FP counseling and referrals are an essential component of the national pre-ART and ART programmes.

A number of policy documents have been developed that place a strong emphasis on the importance and the role of communication and behaviour change to improve FP uptake. *The National Reproductive Health Strategy* aims “to promote through informed choice, safer reproductive health practices by men, women and young people, including increased use of high quality, accessible reproductive health services.”¹ These guidelines support the policy framework with specific guidance on how to strengthen the impact and quality of behaviour change interventions to help communities and families secure a better quality of life.

Guidelines for Family Planning Communication provides the framework for implementation of FP communication programmes in Malawi. It provides the tool to ensure that efforts of the Government of Malawi and NGOs and CBOs are coordinated and will have greater impact towards improved FP uptake in Malawi and the country’s future development.

¹ Malawi Ministry of Health. (2006). National Reproductive Health Strategy 2006–2010.

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Foreword: Why Guidelines for Family Planning Communication?

Family planning (FP) is a key development issue that impacts the quality of lives of families, communities, and broader society. Increased use of FP services leads to large improvements in the health of mothers and children, the status of women, and economic development. Malawi has made great strides in the last decade to improve FP programmes in the country. Communication is a critical element of a family planning programme. It is essential to overcome myths and misconceptions about modern FP methods and have open discussion and dialogue in the community about the role of FP in safeguarding the health and wellbeing of our mothers and children.

Currently, many partners are working on FP communication in the country, in collaboration with Ministry of Health (MOH) staff and services. However, it has become clear that many initiatives are taking place in isolation, with overlapping and sometimes confusing messages and approaches. The Health Education Unit of the MOH responded by bringing together all major partners in FP communication in the country to map out a common framework for FP communication. The resulting document, *Guidelines for Family Planning Communication*, will be rolled out to district and community levels. It will ensure everyone is working in concert, and that we are all using our limited resources to their greatest effect.

This exercise would not have been possible without technical and financial support from USAID through the Communication for Change Project (C-Change). The MOH would like to thank all individuals and institutions for their contributions to this document, and urges all public and private institutions to make maximum use of it to guide FP communication programmes in Malawi.



Hon. Professor David Kapererera Mphande, Member of Parliament
Minister of Health

Introduction

Family planning (FP) is a key development issue that impacts the quality of lives of families, communities, and broader society. Increased use of FP leads to large improvements in the health of mothers and children, the status of women, and economic development. A recent publication from the Government of Malawi, *Rapid Population and Development, Malawi*, states:

The results of the 2008 Population and Housing Census estimate the population of Malawi at 13,077,160 people. The population increased by 32 percent from 1998 to 2008, representing an annual growth rate of 2.8 percent (NSO, 2008). This reflects the current total fertility rate (TFR) of 6.0 births per woman (NSO 2008 and ORC Macro, 2005). If this fertility rate remains constant, the population of Malawi will reach approximately 40.6 million by 2040.

This population growth will have far-reaching consequences for the future health and development of Malawi, as will high maternal mortality rates of 807 per 100,000 live births. That 30 percent of these deaths are attributed to abortion-related complications demonstrates the unmet demand for FP.² Early pregnancy among teenagers and high fertility rates also increase risk of maternal and neonatal mortality. Adolescents under age 20 are responsible for 25 percent of all deliveries in Malawi, and 20 percent of all maternal deaths occur among adolescents. Girls, as young as 12, are getting pregnant. Their bodies are physically undeveloped for the demands of pregnancy, and they are at higher risk of complications. These pregnancies may be unwanted and end in abortion.

FP ensures that women are able to delay their first pregnancy until they are physically and mentally ready to have children. FP allows women to space their children and gives mothers a chance to recover, build their own strength, and provide each child with adequate nutrition and attention. FP also helps couples with HIV to avoid unwanted pregnancies.

It is also imperative to strengthen the integration of FP and HIV services to prevent mother-to-child transmission (PMTCT) of HIV and address the FP needs of people living with HIV (PLHIV). Given that over 50,000 HIV-positive pregnant women will be identified in Malawi's PMTCT programme each year, efforts need to be made to enroll as many of them as possible within the new national pre-ART programme and ensure that FP counseling and referrals are essential components of the national pre-ART and ART programmes. At the community level, PLHIV networks should incorporate access to FP into their support groups.

Guidelines for Family Planning Communication will assist district health management teams (DHMTs) and community organizations to review their FP communication programming. The guidelines will help them to:

- analyze data in the district and community and increase understanding of FP issues
- segment target populations based on the FP issues unique to a community
- identify and overcome specific barriers to FP uptake
- ensure accurate and consistent messaging on FP
- develop effective interventions to reach target populations

² National Statistical Office (NSO) [Malawi] and United Nation's Children's Fund. 2007. Multiple Indicator Cluster Survey 2006.

- promote participatory action planning to utilize all resources and ensure all communities are reached with FP communication programming
- monitor and evaluate programming to achieve success

How the Guidelines Support the National Reproductive Health Strategy

A number of current policy documents place a strong emphasis on the importance and the role of communication and behaviour change to improve FP uptake. For example, the aim of the *National Reproductive Health Strategy* is “to promote through informed choice, safer reproductive health practices by men, women and young people, including increased use of high quality, accessible reproductive health services.”³ FP is a major focus and building block of the strategy, which aims to strengthen:

- access to and the availability and utilization of FP services at health facility and community levels
- human resources to provide quality FP services
- contraceptive commodity security
- **behaviour change interventions**
- the integration of FP services into other Essential Healthcare Package (EHP) components
- monitoring and evaluation (M&E) mechanisms for better decision-making and FP service delivery.

Another important policy document is the *Advocacy and Communication Strategy for Sexual and Reproductive Health and Rights Programs*, which highlights the importance of addressing sexual and reproductive health issues through prevention. The *National Prevention Strategy* (2009) is another, which seeks to integrate FP within traditional HIV prevention interventions at facility and community settings.

These policy documents outline the overall framework within which FP is taking place in Malawi. The guidelines presented in this document support the policy framework with specific guidance on how to strengthen the impact and quality of behaviour change interventions to help communities and families secure a better quality of life.

Goal of the Guidelines

The goal of *Guidelines for Family Planning Communication* is to create partnerships between governmental and non-governmental organizations (NGOs) at the central, district, and community levels to maximize effective implementation of FP communication programming.

Better coordinated and strategic FP communication will lead to increased demand for and greater uptake of FP services. The guidelines will support DHMTs in working with all stakeholders in their districts to develop evidence-based action plans for greater coverage and utilization of scarce resources.

³ Malawi Ministry of Health. 2006. National Reproductive Health Strategy 2006–2010.

Target Population

The guideline's target population includes:

- DHMTs
- civil society organizations
- traditional networks
- service providers

DHMTs are responsible for coordinating health programming and responses at district levels. The guidelines are meant to support this coordination role as well as guide all civil society organizations working on FP or planning to integrate FP, along with all traditional networks and service providers, including non-traditional partners working in the area of HIV and AIDS at district levels.

How to Use the Guidelines

A coordinated and concerted effort is needed to effectively use all resources for social and behaviour change communication (SBCC) at scale and have an impact on social norms and behaviours related to FP.

Each section of the guidelines contains a series of questions to guide the development of district and community plans. Annex B contains a simple facilitator's guide, which can be used to support further investigations and ensure that strategic planning is based on local needs at the district level and includes the participation of other key stakeholders.

Issues in FP: What Do the Data Tell Us?

FP indicators in Malawi have improved in the last decade:

- The country's total fertility rate (TFR)⁴ declined from 6.7 in 1992 to 6.3 in 2000 and 6.0 in 2004.
- The contraceptive prevalence rate (CPR)⁵ for modern contraceptive methods increased significantly, from 7 percent in 1992, to 14 percent in 1996, to 26 percent in 2000, and to 28 percent in 2004.
- Unmet need for FP declined from 36 percent in 1992 to 30 percent in 2000 and 28 percent in 2004.⁶

List of major modern contraceptive methods available in Malawi:

- Male and female condoms
- Oral contraceptive pills
- Injectables, e.g., Depo-Provera
- Implants, e.g., JADELE
- Emergency contraception
- Male/female sterilization
- Intrauterine device (IUD)

Several studies on FP in Malawi indicate a rise in the use of contraceptives. This increase was observed in both rural and urban areas and among different population groups.⁷ However, despite a significant increase in contraceptive use, a greater proportion of women do not use contraception compared to those who do use contraception, and a significant proportion do not intend to use contraception in the future. There is still much to be accomplished to change the social norm around the use of FP services.

⁴ TFR is the average number of children that would be born to a woman over her lifetime if she were to experience the exact current age-specific fertility rates throughout her lifetime and survived to the end of her reproductive life.

⁵ CRP is the percentage of women between ages 15 to 49 who are practicing or whose partners are practicing, any form of contraception.

⁶ National Statistical Office (NSO) [Malawi] and ORC Macro. 2005. Malawi: Demographic and Health Survey, 2004.

⁷ National Statistical Office (NSO) [Malawi] and ORC Macro. 2005.

A number of key issues have been identified as a priority in policy documents:

- *Unmet need for FP*, since 28 percent of the women and families surveyed indicated their interest in practicing FP, but they also indicated they are constrained from doing so.
- *Resistance to modern methods* among some sectors, such as religious communities.
- *Discontinuation of certain methods* due to side effects.
- *Early and sustained childbearing*, which increases the risk of maternal mortality and complications around childbirth that affect both mother and child).
- *Couples living with HIV* who do not access FP to prevent untimely pregnancy.
- *Unsustainable community-based distribution* of services.
- *Low utilization of male and female condoms*.
- *Limited access to services for rural populations* (83 percent of Malawians).

A Case for Targeting Rural Populations

Studies show considerable differences between urban and rural populations, in Africa and elsewhere. Women who live in urban areas attain higher levels of education, have a larger number of living children, are better off economically, and are more likely to use contraception. Conversely, women who live in rural areas tend to be less educated, have fewer living children, are worse off economically, and are less likely to use contraception. With 83 percent of the population of Malawi living in rural areas, it will be important to focus on rural communities.

Questions to answer locally: To understand the issues in your community, a number of important questions need to be answered:

- What are the FP statistics in your district?
 - Total fertility rate (TFR)
 - Contraceptive prevalence rate (CPR)
 - Uptake of specific contraceptive methods
 - Discontinuance rates for specific contraceptive methods
- Where are FP services currently offered within health facility and community settings?
 - FP facilities
 - Antenatal care clinics
 - Postnatal wards
 - HIV clinics
 - Community-based distribution agents (CBDAs)
 - Health surveillance assistants (HSAs)

Target Audiences: Who Do We Need to Reach?

Key target populations for FP communication programming in Malawi are people directly affected and community networks, community leaders, and opinion leaders that influence them.

People directly affected

At the individual level, families need to adopt and sustain FP practices to be healthier and more prosperous. Properly developed behaviour change communication (BCC) interventions need to reach specific segmented target audiences by age and gender, with a focus on rural communities.

People directly affected include:

- adult women
- adolescent girls
- adult men
- adolescent boys
- male and female PLHIV

Community networks directly influencing people who are directly affected

FP uptake is also linked to community and social network support, which creates an enabling environment for FP use. Using social mobilization interventions, the following networks will be targeted:

- traditional networks
- faith-based networks
- women's and men's organizations
- NGOs and community-based organizations (CBOs)
- workplace settings
- PLHIV support groups

Community leaders and opinion leaders indirectly influencing people directly affected

Using advocacy interventions, key leaders need to be convinced that FP is fundamental to the quality of their communities and community resources. Those targeted include:

- traditional leaders
- political leaders
- religious leaders
- health workers
- private sector leaders

It is also important to segment the key target populations for FP so interventions and messages are effectively targeted for greatest impact. Segmenting means dividing and organizing an audience into smaller groups who have similar communication-related needs, preferences, and characteristics. Segmentation helps a programme to prioritize limited resources by reaching a defined audience with more intensity and with potentially higher impact than it would have if it tried to reach the whole population. Through segmentation, a programme can achieve the most appropriate and effective ways to communicate with the various groups targeted.

When a programme segments its audience for FP programming, it is important to ensure that the segmented groups cover those most directly affected by issues, as well as those who directly and indirectly influence their decision-making. This process should identify key issues that would necessitate different messages and approaches, such as differences related to urban and rural residence, age, education, gender, and community roles.

Questions to answer locally:

- Are there specific groups within your community that need to be targeted?
 - rural vs. urban
 - youth out of school vs. in school

- community leaders, such as traditional leaders and women leaders
- Which community networks in your district and community are influential?
- Who are your key community leaders and opinion leaders?

Barriers and Benefits: What Do We Need to Overcome?

Nationally, a number of studies have identified key barriers that need to be overcome in order to improve FP uptake for both women and men of all ages. A literature review was conducted that yielded some key findings.

Barriers that women face

Fear of side effects: Many women do not want to access FP commodities and services due to fear of side effects.^{8,9}

Those feared include:

- severe or frequent vaginal bleeding (Depo-Provera, IUD, implant, and oral contraceptives)
- weight gain
- weight loss, which carries the risk of HIV stigma (Depo-Provera, Jadele)
- abdominal pains (Depo-Provera, oral contraceptives, IUD, Jadele)
- decreased sexual desire (Depo-Provera, male condom)
- unwanted pregnancy: oral contraceptives, male and female condom)

Summary of Key Barriers

- Myths and misconceptions around the side effects of modern methods
- Low self-efficacy to negotiate FP with partners
- Lack of partner support/communication
- Gender inequalities
- Community norms and practices that encourage early and frequent childbearing
- Stigma around specific methods
- Poor provider-client communication around FP
- Poor integration of FP across entry points within facilities and community settings
- Perceived cost and availability of methods

Social value of parenthood: The expectation that women will have children is a strong social value in Malawian culture. Barden-O’Fallon, in her study involving in-depth interviews with men and women, quotes one childless woman: “When you have a child you are respected and you are also recognized by people. But if you do not have a child you appear to be a fool in the presence of people, as if you are walking naked.”¹⁰

Lack of information, misconceptions, myths, and rumors: There is a lack of adequate correct information as well as misconceptions, myths, and rumors about modern contraceptives.^{11,12, 13} The following are among prevalent misconceptions:^{14, 15}

⁸ Management Sciences for Health/USAID. 2009. Community-Based Family Planning and HIV/AIDS Services in Malawi: Baseline Study.

⁹ Center for Social Research, Save the Children Federation USA, Malawi Ministry of Health and Population, and MEASURE Evaluation. 2004. Avoiding Unwanted Pregnancy and Sexually Transmitted Infections: A Rural Malawi District Study.

¹⁰ Barden–O’Fallon, J. 2005. Unmet Fertility Expectations and the Perception of Fertility Problems in a Malawian Village. *African Journal of Reproductive Health* 9(2): 14-25.

¹¹ Wittenberg J., Munthali A., Moore A., Zulu E., Madise N., Mkandawire M., Limbani F., Darabi L., Konyani S. 2007. Protecting the Next Generation in Malawi: New Evidence on Adolescent Sexual and Reproductive Health Needs. Washington DC: Guttmacher Institute.

¹² Munthali A., Moore A., Konyani S., Zakeyo B. 2006. Qualitative Evidence of Adolescents’ Sexual and Reproductive Health Experiences in Selected Districts of Malawi. *Occasional Report no. 23*, New York: The Alan Guttmacher Institute.

¹³ University of Southampton, UK, Opportunities and Choices Programme. [2002]. Barriers to Use of Family Planning Services in Malawi: Findings from Focus Group Discussions. Fact Sheet 14.

- Oral contraception and IUDs can cause cancer and other illnesses.
- Contraceptive use before having a child can cause impotence or infertility.
- Condoms and IUDs can get stuck inside a woman's body.
- Women become infertile as a result of using contraception.
- Women who use pills and injections develop pimples.
- Condoms may burst inside and enter the uterus.
- Contraceptive pills may make women have many children.

Traditional beliefs: There are a number of cultural beliefs that can impact on FP practices such as:

- belief that use of a traditional rope will protect a woman from becoming pregnant
- practice of *kuchotsa fumbi* (cultural custom of forced sex), which precludes the use of contraception

Shyness about going to the hospital.¹⁶

Male disapproval of contraception, which may sometimes lead to concealed use.^{17,18, 19}

Gender: Women's inability to make decisions about their health because being female makes it difficult to negotiate FP.²⁰

Barriers that men face

Social value of parenthood: As with women, men in Malawi are expected to father children. Barden-O'Fallon provides this quote: "If a man marries this month, we start counting the months, one, two, three; still if nothing happens the elders tell you to go for traditional medicines with your wife so that we should see."²¹

Cost: Men viewed the cost of accessing contraceptives (e.g., time that it takes to access contraceptives, transportation costs, wait time, etc.) to be high. The longer his wife is on a method, the higher the cost.

Male contraception: The option of vasectomy is often rejected.

Trusting one's partner: Men who trust their partners may opt not use condoms.²²

¹⁴ Center for Social Research, Save the Children Federation USA, Malawi Ministry of Health and Population, and MEASURE Evaluation. 2004. Avoiding Unwanted Pregnancy and Sexually Transmitted Infections: A Rural Malawi District Study.

¹⁵ Bisika T. 2008. Cultural Factors that Affect Sexual and Reproductive Health in Malawi. *Journal of Family Planning Reproductive Health Care*, 34(2): 79-80.

¹⁶ Center for Social Research, Save the Children Federation USA, Malawi Ministry of Health and Population, and MEASURE Evaluation. 2004.

¹⁷ Munthali A., Moore A., Konyani S., Zakeyo B. 2006.

¹⁸ Soldan V. 2004. How Family Planning Ideas are Spread within Social Groups in Rural Malawi. *Studies in Family Planning*, 35(4): 275-290.

¹⁹ University of Southampton, UK, Opportunities and Choices Programme. 2002. Barriers to Use of Family Planning Services in Malawi: Findings from Focus Group Discussions. Fact Sheet 14.

²⁰ University of Southampton, UK, Opportunities and Choices Programme. No Date. Who is Using Modern Methods of Contraception in Malawi? Evidence from the Malawi Demographic and Health Survey 2000. Fact Sheet 15.

²¹ Barden-O'Fallon J. 2005. Unmet Fertility Expectations and the Perception of Fertility Problems in a Malawian Village. *African Journal of Reproductive Health* 9(2): 14-25.

²² Meekers D. 1998. Improving Condom Social Marketing in Malawi: Evidence from a Consumer Profile Survey. *PSI Research Division Working Paper No. 18*.

Barriers that youth face

Poor quality services: There are perceived negative attitudes of FP providers towards young people.

Young people who seek contraceptives are labeled promiscuous²³: This inhibits young people from seeking out FP services.

Lack of knowledge of FP service sources²⁴: Youth do not have accurate and complete information on FP methods.

Misinformation on how to prevent pregnancies: For example, some believe that a girl cannot get pregnant if she washes her private parts soon after intercourse, if sex takes place in water, if it is the first sexual act, or if she is standing and the man is sitting during intercourse.²⁵

Discouragement from community leaders²⁶: Community leaders do not support FP services for youth.

Shyness, embarrassment, and/or fear in obtaining contraception or getting advice/treatment for sexually transmitted infections.^{27,28}

Barriers posed by health workers

FP providers who are not youth-friendly: Many providers feel uncomfortable providing contraceptives to adolescents because they believe that this promotes promiscuous sexual activity.²⁹

Provider bias: Providers may bring their own cultural and religious orientations to discussions about FP and make decisions on what is best for the client on that basis.³⁰

Cross-cutting barriers

- Condom use often connotes mistrust or unfaithfulness for spouses and regular partners.³¹
- Desire to have children and childbearing is seen as God's will.³²

²³ Munthali A., Chimbiri A., Zulu E. 2004. Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence. Occasional Report No 15, The Alan Guttmacher Institute, New York

²⁴ Wittenberg J, Munthali A., Moore A., Zulu E., Madise N., Mkandawire M., Limbani F., Darabi L., Konyani S. 2007. Protecting the Next Generation in Malawi: New Evidence on Adolescent Sexual and Reproductive Health Needs. Washington DC: Guttmacher Institute.

²⁵ Munthali A., Chimbiri A., Zulu E. 2004. Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence. Occasional Report No 15, The Alan Guttmacher Institute, New York

²⁶ Management Services for Health/USAID, Malawi. 2009. Community-Based Family Planning and HIV/AIDS Services in Malawi: Baseline Study.

²⁷ Munthali A., Zulu E., Madise N., Moore A., Konyani S., Kaphuka J., and Maluwa-Banda D. 2006. Adolescent Sexual and Reproductive Health in Malawi: Results from the 2004 National Survey of Adolescents, *Occasional Report*, New York: Guttmacher Institute, No. 24.

²⁸ Biddlecom A., Hessburg L., Singh S., Bankole A., Darabi L. 2007. Protecting the Next Generation in Sub-Saharan Africa: Learning from Adolescents to Prevent HIV and Unintended Pregnancy. Guttmacher Institute.

²⁹ Munthali A., Chimbiri A., Zulu E. 2004. Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence. Occasional Report No 15, The Alan Guttmacher Institute, New York

³⁰ Sullivan T., Bertrand J., Rice J., Shelton J. 2006. Skewed Contraceptive Method Mix: Why It Happens, Why It Matters. *Journal of Biosocial Science*, (38):501-521.

³¹ Munthali A., Chimbiri A., Zulu E. 2004. Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence. Occasional Report No 15, The Alan Guttmacher Institute, New York

³² Soldan V. 2004. How Family Planning Ideas are Spread Within Social Groups in Rural Malawi. *Studies in Family Planning*, 35(4): 275-290.

- Long distances from clinics,^{33,34} long waiting times,³⁵ and stock-outs contribute to low uptake of FP services.³⁶
- Inconvenience and fear of side effects.
- Fear of disclosure and exposure³⁷

Perceived Benefits

It is also important to understand the perceived benefits derived from adopting FP. Knowing this information leads to better communication messages and programmes. The following matrix outlines the key target populations, desired changes in behaviour, perceived benefits, and perceived barriers. Understanding these elements are critical to the development of effective SBCC messages and interventions.

Summary of Key Benefits of FP

- Peace of mind when having sex
- Healthy family
- Can continue with education
- Has time to do business or work
- Has time to contribute to development work
- Has time to care for the family

Target Populations	Desired Changes	Perceived Benefits	Perceived Barriers
Adult Women in Urban Areas	<ul style="list-style-type: none"> • To use FP methods • To freely discuss issues of FP with their spouses • To encourage fellow women to practice FP 	<ul style="list-style-type: none"> • Will not have an unwanted pregnancy • Peace of mind when having sex • Has enough time to care for children • Healthy family • Has time for work • Can continue her education 	<ul style="list-style-type: none"> • Side effects of FP methods • Myths and misconceptions • Need for more children • Unavailability of FP methods • Fear of spouse's or partner's anger if using FP • Religious beliefs that prohibit contraceptive use • Long distances to the clinic to access the methods where they may be long waiting times
Adolescent Girls and Young Women in Urban Areas	<ul style="list-style-type: none"> • To freely seek FP methods from health facilities 	<ul style="list-style-type: none"> • Will not have an unwanted pregnancy • Peace of mind when 	<ul style="list-style-type: none"> • Side effects of FP methods • Myths and misconceptions

³³ Center for Social Research, Save the Children Federation USA, Malawi Ministry of Health and Population, MEASURE Evaluation. 2004. Avoiding Unwanted Pregnancy and Sexually Transmitted Infections: A Rural Malawi District Study.

³⁴ Management Services for Health/USAID, Malawi. 2009. Community-Based Family Planning and HIV/AIDS Services in Malawi: Baseline Study.

³⁵ Creel L., Sass J., Yinger N. 2002. Client-Center Quality: Clients' Perspectives and Barriers to Receiving Care. *New Perspectives on Quality of Care*, 2.

³⁶ Hennink M., Nyovani M. 2005. Influence of User Fees on Contraceptive Use in Malawi. *African Population Studies*, 20: 125-141.

³⁷ Munthali A., Chimbiri A., Zulu E. 2004.

Target Populations	Desired Changes	Perceived Benefits	Perceived Barriers
	<ul style="list-style-type: none"> • To use FP methods in their relationships 	<ul style="list-style-type: none"> having sex • Can continue her education • Healthy family 	<ul style="list-style-type: none"> • Unavailability of FP methods • Fear of partner's anger • Religious beliefs • Lack of youth-friendly health services
Adult Women in Rural Areas	<ul style="list-style-type: none"> • To use FP methods • To freely discuss FP issues with spouses or partner and as a family • To encourage other women to use modern FP methods • To get support from partners 	<ul style="list-style-type: none"> • Will not have an unwanted pregnancy • Peace of mind when having sex • Has enough time to care for children • Healthy family • Has time for work • Has time to participate in development of the community 	<ul style="list-style-type: none"> • Side effects of FP methods • Myths and misconceptions • Need for more children • Unavailability of FP methods • Fear of spouse's or partner's anger • Religious beliefs • Traditional beliefs • Need to travel long distance to a health facility to access the methods • Lack support from spouse
Young Women in Rural Areas	<ul style="list-style-type: none"> • To freely seek FP methods from health facilities • To use FP methods in their relationships 	<ul style="list-style-type: none"> • Can continue her education because she is assured that she cannot get pregnant • Peace of mind when having sex because she is assured that she will not have an unwanted pregnancy • Healthy family 	<ul style="list-style-type: none"> • Side effects of FP methods • Myths and misconceptions • Unavailability of FP methods • Fear of partner's anger • Religious beliefs • Lack of youth-friendly health services and clinics • Need to travel long distances to the clinic to access the methods
Adolescent Girls in Rural Areas	<ul style="list-style-type: none"> • To understand the importance of having one sexual partner • To understand the importance of avoiding early pregnancy • To access youth-friendly FP services • To have all methods available in all health facilities 	<ul style="list-style-type: none"> • Healthy families • Reduced number of teen pregnancies and complications • Reduced number of HIV infections 	<ul style="list-style-type: none"> • Shortage of health personnel • Lack of space in health facilities • Negative attitudes of health workers, parents, and guardians • Cultural beliefs

Target Populations	Desired Changes	Perceived Benefits	Perceived Barriers
Adult Men in Urban Areas	<ul style="list-style-type: none"> • To allow their wives to use FP methods • To freely discuss FP issues with their wives or partners • To encourage other men to actively take part in FP—for example, escort their wives to antenatal clinics • To use FP methods available for men, e.g., vasectomy and condoms 	<ul style="list-style-type: none"> • Peace of mind when having sex • Has enough time to care for children • Healthy family • Has time to do business or work • Can continue his education • Able to concentrate on the health and well being of his family • Reduce maternal and child mortality 	<ul style="list-style-type: none"> • Fear of side effects • Myths and misconceptions • Traditional beliefs • Religious beliefs • Need to travel long distances to health facilities • Unavailability of FP methods for men, e.g., vasectomy
Adolescent and Young Men in Urban Areas	<ul style="list-style-type: none"> • To use FP methods in their relationships • To freely discuss FP issues in their relationships 	<ul style="list-style-type: none"> • Peace of mind when having sex • Can continue with his education • Healthy family 	<ul style="list-style-type: none"> • Fear of side effects • Myths and misconceptions • Traditional beliefs • Religious beliefs
Adult Men in Rural Areas	<ul style="list-style-type: none"> • To allow their wives or partners to use modern FP methods • To freely discuss FP issues with their spouses or partners • To encourage other men to actively take part in FP, for example, to escort their partners to antenatal clinics • To use FP methods available for men, e.g., vasectomy or condoms • To discuss with men issues concerning FP • To encourage man-to-man discussions on FP 	<ul style="list-style-type: none"> • Peace of mind when having sex • Able to concentrate on the health and well being of his family • Healthy family • Has time to do business or work • Has time to participate in development work of the community • More men taking part in FP • More women freely taking part in FP • Reduce maternal and child mortality 	<ul style="list-style-type: none"> • Fear of side effects • Myths and misconceptions • Traditional beliefs • Religious beliefs • Need to travel long distances to health facilities • Unavailability of FP methods for men, e.g., vasectomy • Lack of information

Target Populations	Desired Changes	Perceived Benefits	Perceived Barriers
Young Men in Rural Areas	<ul style="list-style-type: none"> To use FP methods in their relationships To freely discuss FP issues in their relationships 	<ul style="list-style-type: none"> Peace of mind when having sex Has time to participate in development work of the community 	<ul style="list-style-type: none"> Fear of side effects Myths and misconceptions Traditional beliefs Religious beliefs Need to travel long distances to health facilities
Adolescent Boys in Rural Areas	<ul style="list-style-type: none"> To use FP methods if sexually action 	<ul style="list-style-type: none"> Will not impregnate sexual partners Delay sexual debut until schooling is complete 	<ul style="list-style-type: none"> Unavailability of free condoms Social norms of initiation camps
PLHIV	<ul style="list-style-type: none"> To plan carefully with health teams if and when to have children to ensure the safety of mother and child To freely discuss FP issues with her partner To encourage other PLHIV to use FP methods To understand the importance of faithfulness to one partner and of complying with HIV testing and counseling (HTC) recommendations To be involved in PLHIV support groups To freely declare their HIV status 	<ul style="list-style-type: none"> Will not experience an unwanted pregnancy Peace of mind when having sex Has enough time to care for children Healthy family Has time to do business or work Can continue education Healthy life Economic empowerment HIV infection will be controlled Reduced maternal and child mortality rates 	<ul style="list-style-type: none"> Lack of information targeting PLHIV Belief that PLHIV shouldn't be sexually active or have children Stigma Lack of resources Traditional beliefs Need to travel Long distances to health facilities to access modern FP methods

Questions to answer locally

- Are there any studies conducted in your district or community that have additional data on barriers to FP uptake?
- Are there any specific cultural issues in your district or community that need to be addressed?
- Do the barriers outlined in this document hold true in your community?
- Are there any specific studies that highlight the perceived benefits of FP in your district?

Communication Objectives: What Do We Want to Accomplish?

The following objectives will gauge the effectiveness of communication interventions for FP. To support greater uptake of FP, it will be important to have open discussion in the community — by individuals, community organizations, and community leaders — on the benefits of FP and barriers that impact access and uptake.

Desired Behaviour Change

- Increase in knowledge of modern FP methods by community members
- Increase in the number of women reporting sustained use of a modern method over time
- Increase in dialogue and discussion about FP in the community
- Increase in couples dialogue and discussion about FP
- Increase in dialogue and discussion about FP for youth and by youth in the community
- Increase in dialogue and discussion about FP for PLHIV in the community
- Change in attitude among health workers on promoting all FP methods

Social Mobilization

- Increase in discussion on FP led by community organizations as part of their ongoing activities (more specifically, dialogue around community norms that encourage early and frequent childbearing)

Advocacy

- Increase in public discussion about FP by community leaders
- Increased integration of FP communication programming in existing programmes
- Increased commitment from district health officers (DHOs) for FP
- Increased political will for FP in the community

Questions to answer locally

- What information have you collected about FP behaviours?
- On which of the objectives listed above would your district be able to collect information?
- Can you measure these objectives before and after you implement the BCC programme? (If you don't do this and have the specific data, you can't measure an increase.)

What Messages Do We Need to Convey?

The Government of Malawi has deemed FP to be a critical component in the country's health and development. Not much effort has been put into FP programming since 2000, due to the priority given to HIV and AIDS. It is now time to reposition and revitalize FP in Malawi.

The overarching theme is “*Time to Plan Our Families*” [Nthawi yolera yakwana]. It is important to move beyond talking to action, at national, district, community, and family levels. The following are the key messages that can unite all FP communication:

- It is your right to choose a suitable FP method after counseling.
- If you have a small family, you will have time for other daily activities.
- It is a man's responsibility to support his wife for FP.

- Use condoms to avoid unexpected pregnancies and as a backup method.
- You can get pregnant even if you wash your private parts after sex.
- Take emergency contraception within 120 hours (5 days) after unprotected sex as a contraceptive method failure such as missed pill, missed injection, accident with a condom, or sexual assault is not a reliable FP method. However, emergency contraception is not a reliable FP method.
- Women and girls who have sex for the first time, or while in the water or standing, can get pregnant.

This overall campaign theme should be used by all organizations working in communities or districts to allow for the greatest synergy and impact. In specific interventions and with specific groups, the benefits and barriers that are outlined above can be discussed.

The information in the table below contains accurate information that can be used in SBCC programming. Messages should provide accurate information, overcome barriers, and speak to the benefits of FP.

Issues to Address	Accurate Information
<p>Talking about FP is taboo</p> <p>Target: Community leaders</p>	<ul style="list-style-type: none"> • Communities need to understand how male and female reproductive organs work as an entry point to the use of modern FP methods. It is imperative to discuss sensitive issues for better understanding. • Communities and families should initiate open discussion about FP and spacing children. This will allow myths and misconceptions to be aired and dispelled and positive benefits of FP to be discussed. These include having: <ul style="list-style-type: none"> ○ a healthier mother and baby ○ resources to raise healthy children ○ a healthier and more prosperous community
<p>Strong belief that modern FP methods have side effects for women</p> <p>Target: Adult men and women</p>	<ul style="list-style-type: none"> • Almost all contraceptive methods have some potential side effects: <ul style="list-style-type: none"> ○ Oral contraceptives may cause nausea, headaches, or spotting between menstrual periods. ○ Injectables and implants may cause irregular or prolonged bleeding, or amenorrhea (no menses). ○ IUDs may lead to increased bleeding and pain during menses. • Side effects are usually not harmful, but can be distressful for a client who is not prepared for them. • Serious medical complications are rare with modern contraceptive methods. Those who experience them should go to the nearest health facility for assistance or see an FP provider. • Some women experience minor side effects like spotting and cramping. These are normal and usually go away after the first four weeks of use. If these symptoms persist, medical help should be sought from the nearest health facility. • Bodies react differently to different methods at times in life; everyone needs to choose method that suits them best.

Issues to Address	Accurate Information
	<ul style="list-style-type: none"> • The financial, emotional, and health benefits of spacing a family should overcome minor side effects. It has been shown that counselling on possible side effects can dispel fears and overcome myths and misconceptions. • Most modern FP methods do not decrease sexual desire or ability to have sexual relations. In rare cases, Depo-Provera, has shown a decrease in sexual desire.
<p>Perception that FP leads to sterility</p> <p>Target: Adult men and women</p>	<ul style="list-style-type: none"> • All reversible FP methods are safe for fertility resumption. • There are many couples who have delivered babies after using FP methods for a long period of time. • Depending on the method, fertility may return immediately after discontinuation of FP or may be delayed. • Resuming child-bearing after use of a longer-term reversible method (i.e., implant, Depo-Provera) may take a few months. For example, the injectable can often delay the return to fertility for several months, but is not a permanent method.
<p>Male opposition: Most men who find their partners using modern methods of contraception disapprove or even threaten divorce</p> <p>Target: Adult men</p>	<ul style="list-style-type: none"> • Community leaders and men should initiate the conversation on FP. • The community should support young couples in planning for their families. • Many women use contraception without consulting their partners for fear of disapproval. • An open community discussion on the importance of FP for the whole community should be encouraged. • Men should accompany their partners to FP clinics so that choices are made together.
<p>Strong community social norms and male values to have many children</p> <p>Target: Adult men and women</p>	<ul style="list-style-type: none"> • Families can have as many children as they want while using FP methods. • With FP, having a child can be a choice, not an accident. • Spacing and limiting the number of children can ensure a healthier mother, children, and father. • Men should play an important role in ensuring that their families are healthy and prosperous. • Men should open the discussion on planning their family with their partners. • A woman who has many children experiences pressure and is predisposed to poor health. .
<p>Belief of religious leaders that the birth of children is God's will.</p> <p>Target: Religious leaders</p>	<ul style="list-style-type: none"> • Spacing and limiting the number of children can ensure healthier mothers and children. Religious leaders should encourage their congregations to plan for healthy mothers and children. • Mothers who do not use FP methods bear more children. This increases their risk of death due to complications around childbirth as well as the risk of their unborn children.

Issues to Address	Accurate Information
Youth stigmatized if they seek FP services Target: Health care workers	<ul style="list-style-type: none"> • It is important to delay having a first child until about age 20. This protects both young mothers and their unborn children from complications due to early fertility. • Youth have a right to access all health services, including FP services.
Youth misinformed about sex and pregnancy. Target: Youth	<ul style="list-style-type: none"> • Community leaders and parents need to ensure youth have access to accurate information on sex and pregnancy. • Washing private parts after having sex will not prevent pregnancy. • Emergency contraceptive methods can be used within 120 hours (5 days) after unprotected sex or contraceptive failure, such as a missed pill/injection, an accident with a condom, or sexual assault (when not on a regular method). • Women and girls can get pregnant the first time they have sex. • Women and girls can get pregnant when they have sex while in the water or standing.
Long waiting times make clients reluctant to seek FP services. Target: Community leaders and health workers	<ul style="list-style-type: none"> • Dialogue between FP services and communities can help educate both providers and clients on access issues. • Communities and community leaders should work with health services through advocacy to address access issues.

Interventions: How Can We Best Reach the Target Population?

There are three major types of interventions that, working in concert, can have a major impact on FP behaviours:

- **advocacy** to raise resources, political and social leadership commitment for development action and goals
- **social and community mobilization** for wider participation, coalition building, and ownership
- **behaviour change communication** for changes in knowledge, attitudes, and practices of specific participants/audiences in programmes



Advocacy interventions

Advocacy for FP can include working with community leaders to overcome some of the structural, commodity, and access barriers, including by developing interventions to ensure that FP is on the agenda for key leaders and organizations. An example of an advocacy intervention is an effort to

convince political and community leaders of the importance of supporting FP programming with appropriate resources.

District and community meetings: Banja La Mtsogolo (BLM) conducts meetings with different stakeholders at district and community levels to mobilize resources and support for FP services. BLM ensures that FP activities are incorporated into district implementation plans.

Social mobilization interventions

Social mobilization interventions can include working with traditional and religious organizations to integrate FP discussions and actions into their ongoing activities.

Tapping into local networks: Population Services International (PSI) works with community clubs such as farmers', women's, and PLHIV groups to introduce radio-listening activities related to FP in eight districts: Karonga, Kasungu, Salima, Nkhota-kota, Balaka, Mangochi, Phalombe, and Chikwawa. Every Wednesday, members listen to the radio drama aired on Radio 2 fm at 3:30 pm, then use a discussion guide to talk about issues raised.

The BRIDGE II project is working with PLHIV networks on FP as part of prevention with positives interventions.

SBCC interventions

SBCC interventions can target mass media and other segments of society, communities, and individuals. Examples of SBCC interventions for FP include peer education, outreach through clinics and health centers, counseling, and education through community-based distributors of FP commodities. In each district, partners will bring different resources. In addition, radio and TV programmes can be used by the district partners in their local programming.

Community drama performances: PSI works with community-based drama groups in eight districts to engage communities in FP. These drama groups have been trained in interactive theatre performance, and go from village to village giving performances. The content of the dramas is linked to the locally aired radio drama on FP, but it could also be developed independently, using the guidelines for key messages. Print materials that echo key messages are distributed.

Door-to-door: BLM engages reproductive health assistants (RHAs) to advocate for the use of FP methods. The RHAs move from door-to-door to sensitize community members about the benefits of FP. BLM has 31 centers and is working in 500 government and CHAM facilities in all districts except one.

The Community-Based Distribution Agents (CBDA) Project of MSH is integrating door-to-door HTC and FP in eight districts.

For all approaches, an analysis of the existing issues for behaviours, access, and underlying structures dictate the interventions to be developed. If FP uptake is hindered by long wait times at clinics, then advocacy for community-based distribution can be undertaken and door-to-door FP promotion can be organized.

The integration of FP with other health areas also needs to be explored in each district. FP and HIV integration is critical in reaching PLHIV and expanding the reach of FP programming. This includes outreach to communities for ART adherence, HCT, and PMTCT outreach initiatives.

During the development of district action plans, integration should be a key focus to ensure efficient use of networks and resources.

Examples of do-able actions for each group targeted:

Women

- Discuss with your partner the importance and benefits of FP for the health of each other and the family.
- Go for an HIV test with your partner to know your HIV status as a couple and help select an FP method that protects both you and your unborn child or children.
- Find out who in your area can regularly provide FP commodities.
- Choose a suitable FP method, ideally as a couple, based on counseling, support, and awareness of normal and abnormal side effects.
- Go immediately to the CBDA or FP provider if you experience any unusual side effects.
- Get support from your friends around choosing a FP method and for adherence to it, particularly for daily pill use.
- Keep male or female condoms in the house as a method of choice or a backup method.
- Go to a facility within three days for emergency contraception and post-exposure prophylaxis (PEP) if you have experience contraceptive failure or have been sexually assaulted.
- Support others to learn about the benefits of FP for the health of their families and to choose a method suitable for them.

Men

- Discuss child spacing with your partner to ensure that you are taking care of your partner's health and the health of your children.
- Choose a suitable FP method with your partner, based on counseling, support, and awareness of normal and abnormal side effects.
- Consider safe FP methods available for men, particularly if you and your partners have decided not to have more children.
- Go for an HCT test with your partner so that you can plan the safety of your family together.
- Keep male or female condoms in the house as a method of choice or a backup method in case of contraceptive failure.
- Support others to learn about the benefits of FP for the health of their families and to choose a method suitable for them.

Family members

- Support newly married couples in delaying their first pregnancy until they want a child.
- Encourage couples to know their HIV status together and to time the birth of each child to ensure the health of the mother, child, and family.
- Challenge myths around the need for early and unchecked childbearing, as well as traditional methods that are unsafe or not effective in preventing pregnancy.
- Support others to learn about the benefits of FP for the health of their families and to choose a method suitable for them.

Community leaders

- Engage community members to explore norms and practices that may encourage early, unwanted, or unchecked childbearing and their impact on family and community health (such as initiation practices, sexual cleansing rituals, and early marriages).
- Refer couples to HCT and FP services to learn about FP and choose a suitable method based on their HIV status.
- Advocate for FP services to be delivered within communities to increase access to methods and support.
- Encourage access to male and female condoms as a method of choice for everyone or as a backup method for contraceptive failure.
- Ensure that groups often overlooked, such as PLHIV support groups and youth, benefit from FP information and services.
- Provide support so that women who have been sexually assaulted can access PEP within three days.
- Develop a plan of action to address factors that contribute to sexual assault.

Young people

- Delay sexual debut until physically and mentally ready.
- Delay first pregnancy until physically and mentally ready.
- If sexually active, seek FP information and services to prevent unwanted pregnancy and STIs, including HIV.
- Find out your HIV status and the HIV status of your partner and choose a suitable FP method.
- Support friends to delay sexual debut and/or encourage them to access FP.
- If newly married, discuss with your partner the benefits of timing the first child to ensure the health of the mother and child.

Health workers

- Provide all clients, regardless of background, with comprehensive FP information and counseling so they can choose a suitable FP method.
- Encourage clients to return if they experience any unusual and persistent side effects with the method chosen.
- Help clients who are dissatisfied with their method to try a different method.
- Support women who have been sexually assaulted to access PEP in a caring way. Help to refer them to other key legal and support services in a timely manner.

Questions to answer locally

- Which organizations are working in your district or community?
- What interventions are they carrying out?
- Are their interventions for advocacy, social mobilization, and BCC?
- Are the interventions linked to existing services?
- On which target populations are interventions focused?
- What kinds of materials are available to support the interventions?
- What are the gaps in coverage and content for the existing interventions?
- What resources are available to implement communication interventions for FP?

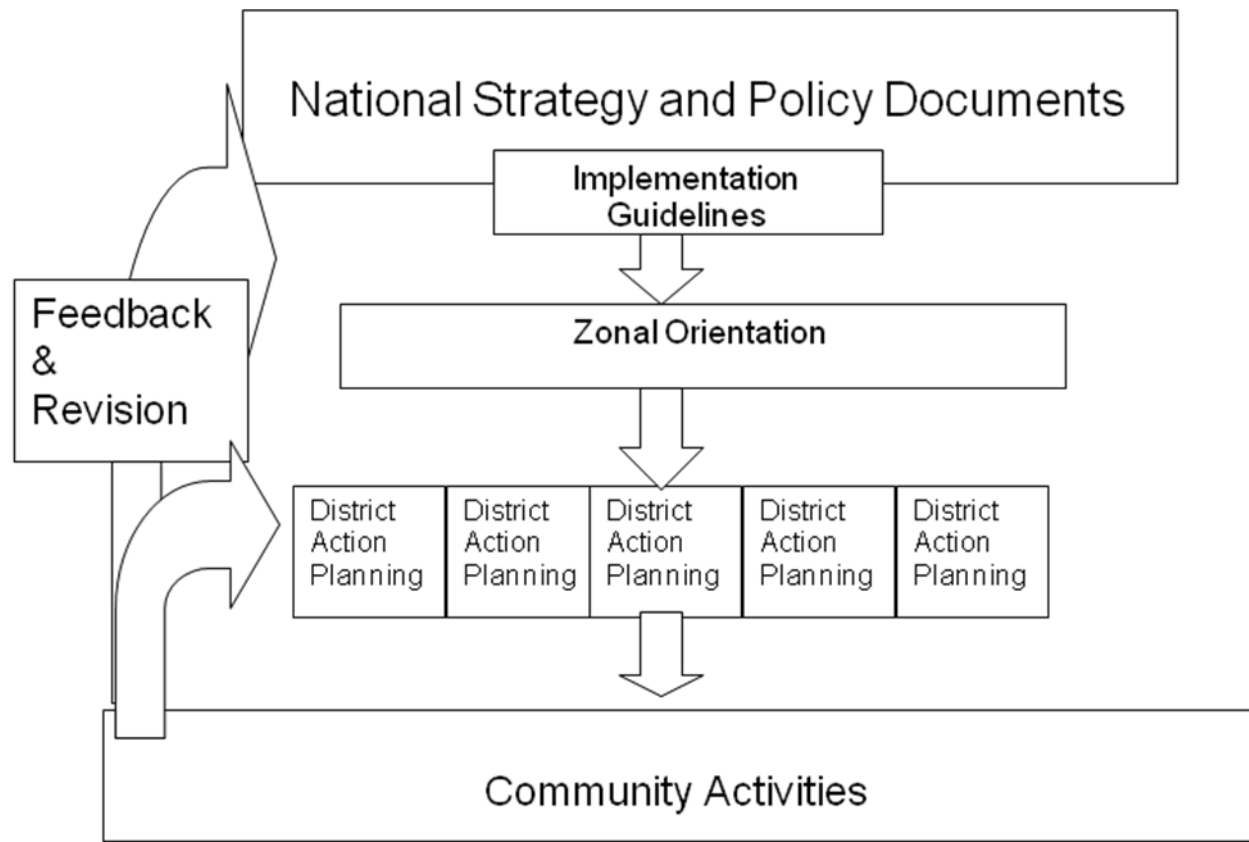
Implementation Action Plan: How Do We Work Together?

District- and community-level strategic action plans can be developed with all stakeholders to ensure scale, impact, and coverage that is tailored to the local situation. To reach the goals of increased community dialogue and discussion on FP uptake, including by youth and PLHIV, it is important to include all potential stakeholders and go to scale throughout the country.

The following graph illustrates the action planning proposed to reach all communities. National policy documents provide the mandate for the importance of FP, and these guidelines provide the overall communication framework.

The guidelines will be rolled out via the zones to all districts. Each district will use their own resources as they reach out to local networks and channels to mobilize communities to take action on FP.

FP Communication: National Roll-Out Process



To start the planning process, it will be necessary to identify all existing and potential partners for FP programming in your district. This can include contacting traditional leaders, faith-based organizations and networks, NGOs active in the district, women’s groups, private-sector companies, and public and private health system networks.

The list should include:

- DHO and district environmental health officers , coordinators of FP, HIV, PMTCT, Safe Motherhood, and IEC programmes in the district
- Representatives from each partner working on FP and HIV and AIDS
- Representatives from the Private Hospital Association of Malawi (PHAM) and the district commissioner
- Traditional leaders from each traditional authority

Orientation on the guidelines will take place at zonal levels, followed by rollout at district levels. The focus will be on utilizing existing resources and networks and on creating synergy between interventions to ensure all programming follows the guidelines and is consistent in messaging, effective, and efficient.

A planning workshop will take place in each district to ensure that:

- local culture and gender issues are being addressed.
- FP services and commodities exist.
- all potential resources are shared for greater impact.
- activities are coordinated.
- messages are consistent.
- geographic and method coverage of the entire district

Implementing partners in districts will work hand-in-hand with the Ministry of Health to roll out district plans by

- participating in all planning meetings
- revising communication materials and interpersonal programming to be in line with guidelines
- working cooperatively with the DHMTs and other partners to expand the depth and reach of FP coverage.

A facilitator's guide for the two-day meeting is attached as Annex B.

Coordination and Sustainability: How Can We Ensure Programming Over Time?

In order for FP communication programming to be sustainable, it will be necessary to ensure that FP is integrated into HIV and AIDS, maternal and child health, community, and other programmes. This can be done by first identifying existing community services and networks and then working with them to develop an action plan for FP discussions as an ongoing part of their activities. For example, FP discussions can take place during traditional events and festivals, through the activities of religious and women's organizations, and at meeting places for men.

FP coordination can take place at the district level, with FP communication integrated as a priority into existing health committee meetings.

Questions to be answered locally

- What are the traditional associations in your community?
- Are there microenterprise and income-generating activity groups?
- Are there women's and men's organizations that meet regularly?

- Are there religious organizations that are willing to discuss FP?
- What resources are available locally?
- How can FP communication be integrated into existing community services for other health issues, such as HIV and AIDS and maternal and child health?

M&E Plan

A common and simple M&E plan needs to be developed in each district that can assess progress towards the common goal of increased dialogue and discussion leading to increased uptake of FP among target populations. A system for collecting data and reporting on the specific output indicators for each activity should be developed and implemented. Monitoring should be done at the project level, with strong coordination with the DHMT and other stakeholders.

A common set of indicators will be measured to ensure that joint progress can be tracked towards increased uptake of FP services and decreased unmet need for contraception. For each communication objective, it is important to have indicators to measure success.

The following are illustrative programme output indicators:

- number of trainings held
- number of people trained
- number of peer educators holding sessions with target audiences
- number of materials distributed, by type and topic area
- number of advocacy meetings held
- number of community organizations and projects integrating FP in their programmes
- number of supervisory visits
- number of people reached during advocacy and social mobilization meetings

Behavioural outcome indicators are used to assess whether changes in behaviours are occurring, based on the communication objectives.

BCC objectives and indicators

Objective: Increase in knowledge of modern FP methods by members of the community

Indicator

- Percentage of men, women, and youth who have accurate knowledge about modern FP methods

Objective: Increase in dialogue and discussion about FP in the community.

Indicator

- Percentage of men and women who report having a discussion about FP in their community

Objective: Increase in couple dialogue and discussion about FP

Indicator

- Percentage of women who report having dialogue and discussion with their spouses on FP
- Percentage of men who report on speaking with their partners about FP

Objective: Increase in dialogue and discussion about FP for youth and by youth in the community.

Indicator

- Percentage of young people who report having a discussion about FP and modern methods, including in peer groups

Objective: Increase in dialogue and discussion about FP for PLHIV in the community.

Indicator

- Percentage of PLHIV who report having a discussion about FP

Objective: Change in attitude among health workers on promoting all FP methods.

Indicator

- Percentage of health workers showing a positive attitude about promoting all modern methods

Social Mobilization Objective

Objective: Increase integration of FP communication programming in existing programs.

Indicator

- Number of community organizations integrating FP communication programming activities into their existing programmes

Advocacy Objectives

Objective: Increase in public discussion about FP by community leaders

Indicator

- Number of community leaders who regularly speak out about the need for FP

Objective: Increase integration of FP communication programming in existing programmes

Indicator

- Number of community organizations that lead discussions on FP as part of their ongoing activities.

Objective: Increase political and financial commitment from DHOs for FP

Indicator

- Number of DHOs who speak out on the need for FP, if it is possible to collect data
- Increase in fund allocation for FP commodities and programmes

Impact indicators are used to assess whether desired programme impacts were achieved.

- Contraceptive prevalence
- Uptake of modern methods
- Discontinuation of modern methods

Questions to answer locally:

- What information is routinely collected in your district?
- Which indicators would be most useful to track district-wide?
- Is there M&E expertise in your district?

Annex A: Summary of District Planning Checklist

Summary of District Planning Checklist

District FP Statistics

- What are the FP statistics in your district?
 - Total Fertility Rate
 - Contraceptive Prevalence Rate
 - Uptake of specific methods
 - Discontinuance rates
- Within facility and community settings, where are FP services currently offered?
 - FP
 - Antenatal clinics
 - Postnatal wards
 - HIV clinics
 - Community based distribution agents
 - Health surveillance assistants

Target Audiences

- Are there specific groups within your community that need to be targeted?
 - Rural vs. urban
 - Youth out of school and in school
 - Community leaders, traditional leaders, and women leaders
- Which community networks in your district and community are influential?
- Who are your key community leaders and opinion leaders?

Local Barriers and Benefits

- Are there any studies that have been conducted in your district or community that have additional data on barriers to FP uptake?
- Are there any specific cultural issues in your district or community that are barriers to FP uptake?
- Do the barriers outlined in this document hold true in your community?
- Are there any specific studies that highlight perceived benefits for adopting FP in your district?
- What information are you currently collecting about FP behaviours?
- On which objectives would your district be able to collection information?
- Will these objectives be measurable, before and after you implement the behaviour change communication programme? (If not, and unless the specific data exist, you can't measure an increase.)

Interventions

- Which organizations are working in your district or community?
- What interventions are they carrying out?
- What interventions exist for advocacy, social mobilization, and behaviour change communication?
- Are the interventions linked to existing services?
- Which target populations are they focussed on?

- What kinds of materials are available to support the interventions?
- What are the gaps in coverage and content for the existing interventions?
- What resources are available to implement communication interventions for FP?

M&E

- What information is routinely collected in your district?
- Which indicators would be most useful to track as a district?
- What M&E expertise exists in your district?

Partnerships

- What are the traditional associations in your community?
- Are there micro enterprise and income generating activities?
- What women's and men's organizations meet regularly?
- What religious organizations would be willing to discuss FP?
- What resources are available locally?
- How can FP communication be integrated into existing community services for other health issues, such as HIV and AIDS and maternal and child health?

Annex B: Facilitator's Guide for District Action Planning

Facilitator's Guide for District Action Planning District Roll Out

Agenda

Time	Activity	Facilitator
Day One		
8:30 – 9:15	1. Introductions and Objectives	HEU
9:15 – 10:45	2. Overview of Social and Behaviour Change Communication	HEU
10:45 – 11:00	Tea Break	
11:00 – 11:45	3. Presentation on Guidelines	HEU
11:45 – 12:30	4. Presentation on Local Data <ul style="list-style-type: none">• Family planning statistics• Behavioural Data• Supplies and services	DHMT
12:30 – 1:30	Lunch	
1:30 – 3:30	5. Target Population Profiles for District; Segmentation of Target Populations; Benefits and Barriers	DHMT
3:30 – 3:45	Tea Break	
3:45 – 5:30	Target Population Profiles continued	HEU
Day Two		
8:30 – 9:30	6. Communication Objectives	DHMT
9:30 – 10:30	7. Stakeholder and Intervention Analysis	HEU
10:30 – 10:45	Tea Break	
10:45 – 11:30	Stakeholder and Interventions Analysis continued	HEU
11:30 – 12:30	8. Messages and Materials	
12:30 – 1:30	Lunch	
1:30 – 2:30	9. Monitoring Indicators	DHMT/HEU
2:30 – 4:30	10. Action Plans (tea break during session)	DHMT
4:30 – 5:00	11. Coordination Mechanisms	DHMT
5:00	Closing	

Session 1: Introductions and Objectives

Time: 45 Minutes

Objectives: By the end of the session, participants will be able to agree on the objectives of the meeting:

- Orientation on *Family Planning Communication Guidelines*
- Outline geographic and programmatic coverage
- Develop action plans on FP communication
- Reach consensus on coordination mechanism

Materials: Flip chart paper, pens

Process

Step 1: (5 Minutes) Opening remarks from the DHMT and HEU

Step 2: (10 Minutes) Self introductions

Step 3: (15 Minutes) Presentation on objectives

Step 4: (15 Minutes) Discussion and agreement

Session 2: Overview of Social and Behaviour Change Communication

Time: 1 hour 30 minutes

Objectives: Provide an overview of SBCC as it relates to family planning

Materials: PowerPoint presentation, flip chart, paper, pens

Process

Step 1: 30 minutes

Discuss how people have different behaviours and have to change or modify them in the course of their lives. Suggest that various aspects of their own lives — such as dressing, eating habits, smoking, drinking, exercise — may represent personal examples of behaviour change.

Ask participants to break up into small groups. Write on a flip chart “unchanged behaviour” on the left side and “changed behaviour” on the right side. Ask them to imagine that they are on the side marked “unchanged behaviour,” with certain behaviour that they want to change and that their goal is to cross over to the “changed behaviour” side. Ask them to discuss behaviours that they may have had to or tried to change and the steps they had to undertake to make this change. The objective is to illustrate the steps involved in behaviour change and to identify factors that may influence behaviour. Ask the group to pick one of the behaviours discussed within the group and answer the following questions:

1. What are the outside influences that impact on this behaviour?
2. What is your key benefit in changing this behaviour?

3. What is the major barrier you are facing to change this behaviour?
4. If you changed this behaviour, have you ever had a relapse?
5. How long did it take for you to change this behaviour?
6. How would you support someone else to change a similar behaviour?

Step 2: 30 minutes

Have each group present their case study to the larger group.

Step 3: 10 minutes

The facilitator will capture cross cutting issues on a flip chart as they are raised by the groups, including:

- intention
- environment
- peer pressure
- knowledge
- skills
- self-efficacy
- benefits
- barriers

Step 4: 10 minutes

Give a basic presentation on social and behaviour change communication.

Session 3: Presentation on Guidelines

Time: 30 Minutes

Objectives: Provide an overview of the draft national communication guidelines for family planning communication.

Materials: PowerPoint presentation, flip chart, paper, pens

Process

Step 1: (25 minutes) Give presentation on guidelines

Step 2: (20 minutes) Discussion

Session 4: Presentation on Local Data

Time: 45 Minutes

Objectives: Provide overview of local statistics and issues related to FP

Materials: PowerPoint presentation, flip chart, paper, pens (outline for presentation can be found in Annex F of the guidelines)

Process

Step 1: (25 minutes) Give presentation on local issues

Step 2: (20 minutes) Discussion

Session 5: Target Population Profiles

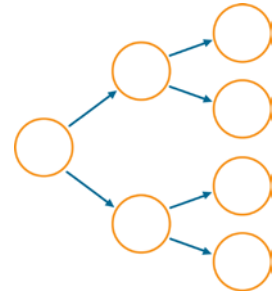
Time: 2 hours

Objective: To have a clear understanding of local segmented target populations

Materials: flip chart, pens

Process:

Step 1: Split participants into target population groups. Using the guidelines, segment the main target populations for the district with a focus on prioritizing key segments for people directly affected. See chart on right:



Step 2: For each segmented group, identify the key community networks and community leaders that influence that group, including traditional networks and women’s organizations

Step 3: Fill out the following chart for each key prioritized segment. Go back to the Guidelines to compare with knowledge from the district.

Audience Segment	Desired Change Attitude, value, behaviour, social norm, policy, service, product, or other change	Barriers Contextual or behavioural reason(s) impacting on FP uptake	Perceived Benefits
Community Networks:			

Step 4: (30 minutes) Small group presentations (Gallery Walk) and discussion

Step 5: (20 minutes) In plenary, reach consensus on the key target populations for the district.

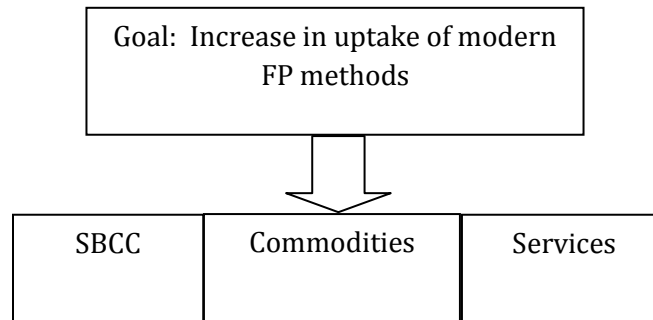
Session 6: Communication Objectives

Time: 1 hour

Objectives: Identify communication objectives most relevant to the FP issues in the district.

Materials: FP Communication Guidelines, flip chart, paper, pens

Step one: (15 minutes) On a flipchart draw the following:



Point out that you need objectives for each of these, including SBCC objectives.

Step Two: (15 minutes) Read through the communication objectives section in the guidelines.

Step Three: (30 minutes) In plenary, based on the perceived barriers outlined in the Session 5, identify the objectives from the guidelines that are more appropriate for the issues in your district.

Session 7: Stakeholder and Intervention Analysis

Time: 2 hours

Objectives: Clearly outline the partners, coverage, resources, and programming for FP in the district.

Materials: List of all traditional authorities in the district, cards, flip chart, paper, pens

Process

Step 1: (1 hour). Put up a flip chart paper for each Traditional Authority (TA):

TA
Partners
Interventions: Services and Programmes
Communication Channels and Materials

Step 2: For each element and in five groups, have participants fill out cards on what they know is the case in each TA. They can quickly paste their cards to the appropriate flip chart. Use different colored cards for each element. Repeat this process until all of the elements have been discussed.

Step 3: In groups, have participants identify gaps in coverage of the target populations and interventions to work with community leaders.

Step 4: In plenary, have the group discuss the gaps and develop action points.

Session 8: Key Messages

Time: 1 hour 45 Minutes

Objectives: Reach consensus on key messages for target populations in district.

Materials: Flip chart, paper, pens

Process

Step 1: (10 minutes). Provide a review of the key messages from the guidelines. Paste all of the materials on the wall and introduce participants to the proposed set of materials for production.

Step 2: (40 minutes). Have participants organized in target population groups to look at the key messages in the guidelines and materials and agree on which ones are relevant for the local target populations, depending on FP methods available, access, and cultural and gender issues.

Step 3: (35 minutes). Present findings in plenary and reach consensus on key messages relevant for the local population and context. Identify gaps in materials.

Session 9: Monitoring Indicators

Time: 45 minutes

Objectives: Agree on common monitoring indicators and approaches.

Materials: Flip chart, paper, pens

Process

Step 1: (15 minutes) Provide a quick presentation on the communication objectives from the guidelines

Step 2: (30 minutes) In plenary, reach agreement on which indicators would be used in the district that can be linked to an existing MIS.

Session 10: Action Planning

Time: 2 hours

Objectives: Develop action plans for FP communication for the district

Materials: Flip chart, paper, pens

Process

Step 1: (1 hour) Split participants into small groups to fill out specific action items for each area in the action planning template. The template will be provided to the groups (see Annex E).

Step 2: (1 hour) Present the action plans in plenary. From these, facilitators will develop a consensus action plan for the district.

Session 11: Coordination Mechanisms

Time: 1 hour

Objectives: Decide on a coordination mechanism for FP communication activities in the district.

Materials: Flip chart, paper, pens

Process

Step 1: (1 hour) In plenary, list the existing coordination mechanism and reach agreement on how to coordinate activities in the district for greater impact.

Step 2: (20 minutes) Agree on who will participate in coordination meetings.

Annex C: Family Planning Statistics

Malawi Demographic Health Survey (MDHS)
Multiple Indicator Cluster Survey (MICS)

Method	1992 MDHS	2000 MDHS	2004 MDHS	2008 MICS
Any method	13.0	30.6	32.5	41.0
Any modern method	7.4	26.1	28.1	38.4
Female sterilization	1.7	4.7	5.8	4.4
Male sterilization	0.0	0.1	0.0	0.1
Oral contraceptive	2.2	2.7	2.0	2.4
IUD	0.3	0.1	0.1	0.3
Injectables	1.5	16.4	18.0	29.0
Implants	NA	0.1	0.5	0.7
Male condom	1.6	1.6	1.8	1.5
Female condom				0.0
Diaphragm/foam/jelly				0.1
LAM				0.2
Any traditional method	5.6	4.5	4.3	2.6
Rhythm/periodic abstinence	2.2	0.9	0.5	0.7
Withdrawal	1.5	1.5	2.1	0.8
Other traditional methods	2.0	2.1	1.7	0.8
Number of women	3,492	9,452	8,312	19,005

Source:

National Statistical Office (NSO) [Malawi] and ORC Macro. 2005. Malawi: Demographic and Health Survey, 2004.

National Statistical Office (NSO) [Malawi] and United Nation's Children's Fund. 2007. Multiple Indicator Cluster Survey 2006.

Annex D: List of Resource Documents

Policy Documents

1. Malawi Ministry of Health. 2006. National Reproductive Health Strategy.
2. Malawi Ministry of Health. 2009. Advocacy and Communication Strategy for Sexual and Reproductive Health and Rights Programmes.

List of Family Planning Studies Related to Malawi

1. Munthali A., Chimbiri A., Zulu E. 2004. Adolescent Sexual and Reproductive Health in Malawi: A Synthesis of Research Evidence. Occasional Report No 15, The Alan Guttmacher Institute, New York
2. Abhijeet A., Shiraishic R., Bunneld R., Jacobse K., Solehdinc N., Abdul-Quaderc A., Marumc L., Muttungaf J., Kamotog K., Aberle-Grassecc J., Diaz T. 2009. Knowledge of HIV Status, Sexual Risk Behaviors and Contraceptive Need Among People Living with HIV in Kenya and Malawi. *AIDS*, 23:1565-1573.
3. Bankole A., Biddlecom A., Guiella G., Singh S., Zulu E. 2007. Sexual Behavior, Knowledge and Information Sources of Very Young Adolescents in Four Sub-Saharan African Countries. *African Journal of Reproductive Health*, 11(3): 28-43.
4. Barden-O'Fallon, J. 2005. Unmet Fertility Expectations and the Perception of Fertility Problems in a Malawian Village. *African Journal of Reproductive Health* 9(2): 14-25.
5. Biddlecom A., Hessburg L., Singh S., Bankole A., Darabi L. 2007. Protecting the Next Generation in Sub-Saharan Africa: Learning from Adolescents to Prevent HIV and Unintended Pregnancy. Guttmacher Institute.
6. Bisika, T. 2008. Cultural Factors that Affect Sexual and Reproductive Health in Malawi. *Journal of Family Planning Reproductive Health Care*, 34(2): 79-80.
7. Center for Social Research, Save the Children Federation USA, Malawi Ministry of Health and Population, MEASURE Evaluation. 2004. Avoiding Unwanted Pregnancy and Sexually Transmitted Infections: A Rural Malawi District Study.
8. Cohen, B. 2000. Family Planning Programs, Socioeconomic Characteristics, and Contraceptive Use in Malawi. *World Development*, 28(5): 843-860.
9. Creel L., Sass J., Yinger N. 2002. Client-Center Quality: Clients' Perspectives and Barriers to Receiving Care. *New Perspectives on Quality of Care*, 2
10. Tesfayi G., Mishra V. 2007. Spousal Agreement on Family Planning in Sub-Saharan Africa. DHS Analytical Studies No. 11. Calverton, Maryland: Macro International
11. Heard N., Larsen U., Hozumi D. 2004. Investigating Access to Reproductive Health Services Using GIS: Proximity to Services and the Use of Modern Contraceptives in Malawi. *African Journal of Reproductive Health*, 8(2): 164-179.

12. Hennink M., Madise N. 2005. Influence of User Fees on Contraceptive Use in Malawi. *African Population Studies*, 20: 125-141.
13. Kaler A. 2004. The Moral Lens of Population Control: Condoms and Controversies in Southern Malawi. *Studies in Family Planning*, 35(2): 105–115.
14. Kishindo P. 1995. Family Planning and the Malawian Male. *Nordic Journal of African Studies*, 4(1): 26–34.
15. Management Services for Health/USAID, Malawi. 2009. *Community-Based Family Planning and HIV/AIDS Services in Malawi: Baseline Study*
16. Save the Children. 2008. *Integrating Innovate Family Planning Strategies into an Adolescent Reproductive and Sexual Health Program in Malawi*.
17. Meekers D., Van Rossem R., Silva M., Koleros A. 2007. The Reach Effect of Radio Communication Campaigns on Condom Use in Malawi. *Studies in Family Planning*, 38(2): 113-120.
18. Meekers D. 1998. *Improving Condom Social Marketing in Malawi: Evidence from a Consumer Profile Survey*. PSI Research Division Working Paper No. 18,
19. Munthali A., Moore A., Konyani S., Zakeyo B. 2006. *Qualitative Evidence of Adolescents' Sexual and Reproductive Health Experiences in Selected Districts of Malawi*. Occasional Report no. 23, New York: The Alan Guttmacher Institute.
20. Munthali A., Zulu E., Nyovani M., Moore A., Konyani S., Kaphuka J, Maluwa-Banda D. 2006. *Adolescent Sexual and Reproductive Health in Malawi: Results from the 2004 National Survey of Adolescents*, Occasional Report, New York: Guttmacher Institute, No. 24.
21. National Statistical Office, and UNICEF. 2007. *Malawi Multiple Indicator Cluster Survey (MICS) 2006*. Preliminary Report.
22. Soldan V. 2004. How Family Planning Ideas are Spread Within Social Groups in Rural Malawi. *Studies in Family Planning*, 35(4): 275-290.
23. Solo J., Jacobstein R., Malema D. 2005. *Repositioning Family Planning – Malawi Case Study: Choice not Chance*, New York: The ACQUIRE Project/EngenderHealth
24. Stephenson R., Baschieri A., Clements S., Hennink M., Adise N. 2007. Contextual Influences on Modern Contraceptive Use in Sub-Saharan Africa. *American Journal of Public Health*, 97:1233-1240.
25. Sullivan T, Bertrand J., Rice J., Shelton J. 2006. Skewed Contraceptive Method Mix: Why It Happens, Why It Matters. *Journal of Biosocial Science*, (38):501-521
26. Taulo F., Berry M., Tsui A., Makanani B., Kafulafula G., Li Q., Nkhoma C., Kumwenda J., Kumwenda N., Taha T. 2009. Fertility Intentions of HIV-1 Infected and Uninfected Women in Malawi: A Longitudinal Study. *AIDS Behavior*, 13:S20-S27.

27. Tavory I., Swidler A. 2009. Condom Semiotics: Meaning and Condom Use in Rural Malawi. *American Sociological Review*, 74:171-189.
28. The ACQUIRE Project/Engender Health. 2005. Moving Family Planning Programs Forward: Learning From Success in Zambia, Malawi, and Ghana. The Repositioning Family Planning Case Study Synthesis Report. New York, NY: The ACQUIRE Project/Engender Health.
29. University of Southampton, UK. Characteristics of Users of BLM Reproductive Health Services in Lilongwe, Fact Sheet 17.
30. University of Southampton, UK, Opportunities and Choices Programme. 2002. Barriers to Use of Family Planning Services in Malawi: Findings from Focus Group Discussions. Fact Sheet 14.
31. University of Southampton, UK, Opportunities and Choices Programme. No Date. Who is Using Modern Methods of Contraception in Malawi? Evidence from the Malawi Demographic and Health Survey 2000. Fact Sheet 15.
32. Yeatman S., Trinitapoli J. 2008. Beyond Denomination: The Relationship Between Religion and Family Planning in Rural Malawi. *Demographic Research*, 19(55): 1851-1881.

Annex E: District Action Planning Template

District Action Planning Template

District: _____

Background

- General background on the district
- Highlight major problem for family planning in the district
- Importance of family planning in Malawi and in the district

Data from the District

- Demographic data from NSO 2008
- District socio-economic profile — includes all TAs
- Statistics on family planning uptake and services
- NGOs in the district

Priority Target Populations in the District

Audience Segment	Desired Change Attitude, value, behaviour, social norm, policy, service, product, or other change	Barriers Contextual or behavioural reason(s) that impact on FP uptake	Perceived Benefits	Communication Objective
Youth in School Females				
Community Networks and Opinion Leaders:				
Youth in School Males				
Community Networks and Opinion Leaders:				
Youth out of school Females				
Community Networks and Opinion Leaders:				

Youth out of school				
Males				
Community Networks and Opinion Leaders:				
Adult rural women (HIV positive and negative)				
Community Networks and Opinion Leaders:				
Adult rural men (HIV positive and negative)				
Community Networks and Opinion Leaders:				
Youth Ages 10-12				
Community Networks and Opinion Leaders:				

Number	Activity	Timeframe	Outputs	Resources Needed	Potential Partners
Target Populations					
Monitoring and Evaluation					
Coordination					

Annex F: Outline for District Presentations

Each district should have a presentation outlining the issues for family planning (FP) in their district to set the stage for discussions and action planning. The following topics should be covered:

1. Demographic data
 - Population
 - Women of reproductive age
 - Education
 - Socio/economic status
2. FP services
 - What services are offered and where?
 - What methods are available?
 - Where are their gaps in service delivery?
3. FP statistics and trends in the district
4. Behavioural issues for FP uptake in the district:
 - Cultural and gender issues
 - Studies conducted on FP uptake in the district
5. Partners for FP services
 - List the organizations in the district working on service delivery
6. Partners for FP communication
 - List the organizations providing communication programming for FP in the district
7. Resources available for FP in the district
8. Communication materials available for FP in the district
9. Coordination mechanism for FP programming in the district
10. Strengths for implementing FP in the district
11. Challenges for implementing FP in the district

