Drivers and Lessons from Malawi's Success in Accelerating Modern Contraceptive Uptake

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Background

Family planning (FP) programmes are vital for enabling individuals and couples choose when and how many children to have.[1] Overall, FP programmes in sub-Saharan Africa (SSA) have been relatively less successful in increasing modern contraceptive uptake. Modern contraceptive prevalence rate (mCPR) in SSA is estimated at 33% compared to 73% in Latin America and the Caribbean.[1,2] Malawi is one of the few countries in SSA that has made significant progress in accelerating contraceptive uptake. Modern contraceptive prevalence (mCPR) among married women in Malawi increased from 7% in 1992 to 66% in 2024.[3,4] In this article, we examine the drivers and lessons from Malawi's exemplary FP performance from 1994 to 2025.

Methods

We used a mixed methods approach involving scientific literature review, quantitative data analysis, policy and programme review, and qualitative data to identify the drivers of Malawi's success in FP and the lessons therein. The literature review identified the socio-economic determinants of contraceptive use. For the quantitative data analysis, we conducted a decomposition analysis to examine the effect of individual, household and system-level determinants of mCPR change between 2005 and 2016. We also reviewed policy and programme documents as well as FP financing data. We further collected and analysed qualitative data to provide context and validate findings from the other three data sources.

Findings

A synthesis of results across the four research methods show that Malawi's success in accelerating modern contraceptive uptake was driven by four key factors: (a) enabling policy environment for FP (b) effective demand creation (c) expanded and effective supply of FP services, and (d) women's autonomy and empowerment. Details of these findings are summarised below.

Enabling Policy Environment for Family Planning

Before 1994, Malawi's FP policy environment was highly restrictive, requiring married women to seek consent from their husbands to access contraceptives. Modern contraceptive prevalence rate in this period was estimated at just 4%.[5] Starting from 1994, Malawi formulated and implemented key policies aimed at accelerating access to contraceptives. Malawi formulated its first National Population Policy in 1994 and adopted the International Conference for Population and Development Programme of Action (ICPD PoA) in the same year. These two policies shifted Malawi's FP goal from

child-spacing to a right that has to be guaranteed to all, regardless of age, parity or marital status. The Guidelines for Contraceptive Distribution, formulated in 1996, removed age and parity barriers as well as spousal consent for women to access FP services. These efforts resulted in an increased in mCPR from 6.3% in 1992 to 21.5% in 2000—an increase of more than 200% in eight years.[5,6] In 2008, the Ministry of Health revised the Guidelines for Contraceptive Distribution to allow Health Surveillance Assistants (community health workers) to deliver injectables. Malawi's Essential Healthcare Package was also revised to provide FP services at little or no cost to clients. These efforts reduced out-of-pocket payment for FP services, and accelerated mCPR from 32.6% in 2010 to 49% in 2020, an increase of 50% in ten years. Other important policies that have contributed to Malawi's progress include the National Youth Friendly Health Services Strategy (2015–2020) and FP2020.

Effective Demand Creation Activities

Malawi embarked on demand creation activities aimed at increasing knowledge and demand for FP services. This included disseminating FP information via television, radio, community health workers, youth volunteers and FP champions such as religious and traditional leaders. These activities increased knowledge of FP and created demand services. Results of the decomposition analysis shows that the increase in mCPR (between 2005 and 2015) was disproportionately driven by the increased knowledge of FP methods. Specifically, an increase in the mean number of modern FP methods women have ever heard of (mean difference= +1.210) was responsible for more than half (57.8%) of the total increase in mCPR.

Table 1. Decomposition analysis on the drivers of mCPR change in Malawi (2005-2016)

Determinants of contraceptive use	*Estimated co-efficient*	*Mean difference (2015-2004)*	*Predicted changes in mCPR*	*Share of predicted change (%)*
Outcome: mCPR	–	*0.317*	*0.075*	*23.6*
Respondent participates in decision-making (2 decisions; -2 to 2 higher score = respondent participates)	0.010	1.117	0.011	14.5
Any child loss (0=no, 1=yes)	-0.071	-0.119	0.008	11.3
Respondent's years of education (continuous)	0.005	1.298	0.007	8.8
Employed in last 12 months (0=no, 1=yes)	0.039	0.111	0.004	5.8
Age difference (continuous; respondent - partner)	0.002	0.533	0.001	1.2
Age at first sex (continuous)	0.005	-0.031	0.000	-0.2
Wealth index (1-10)	0.006	-0.233	-0.001	-1.8
Age at first cohabitation (continuous)	-0.011	0.476	-0.005	-6.8
# of modern FP methods ever heard of (range: 0-9)	0.036	1.210	0.043	57.8
Visited a health facility in past 12 months (0=no, 1=yes)	0.092	0.076	0.007	9.5

Source: Malawi Demographic and Health Survey, 2004 & 2015

Expanded and Effective Supply of Contraceptives

On the supply side, Malawi implemented interventions that extended FP services to hard-to-reach areas and underserved populations. The use of HSAs and volunteers to deliver injectables, pills and condoms increased access to these contraceptives. Mobile and outreach clinics operated by not-for-profit organisations such Banja La Mtsogolo, Population Services International and Family Planning Association of Malawi have been key in extending contraceptive services to rural and remote communities.

Socio-economic empowerment of women

Increased women's education increased and autonomy in contraceptive decision making were key increasing contraceptive uptake. The decomposition analysis showed that women's participation in decision-making was the second most important positive contributor to mCPR change, accounting for 14.5% of the total change. The qualitative data showed that increased female education also contributed significantly to contraceptive uptake. Educated women were thought to be better informed about the benefits of FP and faced fewer barriers in accessing contraceptives.

Conclusion

Malawi's success in contraceptive uptake demonstrates that a strong FP programme combined with women's empowerment are critical for increasing contraceptive use. These findings contain lessons and best practices that can be implemented elsewhere in SSA and other LMICs.

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