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Research Article

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Effects of Public Health Financing on Reproductive Health Service Delivery in Malawi

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ABSTRACT
Modern contraception is critical for achieving global health outcomes, like reducing maternal mortality, maximizing the health benefits of birth spacing, and promoting the economic empowerment of women. Domestic financing remains the most sustainable source of investment that can drive transformative results with strong accountability mechanisms and enabling legislation and policies. Trends in stockout rate for a selected modern contraceptive (Depo-Provera), utilization of modern contraceptives, and household expenditure on family planning in comparison to changes in government expenditure on family planning were used. Data was collected between the years 2013 and 2021 in the Open Logistics Information Management System (Open LMIS), District Health Information System 2 (DHIS2), Health Management Information System (HMIS), and National Health Accounts (NHA). Health facilities data reported during FY2013/2014 to FY2020/21 for the Open LMIS and FY2015/16 to FY2017/18 for DHIS 2 and NHA data. Results show that between FY2013/14 and FY2020/21, the country experienced inconsistent availability of Depo-Provera despite the increase in government budgetary allocation since FY2013/14. Between FY2015/16 and FY2017/18, the utilization of modern contraceptives in Malawi had grown tremendously despite the stagnant government expenditure on family planning. Lastly, the study found that the stagnant government expenditure on family planning between FY2015/16 and FY2017/18 coexisted with increased household expenditure on family planning. Funding gaps for family planning commodities coexist with ineffective supply chain systems which affect the availability of commodities in health facilities. An increase in the utilization of modern contraceptives in Malawi exists amidst a high unmet need for modern contraceptives and unintended pregnancies.

Keywords: Modern Contraceptives, Unintended Pregnancies, Open Logistics Information Management System (Open LMIS), District Health Information System 2 (DHIS2), Health Management Information System (HMIS), and National Health Accounts (NHA)

Background

Access to quality health services, whether preventative or curative, remains a prerequisite for the population to attain health and achieve healthy lifestyles [1]. Universal health coverage (UHC), embedded within the 2030 Agenda for Sustainable Development, is defined by the World Health Organization (WHO) as all individuals and communities having access to any health services they need, of sufficient quality to be effective, without suffering financial hardship [2]. The World Health Organization defines a health system as consisting of all organizations, people, and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities [3]. On the other hand, health financing refers to the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system [3]. The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" [3].

Health financing is a core function of health systems that can enable progress towards universal health coverage by improving effective service coverage and financial protection. Today, millions of people do not access health services due to the cost. Many others receive poor quality health services even when they pay out-of-pocket. Carefully designed and implemented health financing policies can help to address these issues [2]. For example, contracting and payment arrangements can incentivize

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care coordination and improved quality of care; sufficient and timely disbursement of funds to providers can help to ensure adequate staffing and medicines to treat patients.

In April 2001, heads of state of African Union countries met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector. At the same time, they urged donor countries to "fulfil the yet to be met target of 0.7% of their GNP as official Development Assistance (ODA) to developing countries". This drew attention to the shortage of resources necessary to improve health in low-income settings. At that time, the median level of general government health expenditure from domestic resources (GGHE-FS) in African Union Countries was very close to US$10 with a thousand-fold difference between the minimum (US$0.38) and maximum (US$380). In terms of ODA, five of the 22 donors then reporting to the OECD were already giving at least 0.7% of their Gross National Income (GNI) with an average (unweighted) of 0.4 %.

Malawi, being one of the African Union member states, committed itself to allocating at least 15% of its total government budget to the health sector. Unfortunately, since 2012/13, the government has, on average, allocated 9% of its annual budget to health. The 2017/18 health budget is approximately 3% of the Gross Domestic Product (GDP) of Malawi. Despite this, Health and Population is one of the five priority areas of the Government for the next five years as outlined in the Third Malawi Growth and Development Strategy (MGDS III). Through the MGDS III, the Government committed itself to improve access, equity, and quality of primary, secondary, and tertiary health services. In recent years, the Government developed robust health sector policies and plans to guide its interventions and to inform health sector resource mobilization and allocation. In 2017, the Government launched the second Health Sector Strategic Plan (HSSP II), Essential Health Package (2017-2022), Sexual and Reproductive Health Policy (2017-2022), National Community Health Strategy (2017-2022) and the Country Multi-Year Plan for the Expanded Program on Immunization (2017-2021).

To support the achievement of its family planning commitments, the Malawi government pledged to increase budgetary allocation for family planning and youth programming as well as add a family planning commodity budget line by fiscal year. In 2019 the government was commended by donors for spending nearly 75% of the contraceptive budget and supporting many health system-wide costs that improved family planning service delivery i.e., health worker remuneration, health facility, maintenance, and drug supply. Unfortunately for the citizenry, the evidence to back up this improvement is unknown. Malawi presently faces critical constraints in financing their health systems to provide a basic package of cost-effective health care interventions deemed necessary to achieve the health-related Millennium Development Goals (MDGs). The government to improve the equity, efficiency, and sustainability of health financing mechanisms has undertaken health financing reforms as part of the broader health sector reform agenda. Malawi's health sector is heavily dependent on foreign resources. Based on its revised estimates, the government of Malawi (GOM) allocated 9.7% of its fiscal year (FY) 2014/15 budget to health. This allocation reflects a significant reduction in budget support from donors; GOM represented 92% of the total health allocation. For FY 2011/12, the purely domestic government allocation was only 6.2% of the total GOM budget. As if that is not enough, government health expenditure as a percentage of total health expenditure (THE) declined from 22% to 16%. Donors have continued to provide most resources in the health sector, at 58.6 percent of total health expenditure. Malawi's limited economic capacity has restricted GOM health expenditure to US$9.6 per capita in 2017, which falls short of the World Health Organization (WHO) recommendation of US$86 per capita per annum needed for UHC. Thus, financial support from development partners has been critical for the health sector in Malawi. According to WHO, partner funding from 2009 until 2017 was approximately US$27 per capita per annum, or 63% of total spending on health compared with a regional average of 27%.

The Government of Malawi signed up to the Abuja Declaration, committing to spend at least 15% of its government budget on health. While Malawi has not met this target since 2008, the planned 2014 budget only allocated 12% of government spending to health. In 2013, the Government of Malawi only spent US$21 on each person's health. The planned 2014 budget reduced this to US$19 per person, and in 2022 the government has reduced the budget to 2$ per person, further undermining Malawi's ability to provide its citizens with basic universal healthcare. On average, less than 1% of Malawi's overall government expenditure from 2009 to 2012 was spent on reproductive health. This includes money spent on all maternal health services, antenatal care, prenatal care, family planning counselling and commodities, and other reproductive care-related services. Between 2009 and 2012, estimates of government spending on women and children's health as a share of total government spending on health increased from 12% to 15% (Ministry of Health, Department of Planning and Policy Development, 2009/11, 2011/12).

The health sector in Malawi is currently faced with liquidity problems, fragmentation of funding, and a reduction in programme implementation. While it was expected that donors who stopped channeling funds through the pooled funding mechanism would use alternate funding mechanisms, anecdotal evidence suggests that the level of donor financing has declined. Considering that measures to tighten fiduciary control systems and regain donor confidence take time, Malawi's health programme could be at risk if alternative measures to mobilize additional domestic resources are not implemented urgently. Even before the Cash gate scandal, health financing in Malawi has been problematic and it had been recommended that Malawi needs to identify and implement alternative options to finance the health sector.

The trend from the last four years of budgetary allocation in Malawi shows that sexual reproductive health is allocated 1.3% out of the 25.5% allocated to the entire health ministry. Public health experts recommend an allocation of 5.5% towards sexual reproductive health service delivery out of the 25.5% health budget allocation. Malawi has experienced a decline from the 3.1% allocation for SRHR in 2012. As a result of inadequate health financing in Malawi, the country has experienced risks to the quality and adequacy of sexual reproductive health especially for vulnerable populations in rural communities, jeopardizing the welfare of the populations. Community members especially the youth are subjected to many risks inter alia such as inaccessible

drugs, shortage of other medical supplies, teen pregnancies, and lack of information on SHRH.

A prominent challenge has been that the bulk of external resources is earmarked for the provision of HIV/AIDS, Malaria, and Reproductive Health (RH) services which makes it difficult to reprioritize; HIV/AIDS allocation was at 35%, Malaria at 16%, and Reproductive Health at 11% of the total external health expenditure between 2012/13 and 2014/15 and this creates rigidities in resources allocation. Earmarking donor funding to disease programmes reduces the government's flexibility in resource allocation and ability to re-prioritize funding to emergent needs. In addition, donor resources are uncertain, and commitments are made for short periods, and this makes it difficult to implement sustainable long-term strategies. Ideally, Malawi is supposed to allocate 15% of its total national budget towards sexual reproductive health but Malawi is not meeting this commitment since signing. This study, therefore, described the trend in the stockout of family planning commodities, utilization of modern contraceptives, and household (out-of-pocket) expenditure on family planning in comparison to changes in government expenditure.

Main Objective

The main objective of the study was to examine the effects of government expenditure on the delivery of family planning services in Malawi.

Specific Objectives of the Study

a). To assess changes in stockout rates for Family Planning (FP) commodities in comparison to domestic budgetary allocation towards Family Planning (FP) commodities
b). To examine the changes in the utilization of modern contraceptives in comparison to government expenditure on FP
c). To compare the changes in household (out-of-pocket) expenditure on FP with government expenditure on FP

Methods

The study used cross-sectional and routine data collected between the years of 2013 and 2021 in the OpenLMIS, DHIS2, and NHAs. The study used a trend analysis approach to describe how stockout of selected contraceptive commodities (specifically Depo-Provera) and the reach of contraceptives had changed in comparison to changes in domestic financing. The descriptive research design was used to compare the changes in variables of interest without any intention to provide information on cause-effect relationships [4].

Data used for objective one was sourced from OpenLMIS and Ministry of Health budget documents. An average of 700 health facilities were expected to report in OpenLMIS to give the national status for the Fiscal Years under study (FY2013/14 to FY2020/21). The Government of Malawi created a budget line for family planning in FY2013/14. Data used for objective two was sourced from DHIS2 and NHA reports. A total of 781 health facilities were expected to report family planning data in DHIS2 in FY2015/16, FY2016/17, and FY2017/18. The first NHA for Malawi covered the FY1998/99, however health expenditure on family planning in Malawi was only available in the latest NHA which covered FY2015/16, FY2016/17, and FY2017/18 and hence objective three relied on this data source [5].

Data Collection Tools

Open Logistics Information Management System (OpenLMIS)

OpenLMIS is a web-based system that collects health commodity logistics data nationwide with over 650 (95 percent) of Malawi's 684 health facilities having access to and using it [6]. The system has data for more than 300 essential health commodities across six national health program areas [6]. Access to OpenLMIS is subject to authorisation by the Health Technical Support Services Directorate of the Ministry of Health. The system was used in this study as a source of data on the availability of Depo-Provera between FY2013/14 and FY2020/21.

National Health Accounts (NHA)

NHA generated important information on the financing of health in general, the flow and management of resources in the health sector, and the distribution of expenditures across disease areas [7]. The Malawi 2020 NHA obtained data from both primary and secondary sources for FY2015/16, FY2016/17, and FY2017/18 using the Systems of Health Accounts 2011 framework. NHA was used in this study as a source of data on domestic spending for family planning in FY2015/16, FY2016/17, and FY2017/18.

District Health Information System 2 (DHIS2)

DHIS2 is a web-based open-source information system used to store, monitor, and analyse health data. The system is accessible to authorised users through the Central Monitoring and Evaluation Department of the Ministry of Health. DHIS2 was used in this study as a source of data on access to contraceptives in FY2015/16, FY2016/17, and FY2017/18.

Description of Variables Used in the Study

a). **Average annual stockout rate**
Stockout rate was calculated by diving the number of facilities that reported unavailability of a particular commodity by the total number of facilities that reported on the commodity. National level monthly reports were generated from OpenLMIS and annual (Fiscal Year) estimates were derived by taking the average of 12 months (July to June cycle).

b). **Domestic funding for family planning commodities**
This was estimated by the budgetary allocation by the Malawi government towards the purchase of family planning commodities. The amounts used in this study were not the actual amount that was received and used by the Ministry of Health to purchase commodities. This variable was measured in Malawi Kwacha.

c). **Domestic expenditure on family planning**
The total amount of expenditure by the government towards family planning programming and commodities. The variable was measured in Malawi kwacha.

d). **Utilization of contraceptives (Reach)**
The total number of men and women who accessed contraceptives in the particular fiscal year. The values were generated from DHIS2.

e). **Total household expenditure on family planning**
The total amount of expenditure by Malawian households towards family planning commodities and services. The variable was measured in Malawi kwacha.

Data Analysis

Monthly reports on stockout rate by product were exported to a Microsoft Excel file. Annual average stockout rates

were calculated from the monthly reports. Similarly, family planning service data reports from DHIS2 were exported to Microsoft Excel, and the total number of clients who accessed contraceptives was calculated for each fiscal year.

Microsoft Excel was further used to compute descriptive statistics for study variables and perform trend analysis of the variables that were examined. Excel was also used to plot graphs showing the trend in stockout rates and trend in contraceptive use in relation to domestic funding for FP commodities and domestic expenditure on FP respectively.

Ethical Considerations

The study's ethical approval was obtained from the Malawi Institute of Management (MIM) research ethics committee and commitment to safeguarding the use of data from OpenLMIS, DHIS2 and National Health accounts was key. No human subjects were involved.

Limitations

The study explored trends in the stockout rate of a selected family planning commodity, utilization of modern contraceptives, and household expenditure on family planning in comparison to government expenditure. However, the study did not perform a regression analysis to measure the independent effects of government expenditure on the observed stockout rates, utilization of modern contraceptives and household expenditure on family planning.

Results

Data about facilities

Data was collected from 596 facilities that reported in OpenLMIS between FY2013/ 2014 to FY2020/21 and 464 facilities that reported in DHIS 2 for FY 2015/16, 442 facilities in FY2016/17, and 551 facilities FY 2017/18.

Descriptive Statistics for Study Variables

Average stockout rates for selected family planning commodity (Depo-Provera)

Average annual stockout rates were computed for FY2013/14, FY2015/16, FY2016/17, FY2017/18, FY2018/19, and FY2019/20. The average annual stockout rates in this period raged from 4 percent to 18.5 percent, with a mean value of 10.2 percent. The lowest stockout rate was experienced in FY2016/17 and the highest stockout rate was experienced in FY2018/19. This shows that in FY2018/19 more facilities in Malawi (18.5%) had run out of Depo-Provera compared to facilities that had run out of Depo-Provera in FY2016/17.

Domestic Funding for Family Planning Commodities (Depo-Provera)

Annual government allocation towards family planning commodities was tracked for seven years (FY2013/14 – FY2019/20). The funding increased from 26 million Kwacha in FY2013/14 to 186 million Kwacha in FY2019/20. The mean annual government allocation towards family planning commodities in the seven years was 78 million Kwacha. Overall, government allocation towards family planning commodities has been increasing over the study period.

Domestic Expenditure on the Family Planning Program

The government's total expenditure on family planning increased from 2,809,660,000 Kwacha in FY2015/16 to 3,129,560,000 Kwacha in FY2016/17 and dropped to 2,772,660,000 Kwacha in FY2017/18. This shows that on average the government was spending slightly over 2.9 billion Kwacha annually on family planning between FY2015/16 and FY2017/18.

Utilization of Modern Contraceptives (Reach)

A total of 1,556,274 women and men used a modern method of contraception between FY2015/16 and FY2017/18. The utilization of modern contraception increased from 375,916 in FY2015/16 to 725,635 in FY2017/18 with average annual utilization of over 500,000 women and men.

Household Expenditure on Family Planning

Households in Malawi were spending an annual average total of 1,355,240,000 Kwacha on family planning between FY2015/16 and FY2017/18. The household expenditure on family planning increased from 1,203,710,000 Kwacha in FY2015/16 to 1,440,790,000 Kwacha in FY2017/18.

Study Findings According to Specific Objectives

Analysis of trend in stockout of Depo-Provera in comparison to changes in domestic funding.

As can be seen from Figure 8, the study showed that since the introduction of the budget line for family planning commodities in FY2013/14, the stockout rate of Depo-Provera declined from 9 percent to 4 percent in FY2016/17. This suggests that the funds contributed by the government helped to ensure that more commodities are procured and distributed to health facilities in the country. The Stockout rate for Depo-Provera started to increase following the fall in budgetary allocation in FY2016/17. The increased stockout rates between FY2016/17 and FY2018/19 suggest that the variations cannot be explained by domestic funding alone. It is worth noting that the heavy increase in funding from the government as experienced in FY2019/20 resulted in an instant drop in the stockout rate.

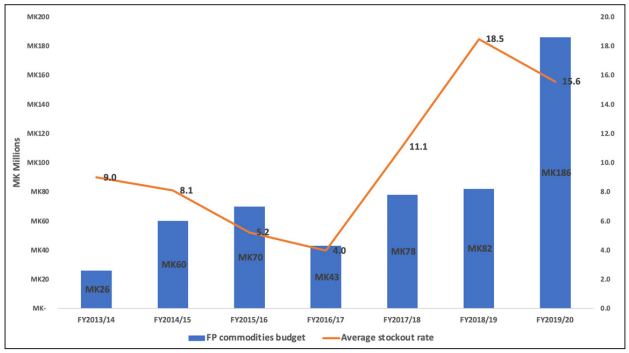

Figure 1: Stockout of Depo-Provera in comparison to changes in domestic funding

Analysis of Trend in the Utilization of Contraceptive Methods in Comparison to Changes in Domestic Expenditure on Family Planning.

As can be seen in Figure 9, data from the National Health Accounts for FY2015/16, FY2016/17, and FY2017/18 showed a gradual increase in government expenditure on family planning. Despite the gradual changes in domestic financing, there was a tremendous increase in the number of women and men who

accessed modern contraceptives in the country, from 375,916 in FY2015/16 to 725,635 in FY2017/18. The unmatching change in the utilization of modern contraceptives compared to government expenditure on family planning suggest that other expenditure sources are key to explaining the changes in the utilization of modern contraceptives.

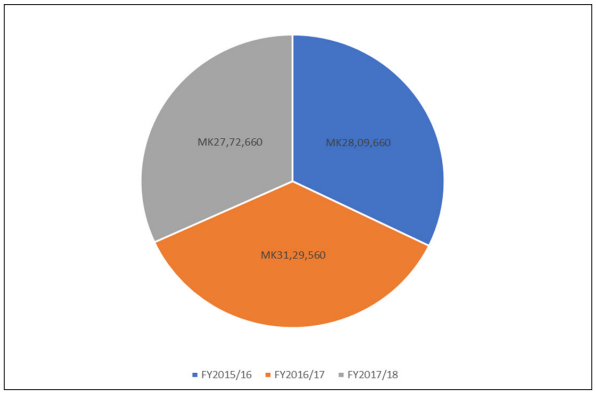

Figure 2: Utilisation of modern contraceptives in comparison to changes in domestic funding

Analysis of Trend in Household Expenditure on Family Planning in Comparison to Changes in Domestic Expenditure on Family Planning.

As can be seen in Figure 10, data from the National Health Accounts for FY2015/16, FY2016/17, and FY2017/18 showed that household expenditure on family planning has been increasing since FY2015/16. Despite the slight increase in domestic financing for family planning between FY2015/16 and FY2016/17, the amount that households in Malawi spent on family planning still increased. As a proportion of the total expenditure on family planning, household expenditure represented 7 percent in FY2015/16, nine percent in FY2016/17, and five percent in FY2017/18. However, as a proportion of government expenditure, household expenditure on family planning reached 53 percent in FY2017/18 from 43 percent in FY2015/16.

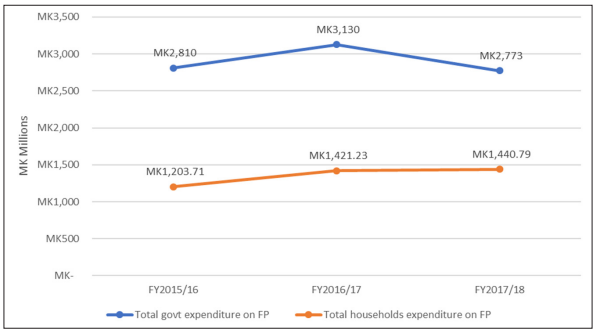

Figure 3: Trend in household expenditure on FP in comparison to changes in domestic funding.

Discussion

The study found that between FY2013/14 and FY2020/21 the country experienced inconsistent availability of Depo-Provera despite the increase in government budgetary allocation since FY2013/14. The study also found that between FY2015/16 and FY2017/18 the utilization of modern contraceptives in Malawi had grown tremendously despite the stagnant government expenditure on family planning. Lastly, the study found that the stagnant government expenditure on family planning between FY2015/16 and FY2017/18 coexisted with increased household expenditure on family planning. These findings are discussed in this chapter in relation to existing knowledge.

Persistent Stockout of Family Planning Commodities Amidst Low Domestic Funding for Family Planning Commodities

Modern contraceptive choice of women and men is restricted by stockouts and low method availability, which force them to choose methods that may not suit their preferences and needs [8]. It should be noted that despite the importance of measuring stockouts, existing research on factors that affect stockouts is limited [8]. However, domestic funding, the functionality of the supply chain, and the quality of the reported data are arguably key.

Financing for Family Planning Commodities

In a significant step towards meeting its FP2020 commitments, the Government of Malawi (GOM) created a Family Planning (FP) commodity budget line in the fiscal year (FY) 2013-14 and committed funds to this budget line each year since its inception. Although the level of budget funds allocated to this line has increased from MK26million in FY 2013/14 to MK186 million in FY 2019/20, the overall proportion of domestic funding for FP commodities remains extremely small at approximately 1.4 percent of total budget in 2019/20. This suggests that the persistent stockout of Depo-Provera as shown in the previous chapter is partly due to inadequate funding from the government. While the Ministry of Health conducts annual quantification and forecasting of FP commodities needs with consideration given to population dynamics and utilization of modern contraceptives, the government funding for FP commodities is rarely informed by the exercise.

During FY2019-20, international development partners financed over 98% of FP commodities in Malawi, with half of this amount provided through emergency funding via the Health Services Joint Fund (HSJF). It was made clear by the HSJF partners (Norway, Germany, and the UK) that this emergency financing would not be repeated for FY 2020-21, leaving a potentially large funding gap. A study done by showed that the low government funding is coupled with the late release of funds which contribute to low expenditure rates and delayed procurement and receipt of contraceptives (particularly given long lead-in times for FP commodity procurement) [9]. For instance, as of March 2020, none of the MK186 million allocated for FY 2019/20 had been released by the Treasury, just three months before the end of the 2019/2020 financial year.

Lastly, tracking the funds allocated for family planning commodities is also a challenge. The lack of processes and tools in place to track expenditure on the family planning commodities budget line contribute to inefficiencies and poor oversight of spending. This was evident in the study by Options Malawi, 2021 as it was found that not all the funds allocated to FP commodities are spent on FP commodities.

In conclusion, an increase in domestic funding on family planning commodities should be coupled with proper tracking of expenditure and timely release of funds to ensure improved availability of modern contraceptives.

Procurement, Storage, and Distribution of FP Commodities

The functionality and quality of data in the supply chain also contribute to the observed trend in the stockout of family commodities. A study on Mapping of FP/SRH funding flows in Malawi found that multiple stakeholders are involved in the procurement of FP commodities, and they have different systems in place with varying lead-in times for ordering and receipt of contraceptives into central and regional warehouses. The study found little evidence to demonstrate that these parallel procurement processes are properly monitored or coordinated, either by the Central Medical Stores Trust (CMST) or the Reproductive Health Directorate.

The stockout rates were also higher in peripheral health facilities compared with district hospitals. Weak supervision by districts and a lack of resources for transport contribute to a situation whereby facilities are often out of stock while District Health Offices (DHO) retain contraceptive stocks. The fact that FP commodities continue to be financed and distributed directly from the centre potentially removes the motivation for the district to oversee and ensure effective FP stock levels.

Lastly, the quality of data that is reported in the supply chain system to trigger distribution of family commodities is also key. Studies show that data on stockouts by contraceptive method are usually of poor quality, and Malawi missed on the list of a few countries that are able to monitor stockouts routinely at the facility level [10].

Uptake/utilization of FP

The study found a positive relationship between total government expenditure on family planning commodities and the number of clients using modern contraceptives. It was noted that the more money government spent on contraceptives the more people were using contraceptives. These findings are in line with what the FP2020 progress report found, they indicated a rise in the number of additional users of modern methods of contraception from 0 in 2012 to 534,000 in 2016 and 729,000 in 2018 with 2020 recording 933,000 new users. The report further indicated a rise in contraceptive prevalence rate for modern contraceptive methods (mCPR) among women from 38.1% in 2012 to 45.0% in 2015 and 47.7% in 2018 with 2020 recording 49.9% [11]. in addition, the percentage of women with an unmet need for a modern method of contraception (married/in union) reduced from 25.5% in 2012 to 20.2 % in 2015 and 17.8 % in 2018 and 2020 recording 16.7 %. This shows some positive gains the country has made in reducing the unmet need for FP among women and this is also reflected in the percentage of women whose demand is satisfied with a modern method of contraception (married/ in-union), in 2012 we had 65.9% of women whose demand was satisfied to 74.2 % in 2015 and 77.4% in 2018 and 78.9% [11].

Despite making these giant strides, less progress was registered among the adolescent girls and young women wanting to delay pregnancy, during the study period, the number of unintended pregnancies grew from 417,000 in 2012 to 423,000 in 2015 and 437,000 in 2018, and 452,000 in 2020 [11].

In conclusion, uptake/utilization of FP services has increased greatly during the study period but not all these gains can be attributed to increasing in domestic allocation or expenditure towards FP commodities because most of the money spent on FP was heavily financed by the donors during the entire period. In addition to the fact that increase in the utilization of FP not being influenced by budgetary allocation, is the fact that population has been growing upwards each year. The rise in population also affects the rise in demand for FP services and also most civil society organisations have been implementing social behaviour change interventions across the country aimed at changing the mindset of Malawians towards FP especially LARCs and demystifying the myths, cultural and religious beliefs which exist around the use of contraceptives among women of childbearing age. Several strides have been made in engaging the chiefs, religious leaders, parents, guardians, and young people themselves in reaching them with true and accurate knowledge on contraceptives, its benefits and where to access them. So, all these multiple things can be attributed to the rise in the utilization of FP services.

Increasing Household Expenditure on Family Planning Amidst Inconsistent Government Expenditure on the Same

The study found that households' expenditure on family planning has been increasing throughout the study period. Despite the absolute increase, Malawi's household expenditure on family planning as a proportion of total expenditure on family planning is lower compared to the average household expenditure registered in 69 FP2020 focus countries in 2015 [12]. The lower proportion of household expenditure on family planning is not unique to Malawi as a study conducted in 132 lower-and-middle-income countries found that such expenditure only makes up a small share of the total expenditure on family planning [13]. Studies suggest that a higher percentage of the household expenditure on family planning is spent on short-term contraceptive methods such as pills and injectables [13]. In Malawi, injectable contraceptives are used by a majority of family planning users, which affects their availability in public health facilities. An increase in household expenditure on family planning is attributed to inadequate public funding and limited coverage of health insurance mechanisms. This trend is worrisome in view of a global commitment to achieving Universal Health Coverage as it makes family planning inaccessible to vulnerable households. In addition to linkage with funding, increased household expenditure on family planning may also reflect poor supply chain systems as well as the quality of care in public health facilities.

Limitations of the Study

The main limitation for the study was that data was only available at the national level such that government expenditure data was not readily available at regional and district levels. Hence, we could not perform inferential statistics to measure the independent effects of government expenditure on the observed stockout rates, utilization of modern contraceptives, and household expenditure on family planning. The other limitation for the study was the unavailability of published studies in relation to the research topic as this area is under-researched.

Recommendations for Future Research

The current study did not look at the independent effects of government expenditure on stockout rates, utilization of modern contraceptives and household expenditure on family planning. Future research could consider estimating subnational

government expenditure on family planning from national-level estimates. This could aid regression analysis to unveil the independent effects of government expenditure while controlling for other confounding variables.

Research Questions and Findings

In this study, we examined how stockout rates for Family Planning (FP) commodities changed between FY2013/14 and FY2020/21 in comparison to domestic funding for Family Planning FP commodities. Secondly, we examined how the trend in the utilization of modern contraceptives changed between FY2015/16 and FY2017/18 in comparison to government expenditure on FP. Lastly, we looked at the trend in household expenditure on FP changed between FY2015/16 to FY2017/18 in comparison to government expenditure on FP. The study established that between FY2013/14 and FY2020/21 the country experienced inconsistent availability of Depo-Provera despite the increase in government budgetary allocation since FY2013/14. The study also found that between FY2015/16 and FY2017/18, utilization of modern contraceptives in Malawi had grown tremendously despite the stagnant government expenditure on family planning. Lastly, the study found that the stagnant government expenditure on family planning between FY2015/16 and FY2017/18 coexisted with increased household expenditure on family planning.

Study Limitations

While the study has presented important gaps that are attributable to low government expenditure on family planning, it did not examine the independent effects of government expenditure on stockout rates, utilization of modern contraceptives, and household expenditure on family planning. The study was limited by the unavailability of data at sub-national levels which could be used to run a robust regression analysis to examine the association between dependent and independent variables. Additionally, the study only examined government expenditure in three Fiscal Years which did not give a detailed trend to inform policy and research recommendations.

Study Implications and Recommendations for Future Research

Earlier studies point to the need to analyse and identify the gaps created by budgetary constraints to reproductive health service delivery. This study showed that such gaps may include persistent stockout of family planning commodities and increased household expenditure on family planning. The results from this study support calls for increased government expenditure on family planning to address the challenges of inconsistent supply of commodities which increases inequalities as vulnerable populations cannot afford to access contraceptives from private providers.

Future research in this area should focus on identifying the independent effects of government expenditure towards family planning on the availability of commodities, utilization of modern contraceptives, and household expenditure on family planning. There is also a need for research to understand the bottlenecks in the supply chain for family planning commodities amidst multiple sources of funding.

Lastly, key recommendations to government through the Ministry of Health are;

a). There is need to iincrease investment in family planning to ensure that commodity stockouts and out-of-pocket expenditures on family planning commodities are reduced.

b). There should be improvement in the supply chain for family planning commodities to reduce stockout rates, for this to happen, central medical stores need to work efficiently with central and district hospitals and health centres to ensure a smooth flow of commodities and lead times are respected.

c). Push for collective, international action to limit theft, fraud, and misappropriation of drugs and SRH supplies.

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