Malawi: Improving Sexual and Reproductive Health Services in Rural Mangochi District

By Henry Chimtengo

Community-based distribution agent, Annie Ng’omba (right) offers family planning products to a 19-year-old mother, Zione Chilembwe, at Nsalika Village, Mangochi. ©UNICEF Malawi/2021/Edward Kabuye
It’s a Sunday, usually my day off from work at the Malombe Health Centre in Malawi’s Mangochi district. However, I’ve just performed male circumcision on four boys aged 16, 15, 13 and 10 years. I couldn’t turn away the boys and the parents accompanying them. I live at the health centre and my door is always open. Besides, I’m glad my message has got across to the community – male circumcision reduces the risk of HIV infection in males and has to be carried out at a health centre and not in unsterile conditions in the community, which has often happened in the past.

Before I performed the procedures, I provided essential information and talked to the boys and their parents about matters relating to sexual and reproductive health. For example, I counselled and tested the boys for sexually transmitted infections and HIV, and talked to the older ones about family planning options, particularly condom use. Boys and girls here are often sexually active in their teens and HIV continues to be a challenge in the community.

Male circumcision is just one of many services that I provide as a clinical assistant at the health centre. I had wanted to become a clinical officer but I could only afford to enrol on the certificate instead of the diploma course. I am looking forward to the opportunity to further my studies in the future so I can be promoted to clinical officer. This would mean I could perform other critical procedures.

Meanwhile, I’ve been making the most of the on-the-job training I have been receiving, such as our training in 2019 by the district health officers on delivering integrated health services. I understand this training was part of a UN programme known as 2gether 4 SRHR programme (2018-2022) which is in partnership with the Swedish International Development Cooperation Agency (SIDA). I think this training has greatly improved our services and, as a result, has encouraged more people to come to our health centre, particularly young people who in the past have been hard to reach.

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In Eastern and Southern Africa, one in four women aged 20-24 years give birth before the age of 18, one of the world’s highest pregnancy rates, and about 2 million adolescents and young people (15-24 years) are living with HIV.

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3. The joint four-year regional 2gether 4 SRHR programme (2018-2022) in East and Southern Africa has brought together the expertise of four UN agencies – the Joint United Nations Programme on HIV/AIDS (UNAIDS), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF) and the World Health Organization (WHO) – to work with governments and partners, as well as regional economic organizations like the Southern African Development Community (SADC).
Since the training, we have been providing a range of services on the same day whereas before I focussed only on HIV counselling, testing, and adherence to anti-retroviral treatment. If a client came for HIV treatment but also wanted to have advice on family planning, I didn’t have the means to help the client and would have to refer him or her to another health worker specializing in that area. Sometimes that would mean the client had to return on a different day, and therefore might not return at all.

These days, I offer a range of services which include family planning and also screening for sexual and gender-based violence (SGBV). The screening for SGBV has been a critical area that, before the training, had insufficient attention. Apart from treating and referring survivors of SGBV to the appropriate agencies, health workers can also be called on to supply health evidence in court. Last year, my health report on two cases of SGBV contributed to convictions that resulted in long prison sentences, including over 20 years in prison for a man who had raped a teenage girl.

As it’s so remote here, we rely a lot on our community health workers to help us in our integrated health service delivery. Some of them, like Annie N’goma, took part in the training with us on integrated health service delivery. As a community-based distribution agent, she offers advice on family planning and distributes family planning products, the contraceptive pill and condoms, in her remote community. Every month, she makes the 10-kilometre journey on foot to the health centre to share her data with us and collect more family planning products. She told me that these days, many young people come to her home asking for family planning products and advice. She also refers people when necessary to the health centre.

However, there is still room for improvement in our delivery of integrated health services. Besides the COVID-19 pandemic, the main challenges we face are drug stock-outs, staff transfers and lack of public transport. Moreover, there is no ambulance at the health centre, which has a catchment of over 25,000 people. This can be a major problem when for example, we have a pregnant woman in labour with complications.

The huge responsibility that falls on our shoulders makes it even more critical that we keep improving our skills so we can keep doing better at preventing, treating and referring cases and improving the overall health and well-being of our rural communities.

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