One Stop Shop, or Service Silos? A Cross-Sectional Analysis of Postpartum Family Planning (PPFP) Integration with Maternal, Newborn, and Child Health Services Using a Client Flow Assessment Tool

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Background
• About 30% of maternal deaths in developing countries could be averted by meeting women’s needs for family planning (FP); if all pregnancies were spaced 2 years apart, infant deaths would decrease by 10% and child deaths by 21% (Cleland et al., 2012).
• Antenatal care (ANC), labor and delivery, postnatal care (PNC), and child health services offer valuable points of contact for postpartum family planning (PPFP) integration to improve spacing of pregnancies.
• This descriptive evaluation examined implementation models used to integrate FP into maternal, newborn, and child health (MNCH) services in Kenya and India.

Main Questions
1. To what extent did clients accessing MNCH services at study facilities also receive integrated FP counseling or services?
2. Which client characteristics predict receipt of integrated MNCH-FP services? Is integration associated with differences in service delivery?

Methodology
• Cross-sectional analysis of client flow data collected May/June 2014 from 6 hospitals and 4 health centers (HCs) in Kenya and India.
• Program implementation models
  • PPIPUID (postpartum intrauterine device): Bihar, India; Jharkhand, India; eastern Kenya
  • Maternal, infant, and young child nutrition (MIYCN) and FP/Western Kenya
• Inclusion criteria: All women age 18 or over accessing services who were pregnant and/or had a child under 2 years old.
• Only ANC, PNC, and child health clients included; laboring women were excluded.
• Provider(s) seen checked off care they provided to the client on a checklist.
• Main outcome: Receipt of integrated MNCH-FP services.

Results
• 2,158 client visits tracked: 1,294 in India and 864 in Kenya.
• Large variation in levels of MNCH-FP integration across facilities.

Results, cont.
• Large differences in proportion of clients receiving MNCH-FP integrated services by service area accessed within facilities.
• Higher levels of FP integration in ANC in sites with PPIPUID interventions emphasizing PFP counseling during ANC (India, eastern Kenya); higher levels of FP integration in PNC and child health in the MIYCN-FP intervention sites (western Kenya).

Implications
• Findings suggest the importance of providing specific programmatic support for integration, which was most prominent in the MNCH service areas that received support for FP integration and did not organically shift into other facility service areas at the same levels.
• Clients who accessed integrated MNCH-FP services (compared to those who accessed MNCH services alone) tended to see a larger number of providers. Nonetheless, the amount of time they spent at the facility did not significantly increase, suggesting that integration may not impose an undue burden.
• From the client perspective, attention should be given to the needs of clients who live furthest from facilities, as they are least likely to receive integrated services.

Reference

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This poster was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00 and Cooperative Agreement AID-OAA-A-14-00028. The contents are the responsibility of the authors and do not necessarily reflect the views of USAID or the United States Government.