Improving Access to Services through Family Planning and Immunization Service Integration in Malawi

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Background

Malawi's overall modern contraceptive prevalence rate is 58%, however contraceptive use among women in extended postpartum period is likely substantially lower. WHO estimated Malawi's nationwide DPT3 vaccination coverage was 84% in 2016. At the policy level, FP and immunization services are integrated as part of Malawi's Essential Health Package. However, in practice services have been provided in parallel with different service schedules or by different providers. FP and immunization service integration has been identified as a "promising" high impact practice for FP. In Malawi, MCSP supports immunization, FP, and nutrition as high-impact interventions for preventing child and maternal deaths. MCSP supported the MOH in two districts to integrate FP and immunization services between July 2016 and November 2017.

Program Intervention Tested

The intervention involved service integration through outreach clinics and health facilities, at full saturation (all 43 facilities and associated outreach sites) in two districts: Dowa and Ntchisi. The study explored effects of service integration on service provision, utilization, and perceptions of quality.

Intervention Approach

Health workers offer same-day, intrafacility linkages at health facilities.	At outreach sessions, health surveillance assistants offered mothers both routine infant immunizations and voluntary FP and referrals.	Local government committees (or Area Development Committees) were engaged to promote the use of integrated services.

Methodology

The study used a mixed methods process evaluation approach, including analysis of service statistics and qualitative data collection.

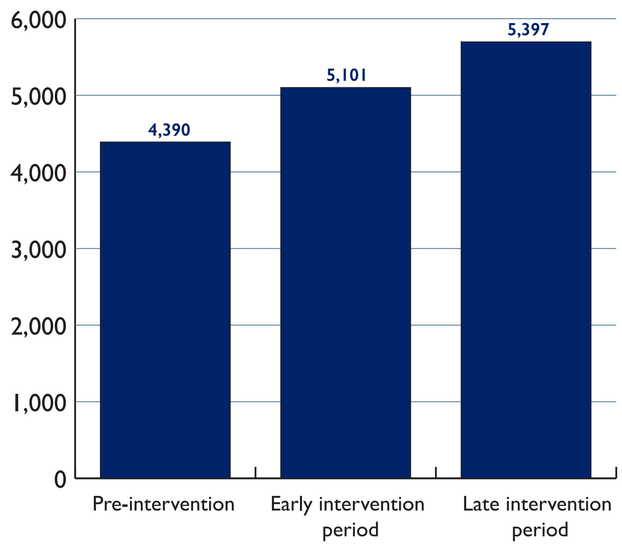
Methodology (cont'd)

For the qualitative data collection, in each district we selected one hospital and three health centers as well as one outreach site per fixed facility where FP/immunization integration activities occurred. At each site, we interviewed one FP provider, one health surveillance assistant (HSA), and a facility supervisor. We conducted focus group discussions with mothers and fathers of children under age 1, including women who accepted and declined referrals between the services. District- and national-level representatives were also interviewed.

For the quantitative evaluation, we used FP and immunization data from DHIS2. Due to challenges with incomplete FP data reporting (which was not a challenge for immunization data), only data from facilities that submitted at least 80% of FP monthly reports from January 2016 to September 2017 were included. None of the facilities in Ntchisi met this criterion, while 14 of 22 facilities providing FP services in Dowa were included in the quantitative analysis.

Key Findings

Study results are as follows:



- There was a statistically significant increase in total voluntary community-based FP use shortly after start of intervention: trends show a shift in use of FP from facility to community. Average number of total FP clients who accessed community-based FP provision each month almost doubled between pre- and postimplementation (1,819 average monthly clients during January–May 2016, to 3,534 June 2016–September 2017), while the number of clients accessing FP at facilities fell by roughly 30% (from 2,805 average monthly clients to 1,947).

Key Findings (cont'd).

- Immunization doses administered, dropout, and use of facility-based versus outreach immunization services did not change significantly.
- Caregivers noted benefits in time savings, convenience, and improved knowledge/understanding of the other service.
- There were variations in levels of integration across sites.
- Contextual factors affecting provision/use of services included human resource availability, FP commodity availability, level of community engagement, data collection procedures/availability, FP social barriers, service setup and days available, supervision and commitment of HSAs, and coordination and collaboration between nurses and HSAs.

Program Implications

Support increased staffing for both facility- and outreach-based services. Review roles and responsibilities of nurses and HSAs.

- Ensure uninterrupted availability of commodities and educational information on FP and immunization for caregivers.
- Strengthen link to wider community engagement to address FP norms.
- Give greater emphasis on timely, consistent reporting of FP data. Incorporate measurement of PPFP in the HMIS.
- Ensure that HSAs continue counseling on range of FP methods, including long-acting and permanent methods as desired.
- Findings are reassuring to immunization community, revealing the intervention likely did not negatively affect immunization outcomes.
- Shifts in provision of FP from facility to community suggest many women chose to switch from static facility-based provision of FP to community-based provision because the latter is more accessible.

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