



ONSE Health Activity

June 2021

ASSESSING COUPLE YEARS OF PROTECTION IN MALAWI

The USAID Organized Network of Services for Everyone's (ONSE) Health Activity undertook a rapid assessment in October 2018 to understand how family planning (FP) services are provided, by whom, and the estimated protection provided.

Key Takeaways

WHO: While the Ministry of Health of Malawi (MOH) provides the most FP services in the country, those provided by the ONSE Health Activity provide higher Couple Years Protection (CYP) because of ONSE's provision of the full complement of FP services with attention to long-acting and permanent methods.

WHERE: More FP services are provided at the community level, but services yielded at health facilities provided more CYP.

WHICH: At the facility level, the MOH and ONSE provide more short-term methods. At the community level, the MOH provides exclusively short-term methods while ONSE provides long-acting reversible contraceptives (LARCs) and permanent methods.

HOW: FP data were underreported in the national health management information system (HMIS), and few facilities followed MOH guidelines of having two FP registers to record facility and outreach FP services.

FP Service Delivery in Malawi

There is a clear gap in the use of short-term contraception methods compared to LARCs and permanent methods in Malawi. According to the Malawi DHS 2015–16, the majority of married women opt for injectables (30%), implants (11%), and tubal ligations (11%) as their FP method of choice. This means that most women do not use a method until they are done bearing children, which can be attributed to a wide variety of reasons, including cultural, logistical, and misinformation. There is a need to make more methods available to women, and ONSE has helped women realize those options and act on them.

Malawi's MOH provides FP services at both the facility and community levels. However, there is a gap between the demand for LARCs and permanent methods and the ability of the government to provide these services. At the community level, the MOH trained and supported health surveillance assistants (HSAs) and community-based distribution agents (CBDAs) to provide services along with MOH-deployed outreach teams. Nongovernmental organizations (NGOs) support government services. In communities, they deploy their own outreach teams, and NGOs regularly visit facilities to provide specialized services, such as LARCs and bilateral tubal ligations (BTLs). The Christian Health Association of Malawi provides nearly 40% of all health care services in Malawi, but

FP service availability varies by facility. Some provide no FP services, others provide only short-term or natural methods, and some only offer services on limited days. As such, FP services at the community level are especially important in the catchment areas of these health facilities. This ensures that adults of reproductive age living within these catchment areas have access to a full mix of contraceptive methods.

About ONSE Health Activity

The Organized Network of Services for Everyone's Health Activity (ONSE) is a five-year contract funded by the US Agency for International Development (USAID), working to improve maternal and child health in Malawi. The activity works through four objectives: (1) improve access to health care services, (2) improve quality of health care services, (3) strengthen health systems, and (4) increase demand for services. ONSE works across a series of priority health areas, including maternal, newborn, and child health (MNCH); family planning and reproductive health (FP/RH); malaria; nutrition; and water and sanitation. The activity builds on previous and current successes in the health sector and focuses on district-based service provision and systems strengthening.

ONSE collaborates with the MOH and its Reproductive Health Directorate to deliver a multisectoral approach to improving access to quality FP services in 11 districts in Malawi. The Malawi affiliate of MSI Reproductive Choices—Banja la Mtsogolo—is a key ONSE partner. ONSE designed its FP strategy to build the capacity of the MOH to provide a full range of FP methods, with specific attention to LARCs and permanent methods. The strategy seeks to complement MOH activities and fill any gaps in service provision while ensuring the sustainability of service. For providers, developing clinical capacity for FP is essential, especially for LARCs and BTLs. ONSE implements interventions to target both FP service providers and their clients. Understanding that social and cultural norms often limit the demand for FP services, ONSE works to ensure that all clients, including

youth, have appropriate knowledge of, demand for, and autonomy to access FP. ONSE contributes to the direct service delivery of FP through MOH-integrated family health outreach clinics (IFHOCs), mobile youth outreach clinics, facility-based outreach teams, and a nested provider model. To support Malawi’s efforts to strengthen the health system, ONSE emphasizes systemic capacity building across key system components, enabling and sustaining high-quality performance among individuals and teams who work within and with the system through HMIS strengthening, strengthening of supply chain, distribution of social behavior change materials, and supportive supervision and mentorship.

ONSE CYP Assessment

Globally, CYP is used to quantify the estimated protection from contraceptive services. CYP is calculated using the distribution of contraceptives to clients and therefore is calculated using service delivery statistics quantifying the number of clients receiving an FP method in a given period of time. As part of this assessment, ONSE reviewed both service delivery and CYP trends since service delivery provides important information about the number of clients choosing various methods and CYP provides critical information about the population protection from short, long, and permanent methods.

ONSE uses the FP service delivery statistics collected in the national HMIS to calculate CYP for the 11 supported districts as part of the Activity’s reporting process. Data are available in the HMIS but do not provide a granular understanding of whether services are provided at the community or facility level, so it was difficult to understand where ONSE fits into the national landscape. CYP is also a critical donor-mandated indicator, and ONSE wanted to better understand the data flow and composition of data comprising the CYP values reported each quarter to better understand ONSE’s contribution to this national statistic.

Over the life of the project, and particularly between project years one and two, CYP in the 11 districts increased significantly. To better understand how the Activity’s interventions contributed to increased CYP at the district level, ONSE conducted a rapid assessment of FP data in October 2018. This assessment gathered data from a stratified, random selection of 20% of facilities within the 11 districts (31 facilities in total). The assessment aimed to document data capture, the Activity’s direct support (i.e., service delivery inputs), and evidence of its indirect support to facilities to determine the overall contribution of this support to CYP output.

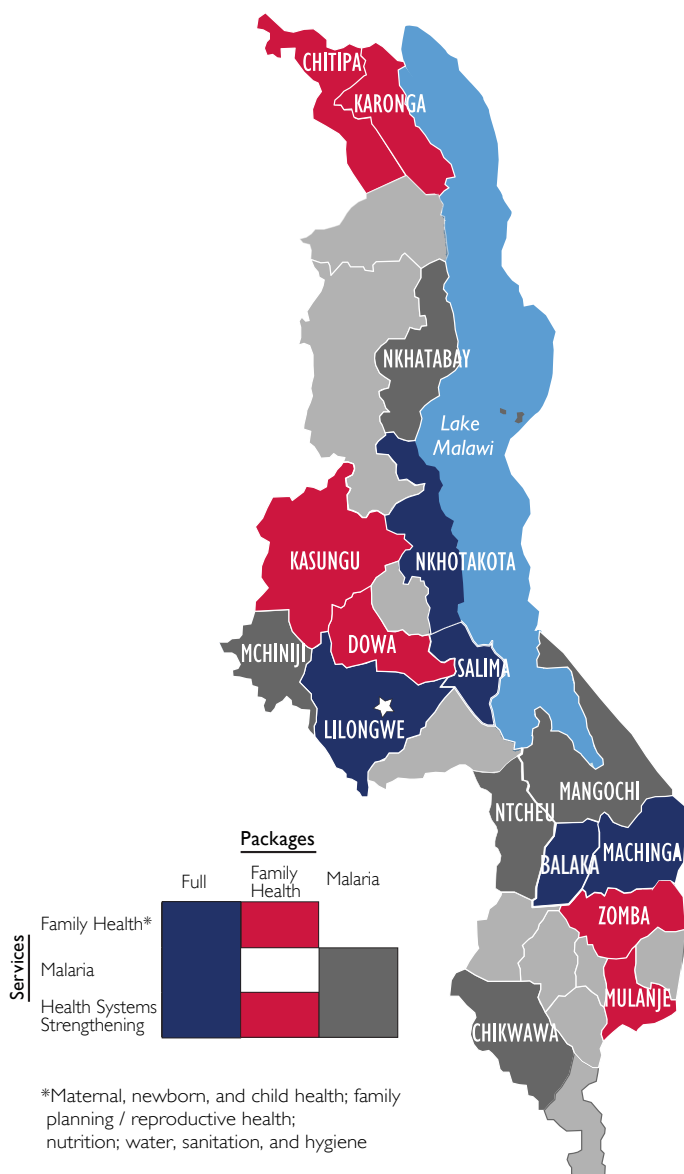


Figure 1. ONSE District Package Map

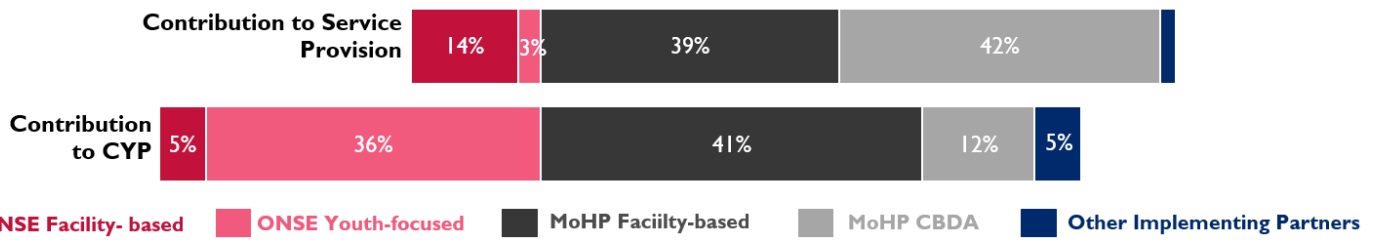


Figure 2. Services and CYP by Service Provider

ONSE sought to better understand the factors that influenced the observed increase in CYP by looking at:

- Who provided services and the amount various service providers contributed to CYP
- Where services were provided since ONSE, the MOH, and other partners provide different services in facilities than in communities
- What FP methods were provided and to which age groups
- How FP data are captured in the national HMIS

Who Provides Contraceptive Services?

The MOH provides direct FP services to the majority of clients. The MOH provides 81% of all contraceptive services at the assessed facilities and surrounding catchment areas. By comparison, ONSE provides 17% of FP services via mobile youth outreach clinics that go into the community or facility-based services. When considering the role of other implementing partners, ONSE provides only a small proportion of services (2%).

However, ONSE contributes a larger proportion of the CYP for the same contraceptive services provided. To calculate CYP, service provided are multiplied by unique factors for each method. Longer-term and permanent methods have larger factors than short-term methods. When looking at the same services provided and applying CYP conversion factors based on the method provided, ONSE is contributing a larger share of CYP. While ONSE is only providing 17% of services, those services are translating into 41% of the CYP. The MOH is providing 81% of services and generating 53% of the CYP. Put another way, ONSE contributes 1.87 CYP per person served as compared to the MOH's 0.511 CYP per person served.

Where Are Contraceptive Services Provided?

The results of the CYP assessment allow ONSE to better understand where FP services are being provided, who provides them, and the relationship between the facility and community levels and MOH and non-MOH inputs.

Among the services provided in the catchment areas of the facilities surveyed, more than half are at the community level. The MOH provides 42% of community FP services, and ONSE provides 14% through mobile youth outreach clinics. Facility-level FP services are largely provided by the MOH (39%), with a smaller share provided by ONSE (3%).

Notably, more services were provided at the community level, but the estimated CYP of these services was less than those provided at the surveyed health facilities.

What Contraceptive Services Are Provided?

Aggregate data on method mix (figure 4) for the facilities surveyed as seen in the national HMIS shows a split of 27% of CYP from short-term methods (6,984 clients); 41% from long-acting methods (10,727); and 32% from permanent methods (8,528 clients). However, breaking out the data by location and service provider shows a more detailed picture.

When looking at facility-level services and CYP, ONSE and the MOH are providing mostly short-term methods to clients. For clients receiving services from the MOH, the FP method composition was 88% short-term methods, 10% LARC provision, and 3% permanent methods. Clients seeking voluntary FP services from ONSE are still largely electing to use short-term methods—78% of ONSE-provided clients

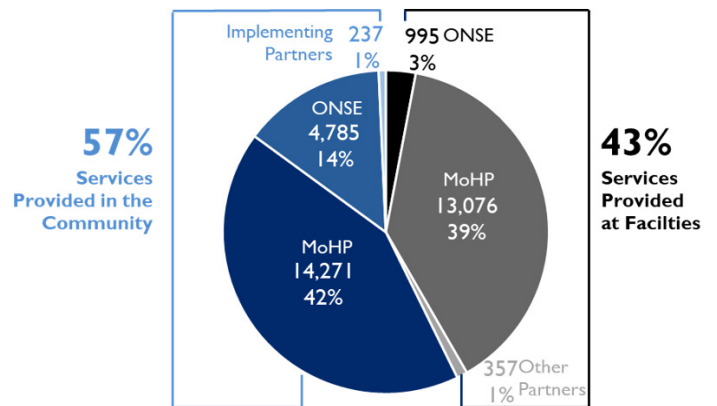


Figure 3. Contraceptive Service Provider by Location

choose a short-term method, but ONSE provided 15% of clients with LARCs and 7% with permanent methods. The larger number of ONSE clients voluntarily selecting and receiving LARCs and permanent methods translates into a larger contribution toward CYP from ONSE at the facility level.

A different picture appears when looking at community-level services and CYP (figure 5). During outreach, ONSE provides fewer short-term methods (58%) and more LARCs (34%). This indicates that significantly more clients at the community level opt for LARC methods than at facilities. The MOH provides almost exclusively short-term methods at the community level, which is likely due to the MOH's distribution of short-term methods via CBDAs and HSAs. As such, ONSE is essentially the only provider of LARCs and permanent methods at the community level.

For ONSE, the combination of slightly more LARC and permanent method provision at the facility level and the significantly higher number of clients opting for LARCs at the community level has major implications for the population protection, or CYP, offered by the two providers. While the MOH provides more services, ONSE provides more population-based protection.

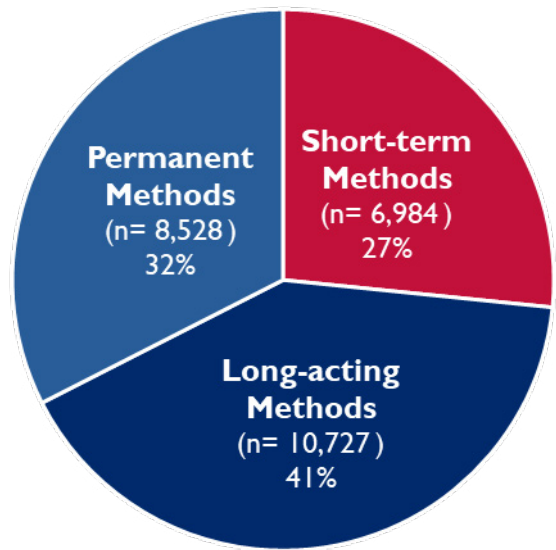


Figure 4. CYP distribution by method type

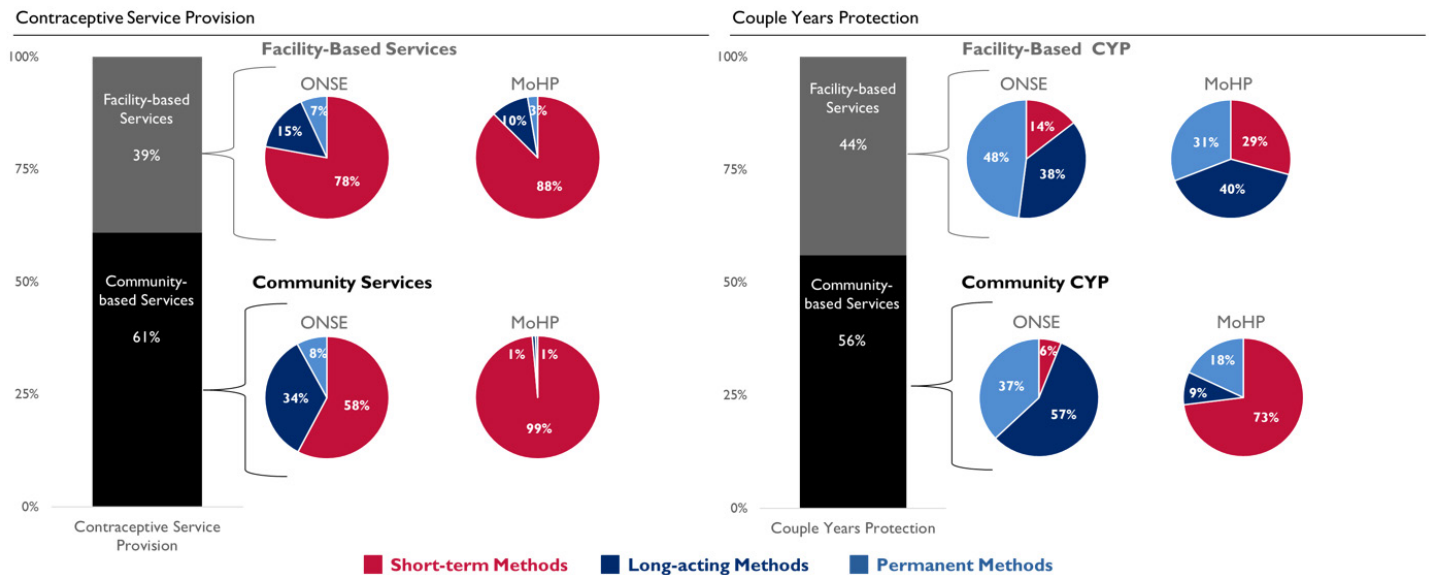


Figure 5. Facility and Community Services and CYP

How Data Are Captured in the HMIS

Per MOH guidelines, there should be two FP registers per facility. One stays at the facility for services provided on site (known as the static register), and the other is used for outreach activities that are routed through that facility and involve health facility staff. During the CYP rapid assessment, ONSE found that only 16 facilities (52%) followed these guidelines. Some facilities were using a single register and others weren't capturing community-level data in a routine way. A comparison of the assessment and the national HMIS also found that FP data were underreported in the national HMIS, which failed to capture 5,508 CYP.

Key Takeaways

The results of the ONSE CYP assessment provide important insight into the sustainability of FP service delivery in Malawi.

While the MOH provides most FP services, ONSE delivers the lion's share of CYP. ONSE is filling a gap by focusing on LARC and permanent method service provision at facilities and in communities. In this way, ONSE is providing substantial protection from pregnancy in a country with a high unmet need for FP. However, sustainability issues, despite smart capacity building efforts, remain a concern.

About half of FP services are provided in the community rather than at health facilities, and ONSE provides almost all LARC and permanent methods at the community level.

Accessing FP services of all kinds at the community level is desirable for clients, and ONSE recognized this demand and responded with increased access to these services. Even during periods of fiscal austerity, ONSE prioritized community-level FP services because they are high impact. However, community-level activities, especially support to MOH outreach (IFHOCs), are resource intensive and particularly vulnerable post-ONSE.

ONSE is providing slightly more services (and CYP) to clients younger than 20 than the MOH, but gaps in reaching and/or creating FP demand still remain. ONSE has prioritized reaching youth through its FP programming, such as mobile youth outreach clinics, but this is a difficult area to demonstrate achievements. ONSE has implemented innovative strategies and approaches, focusing on

counseling and reaching youth where they are—in and out of school, in colleges, and in communities. ONSE has made gains in this area, especially through mobile youth outreach clinics, but there is more room to grow. This is an important area for the MOH and other implementing partners to explore for continued learning and improvement.

Not all family planning data were entered in the national HMIS, and there were 11,178 fewer FP services (5,508 CYP) in the national HMIS than in the registers. This indicates that the MOH does not have all of the data it needs to make important decisions about what FP services to provide and where. ONSE saw a clear need to strengthen various bottlenecks in the data flow process and prioritized FP HMIS data quality improvements.

Additional information can be obtained from:

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