

# Mobile Outreach Services – Addressing inequities in access to family planning services and commodities

August 30, 2016

## Eva Ros, Facilitator

Eva Ros is the Country Support Director at Family Planning 2020. She leads outreach and support to the 69 FP2020 focus countries. She is an international public health professional with 17 years of experience in family planning/reproductive health and HIV/AIDS programs in more than 25 countries. Recently, Eva was the director for global partnerships for the USAID-funded Leadership, Management and Governance (LMG) Project at Management Sciences for Health (MSH).



- Welcome and Introduction
- Presentations
- Q & A
- Closing

HIP

FAMILY  
PLANNING  
HIGH IMPACT  
PRACTICES

## Mobile Outreach Services:

Expanding access to a full range of modern contraceptives

### Mobile Outreach Services

Service Delivery HIP

#### What is the proven high-impact practice in family planning service delivery?

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods.

HIP

FAMILY  
PLANNING  
HIGH IMPACT  
PRACTICES

## Servicios móviles de alcance comunitario:

Expansión del acceso a una amplia gama de anticonceptivos modernos

### Servicios móviles de alcance comunitario

PAI en la prestación de s

HIP

FAMILY  
PLANNING  
HIGH IMPACT  
PRACTICES

## Servicios móviles de proximité :

étendre l'accès à une gamme complète de contraceptifs modernes

### Servicios móviles de proximité

PHI - Prestation de services

Pratique éprouvée

#### Quel est la pratique à haut impact prouvée dans la prestation de services de planification familiale ?

Soutenir la prestation de services mobiles de proximité pour fournir une gamme élargie de contraceptifs, comprenant des contraceptifs réversibles à longue durée et des méthodes permanentes.



#### Contexte

Les services mobiles de proximité permettent de corriger les disparités d'accès aux services et aux produits de planification familiale afin d'aider les femmes et les hommes à satisfaire leurs besoins de santé reproductive. Les modèles de proximité permettent un déploiement stratégique et flexible des ressources (prestataires de soins de santé, produits de planification familiale, fournitures, équipement, véhicules et infrastructures) dans des zones où les besoins sont élevés et à des intervalles qui répondent le plus efficacement possible à la demande.

Des données probantes montrent que les services mobiles de proximité peuvent contribuer à augmenter l'usage de la contraception dans des régions où la prévalence de la contraception est faible, où les besoins non satisfaits de planification familiale sont élevés et où des barrières géographiques, économiques et sociales limitent le recours aux services. Si les services mobiles de proximité sont bien conçus, ils aident les programmes à élargir l'offre de méthodes contraceptives proposées aux clients, en augmentant notamment l'accès aux méthodes réversibles à longue durée d'action (c'est-à-dire désignées par l'acronyme anglais « LARCs ») et aux méthodes permanentes (c'est-à-dire désignées par l'acronyme anglais « PM »). Ces deux catégories de méthodes ne sont généralement pas disponibles dans la plupart des zones rurales ou difficiles d'accès en raison du manque de prestataires compétents, de produits ou d'équipement. La fourniture de services mobiles de proximité permet de surmonter ces barrières en amenant des informations, des services, des contraceptifs et d'autres produits là où les femmes et les hommes travaillent, le plus souvent gratuitement ou à des prix subventionnés. Les programmes mobiles de proximité peuvent également favoriser une trace durable qui renforce les options de santé existantes et le modèle inclut le développement et le renforcement des connaissances des agents de santé locaux et de leurs compétences à fournir une large gamme de méthodes.

Différents modèles de services mobiles de proximité ont été mis en œuvre avec succès à grande échelle. Trois critères sont pris en compte pour distinguer entre les différents modèles : par qui sont fournis les services ? Où les services sont-ils fournis ? Quel type de dispositif régit les relations et les responsabilités partagées entre le secteur public d'un côté, et le secteur privé et les ONG, de l'autre ? Les services mobiles de proximité sont mis en œuvre par, ou en

# Mobile Outreach Services: Expanding access to a full range of modern contraceptives

## What is the proven high-impact practice?

Support mobile outreach service delivery to provide a wide range of contraceptives, including long-acting reversible contraceptives and permanent methods

# Four Cross-cutting Initiatives



**DRIVING COUNTRY-LEVEL SUPPORT**



**PROMOTING DATA USE & PERFORMANCE MANAGEMENT**



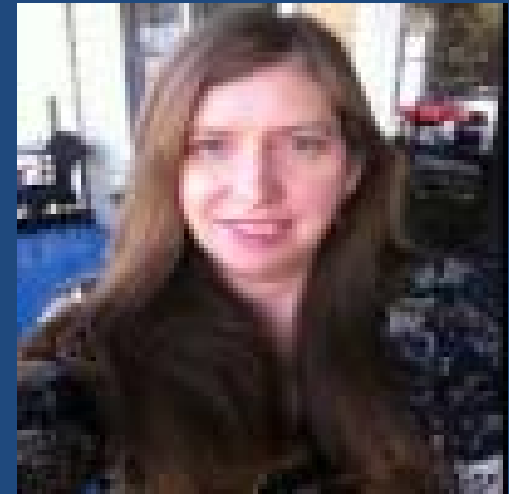
**SHARPENING THE FOCUS ON GLOBAL ADVOCACY, RIGHTS & YOUTH**



**FACILITATING DISSEMINATION OF KNOWLEDGE & EVIDENCE**

### Marguerite Farrell, Presenter

Marguerite Farrell is a Health Officer and the Private Sector Team Leader in the Service Delivery Improvement Division, in USAID's Global Health Bureau, Office of Population and Reproductive Health. She is the Chair of the Family Planning Graduation Working Group. Ms. Farrell has worked in health for 34 years and in international health for twenty six years. She has worked for Project Hope in child survival and village banking, for Development Associates as an evaluation expert and country manager for reproductive health on the Family Health Training Project.





**USAID**  
FROM THE AMERICAN PEOPLE

# HIPs Webinar Overview Mobile Outreach

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Marguerite Farrell  
Private Sector Team Leader,  
Office of Population and  
Reproductive Health, Bureau for  
Global Health  
USAID

MOE-2013



# MOBILE CLINICAL OUTREACH

- Provides all FP (or other) services aims to fill gaps in method choice
  - Extends **LARC and PM** services out to underserved and remote areas
  - Promotes equity in access
  - Low level public clinics where lack of trained clinical providers who do procedures
  - Community areas (e.g. schools, outdoor common space, tents)
- **High volume, high quality services**
- Government or NGO-led
- Can include OJT skills transfer to clinic staff
- Team size + composition can vary (see HIP brief [https:// www.fphighimpactpractices.org/resources](https://www.fphighimpactpractices.org/resources))
- Generally free of charge to clients
- Requires community mobilization , outreach and planning





# MODELS /COMPONENTS



Group counseling, mobile outreach



Interpersonal communication, community mobilization



Dedicated LARC providers, immunization days



Government led mobile outreach

# MOBILE CLINICAL OUTREACH SERVICES



Rural Tanzania, Marie Stopes:  
1 Doctor, 2 nurses for LARCs  
and PMs, Driver helps with  
social mobilization and record-  
keeping, client engagement,  
infection control



And in peri-urban areas:  
1 Nurse in a “bajaj,”  
counseling and  
providing short-acting  
methods



# ZAMBIA: DEDICATED LARC PROVIDERS IN MOH CLINICS



- PSI midwives served in high volume public maternity clinics 1-5 days per week
- Supplement work of regular MOH staff that provide short acting methods
- Increase times that IUDs, implants offered, improve availability of materials, provide information
- Build existing MOH staff competency and confidence

From 2009 – 2011 provided nearly 126,000 voluntary LARCs (4 provinces, 18 midwives)

8/26/2016

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# Mobile Outreach Costs, Value for Money and Sustainability

- Strategic and flexible use of human, equipment and commodity resources
- Low cost (one NGO averages \$100,000 per team for full model. Less for ambulatory nurses and midwives who provide IUDs and implants.) Constantly improving efficiency through data analysis and quality improvement processes.
- Can be 1.45 times more effective than static services
- High volume (Cost per CYP less than static services)
- Strengthen health systems by building existing MOH staff clinical competency and confidence, counselling skills, as well as management of adverse events (as well as local NGO staff skills)
- Delivers and maintains skills more efficiently (Bakamjian 2008)
- Lower complication rates due to high level of expertise from high volume of procedures
- Stimulate demand for LARCs and PMs through increased provision of information and accessibility of quality services
- Can be contracted by MOH to expand access and equity
- Convenient for those who have limited access and cannot afford transportation costs, opportunity costs to seek far way services
- Address cost barriers to services, (user fees) through subsidization and free services

# Mobile Outreach Costs, Value for Money and Sustainability

- Addresses inequities and enfranchises underserved
- Improves quality through broadening method mix (Bruce)
- Increases use of contraceptives (Mulligan 2010)
- Has greater potential to affect maternal mortality and child mortality due to remote populations with inaccessibility of infrastructure, trained personnel, by preventing unintended pregnancies
- In 2012 42% of clients at one NGO lived on less than \$1.25 per day  
41% were new to FP in SSA 57% in S. Asia and Middle East, 59% in SSA switched from short-acting methods , In S.A./M.E. 48%
- Helps address the shortage of health care personnel that is rampant in many countries
- Creates PPP coordination, planning, data sharing with NGOs and public sector as well as convincing public sector of latent and stimulated demand for services
- Important model for conflict and post-conflict services when public sector not functioning

## Tom Ellum, Presenter

Tom Ellum, as the Outreach Channel Director at Marie Stopes International, oversees the strategy and standards for outreach teams serving rural locations and urban slums in 26 countries. He serves on the board of MSI's Nigeria and Tanzania programs. Previously he worked for MSI as Country Director in Papua New Guinea and Director of Operations and Programs in Sierra Leone – both of which have large, challenging but high-performing outreach operations. Tom has worked in business intelligence in online travel, mobile technology, cloud computing and venture capital in Europe, Middle East, Asia and North America.



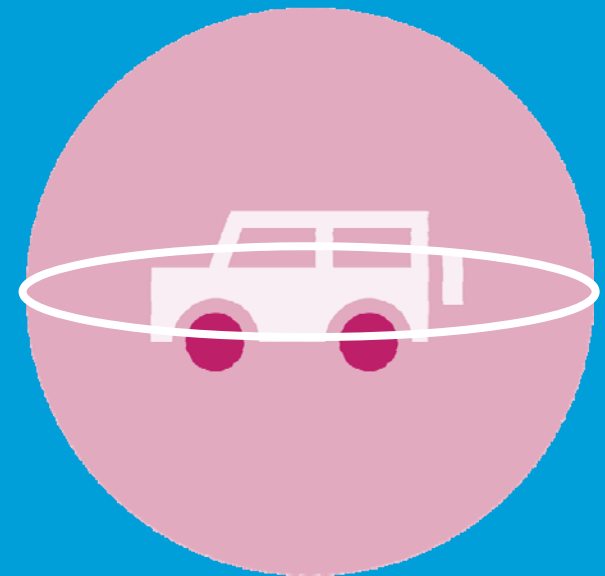




# HIPs Webinar

## Outreach Excellence

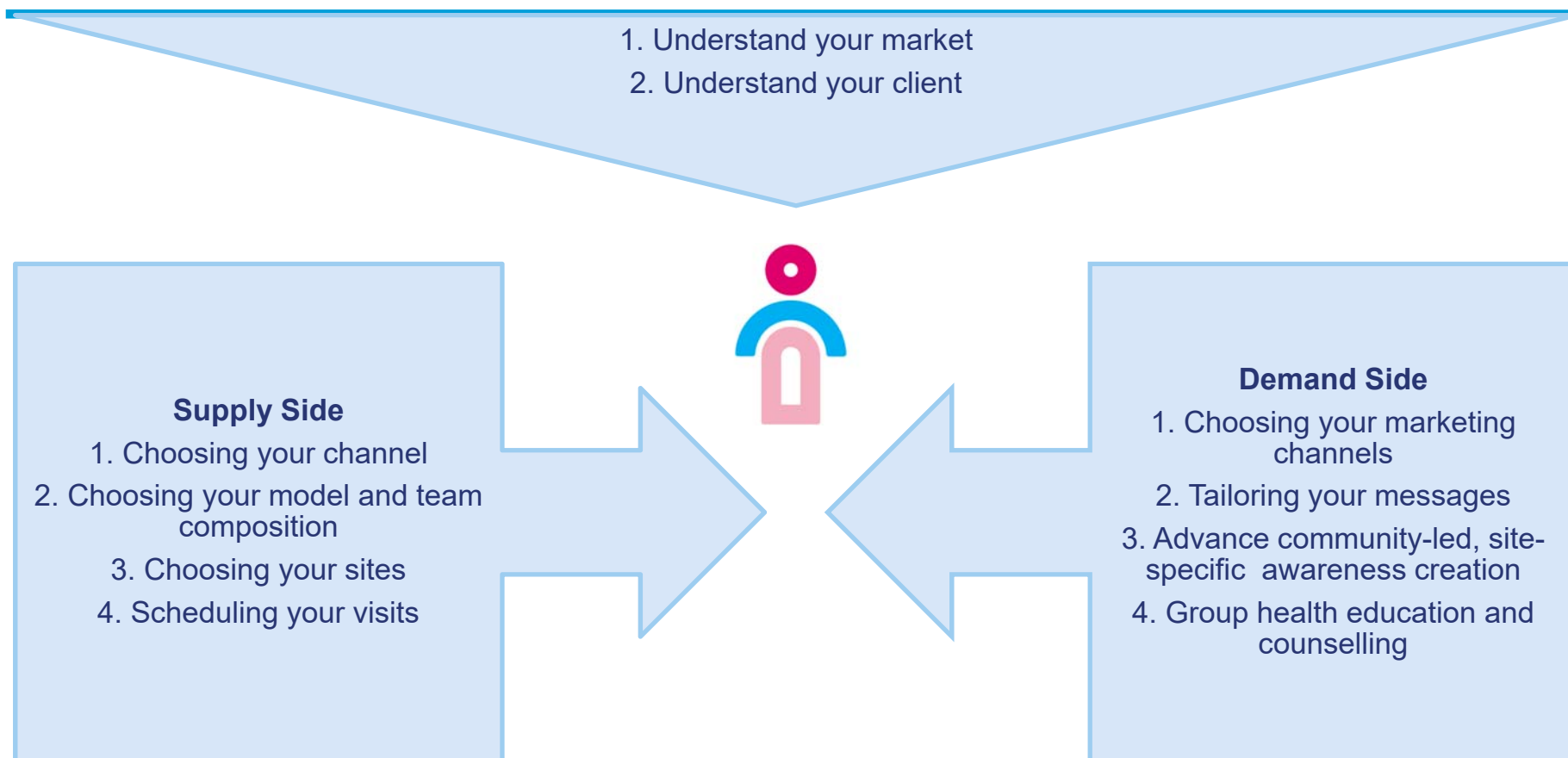
Tom Ellum  
Outreach Channel Director  
Marie Stopes International  
August 2016



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**‘Our outreach channel is intended to expand access and choice to high impact clients, especially in difficult to reach areas. Our objective is to remain a model of best-practice for donors and governments via high quality, cost-effective and measurable service provision. We invest in client information and other systems to optimise cost, better understand our clients and increase accountability.’**

# Outreach Excellence



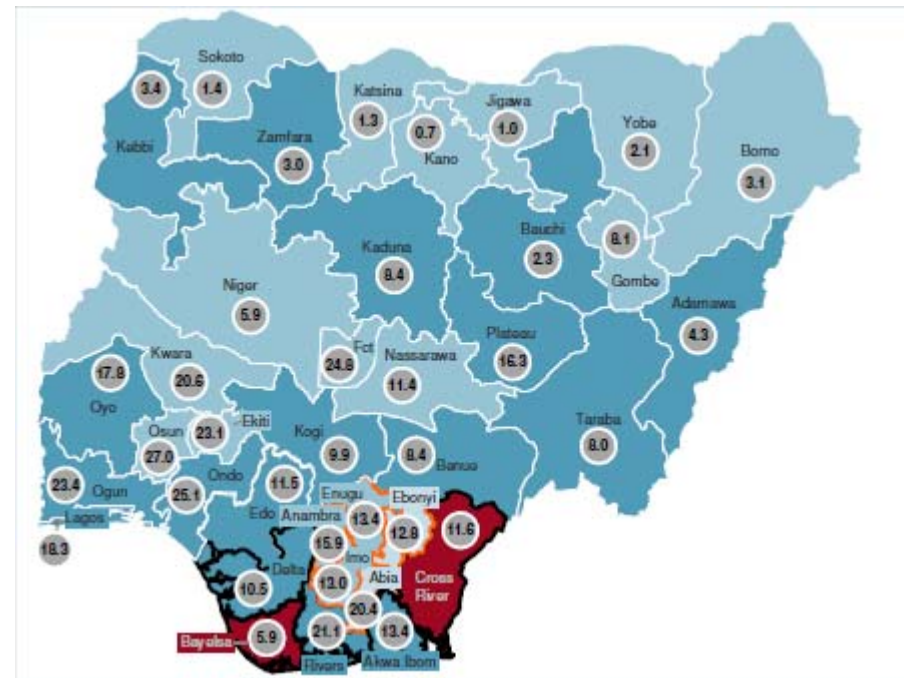
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# Outreach Excellence

**Understanding your market  
and your client**

# Understand your market

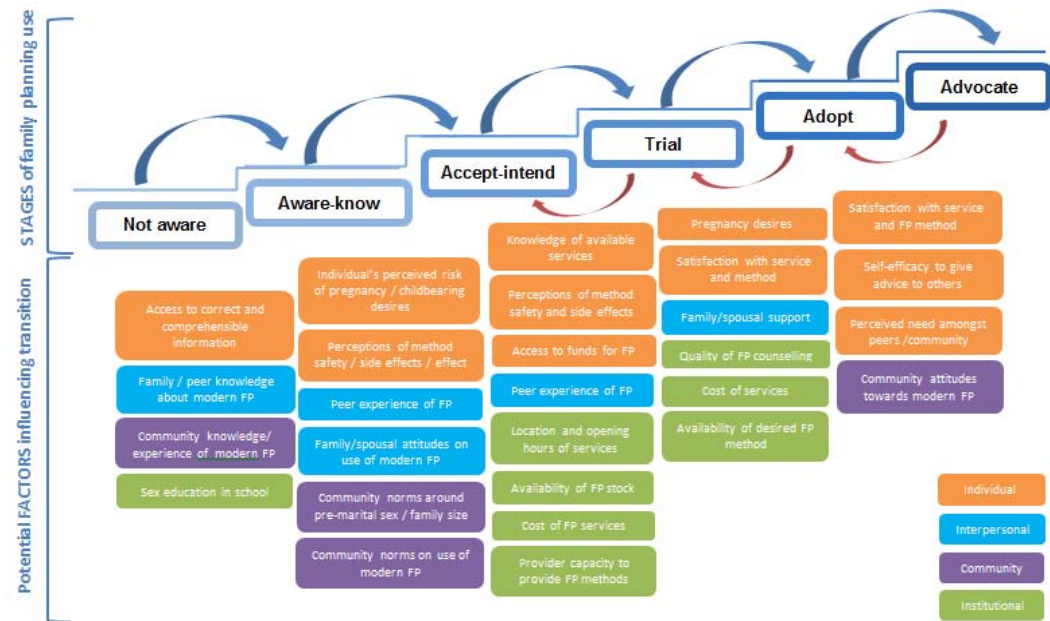
- Market analysis looks at the health context, other providers and the policy environment. In doing so, we understand:
  - where the need is greatest
  - what are the gaps in service provision
  - which groups or communities are underserved
  - who already operates and what services they provide



SOURCE: Bill and Melinda Gates Foundation, *Nigeria Family Planning Landscape*, 10 July 2013; Nigeria Multiple Indicator Cluster Survey 2011

# Understand your client

MSI uses its Behaviour Change Framework to understand how an individual or population can progress towards voluntary family planning use. It outlines different stages, from no awareness or knowledge of family planning, to accepting and intending to use, to trying a method and continuing its use, then finally becoming an advocate of family planning to others. The model also outlines the factors which can influence a person or community's progression from one stage to another.





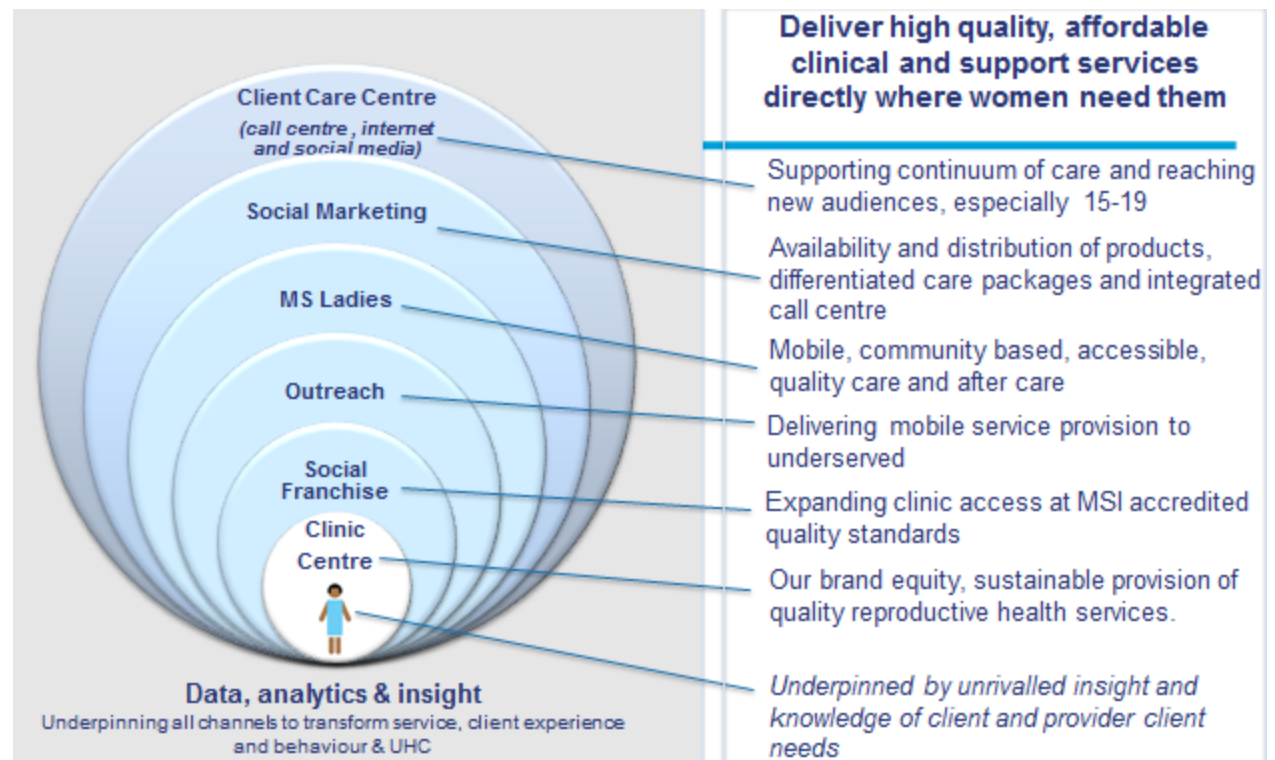
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# Outreach Excellence

## Supply side

# Choosing your channel

- Channels have different comparative advantages to reach different areas and populations
- Urban clients with higher income may prefer the convenience of a nearby clinic
- Young men wanting condoms may prefer to pay for them at a pharmacy
- In general, at MSI, outreach focuses on high impact clients (poor, adopters, youth or no alternative access) in rural areas



# Choosing your model



## MSI Classic Outreach Model

- team of three or four staff (a driver and two to three nurses or midwives)
- providing voluntary FP, including LARCs and PMs out of public facilities in remote, rural areas. Use tents when public facilities are unavailable or derelict
- spending anywhere from one to 21 days in the field, moving from site to site and only returning to base to re-supply and report
- travel with equipment and supplies, so usually use large 4x4 vehicles
- Where task sharing does not allow lower cadres to provide voluntary PMs, a doctor is included in the team where unmet need for PMs is high.

# Choosing your model

## MSI Light Outreach Model

- led by one or two nurses, midwives, or paramedics
- less equipment than classic models, so use public transport or smaller vehicles such as motor bikes or three-wheelers
- may involve team members being nested in facilities with high demand
- mainly deliver voluntary LARCs. As lighter model teams do not have surgical capacity, they refer clients to outreach site, MSI centres or other outreach teams for voluntary short term and PMs
- can be used to serve urban areas where unmet need for LARCs is high and unmet need for PMs is low or erratic.





# Choosing your model

## **MSI Dedicated Provider / Public Sector Strengthening**

- works closely with individual providers at specific facilities under a MoU, MoA or contract
- MSI trainers provide training on infection prevention, FP counselling, short-term, long-acting and permanent methods
- experienced MSI service providers conduct regular supportive supervision
- uses clinical quality assessment, incident management and commodity quality assurance to improve quality
- uses MSI transferrable expertise in service delivery
- often MSI also supports awareness creation and supply chain management as well as conducts advocacy



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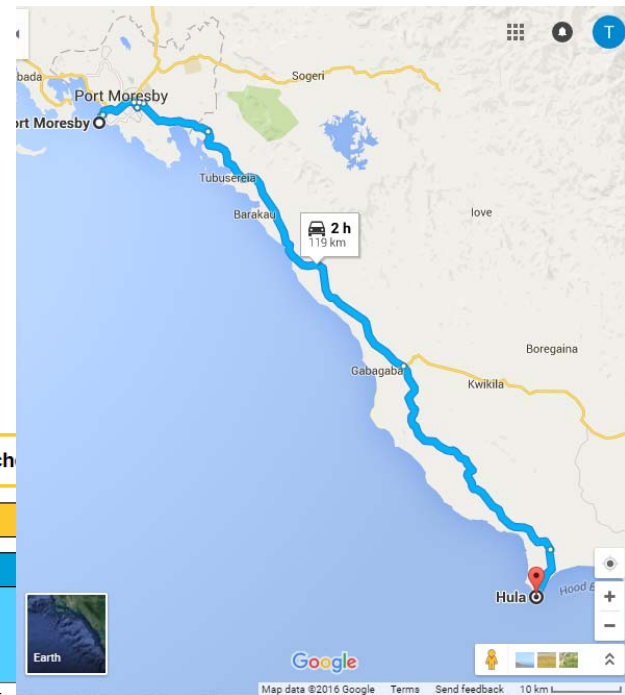
## Choose your sites

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1. **Coordinate with the government and other partners.** If possible, site identification should be done in collaboration with other partners and MSI channels to avoid duplication.
  2. **Choose relevant site selection criteria**, such as: % women of reproductive age (WRA), % unmet need, CPR, maternal mortality ratio, TFR, local service providers, limited method choice, poor transport links etc.
  3. **Identify sites with adequate infrastructure** to allow clinical services to be provided safely, and at high quality.
  4. **Prioritise site locations** with existing health facilities in operation. This will not only reinforce, in the minds of community members, that these facilities are places to seek health services but will also reduce operational costs and set-up time for outreach days.
  5. **Regularly review site selection to** determine whether site visits are still appropriate. Site-level analysis can help understand the reasons for low voluntary uptake.



# Schedule your visits

- Schedule sites based on method mix and level of client demand: if providing STMs, repeat visits every 2-3 months.
- Use route planning between sites to minimise travel time and maximise time spent serving clients
- Consider staying overnight in communities where demand is high, or where the next day's site is nearby
- Arrive on time to minimise waiting times for clients



Please complete the schedule									
Month		August							
Date	Site	Arrival Time	Activity						
26	Hula	09:30	Multiday Outreach - Travel Out	10.00	4	Edna Smith	Phil Jones	Helen Baker	Gareth Bale
27	Hula		Multiday Outreach	30.00	4	Edna Smith	Phil Jones	Helen Baker	Gareth Bale
28	Hula		Multiday Outreach - Travel Back	0.00	4	Edna Smith	Phil Jones	Helen Baker	Gareth Bale
29	Gabagaba	08:00	Day Outreach	20.00	4	Edna Smith	Phil Jones	Helen Baker	Gareth Bale
30	Turama	08:00	Day Outreach	20.00	4	Edna Smith	Phil Jones	Helen Baker	Gareth Bale
-									
Scheduled Outreach Days		15			Approved by		Tom Ellum		
Expected Client Numbers		300			Signature		T. Ellum		

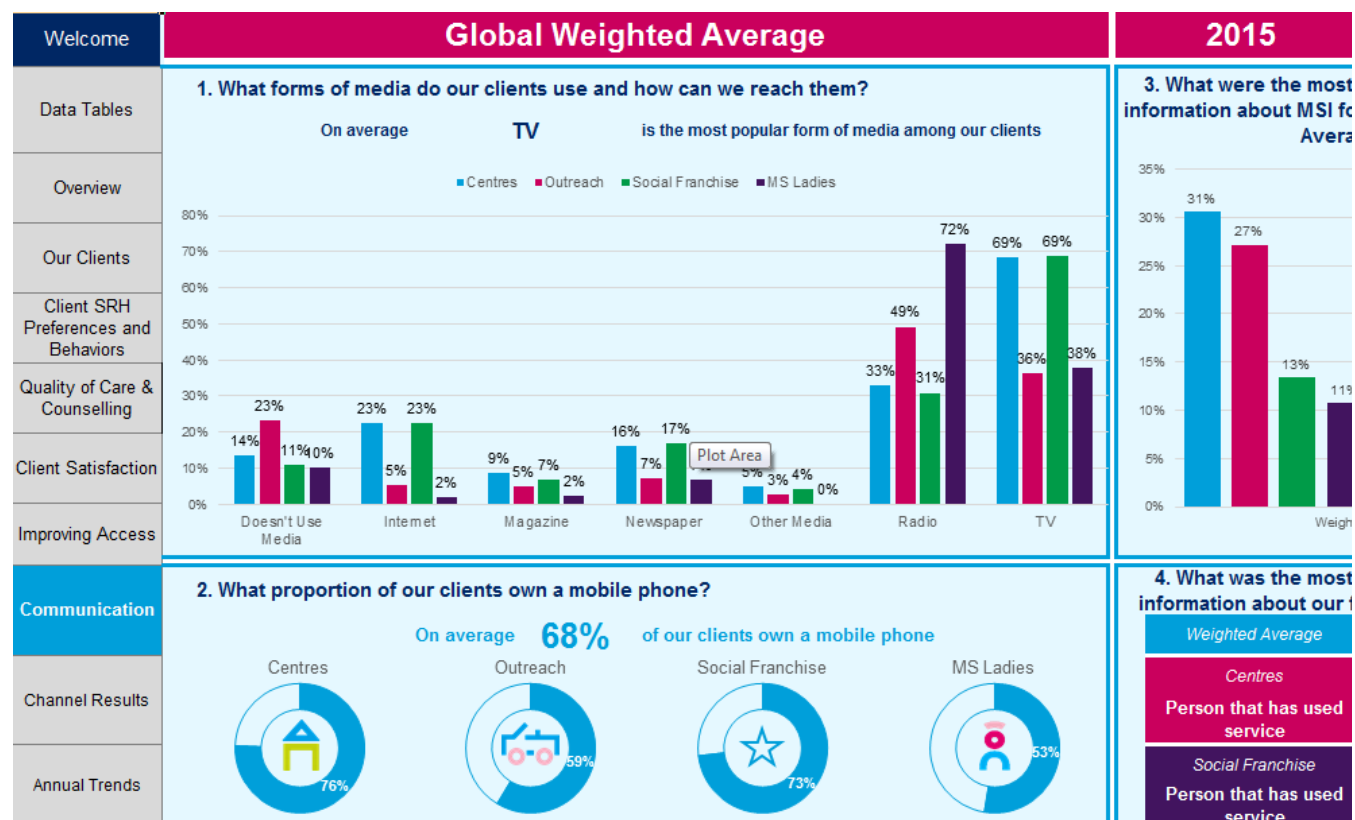
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# Outreach Excellence

## Demand side

# Choose your communication channel

- Our annual Client Exit Interviews, Client Information System and other external sources tell us about the media our clients consume, their mobile phone ownership and usage and how they most commonly hear about our services.
- Based on these insights, we can select the communication channels most likely to reach clients.



# Information, Education & Communication: Tailor your messages

- Messages should be tailored to resonate with particular individuals or populations, based on their stage of family planning behaviour.
- For example, testimonials from satisfied users and information on the benefits of spacing may resonate with women who are aware of family planning but don't yet intend to use it.
- For those who are intending to use family planning, messages about where they can access free services would be more suitable.

	Problem to overcome	Segment profile / audience	Message	Communication channel
Unaware → aware	Low access to accurate, comprehensible FP info	Passive mother	– Facts about family planning methods – Myth busting	– TV, radio and billboards (expensive but can achieve high coverage; non targeted) – Social media (targeted, tailored messaging, high coverage)
	Not aware of benefits of child spacing	Deferential pre-children		
	Lack of family / peer knowledge about FP	Also target peers, family and spouses		
	Lack of community knowledge about FP			
Aware → intend	Negative perceptions of FP safety/side effects	Aspiring mother	– Myth busting – Testimonials of positive experiences of FP use – Info on benefits of spacing/limiting – Accurate information on side effects	– Community meetings or events (targeted, tailored messaging, limited coverage) – Community Based Mobilisers (CBMs) (can be expensive/client) – TV, radio – Social media, website
	Peers have miss-information or bad FP experience	Aspiring pre-children		
	Negative family/spousal attitudes on use of FP	Deferential pre-children		
	Community norms against pre-marital sex /small families	Also target peers, family and spouses		
	Community norms against use of modern FP			
Intend → trial	Can't access funds for FP	Aspiring mother	– Where/how to access free services – Information about location of service delivery points – Call centre number – MSI advertising	– CBM referrals – CBMs – Call centre response – Loud speakers, road shows – Posters, flyers – Website / radio / newspapers
	Doesn't know where to access services	Aspiring pre-children		
	Not aware of or negative perception of MSI	Also provide support to overcome practical barriers		
	Peers lack knowledge of where to access FP			
Trial → adopt	Dissatisfaction with service and method	Informed matriarch	– High quality counselling	– Providers
	Lack of family/spousal support	Aspiring pre-children Also target family/spouse	– Myth busting – Information about a side effects	– SMS/ call centre follow-up – CBMs
Adopt → advocate	Lack of confidence in giving advice to others	Informed matriarch	– Positive experience of advocates	– Client support and training
	Lack of perceived need amongst peer/community		– Myth busting – Positive experience of FP	– Live/video testimonials at community meetings – Testimonials on website, TV, radio, blog, social media, newspaper
	Negative community attitude towards modern FP			

## Advance community-led, site-specific awareness generation

- Advance awareness creation increases the likelihood that all potential clients at the site will know about an upcoming outreach visit.
- By generating awareness in advance, clients have time to consider their options and/or discuss their family planning options with partners.
- A typical awareness creation plan may include:
  - Announcing the date of the visit one month in advance, via promotional leaflets, posters and town criers
  - Engaging community-volunteers to promote the visit
  - Making an announcement at places of worship
  - Re-engaging satisfied clients to bring friends and family





## Group health education and counselling

- Once on site, teams reinforce awareness creation with group health education, often using songs, games and group discussions to engage clients
- Group health education covers all methods, dual protection and other common reproductive issues experienced in the community
- Once complete, individual, private counselling is provided to clients on all methods that are appropriate for his or her fertility intentions, lifestyle preferences, and medical eligibility



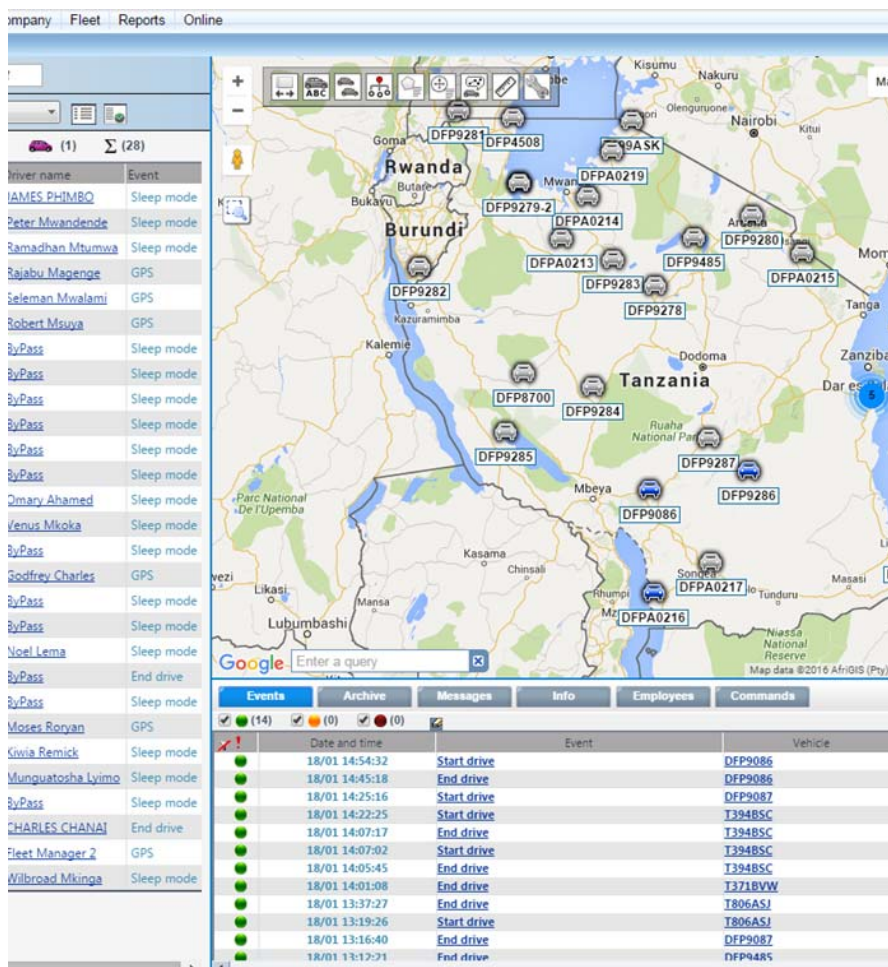


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# Outreach Excellence

## Challenges

## Monitoring of outreach teams



- Monitoring and supporting of outreach teams operating in remote, rural areas remains a challenge
- Number of service delivery days per month vary from under ten to over 20
- Average time spent at site varies from under two hours to over seven
- MSI is now investing in a vehicle tracking system, under its Global Fleet Project, to improve on-time arrival, routing between sites and monitoring
- The aim is to improve operational effectiveness of our outreach teams, improve staff welfare and safety and reduce costs

## Data validation

- Unlike our services in clinics or social franchisees, which are usually backed by a financial transaction, in outreach they are free
- The remote, low-resource contexts in which we operate mean record keeping is predominately paper-based and therefore at risk of fraud
- MSI is tackling this in two ways:
  1. Deploying computerised management information systems (MIS). For example, client details are recorded in real-time and stored in the MIS database which can be audited
  2. Introducing data validation standards, which prescribe minimum documentation-levels at the client -, daily- and monthly-levels. Furthermore, regular verification of this documentation is conducted.



### Ibrahim Muhammad Ibrahim, Presenter

Ibrahim Muhammad Ibrahim is the Executive Director of Planned Parenthood Federation of Nigeria (PPFN). He is a trained physician with a good track record of planning, coordinating and implementing large-scale public health programs at a national level in Nigeria. Ibrahim has worked on Reproductive Health, HIV and AIDS, and Maternal Child Health. He has skills in research, management, strategic leadership, advocacy, policy development and analysis. He has over seven years' experience of working at the senior management level for the Ministry of Health (State and Federal).



## PPFN's Integrated Outreach Approach

**PPFN** Planned  
Parenthood  
Federation of  
Nigeria

Dr. Ibrahim M. Ibrahim  
August 30, 2016





# Presentation Outline

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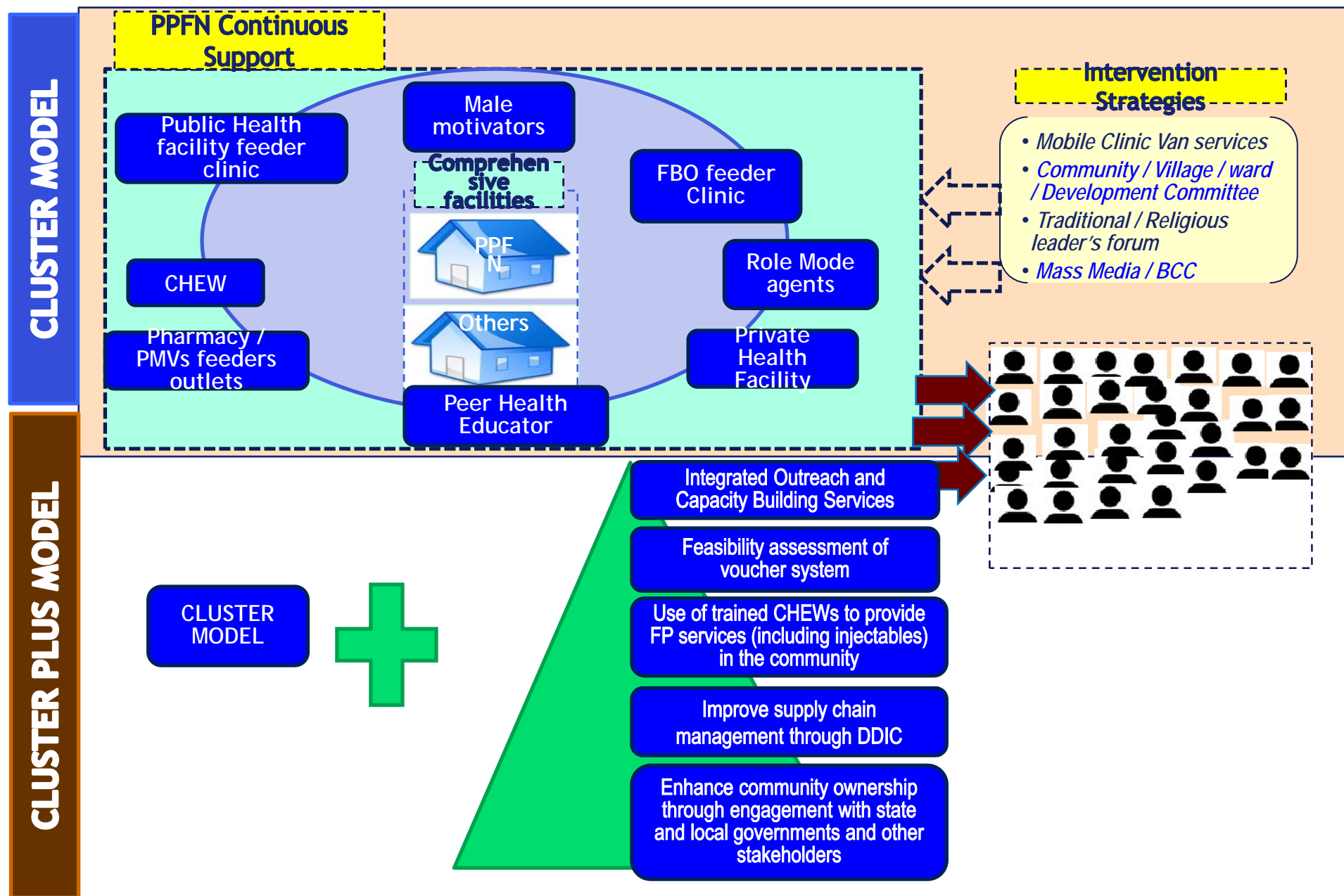
- Introduction of PPFN ClusterPlus Model
- Intervention Strategies of the ClusterPlus Model
- Brief highlights of the Integrated Outreach
- Key Drivers of the Outreach
- Key achievements

# Introduction of Cluster Plus Model

PPFN introduced the Cluster Plus model in 2014 based on the following needs:

- Increase uptake of long acting and reversible method with a focus on Vulnerable groups.
- Facilitate more effective referrals and client follow-up.
- Enhance logistics management.
- Build local leadership and buy-in.
- Increase programme sustainability

# ClusterPlus model Initiative – Diagrammatic View



# Brief highlights of Integrated Outreach

- One of the key intervention strategies under the Cluster Plus model is the integrated outreach.
- The Integrated outreaches are usually conducted for 3 consecutive days on a weekly basis.
- Outreach sites were selected using a mapping system to determine areas that are densely populated and with limited service provision coverage.
- Each outreach team consist of 2 medical doctors (Public and Private), 4 Nurse/Midwives and 2 data officers.
- Prior to any outreach, community dialogue sessions are conducted to enhance community participation and ownership. This is also used as an avenue to dispel any myths and misconceptions about Family planning common within their local context.

# Brief highlights of Integrated Outreach

- Community mobilization activities commences at least a week before each outreach by community mobilizers with adequate training on appropriate FP/SRH messages.
- Outreach preparation include site need assessments using developed outreach checklist to ensure adequate commodities and equipment; and instrument processing.
- Integrated services are provided during outreaches using the Integrated package of essential services such as family planning services, cervical cancer screening, malaria testing and treatment, HIV/STI testing, counselling and treatment, maternal and child healthcare.
- To ensure proper monitoring and follow-up, clients are referred to facilities attached to outreach sites.



# Key Drivers of Integrated Outreach

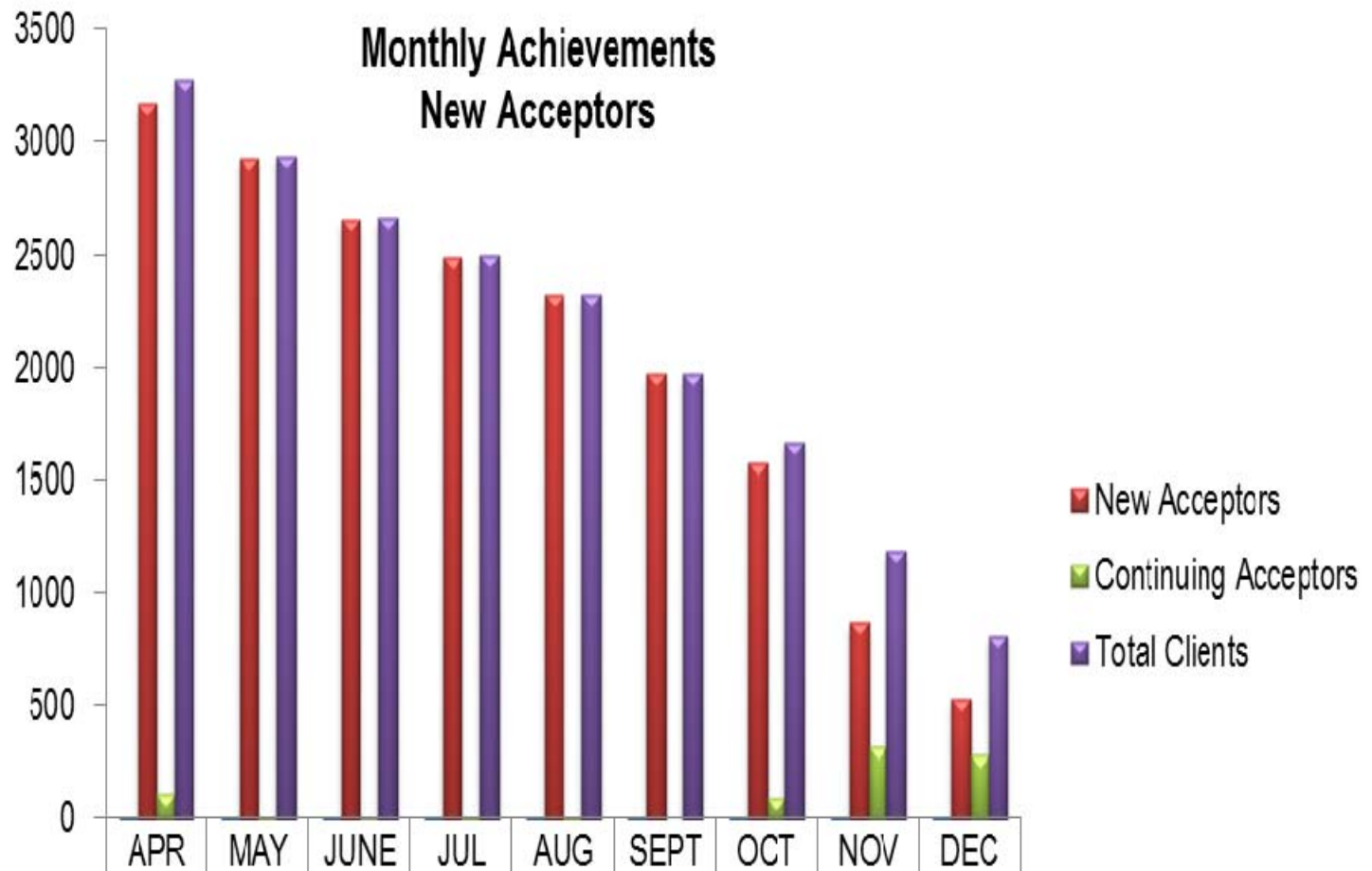
- Peer-to-Peer learning the teams went on exchange visit Uganda to understudy the surgical camp integrated outreach approach.
- Adequate medical supplies, commodities and surgical equipment.
- Community involvement and participation.
- Collaboration with community health volunteers and community mobilizers
- Training and continuous capacity building on quality of care, data management.
- Outreach teams provided with update training on integrated SRH services.
- Quality service provision is ensured by Quality of Care team (QoC).

# Key Achievements

- The integrated outreaches was first piloted in 5 LGAs in Ibadan, Oyo state.
- Baseline and end line surveys conducted during the pilot phase indicated the following:
  - i. Poor and vulnerable population reached with increased FP services.
  - ii. Increased uptake of Long acting and reversible contraceptives (74% of LARC services of the total contraceptive services provided).
- A total of 18,517 new acceptors reached within 9 months of implementation.

# Key Achievements

F1



No of Outreaches conducted	8	4	4	4	4	4	2	2	2
New Acceptors	3,172	2,928	2,657	2,489	2,320	1,974	1,574	872	531
Continuing Acceptors	111	8	11	8	3	-	92	317	285
Total Clients	3283	2936	2668	2497	2323	1974	1666	1189	816

## Slide 45

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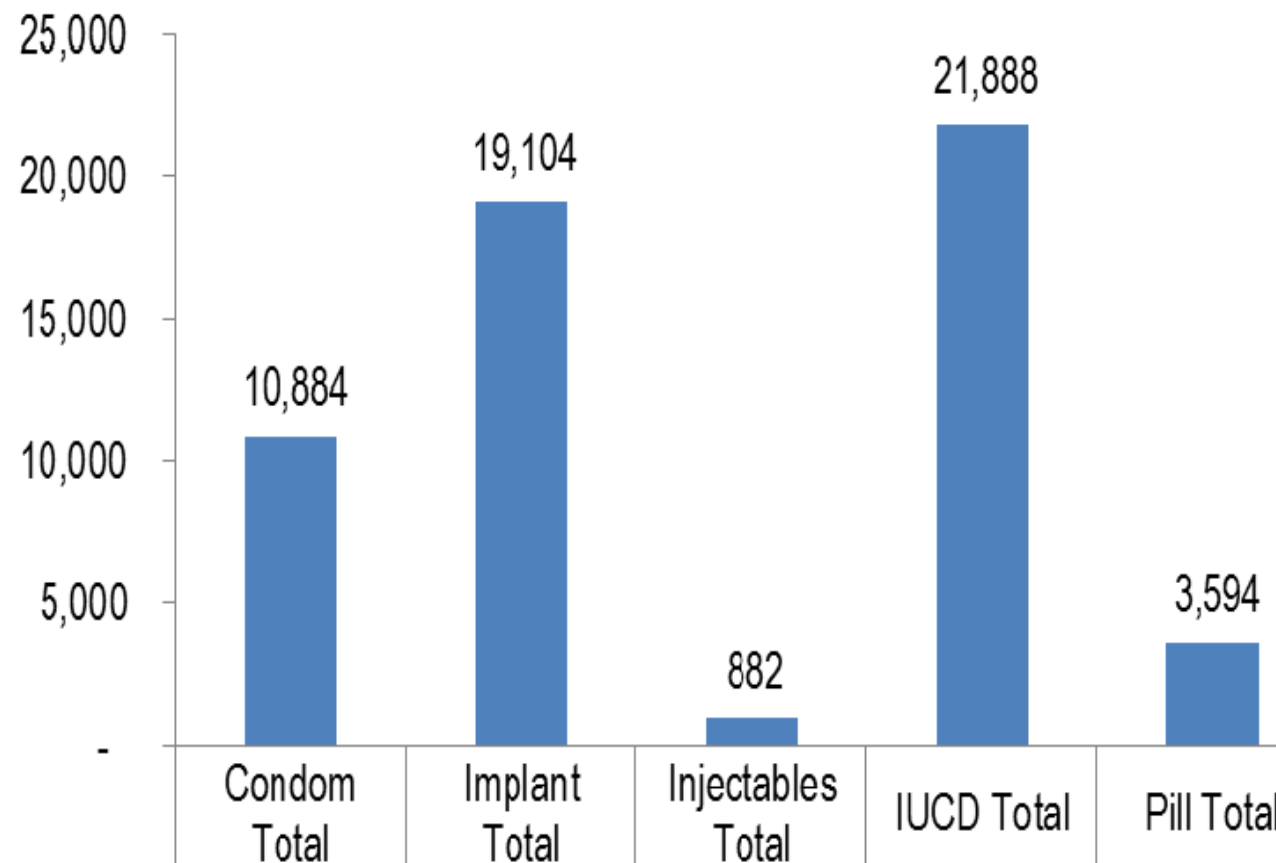
**F1**

if we want to give the pic impression we can use the av. clients per one outreach session

Francis, 8/26/2016

# Key achievements

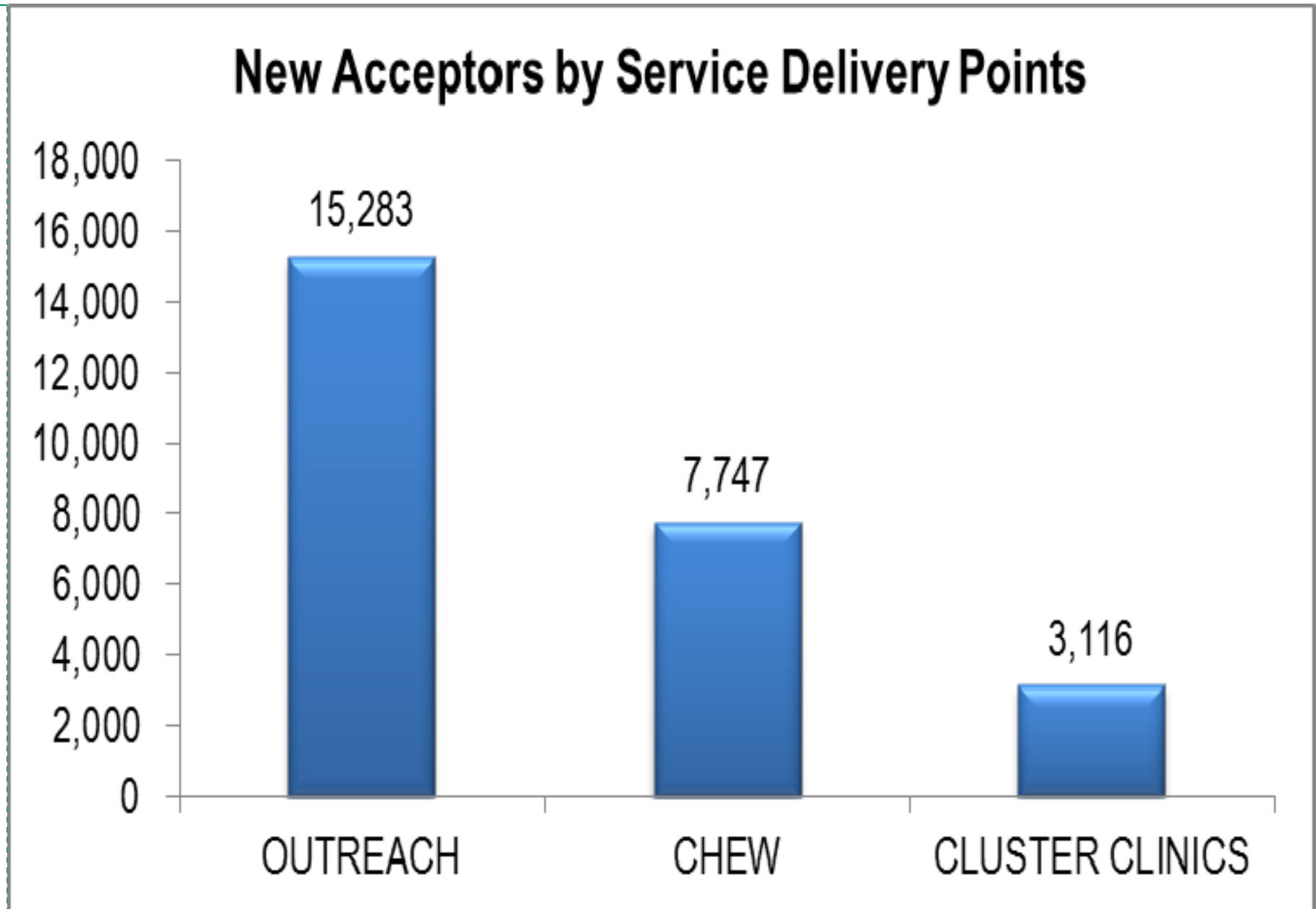
**Total contraceptive services  
by method**



Total Contraceptive Services Total	10,884	19,104	882	21,888	3,594
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# Comparison of achievements by SDPs



# Voices from the field

- *“After each outreach, there is performance review..... the whole team comes together at the end of the three days so we sit down to evaluate what we have done, what has worked, what has not worked, how can we improve on what has not worked” Nurse, and Member State Outreach Team, Ibadan*
- *“It is through community dialogue that the community leaders were sensitised on the schedules for the conduct of outreaches that will take place in those communities After the sessions the community leader pass on the information to others” Community Member*
- *“Provision of services through Outreach..... increased the client flow to our clinic, it improves available clinical services too by enabling us provide integrated services like cryotherapy , so it increases the client flow and access to services” Medical Director, Vines of a Cluster Hospital*
- *“Yes we were able to attend to so many clients that accepted to do family planning and it is now free because... PPFN partners with community by providing FP commodities materials and consumables during outreaches this afforded the clients to receive services free” IDI Participant*









*Thank You*

# Mobile Outreach Services – Addressing inequities in access to FP services and commodities

## Q & A

August 30, 2016



Recording and presentation available  
at:

[https://www.fphighimpactpractices.org/content/  
high-impact-practices-family-planning-webinars](https://www.fphighimpactpractices.org/content/high-impact-practices-family-planning-webinars)

For more information, please visit:

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[www.ibpinitiative.org](http://www.ibpinitiative.org)

[www.familyplanning2020.org](http://www.familyplanning2020.org)

THANK YOU