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# Increasing family planning access and choice

Key lessons from Marie Stopes International's clinical outreach programmes



## Executive summary

Clinical outreach – the delivery of clinical health services by a mobile team of trained providers through periodic visits to a particular site or from a mobile unit<sup>1</sup> – is an invaluable service delivery option for governments and service providers that are eager to reach underserved communities.

There are a number of different approaches to outreach for reproductive health and family planning services. Marie Stopes International's (MSI) outreach programmes typically reflect one of three main approaches: the MSI mobile clinical service delivery team approach; the MSI mobile quality improvement team approach; and the MSI mobile community outreach worker approach. By 2011, MSI had established outreach programmes in 26 countries around the world. The specific approach to outreach used by MSI differs within and between countries, depending upon the particular challenges and opportunities in that country and / or region. Despite these differences, the benefits of each outreach programme are very similar, including:

- improving access to highly qualified health professionals and/or specialist services
- delivering reproductive health and family planning services to target populations with an unmet need
- substantially increasing the use of reproductive health and family planning services
- creating a catalytic impact upon national health systems
- providing a more cost-effective option than traditional clinics in some circumstances.

To realise these benefits, outreach programmes require careful planning and implementation, often in partnership with governments. This paper identifies a number of key lessons and emerging practices drawn from MSI's outreach programmes that can be taken to make clinical outreach programmes more robust and effective. In particular:

- unmet reproductive health and family planning needs require identification. This can be achieved by using the latest Demographic and Health Survey data, health service data, site visits and input from the government's health departments
- appropriate locations for outreach services need to be identified. Clinical outreach sites can equally be located in remote rural communities with no service provider or in urban areas that have several service providers nearby



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- the geographical area covered by an outreach programme needs to be mapped to identify appropriate outreach sites and to plan the schedule of each outreach team effectively
- sustained awareness-raising activities are required to maintain the effectiveness of many outreach sites
- rigorous clinical protocols, guidelines and procedures are essential to maintain high-quality services. Awareness-raising activities are unlikely to maintain the effectiveness of a clinical outreach site that delivers poor services. Clients are unlikely to recommend sub-standard reproductive health and family planning services to their friends and family, for example.

The key lessons and emerging practices identified in this paper will evolve and strengthen as MSI and other service providers deliver more outreach programmes and pilot new innovations. In the meantime, the key lessons in this paper will help service providers, programme managers and donors implement and / or strengthen clinical outreach programmes for reproductive health and family planning services.

## Introduction

Reproductive health and family planning services are essential to good health among mothers and their children. These services save lives and empower women.<sup>2</sup> However, they are not reaching everyone around the world who needs or wants them. As a result, ambitious international goals, such as the fifth Millennium Development Goal (MDG 5) are significantly off track.<sup>1</sup>

In remote rural communities, the unmet need for reproductive health and family planning services remains especially acute because clinics or hospitals are scarce, expensive to reach and / or unable to meet the needs of all clients because of a limited number of skilled staff or the limited availability of essential health commodities.<sup>3</sup> In many developing countries, for example, the full range of modern contraception, especially long-acting and permanent methods (LAPMs) such as intrauterine devices (IUDs) or vasectomies, are often only available in urban health facilities.<sup>4</sup> However, the low failure rate of IUDs compared to other methods of contraception, for example, better enables women to avert poor health outcomes as a result of unintended or mistimed pregnancies.<sup>5</sup>

Clinical outreach – the delivery of clinical health services by a mobile team of trained providers through periodic visits to a particular site or from a mobile unit<sup>6</sup> – offers considerable potential to deliver high-quality reproductive health and family planning services to communities that are unable to access them elsewhere. Clinical outreach is used to deliver reproductive health and family planning services worldwide. It is an invaluable service delivery option for governments and service providers that are eager to deliver reproductive health and family planning services to underserved communities.

By 2011, MSI was providing reproductive health and family planning services, comprehensive information regarding all family planning methods and counselling through outreach in 26 countries around the world.<sup>ii</sup> These clinical outreach programmes collectively represent several decades of experience in outreach. This report identifies the key lessons and emerging practices that MSI has gathered and built upon during this time to help service providers, programme managers and donors implement and / or strengthen outreach programmes delivering reproductive health and family planning services.

To construct and identify these programmatic lessons and emerging practices, a desk review was conducted of reports, studies and evaluations regarding MSI's clinical outreach programmes that are held in MSI's internal grants database or have been published by MSI. The documents reviewed were restricted to those completed between 2000 and 2010. This desk review was supplemented by field visits to MSI offices in Bangladesh and Kenya to conduct semi-structured interviews and focus group discussions with key stakeholders including country directors; project, finance and clinical staff; grant managers; and programme support officers. Government ministries responsible for family planning, other private sector service providers, district health offices, local health facilities and their clients were also interviewed as part of this process. In total, 25 semi-structured interviews were conducted to elicit views on the impact of MSI's clinical outreach programmes as well as to identify promising practices and challenges associated with these programmes.



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i. MDG 5 is the internationally agreed goal to reduce by 2015 the global maternal mortality ratio by three quarters and to achieve universal access to reproductive health and family planning services.  
ii. Bangladesh, Bolivia, Burkina Faso, Cambodia, Ethiopia, Ghana, India, Kenya, Madagascar, Malawi, Mali, Myanmar, Nepal, Nigeria, Pakistan, Papua New Guinea, Philippines, Sierra Leone, Sri Lanka, Swaziland, Tanzania, Timor Leste, Uganda, Viet Nam, Zambia and Zimbabwe.

## How can clinical outreach be used by reproductive health and family planning service providers?

There are a number of approaches to clinical outreach for reproductive health and family planning services. The approach used by MSI differs within and between countries depending upon the particular challenges and opportunities in that country and / or region. However, MSI's clinical outreach programmes typically reflect one of three main approaches:

1. The MSI mobile clinical service delivery team approach, whereby MSI provides reproductive health and family planning services at government facilities, sometimes in collaboration with ministry of health personnel. This is MSI's oldest outreach service delivery model and the vast majority of MSI's clinical outreach programmes reflect this approach.
2. The MSI mobile quality improvement team approach, whereby MSI team members work with government health facilities and district health offices to improve the government's delivery of reproductive health and family planning services. The support provided under this approach includes service delivery, awareness-raising among potential clients, supplies, logistics, monitoring and training.
3. The MSI mobile community outreach worker approach, whereby MSI provides reproductive health and family planning services in the community. This approach strips clinical outreach back to its essentials, typically involving one paramedic and one counsellor travelling to communities using transport such as a public bus, motorbikes or rickshaws.

MSI's clinical outreach programmes typically work in collaboration with community health workers and ministries of health to increase access to the full range of contraceptive methods. For example, where community health workers provide short-term contraceptive methods MSI's clinical outreach programmes primarily provide LAPM methods such as IUDs, implants or voluntary sterilisation. MSI's clinical outreach programmes subsequently complement a key role played by community health workers in remote areas. MSI's clinical outreach programmes also work with existing networks of community health workers to help raise awareness of the location and dates of each outreach site (see right).

### MSI's clinical outreach programmes are all built on ten core principles:

1. The outreach programme enables the hard-to-reach, the underserved and the poorly served to make an informed, voluntary choice from a broad range of contraceptive methods, with particular focus on contraceptive methods that are not available in the public sector.
2. The outreach programme provides services to clients who may not otherwise access clinic-based services provided by MSI or other service providers.
3. The outreach programme delivers services that are available free or at a subsidised rate.
4. The resources used, such as doctors, instruments and medicines, are mobile, not static. This means they can be deployed to where they are most needed, within the limits of logistical possibility.
5. Work plans and schedules rotate and are regularly reviewed; dates are set well in advance and are predictable for the local population.
6. The outreach teams are the only service provider offering the selected services that visit the communities on a regular basis.
7. Clinical standards are rigorous and regularly audited. Individual and group counselling is always offered; informed consent is mandatory for all permanent procedures and follow-up mechanisms are put in place to help ensure continuity of care.
8. Clinical procedures are delegated to (or 'shared' with) lower-level health workers where possible to maximise productivity.
9. Community marketing and awareness-raising activities are used to dispel popular myths concerning family planning and to educate and provide information to potential clients in a target area. Services are 'de-medicalised' so they are less intimidating and clinical.
10. Partnerships with the public and private sector are used to make sure that outreach efforts contribute to a sector-wide approach, substituting government services where these are lacking, or technically assisting where government services are limited.

## Why is clinical outreach so important for reproductive health and family planning services?

### Clinical outreach improves access to highly qualified health professionals and / or specialist services.

For many of the communities they visit, clinical outreach teams are often the only regular source of reproductive health and family planning services. MSI's clinical outreach teams in Bangladesh, for example, are directed by the government to communities where no skilled doctors are available, where the government's family planning medical officer post is vacant or to communities that are considered hard-to-reach. Dr A. K. M. Mahbubar Rahman, the Line Director of Clinical Contraception Service Delivery in the Directorate General of Family Planning in Bangladesh, emphasised this: "The focus for [MSI's] roving teams is primarily to fill gaps in services created by some 400 vacant doctor posts we are dealing with in the country, out of 1,000 sanctioned posts".

### Clinical outreach delivers reproductive health and family planning services to target populations with an unmet need.

Clinical outreach teams are often the only way clients can obtain the reproductive health and family planning services they want and / or need. Recent research in Kenya, for example, highlighted that poor women are least likely to achieve their desired fertility, that modern contraceptive use is lowest among the poorest women, and that the unmet family planning need of poor women is double that of women with a high socio-economic status.<sup>7</sup> Data from Demographic and Health Surveys show that the low use of contraception by poor women is persistent and that the inequality in contraceptive use compared to wealthier populations is growing.<sup>8</sup> MSI uses standardised exit interviews to assess the profile of its outreach clients in more detail. Education can be used as a proxy for poverty; people who have little or no education typically have a low socio-economic status.<sup>9</sup> In 2010, MSI investigated the educational background of 4,273 MSI clients who had received either an intrauterine device (IUD) or an implant from an MSI outreach programme in one of five countries.<sup>10</sup> Approximately 80% of clients surveyed in Ethiopia, Pakistan and Sierra Leone had not been educated beyond primary level. A significant proportion of this group had no formal education at all.

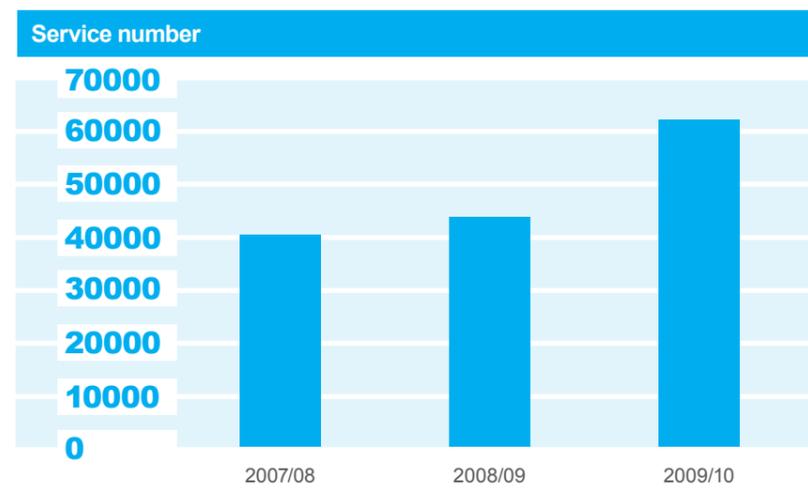
### Clinical outreach substantially increases the use of reproductive health and family planning services.

Clinical outreach programmes significantly increase the use of reproductive health and family planning services by ensuring a broad range of services for clients with an unmet need. In the Philippines, for example, MSI's clinical outreach programme increased the contraceptive choices available to clients by providing LAPM contraceptive methods. Short-term contraceptive methods were commonly available from the public sector, whereas long-acting methods were difficult to obtain because of a lack of commodities. MSI's clinical outreach programme in the Philippines was subsequently responsible for a five-fold increase in the use of IUDs between 2005 and 2007 – from 10,700 in 2005 to more than 56,000 in 2007.<sup>11</sup>

Similarly, outreach carried out by MSI in Bangladesh contributed to a 50% increase in the number of men having a vasectomy between July 2008 and June 2010 (see Figure 1). MSI helped the government to meet demand for voluntary male sterilisation because the skilled staff and commodities available to the public sector resulted in the public sector primarily providing other contraceptive methods.

Critically, by targeting clients with an unmet need, clinical outreach programmes increase the number of new family planning users. In April 2010, MSI surveyed more than 4,000 women who had received either an IUD or an implant from an MSI outreach programme across five countries.<sup>12</sup> Of these women, more than 97% had never used a long-acting contraceptive method before. More than 50% and 75% of the women surveyed in Pakistan and Sierra Leone respectively who had obtained an IUD had never used any kind of family planning method at all in the past.

**FIGURE 1:** Total number of vasectomies delivered in the 45 districts participating in MSI's outreach programme in Bangladesh\*



\*MSI's outreach programme was introduced in Bangladesh in 2008/09.

**Clinical outreach has a catalytic impact upon national health systems.**

Successful clinical outreach programmes can leave a lasting legacy that catalyses and strengthens existing public health services. For example, MSI's clinical outreach programme in the Philippines strengthened lower-level health workers' knowledge of and ability to inform clients about all family planning methods. Training provided by MSI has created a group of health workers delivering services in 10 regions in the Philippines who are capable of providing comprehensive counselling and education to clients, helping these clients to make informed choices regarding family planning.

MSI's clinical outreach programme in Kenya also delivers on-the-job training to medical and paramedical personnel in the public sector on how to safely provide male circumcision to ensure the government is less reliant on the expertise of private service providers in the future.

**Clinical outreach is more cost-effective than traditional clinics in some circumstances.**

Research suggests that mobile outreach teams can be more cost-effective than static clinics in regions of low population density.<sup>13</sup> One recent study involving 532 outreach clients in Ethiopia found that clinical outreach services in areas including general surgery and gynaecology were delivered at 69% of the cost of identical services delivered by a referral hospital – the traditional service delivery model for those living in rural and remote areas.<sup>14</sup> This study also found that doctors at clinical outreach sites were able to see 21% more clients than would have been possible in a referral hospital setting.<sup>15</sup> In some circumstances, clinical outreach may therefore have a greater impact on health than other service delivery mechanisms for a lower cost.

**What practical steps can be taken to implement a clinical outreach programme effectively?**

Delivering services outside a traditional clinic setting can pose substantial challenges. However, a number of practical steps can be taken to make clinical outreach programmes more robust and effective. These include:

**Identifying unmet reproductive health and family planning needs.**

Clinical outreach programmes need to identify which communities do not access existing service providers, which members of these communities have an unmet need for reproductive health and family planning services and what that particular unmet need is. Doing so ensures that a clinical outreach programme meets unmet need and does not simply provide an additional service delivery point to users of an existing reproductive health and family planning service provider. It also helps a clinical outreach programme to develop a service plan tailored to the needs of the target population. In Kenya and Bangladesh, MSI works closely with the government to achieve this using the latest Demographic and Health Survey data, health service data, site visits and input from the government's health departments.

**Identifying appropriate locations for outreach services.**

Clients with unmet reproductive health and family planning needs are not always far from an existing service provider. Clients may simply find the existing services unaffordable or believe that a nearby service delivery point is not targeted at them. As a result, clinical outreach sites can equally be located in remote rural communities with no service provider or in urban areas that have several service providers nearby.

In Dhaka, Bangladesh, for example, MSI conducts outreach activities targeted at the homeless using a mobile unit that moves between ten pre-identified locations each fortnight.

Any site used for clinical outreach needs to be safe, clean and private. In particular, clients need to be able to obtain private and confidential counselling. The services offered to clients also need to be conducted in sanitary conditions, with adequate room for post-procedure care and access to suitable toilet facilities. These requirements are achievable in most locations. MSI's clinical outreach sites include government health facilities, school classrooms, factories and temporary campsites, for example.

**Mapping the geographical area covered by an outreach programme.**

Mapping the location of target communities or the expected movements of any nomadic groups within an outreach programme's catchment area enables service providers to identify appropriate outreach sites and to plan the schedule of each outreach team effectively. MSI's maps are typically paper-based. However, in Uganda, MSI is developing a geographical information system (GIS).<sup>iii</sup> MSI is using a global positioning system (GPS) device to record the coordinates of communities within the catchment area of MSI's clinical outreach programmes. These coordinates, as well as the population size and key health, social and demographic data of each community, are added to the GIS database. This database uses the information to provide a visual representation of the population demographics, client catchment areas of and possible transport routes to MSI's clinical outreach sites. The GIS database is expected to be available by late 2011.

**Raising awareness of the outreach programme.**

Sustained awareness-raising activities are critical to maintain the effectiveness of clinical outreach sites. However, raising awareness of an outreach programme among a target population presents significant challenges. Clients may be spread out across a large geographical area and only reached through different communication channels. Outreach clients in urban and rural settings may also have limited access to mainstream media channels.

Data taken from MSI client exit interviews emphasise the importance of using several communication channels to raise the target population's awareness of an outreach programme.<sup>16</sup> For example, MSI clinical outreach clients commonly report that they first heard of a clinical outreach programme either through the radio, in newspapers or at community events, as well as from friends or satisfied clients.

iii. MSI is developing this system with funding from the United States Agency for International Development (USAID).

MSI's client exit interview data also highlight the particular importance of community health workers in terms of raising awareness of an outreach programme. MSI's clinical outreach clients regularly identify community health workers as their primary source of information about an outreach programme.<sup>17</sup> MSI uses community health workers to communicate the location and dates of MSI outreach programmes to the target population during the days and weeks beforehand. Community health workers typically live in the community they serve; many will have been appointed by community members. As a result, community health workers have strong local networks and knowledge, meaning that they are better placed to respond to local societal customs, as well as ensuring community acceptance and ownership of certain health measures.<sup>18</sup>

**Delivering high-quality services.**

Awareness-raising activities are unlikely to maintain the effectiveness of a clinical outreach site that delivers poor services. Clients are unlikely to recommend sub-standard reproductive health and family planning services to their friends and family, for example. Similarly, clients are also unlikely to return to an outreach programme if they are unsatisfied with the services delivered.

Clients need to be informed about the full range of family planning options available to them, including the benefits and risks of each option and how it complements their lifestyles. Any clinical procedures also need to be performed safely and effectively, with the client's documented consent. Furthermore, clients need comprehensive care and information regarding any post-procedure complications.

To achieve a high standard of care, MSI has developed rigorous clinical protocols and guidelines that apply the same high standards of care provided in a clinic to all outreach sites. MSI's clinical outreach team members are trained in these clinical protocols and guidelines through courses and training delivered by MSI trainers. MSI's Medical Development Team has also developed interactive and competency based MSI training packages, including self-learning training DVDs for ongoing professional development support. The training course and materials have been developed using international best practice, researched in conjunction with MSI's medical providers through global symposiums.



## Conclusion

Clinical outreach offers considerable potential to deliver high-quality reproductive health and family planning services to underserved communities.

Clinical outreach is used to deliver reproductive health and family planning services worldwide. MSI clinical outreach programmes currently exist in 26 countries worldwide. They deliver high-quality reproductive health and family planning services to communities that are unable to access these services elsewhere; in both remote rural locations and in densely populated urban areas. MSI's clinical outreach programmes ensure that more people are able to choose between a broad range of reproductive health and family planning services and are able to make an informed, voluntary choice regarding which contraceptive method to use.

Clinical outreach can be replicated in any setting with sufficient planning, particularly in partnership with governments. To implement and / or strengthen clinical outreach programmes, service providers, programme managers and donors are encouraged to consider the following recommendations:

- identify unmet reproductive health and family planning needs. This can be achieved by using the latest Demographic and Health Survey data, health service data, site visits and input from the government's health departments
- identify appropriate locations for outreach services. Clinical outreach sites can equally be located in remote rural communities with no service provider or in urban areas that have several service providers nearby
- map the geographical area covered by an outreach programme to identify appropriate outreach sites and to plan the schedule of each outreach team effectively
- undertake sustained awareness-raising activities to maintain the effectiveness of many outreach sites
- develop rigorous clinical protocols, guidelines and procedures to maintain high-quality services. Awareness-raising activities are unlikely to maintain the effectiveness of a clinical outreach site that delivers poor services. Clients are unlikely to recommend sub-standard reproductive health and family planning services to their friends and family, for example.

MSI's clinical outreach programmes also give 'take home cards' to clients who undergo a clinical procedure at one of its outreach sites to ensure a high standard of care. This 'take home card' reiterates comprehensive information given to clients verbally about what complications to look out for and who to contact if there is a complication. According to Dr Katherine Kareko, the Embu District Medical Health Officer who manages the government's relationship with MSI's outreach programme in Kenya: "[these cards make] people feel comfortable with the service because they are given the number of MSI's outreach doctor in case they experience any problems [after receiving the service]".

To ensure that these clinical protocols, guidelines and procedures are implemented correctly, MSI's clinical outreach programmes are supervised regularly and are subject to random spot checks and visits from mystery shoppers, as well as anonymous complaint and support telephone lines. MSI also undertakes a comprehensive clinical audit of at least two or three outreach teams per year. After completing an audit, the outreach programme's management team (including the country director and the clinical director) are debriefed on the standard of clinical services. Any areas that need improvement are discussed and a structured report and prioritised action plan are developed to improve that aspect of service delivery.

MSI's clinical outreach programmes subsequently maintain a high quality of care. For example, the discontinuation rates associated with many of MSI's clinical outreach programmes are lower than or are in line with, the discontinuation rates of other service providers. A low level of early discontinuation is expected among clients choosing any family planning method. High levels of early discontinuation are a potential sign of poor quality services.

Client satisfaction with MSI's clinical outreach programmes is also high<sup>20</sup> and the complication rates associated with many of MSI's clinical outreach programmes compare well with leading service providers. In Malawi, for example, 5% of tubal ligations performed at outreach sites associated with one of nine MSI clinics in August 2008 resulted in a minor complication. No major complications were reported during this time.<sup>21</sup> These complication rates compare favourably with estimated complication rates from Kenya; 0.7% for major complications and 3.4% for minor complications.<sup>22</sup>



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