



TAKING FAMILY PLANNING TO THE VILLAGE

Togo

Using mobile outreach services to increase access to voluntary family planning in rural Togo

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INTRODUCTION

Togo, with a population of just over seven million, is one of the smallest and most densely populated countries in West Africa. Fertility in Togo is high, and family planning (FP) use is extremely low. Togolese women have on average 4.8 children, and only 17% of married Togolese women currently use a modern method of contraception. Yet more than a third of women in Togo (34%) have an unmet need for family planning (FP), with approximately 22% unmet need for spacing and 12% for limiting births. The contraceptive prevalence rate is lower in rural than in urban areas (16% vs. 19%), and rural women have on average two more children (5.7) than their urban counterparts (3.7).¹

Rural areas of Togo, where more than 60% of the population resides,² are underserved by health care in general and FP in particular. The World Health Organization (WHO) has identified Togo as a country with a severe shortage of trained health workers,³ particularly outside of urban areas. As is the case in many countries, reaching women in rural areas with FP is particularly challenging. Rural public health facilities in Togo generally offer only short-acting contraceptive methods, primarily because few rural health care providers are trained in intrauterine device (IUD) or implant insertions and removals. Permanent methods are extremely limited in Togo: vasectomies are available only in the capital, Lomé, and tubal ligations are performed only in a handful of the largest maternity hospitals in the main cities. The most remote villages in the country, which may lack any local health facility, generally have little or no access to any modern contraceptive methods.

In 2009, PSI/Togo initiated a mobile outreach service strategy through its POMEFAⁱ social franchise clinical networkⁱⁱ to expand access to voluntary FP in Togo's under-served rural areas. Under this initiative, providers from POMEFA's urban and peri-urban clinics began making two mobile service trips per month to rural public sector health facilities in their districts, to expand available contraceptive options beyond short acting methods to include IUD and implant services. In 2012, PSI/Togo added a second approach to this model by creating a full-time dedicated mobile outreach team to provide FP services in interior areas of the country not reached through the bi-monthly POMEFA outreach activities. Since the dedicated team is not attached to a specific clinic or health district, it can prioritize travel to locations that are more remote than those not covered by the POMEFA mobile team, including many areas with no formal health facilities.

This brief describes PSI/Togo's two-pronged approach to providing a broad range of voluntary FP options in underserved rural areas through mobile outreach services. Included are a description of the rural mobile outreach model, a presentation of key findings, implementation challenges and programming considerations gleaned from initial program implementation.

MOBILE OUTREACH SERVICES FOR FAMILY PLANNING MODEL

At the core of the mobile outreach model is a trained, supervised provider team. This team works in close collaboration with district health officials and local clinics to conduct FP service delivery, including long-acting reversible contraception (LARC), in areas where access is otherwise limited due to shortages of trained personnel and insufficient infrastructure. Extensive logistical preparation takes place before every outreach activity to set up the mobile site and to ensure availability of sufficient products and equipment to serve a large volume of clients in a single day, when on-site disinfection and sterilization may not be possible.

Mobile teams work with local leaders and health agents before and during each event to reach community members with FP information and to inform them of the upcoming event. Staff from local clinics, trained in basic FP skills, also assist with counseling and observe service provision of LARCs first hand during the event days.

Mobile Outreach Service Teams

The mobile teams include three trained health providers and a driver. Before starting the program, PSI/Togo trained and verified the competency of all team members in FP counseling and service provision, including LARC. It also evaluated the teams on-site quarterly, providing real time feedback and reinforcement as needed. Frequent outreach trips offered mobile team members the opportunity to provide IUD and implant services on a regular basis, to maintain their insertion and removal skills. From a provider competency perspective, it is preferable to work in small mobile teams rather than in larger teams where providers may perform insertions and removals far less frequently and become less adept with the procedures over time.⁴

Site Selection

Mobile outreach sites are selected in collaboration with district health officials based on an initial needs assessment. Site selection is primarily determined by distance and need: areas furthest from an established health facility with the highest estimated unmet need are prioritized. Other factors, such as seasonal accessibility of roads or potential overlap of services by partner organizations, are also taken into account. Schedules are set several months in advance to allow for sufficient community mobilization and planning.

i.POMEFA stands for "A Better Family" in French (Pour une Meilleure Famille)

ii.Social franchising is a model for organizing networks of providers (most often in the private sector) to deliver a range of quality-monitored health services that are known to improve health or avert disease or disability.

Site Preparation

POMEFA mobile outreach teams use short-acting methods and basic equipment available at local public health facilities and also bring products and equipment for IUD and implant insertions and removals. The dedicated mobile outreach team, on the other hand, travels with its own supplies, including exam beds, scales, medical waste disposal bins and two large tents, in addition to a broad range of contraceptive methods. Employing a flexible model, the team uses village health facilities, when available, to provide services. In more remote locations with no health facility, a secure structure that offers privacy is turned into a temporary clinic. When no such structure exists, the mobile outreach team erects a tent, ensuring that services can be delivered safely and privately no matter the location.

On-site FP Training

Mobile outreach teams work with local health providers and train them in basic follow-up care and referral procedures when needed. To further build FP capacity, staff at these health facilities assist mobile teams with counseling sessions and observe LARC insertions and removals.

Communication and Demand Creation

Because traditional media channels do not reach most of the rural Togolese population, mobile service promotion relies heavily on interpersonal communication. This takes place primarily through word of mouth, usually by local community health agents (CHAs) who work with rural health facilities. In the weeks leading up to a mobile outreach visit, CHAs fan out across nearby villages talking to women, men and community leaders about voluntary FP and the upcoming mobile outreach visit. In areas without a formal health facility and no local CHAs, health agents from nearby areas are often dispatched, though they may have to travel long distances and be unfamiliar with the local villages.

Client Counseling

At the beginning of the mobile outreach visit, one team member leads a group FP education session for all women attending the event. Those interested in a method are offered individual FP counseling and screening in which a provider discusses all of the method options and supports the client in choosing the one that best suits her needs. At the end of the counseling session, women who opt for a short-acting method can receive it on the spot, while those who want an implant or IUD are taken to the dedicated area equipped for LARC service provision. While access to and demand for permanent methods is currently extremely limited in Togo, counselors are sensitized to offer referrals to interested clients where such services exist should they request a permanent method.

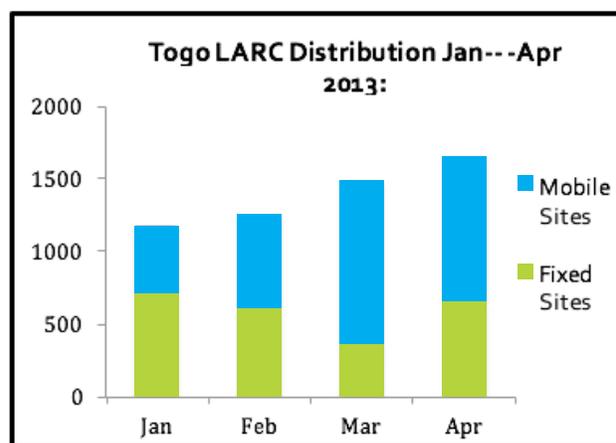
Follow-up Care

Mobile outreach service clients are given information on how to access follow-up care after the mobile outreach day. When mobile activities take place at a health facility, clients are counseled to return to the same health center and speak with the permanent health care providers who have been trained to provide basic follow-up care and referral. When a client needs additional follow-up care, including removal of a LARC method, local providers are instructed to contact the mobile team or PSI/Togo via cell phone to facilitate access to the closest trained provider.

KEY FINDINGS

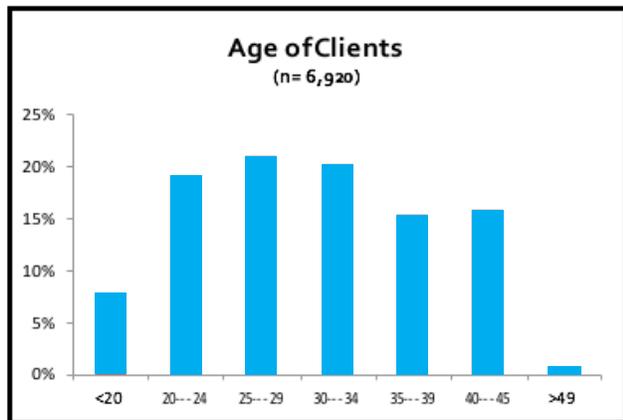
Demand for LARCs at rural mobile outreach is high

While all FP methods are offered by mobile services, including short-acting methods regularly available at public health clinics, nearly all women who receive services at mobile outreach events choose a LARC method. Moreover, many women come to mobile outreach service days specifically for LARCs because it is the only time that these methods are available locally. In fact, the demand for LARCs in rural areas is so high that mobile services accounted for the majority of LARCs provided by PSI/Togo: from January through May 2013, 58% of all LARCs provided by PSI/Togo were through mobile outreach activities (6,239 implants and 681 IUDs).

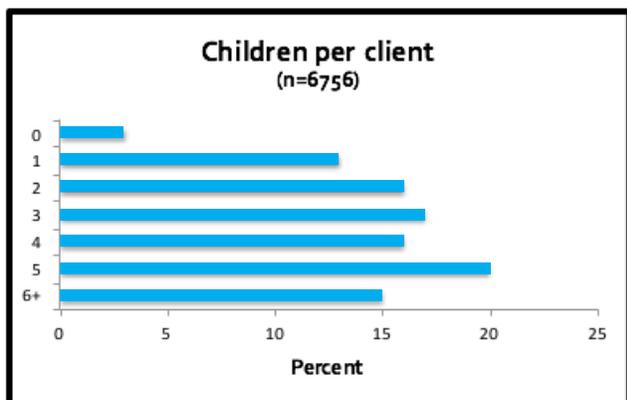


Mobile outreach services reach a diverse profile of rural women

Women of all ages visit the mobile outreach services. The largest proportion (25%) are 25-29 years old, although nearly 17% of clients are under age 25, and anecdotal reports from the mobile outreach team suggest an increase in the number of younger, single women using mobile outreach services.

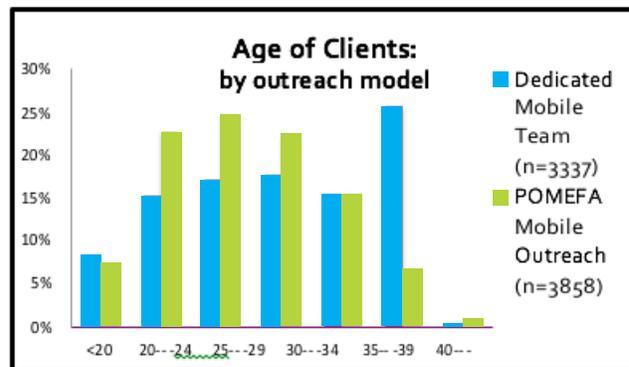


The vast majority of mobile service clients have at least one child, and more than a third have five or more children.

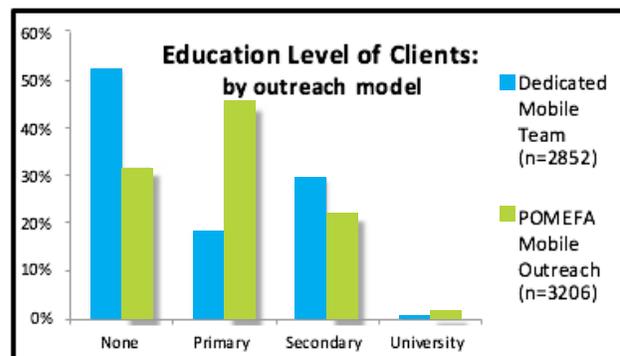


Just over two-thirds of mobile service clients (69%) wanted to space their next birth (or were unsure whether they wanted another child), and 31% wanted to end childbearing. Most have no education (71%), and the overwhelming majority (>90%) are married. The variety in age, parity and reasons for using mobile services suggests that the model is successfully reaching multiple segments of the rural population.

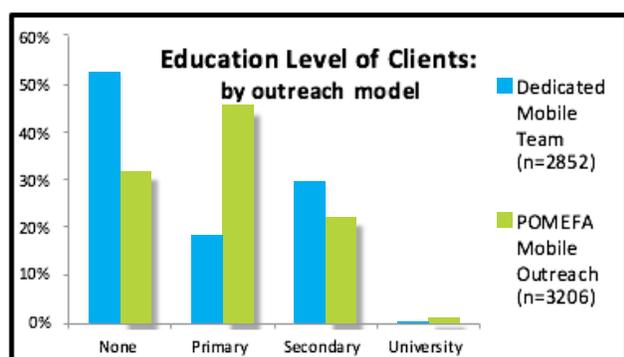
Two mobile models reach different profiles of women



PSI/Togo's two approaches to mobile outreach services for family planning – POMEFA providers travelling bi-monthly to rural public facilities in their designated district and a dedicated mobile team that travels to the most remote areas – generally reach different profiles of women. Women who visit mobile services in more remote rural areas tend to be older and have more children and less education than the women who visit POMEFA partner clinic mobile activities in other areas, which are also in rural areas but generally closer to cities or towns.



There is also a notable difference between the two groups' reasons for FP use: almost half (44%) of the women who accessed mobile services from the dedicated outreach team wanted to end childbearing compared with just 24% at POMEFA outreach sites.



Mobile outreach services are highly effective in attracting new users

The majority of clients using mobile outreach services for family planning are first-time contraceptive users, which is typical for mobile outreach in sub-Saharan African countries. The high proportion of first-time users suggests that mobile outreach is effective in reaching women who have never used FP and who otherwise might not have access to modern contraceptives.

Contraceptive Use Prior to Mobile Services		
None	64.8%	(n=4117)
Condom	3.2%	(n=205)
Pill	5.0%	(n=332)
Injectable	15.0%	(n=964)
IUD	1.5%	(n=97)
Implant	10.0%	(n=636)

LARCs attract women who have discontinued other methods

Just over 20% of mobile service clients had previously used, but discontinued, a short-acting method, and only a small proportion of women were currently using any method at the time of the mobile outreach. This last group was generally comprised of women using short-term methods who wanted to switch to an IUD or implant. Among those who had discontinued a method, some women cited undesirable side effects as the reason for discontinuation, but most said that the need for repeated trips to the health center for re-supply was what led them to discontinue. With return visits to the same sites, PSI/Togo has also found that a growing number of women at outreach events had previously used a LARC, removed it to have another child, and then return to a LARC method.

Making services free on mobile outreach service days increases demand

All contraceptive methods and services are offered free on mobile outreach days, which is not the case in public or private clinics during routine service delivery. Many mobile clients report price as a barrier to use, particularly for those who have used IUDs and implants previously. At sites where POMEFA mobile teams have made repeat visits, clients often say they waited for the mobile service day because they knew that contraceptives, particularly LARCs, would be free. A number of clients reported that their husbands had not initially supported their attendance at the mobile outreach day but changed their minds when they learned that contraceptives would be free.

Mobile services in rural areas tend to reach clients with the least ability to pay for family planning. This should be taken into account during program planning to ensure continued access to free or highly subsidized services for these clients. Segmenting clients geographically or using means testing for individual clients can help target subsidized services to maximize limited program resources. Programs can also explore opportunities for cross-subsidy with other services, or third party payment mechanisms to help offset costs.

Women tend to come to mobile outreach service events in groups

Mobile service providers have noted that women often come to the service delivery points in groups, traveling together from a nearby village, as opposed to fixed delivery points where women often show up alone. PSI/Togo has found that the novelty of mobile service days creates a buzz among women in the village, and the camaraderie surrounding mobile service visits encourages attendance by those who might otherwise be hesitant to attend. Some women reported coming just to accompany their group of friends and neighbors; presenting them with a chance to learn about FP and helping demystify the experience of seeking FP services.

While a small number of men accompanied their spouses to get services, other women shared that their husbands were aware of their visit, and some even encouraged them to attend following discussions with community health agents. Other women reported that their husbands supported them attending a mobile event due to the availability of free LARC services. Offering free services addresses another underlying barrier to contraceptive use: resistance from husbands due to the repeated cost and time away from home needed to access short-acting methods.

While many women attended services with their husband's knowledge, most seemed content to seek services with female companions. In fact, the camaraderie created by groups of women traveling together and the largely female crowd at the event was what attracted many to attend in the first place.

CHALLENGES FACING A RURAL MOBILE OUTREACH STRATEGY

Transportation

Many rural roads in Togo are difficult to navigate in the best conditions and are impassable during the rainy season. The poor condition of the roads takes a toll on vehicles and equipment, requiring extra care and maintenance to ensure that mobile service vehicles and all medical equipment remain in good condition despite the wear and tear of frequent travel.

Assuring adequate promotion and communication of mobile outreach services

PSI/Togo has found that turnout for mobile service days appears to be closely tied to the amount of promotion and communication prior to the outreach day. Mobile outreach service promotion relies heavily on interpersonal communication and requires particularly intense communication outreach efforts in areas where the population is generally unfamiliar with modern FP methods.

Establishing a system for providing clinical support after mobile activities

Follow-up for complications or removals is particularly challenging when mobile services are provided in remote areas with no local health facility. Women must know how to find qualified providers if they have concerns about potential complications or want a LARC removed. Few health providers in rural Togo are trained in removals or are qualified to deal with potential complications. Other studies have highlighted the difficulty women in sub-Saharan Africa face when trying to get an implant/IUD removed¹⁴, and while PSI/Togo promotes planned return dates for mobile service trips that include free LARC removals, it is unrealistic to expect all clients to wait for a return mobile service for removal. Women may have to travel substantial distances for product removal, and a high turnover rate

of health workers makes it difficult to guarantee that removal services will be permanently available at any particular health facility.

Clients and health center staff must know where referral facilities offering comprehensive FP training are located – which may not be the nearest health center. PSI/Togo has addressed these challenges by making repeat mobile service visits to the same area, emphasizing on-the-ground training for staff during mobile days and distributing updated lists of referral facilities and providers trained in removals to help ensure continuity of care following mobile outreach days.

LESSONS LEARNED AND RECOMMENDATIONS

Transportation Demand for LARCs at mobile sites can be far greater than anticipated

The vast majority of women who visit mobile outreach sites want to use LARCs. This is in contrast to the preference for short-acting methods seen in fixed facilities in urban areas (where injectables are the most popular method). Turnout at mobile days and demand for LARCs varied widely – from five insertions a day to over 40. Since resupply in areas far from large cities can be difficult, particularly when mobile outreach teams travel for week-long trips, the teams should travel with substantial quantities of contraceptive methods to ensure there are no stock-outs on the road.

Clients must be made aware of potential fees for future LARC removal

Although all products and services are free on mobile outreach days, future IUD/implant removal at fixed health facilities, even in the public sector, may not be free. If clients are not explicitly made aware of the cost of LARC removal, client satisfaction may be compromised if women are surprised to learn that they must pay for IUD/implant removal, which may result in discouraging others from using LARCs.

Satisfied clients are key to promoting mobile outreach and LARCs in rural areas

PSI/Togo found that in areas where women give positive feedback about LARCs, there are more requests for return visits. Testimonials from local satisfied mobile outreach clients have proved to be one of the most effective but underutilized communication channels for promoting mobile services, particularly for LARCs. Mobile outreach days are often the first time many rural women learn about LARCs. After hearing a current user share her LARC experience, especially if the user is from a nearby area, many women initially hesitant about using a LARC become more comfortable with the idea of an IUD/implant insertion procedure.

¹ Togo: DHS 2013-14.

² Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, *World Population Prospects: The 2010 Revision and World Urbanization Prospects: The 2011 Revision*.

³ Global Health Workforce Alliance. *Second Global Forum on Human Resources for Health. Press Pack*.

⁴ Bakamjian, L. (2008). *Linking communities to family planning and LAPM via mobile services. Presentation given at Flexible Fund Partner's Meeting. Washington, DC: EngenderHealth*.

⁵ Eva, G and Ngo TD (2010). *MSI Mobile Outreach Services: Retrospective evaluations from Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam. London: Marie Stopes International*.

⁶ Ibid

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SIFPO is a five-year program funded by USAID aimed at improving PSI's capacity in family planning programming worldwide. Working in partnership with IntraHealth International and the Stanford Program for International Reproductive Education and Services (SPIRES), PSI's vision is to significantly scale up delivery of high quality FP products and services to address unmet need in an increasingly targeted and cost effective manner. PSI emphasizes increasing access, expanding contraceptive choice and developing local leadership.

To access the capabilities of SIFPO, USAID missions and bureaus can buy into the cooperative agreement.

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