



TECHNICAL BRIEF

TAKING FAMILY PLANNING TO THE VILLAGE:

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

TOGO

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 extremely low. Togolese women have on average 4.8 children, and only 13% of married Togolese women currently use a modern method of contraception. Yet more than a third of women in Togo (37%) have an unmet need for family planning (FP), with approximately 23% unmet need for spacing and 14% for limiting births. The contraceptive prevalence rate is lower in rural than in urban areas (11.8% vs. 15.4%), and women have on average nearly two more children (5.8) than their urban counterparts (3.5).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)/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.

This case study describes PSI/Togo's approach to providing a broad range of FP options in underserved rural areas through mobile outreach services for family planning and includes a presentation of key findings, challenges and programming considerations from initial program implementation.



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MOBILE OUTREACH SERVICES FOR FAMILY PLANNING MODEL

In 2009, PSI/Togo initiated a mobile outreach service strategy through its POMEFAⁱ social franchise clinical networkⁱⁱ to expand access to FP in Togo's under-served rural areas. Under this initiative, FP providers from POMEFA clinics began making two mobile service trips per month to rural public sector health facilities in their districts, to complement the FP services and short-acting methods offered, by providing long-acting reversible contraception (LARC) products and services. In 2012, PSI/Togo added a second mobile outreach team: a full-time, PSI/Togo dedicated team began providing mobile outreach activities in interior areas of the country not covered by the POMEFA network. Since the dedicated team is not attached to a specific clinic or health district, it can travel to locations that are more remote than those covered by the POMEFA mobile teams, including many with no formal health facilities.

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. It also evaluates the teams on-site quarterly. Frequent outreach trips ensure that mobile team members' skills are up-to-date by regularly providing IUD and implant services. The small size of the mobile teams is preferable, from a provider competence perspective, than larger teams that tend to perform fewer insertions.⁴

Site Selection

Mobile outreach sites are chosen 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.

Site Preparation

POMEFA mobile outreach teams use short-acting methods available at local public health facilities as well as bring 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. The team uses village health facilities, when available, to provide services. In more remote locations with no health facility, either a secure and private structure is turned into a temporary clinic, or the mobile outreach team erects a tent as a mobile health unit, ensuring that services can be delivered safely and privately no matter the location.

On-site FP Training

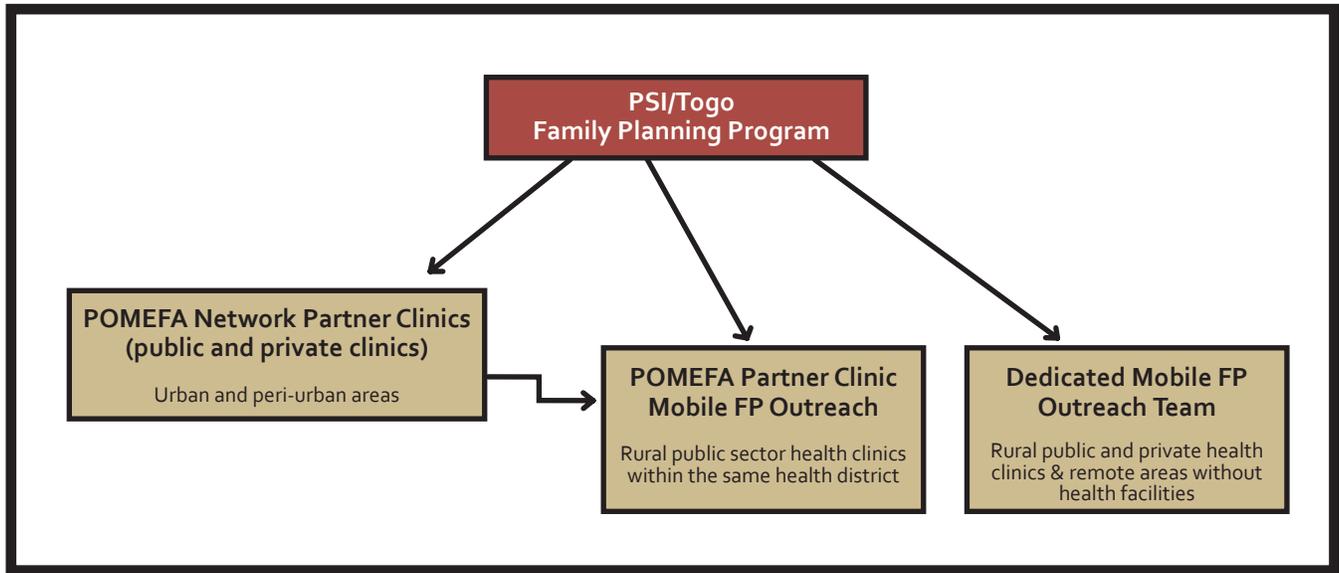
Mobile outreach teams work with local health providers and train them in basic follow-up care and how to make referrals when needed. To further build capacity, staff at these health facilities assist mobile teams with counseling sessions and observe LARC insertions and removals.

THE POMEFA NETWORK

PSI provides high quality FP products and services in Togo through its social franchise network of "POMEFA" branded partner clinics. The POMEFA network integrates FP products and services into existing public and private clinics under the umbrella POMEFA brand. The 79 clinics (70 public and 9 private) in the POMEFA network are located throughout Togo in urban and peri-urban areas, but are more limited in rural areas.

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.



Communication and Demand Creation

As traditional media channels do not reach most of the rural population, mobile service promotion relies heavily on inter-personal communication. This occurs 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 FP and the upcoming mobile outreach visit. In areas without a formal health facility, CHAs from nearby areas are often dispatched, though they may have to travel long distances and may 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. Those interested are offered individual FP counseling and screening in which a provider discusses all of the method options and helps the client choose the one that best suits their needs. At the end of the counseling session, providers give the contraceptive of choice to women who want a short-acting method while those who want an implant or IUD are taken to the dedicated area for LARC service provision.

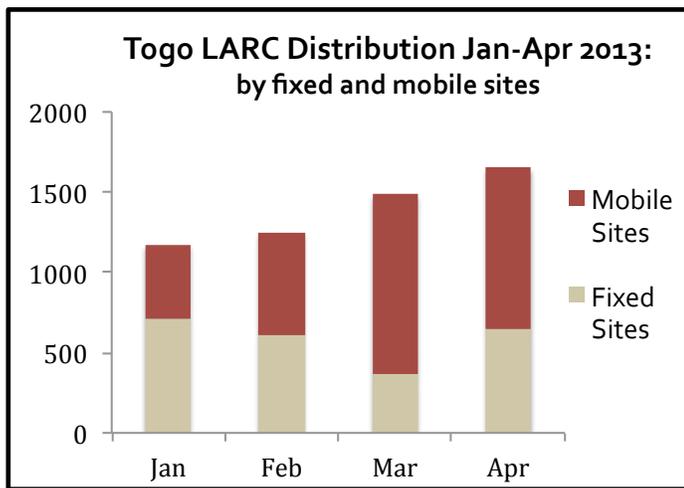
Follow-up Care

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 there who have been oriented to provide basic follow-up care and referral. When a client needs additional follow-up care, including a 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

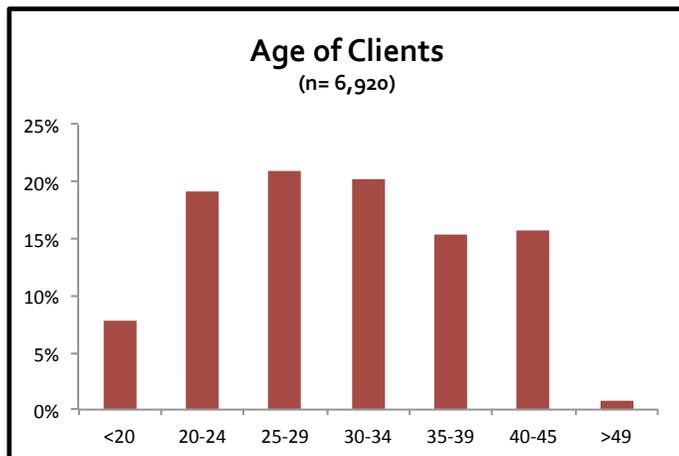
Demand for LARCs at rural mobile outreach is high

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 choose a LARC method. Many women come to mobile outreach service days specifically for LARCs because it is the only time that these methods are available locally. 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).



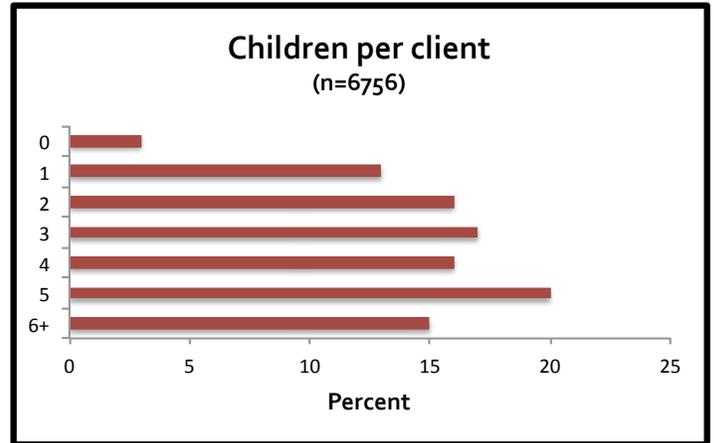
Mobile outreach services reach a diverse profile of rural women

Women of all ages visit the mobile outreach services, but the largest proportion (25%) are 25-29 years old. Most other clients



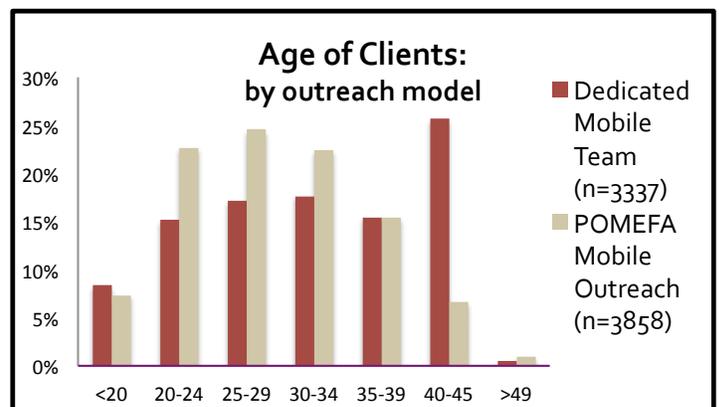
are older, although nearly 17% are under age 25. Anecdotal reports from the mobile outreach team, however, suggest an

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 nearly a third have six or more children.



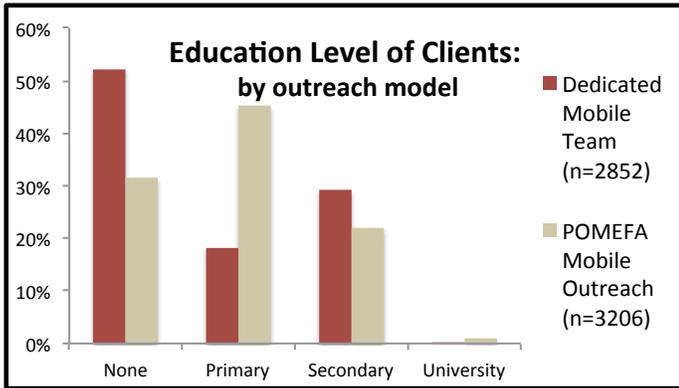
Just over two-thirds of mobile service clients (69%) wanted to space their next birth (or were unsure whether they wanted another child), and 31% wanted to end childbearing. Most have no education (71%), and the overwhelming majority (>90%) are married. The variety in age, parity and reasons for using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

The two different mobile models reach different profiles of women

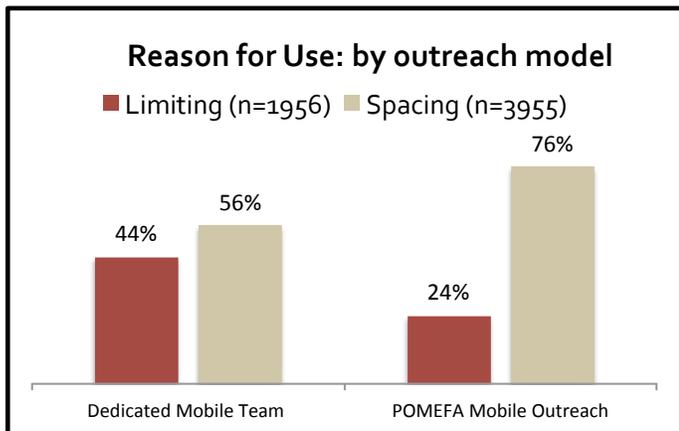


PSI/Togo's two approaches to mobile outreach services for family planning –POMEFA providers travelling bi-monthly to rural public facilities in their designated district and a dedicated mobile team that travels to the most remote areas – generally reach different profiles of women. Women who visit mobile services in the 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 rural areas, which are generally closer to towns or cities. There is also a



notable difference between the two groups in their 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 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.⁵ The high

| 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) |

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.

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. 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 the reason. With return visits to the same sites, PSI/Togo has also found that a growing number of women who previously used a LARC removed it to have another child, and want to 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 when mobile events are not held. 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.

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 – not something usually observed at fixed delivery points. PSI/Togo has found that the novelty of the mobile service days creates a buzz among women in the village, and the camaraderie surrounding mobile service visits encourages attendance by women who might otherwise be hesitant to attend.

By offering free family planning services through mobile outreach, PSI/Togo is able to overcome the time and monetary constraints that keep many women in Togo's rural areas from being able to voluntarily space or limit births.

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 a particular challenge when mobile services take place 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 removed,⁶ and while PSI/Togo promotes planned return dates for mobile service trips which include free LARC removals, it is unrealistic to expect all 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 be aware of the location of referral facilities – which may not be the nearest health center if it does not offer staff comprehensive FP training. 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 guarantee continuity of care following mobile outreach days.

LESSONS LEARNED AND RECOMMENDATIONS

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 teams leave for week-long trips, the mobile outreach teams should travel with substantial quantities of contraceptive methods to ensure there are no stock-outs on the road during mobile service days.

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 comprised 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 satisfied mobile outreach clients have proved to be one of most effective but under-utilized 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, many women initially hesitant about using a LARC are more comfortable with an IUD/implant insertion procedure.

¹ MICS -Togo (2010). Available at http://www.childinfo.org/mics4_surveys.html

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. Available at http://esa.un.org/unup/unup/index_panel3.html

³ Global Health Workforce Alliance. Second Global Forum on Human Resources for Health. Press Pack. Accessed on November, 2013: http://www.who.int/workforcealliance/forum/2011/SecondGlobalForumHRH_Presspack.pdf

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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