LA/PM Community of Practice Technical Consultation

Bringing Long-Acting Reversible and Permanent Contraceptive Methods and Services Closer to the Client: Innovative Approaches

Meeting Highlights

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I. Background and Meeting Objectives

In keeping with its global knowledge function, the Long-Acting and Permanent Methods (LA/PM) Community of Practice (CoP) convened a technical consultation to stimulate learning, foster an exchange of experience among family planning (FP) professionals, and inform strategic thinking and programming within the FP community. This technical consultation, the first in a series that will take place over the next year, focused on mobile outreach and dedicated provider approaches for bringing long-acting reversible contraceptives (LARCs) and permanent methods (PMs) closer to the client. It was cohosted by EngenderHealth (The RESPOND Project), Marie Stopes International (MSI) (Support for International Family Planning Organizations [SIFPO]-MSI Project), Population Services International (PSI) (SIFPO-PSI Project), and the U.S. Agency for International Development (USAID). The specific objectives were to:

- Share evidence-based experiences with the successful provision of LARCs and PMs via mobile services and dedicated provider approaches in various countries by various organizations
- Discuss the question "what are effective service approaches in different contexts and conditions/circumstances that either enable or constrain these approaches?"
- Identify areas for further study and documentation, as well as topics for future consultations

Seventy-one participants from 18 organizations in the U.S. government and cooperating agencies attended the consultation. This report highlights key messages delivered by the presenters and provides a synthesis of plenary and working group discussions. The agenda and links to opening remarks, presentations, and resource documents are embedded, for those who wish to learn more.

II. Opening Session

Harriet Stanley, *Project Director, RESPOND Project/EngenderHealth*, served as the chair for the consultation. In her opening remarks, she mentioned the history of the LA/PM CoP: that it was established in 2009, that its current membership is around 200 individuals, and that The RESPOND Project currently serves as the Secretariat. She discussed the value of "ensuring that we create environments with like-minded peers with the expertise to engage deeply and move ideas forward. We really want to push forward our thinking and practices through a consultation like this, challenging assumptions we bring into the room and keeping an open mind. We're in a constantly changing environment."

Ellen Starbird, *Director, Office of Population and Reproductive Health, Bureau for Global Health, USAID,* welcomed everyone and thanked EngenderHealth, MSI, and PSI for hosting the meeting and for all the work they have done to bring this meeting together and in this

area. Ms. Starbird spoke about why it is important to focus on LARCs and PMs; USAID's support for LARCs/PMs and the agency's direction; and the changing environment with other donors now engaged in expanding access to LARCs/PMs.

Patricia MacDonald, *LA/PM Co-Champion, Office of Population and Reproductive Health, Bureau for Global Health, USAID,* further set the stage by thanking the cohosts and reinforcing Ms. Starbird's sentiments about the role of the LARC/PM CoP. She emphasized the need to expand women's choices of and access to LARCs and PMs within a mix of contraceptive options available to them. Essential to this is the need to strengthen the link between commodity security and planning for scaling up access to LARCs and PMs. She noted the value of mobile services and dedicated provider approaches that offer a full range of contraceptives and/or bring methods that are not available at lower levels, and she asked "should these approaches be considered not as "add-ons" but rather, as an integral part of the overall health service delivery system?" Ms. MacDonald mentioned the USAID high impact practice (HIP) brief on mobile clinical outreach, as well as another on dedicated providers and FP-immunization integration. She underscored that while data and documentation have proven that these models work, the challenge moving forward remains in how these models can be adapted and used by others.

III. Plenary Panel: Evidence-Based Approaches and Country Experiences

Jane Wickstrom, *Technical Team Leader, RESPOND Project/EngenderHealth,* presented on **"Approaches to Mobile Outreach Services: Malawi, Nepal, and Tanzania,"** in which she discussed the methodology, key findings, and challenges/ opportunities from a new study on mobile outreach services. Selected key points follow:

- There is no "blueprint" for programming and managing mobile outreach services. The three countries studied used a variety of service delivery modalities for mobile outreach services.
- In the three countries examined, most outreach services (even those offered by nongovernmental organizations [NGOs]) are provided at public-sector facilities.
- In all three countries, community health workers or volunteers play a role in educating clients about FP, including LA/PMs, and in informing them about the schedule for mobile services.
- In Tanzania, half of all LA/PMs accepted (more than 220,000 in one year 2011) were provided via mobile services.
- In Malawi, more than 170,000 female sterilizations performed in four years (2008–2011) and over 90% of those offered by the largest local NGO were provided via mobile outreach.
- In Nepal, 33% of all no-scalpel vasectomy (NSV) procedures and 19% of all female sterilizations were conducted in mobile settings. In remote "satellite centers," 9% of all intrauterine device (IUD) insertions and 8% of all implant insertions were through mobile services.

Challenges and opportunities include the following:

- Maintaining quality of care is essential. Fielding itinerant teams whose only job is to provide outreach is currently an effective strategy being used in the NGO sector.
- Public-private partnerships are essential, but they must be under the direction of district health and national officials.
- Continuing financing is a challenge. Mobile outreach services are aimed at the poor and underserved and should remain free of charge to these clients.

Ms. Wickstrom offered a proposition for the LA/PM CoP: FP mobile outreach services are here to stay; specifically targeted to meet the poor and underserved, they are not a stopgap measure. The international FP community should work with health systems to support the evolution and growth of mobile outreach services within the health care system.

Anna Mackay, *Deputy Director/SIFPO-MSI Project*, presented on **"Scaling Up Mobile Outreach Services for National Impact: Evidence, Experience, and Lessons."** Looking beyond service statistics, Ms. Mackay described how MSI conducts mobile outreach. MSI has expanded its outreach program significantly over the last three years and currently has 370 teams in 26 countries, reaching more than 1.6 million people in rural and slum locations in 2012. Program experience suggests that this expanded outreach is generating its own demand, with a dramatic upswing in implant and IUD services as more women take up these services and are comfortable using them. MSI tailors its outreach model to meet client preferences, complement what is already available in the public sector, and ensure a broad choice of methods. For example, MSI is increasingly investing in smaller, nurse-led models, with referrals for permanent methods, in response to changing demand patterns. Other selected key points include:

- MSI's exit data demonstrate that outreach can increase access and choice for the most underserved: Across its programs, 42% of MSI outreach clients are FP adopters (i.e., were not using an FP method when they came for the outreach service), and 44% live on less than $1.25 per day.
- Reaching young people through outreach is more of a challenge, with only 7% of outreach clients under 20 years of age. MSI is now testing adapted outreach models that are tailored to young people's FP needs and preferences and is learning from country programs like those of Mali and Sierra Leone, where one in five outreach clients are under 20.
- Countries that have invested in outreach (Malawi, Nepal, and Tanzania) have succeeded in closing the urban-rural gap in contraceptive prevalence rate (CPR).
- Scaling up outreach services can have a national impact, catalyze uptake of LARCs and PMs, and accelerate CPR growth. In Uganda, MSI's expanded outreach services drove a 500% national increase in implant uptake between 2006 and 2011 and are now increasing CPR by one percentage point every year. In Mali, investment in outreach and dedicated providers have led to an increase in CPR growth and a dramatic upswing in LARC use, with a 300% increase in IUD use and one in four Malian FP users now choosing implants.

Ms. Mackay outlined MSI's experience with strengthening operational and monitoring and evaluation systems to enable effective outreach scale-up. Future areas of focus include expanded research to better understand client discontinuation and removal behavior and factors preventing FP uptake among groups with high unmet need, including young people.

Dr. Roy Jacobstein, on behalf of Dr. Joseph Kanama, *Senior Medical Advisor, RESPOND Project/Tanzania, EngenderHealth,* presented on **"Tanzania Public-Sector Mobile Services Capacity Building."** This presentation was developed by Mr. Maurice Hiza, the National Family Planning Coordinator for the Tanzania Ministry of Health and Social Welfare, in collaboration with EngenderHealth Tanzania staff, none of whom were able to attend the technical consultation. In their stead, Dr. Jacobstein discussed the current FP situation in Tanzania; the five action areas of the National Family Planning Strategy, with an emphasis on capacity building and service delivery; the comprehensive technical assistance supported by USAID since 2007; and how the public sector conducts its mobile outreach. Selected points include the following:

- Tanzania is delivering a substantial volume of LA/PM services, with more than 1.6 million clients having received an LA/PM in the past six years, including over 900,000 implant insertions, 400,000 female sterilization procedures, and 350,000 IUD insertions.
- Seventy percent of these services have been delivered by the public sector, and 50–60% of these LA/PM services have been delivered via mobile services that are reaching underserved people and communities, thus increasing equity.
- Capacity and commitment have been built, with more facilities and more providers in more places providing more FP and LA/PM services. The number of government hospitals, health centers, and dispensaries able to provide at least one LA/PM has doubled since 2007 and is continuing to rise, and almost 100% of districts are now making annual allocations for FP, with generally increased amounts per district.
- Tanzania's balanced approach, emphasizing public–private-sector partnership and coordination, is making good progress in meeting unmet need for FP.

While good progress has been achieved, the challenge remains: how to increase access to FP while closing the equity gap? This underscores the rise in unmet need among the poorest segments of the population living in rural areas.

Faustina Fynn-Nyame, *Country Director, Ghana, MSI,* presented on **"Expanding Access and Building Public-Sector Capacity through Mobile Outreach Services: Marie Stopes International Ghana Experience."** Ms. Fynn-Nyame discussed the current FP situation in Ghana, MSI Ghana's strategy for outreach services, and the results of their outreach program. Selected points follow:

- Ghana has a high maternal mortality rate and a low CPR, with unsafe abortions accounting for 20–30% of maternal deaths and rural communities being particularly underserved. These figures result from a lack of access to the full range of FP services, as well as a need to improve the availability of commodities and the capacity/competency of service providers and to reduce the cost of services.
- MSI Ghana mobilized six outreach teams to provide LARC/PM services at 90 outreach sites every month, organized community mobilization activities, provided LARC training for selected public-sector delivery workers, undertook clinical monitoring and supervision, and strengthened back-up/referral systems.
- Since USAID outreach funding started in 2010, there has been a huge increase in FP access and service uptake, with couple-years of contraceptive protection having increased by 600%, to 200,000 in 2013; it is expected that 60,000 LARC/PM services will have been provided through mobile outreach this year. Among the women reached

through the mobile outreach program, two-thirds were new adopters (defined as not those who had not been using a method up to three months prior to the time of service), one-quarter had switched from short-acting methods to LA/PMs, and 40% were 24 years old or younger.

- MSI Ghana works in close partnership with the Ghana Ministry of Health/Ghana Health Service (GHS). The GHS has contracted with MSI Ghana to provide services, and MSI Ghana hopes to expand this public-private partnership in the future, supporting the expansion of Ghana's National Health Insurance Scheme to include FP, as well as task shifting and supporting the government in building providers' capacity.

Despite progress, some challenges remain—namely, the need for an improved nurse/midwife-to-population ratio, integration of services, and the continuing high levels of unmet need for FP in many areas of the country.

Nene Fofana, *Sexual and Reproductive Health Technical Advisor, PSI/Mali,* presented on **"Improving Access and Availability of LARCs in Mali through Dedicated Providers: Lessons Learned for Effective Scale-Up and Sustainability."** PSI uses an urban outreach model that integrates FP services with routine vaccination days in public-sector community clinics. Some highlights follow:

- Although the CPR is below 10% in Mali, the latest Demographic and Health Survey (DHS) shows a positive trend countrywide, with an increase in modern CPR from 17 to 23% in Bamako.
- Vaccination rates are high in Mali. PSI identified this as an opportunity to bring FP services to women in the extended postpartum period who might not otherwise access health centers.
- PSI seconded midwives to public community health centers in Bamako during routine vaccination days to provide group information sessions, counseling, eligibility screening, and on-site, same-day method provision, including LARCs that were not otherwise available.
- In the second year of the intervention, just two PSI midwives provided 15,000 women with the LARC of their choice, more than triple the number of LARC users reported in the 2006 DHS. In 2013, PSI/Mali is projected to serve 50,000 women with LARCs through this model.
- Based on this performance, the project was scaled up to the cities of Kayes and Sikasso, and the model was adapted in a subset of sites to allow transition from direct PSI service provision to indirect support through coaching and supportive supervision.
- Initially, LARC service provision decreased significantly at the sites receiving only indirect support. Through tailored interventions, such as provider behavior change communications, most clinics have returned to their initial level.
- In many clinics, the administration adopted the dedicated provider model, assigning one of its own staff to offer dedicated FP services on vaccination days.
- The role of dedicated FP providers has been acknowledged by the Ministry of Health (MOH), and its success has been cited to support task sharing for FP in the new national strategy.

Lessons shared by Ms. Fofana emphasized the need for MOH engagement for scale-up and the feasibility of replicating the dedicated provider model. Finally, when developing a sustainability strategy, she emphasized that one size does not fit all; PSI tailored its strategy and level of engagement to individual clinics, with dedicated PSI providers still required at many of the sites.

IV. Guest Speaker: Valerie DeFillipo, Director, FP2020

Valerie DeFillipo, Director, Family Planning 2020 Reference Group (FP2020), discussed the vision, goals, and objectives shared by FP2020 and the 24 countries committed to the initiative. Examples of commitments were categorized in four clusters:

- Financial, policy, and service delivery commitments
- Local summits and national FP conferences
- Strategic, detailed, and costed FP plans
- Innovative approaches and partnerships

Ms. DeFillipo explained the FP2020 governance structure and provided details on the working groups, which are the operational arms of FP2020 and provide technical advice and support in four focus areas:

- Country engagement
- Market dynamics
- Performance monitoring and accountability
- Rights and empowerment

Spotlighting the Implants Access Initiative, she explained that it aims to:

- Ensure the choice of methods women and men want
- Secure the availability of supplies needed to reach 120 million new users by 2020
- Guarantee the effective, timely delivery of contraceptive supplies through appropriate data sharing and coordination

Some key features of this initiative are:

- Delivering increased volumes of supplies to meet growing demand
- Ensuring that quality services are in place to deliver higher volumes
- Making sure that new opportunities are within the reach of those who will make a difference
- Confronting the multiplicity of bottlenecks that impede choice and access
- Knowing where to turn for help

V. Mobile Outreach/Dedicated Provider Approaches: Working Groups

Fueled by the morning plenary presentations, meeting attendees self-selected to participate in the following five working group discussions:

- Group 1: Scale-up—opportunities and challenges
- Group 2: Role of these approaches as health systems strengthen
- Group 3: Equity—opportunities and challenges in reaching youth, postpartum women, migrants, and other underserved populations
- Group 4: Integration—opportunities and challenges when integrating services
- Group 5: Mobile outreach high-impact practices

The agenda called for two rounds of repeated, concurrent working groups, allowing for meeting attendees to participate in two groups, each of which lasted approximately 30 minutes. Some meeting attendees commented that the 30-minute interval was too short, given the depth of the content to be discussed, and that they would have preferred to stay focused in one group for a longer time. This is a lesson for the next technical consultation. The feedback from the working groups and the plenary discussion are synthesized in the next section of this report.

VI. Synthesis of Plenary and Working Group Discussions

While there were general observations and comments regarding the three presentations, including the impressive outcome data and the assertion that there is sufficient evidence for this to be classified as a proven practice, much of the discussion was focused on provider behaviors and skills.

Specific questions raised regarding outreach services noted that there is no consistent scheduling; therefore, communities may not know when the service will return. MSI representatives clarified that they provide schedules in advance to public-sector facilities, community health workers, and district health teams. Presenters clarified that follow-up support or referrals for additional support, complication management, or device removals often are provided locally by health care staff or community health workers. However, removals remain an issue, as there is not sufficient knowledge about the client experience following mobile services, nor are there good data on removals overall. MSI advocated for more client studies to better understand side effects management and discontinuation practices, particularly for LARC clients, to ensure that the right counseling and follow-up systems are in place. Regarding complications management, in many cases clients leave with a phone number and the name of a contact. However, this may not be a long-term solution, as client numbers grow and as MSI comes to the end of a three-year first wave of implant services. EngenderHealth reported that public-sector services rely on community health

workers, but communication among public and private sectors needs to be strengthened if women are to be provided with timely follow-up care. Further, more investment is needed in the training of public-sector providers on implants, to ensure that removal services are continually available, which is ever important, especially given the upswing in implant use and the likely increase in implant services owing in part to the price volume guarantee.

Strengthening supervision was identified as a potential benefit of mobile services, as it offers supervisors a venue in which to refresh staff skills, observe services, and update their own knowledge of the service realities. Joint NGO-MOH supervision teams also strengthened collaboration, skills, and shared knowledge.

Creating demand and reaching underserved populations was addressed by several examples, including using mass media and messages based on client research and ensuring that messages are complementary to what other organizations are doing. In some areas, a house-to-house approach is used, so that women not active in the public sphere can be reached. And work with religious leaders and their wives has been important, particularly in countries such as Afghanistan. It was noted that the coordination of demand creation and messaging is essential at the district level, where all public-private actors are coordinated.

Provider skills and behavior were examined in several ways. Commenters asked why public-sector providers are motivated to provide high numbers of services during outreach events but not consistently between events. Some of the reasons may be the high client loads they have for other services and the fact that medical equipment and supplies often come with the outreach services. Until medical supplies and equipment are regularly and sufficiently available and there is sufficient staffing, we cannot expect to see high levels of service provision sustained over time in static clinics. The variance between service provision during outreach events and static clinics also may reflect a lack of confidence or competence among providers who have not had sufficient practice with LARCs or PMs. The question was raised about the value of training thousands of public-sector providers when it is outreach teams that deliver high-volume services; however, the group also noted that both private and public outreach services rely on public-sector staff and infrastructure. Also, in situations where outreach is intended to build a sustainable static service infrastructure, trained public-sector staff will be essential. It was also noted that some of the high-performing dedicated providers in Mali are public-sector staff. Community health workers are often MOH staff and are not paid by private-sector projects. Several respondents asserted that there are many reasons to value the training of public-sector staff.

Further discussion of the dedicated provider model included questions about the importance of individual enthusiasm in selecting a potential provider. Responses included the observation that enthusiasm is important, but that technical competence is equally important. One study showed that 60% of women working as dedicated providers were using LARCs themselves. However, it is important to remember that doing it right takes time. To provide LARCs and PMs with adequate counseling and support, enabling women to make a confident decision, requires significantly more time than many other services. If they have large workloads and need to offer a broad range of services, providers simply will not have the time to provide a lot of FP methods in a day; hence, there is a need for dedicated providers.

Several other health systems issues were identified, including the recognition that models of mobile outreach and dedicated providers need to continually evolve as the health system

evolves. For example, in Ghana, the recent authorization of community health nurses to provide implants has had an impact on systems needs for support and how outreach might be designed. Issues of literacy levels or additional coaching and support, for example, will need to be built into program plans. At the same time, really reaching remote communities may mean not assuming that motorized vehicles and comprehensive teams will be possible. Some examples included having just a driver and a nurse in a rickshaw, able to provide all reversible methods and make referrals for permanent methods. In Nepal, sherpas carry basic equipment and supplies to remote villages.

Discussants reiterated the importance of these service modalities for reaching underserved populations and acknowledged the many systems issues and opportunities inherent in these approaches. They also noted that models evolve as the policy and service delivery environments change and as task shifting/task sharing and other innovations begin to impact providers and the design of services.

VII. Moving Forward

In closing, Harriet Stanley drew the group's attention back to the three objectives of the consultation and acknowledged that the first two had been addressed throughout the day: The community shared evidence-based experiences with the successful provision of LARCs and PMs via mobile services and dedicated provider approaches in various countries by various organizations, and it discussed "what are effective service approaches in different contexts and conditions/circumstances that either enable or constrain these approaches?" The remaining task for the group was to "identify areas for further study and documentation, as well as topics for future consultations." Several comments reflected that little is known about mobile outreach services and dedicated provider costs in the public and NGO sectors and how they contribute to CPR. Most national programs do not disaggregate data by service delivery modality. MSI has a costing model that captures their costs of mobile services; however, this model does not capture the unknown costs of the public-sector contribution to MSI efforts, including public-sector infrastructure, health care and volunteer time and support, district-level organizational support, and government-donated contraceptives and supplies. While costing data are important for program planning and scale-up, the CoP participants also noted that comparing static with mobile service costs may not represent the cost-benefit of offering contraceptive choices to those underserved men and women who cannot access static facilities that offer a full range of methods, especially the LA/PMs that are offered in mobile settings.

It was also suggested that donors and members of the immunization community (and other vertical programs) would benefit from knowing whether integrating FP with immunizations, for example, decreases immunization results (or increases services, or has no effect). A soon-to-be-published HIP brief on postpartum FP and immunization will provide evidence on these integration practices. Other participants raised the need to document the experiences of task shifting/task sharing and to learn the lessons of how they make a difference. Noting that there are political and social implications for shifting/sharing professional responsibilities

and authority, more research is needed on the impact of this significant—and somewhat rapid—change beyond counts of additional services provided.

Further examination of the use of the term "youth" was encouraged, given that the term includes both adolescents and young marrieds, whose needs can be distinctly different. For adolescents, we say contraception; for young marrieds, FP is a more appropriate term.

Another topic requiring additional focus was the fact that the hormonal implant Implanon® currently is considered to have a three-year lifetime, although the World Health Organization (WHO) may extend its recommended lifetime to five years. The CoP was encouraged to advocate with WHO to determine soon if that will be extended, because of the programmatic implications.

Finally, much appreciation was expressed for the consultation planners and presenters from MSI, PSI, RESPOND, and USAID. Special thanks were given to the presenters for sharing what keeps them awake at night. This really represented what a CoP should be, and it was an inspiring day. The LA/PM CoP secretariat housed in the RESPOND Project was applauded, as was the excellent support and catering staff in our attractive venue, the Women's National Democratic Club, The Whittemore House.

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