Using Mobile Outreach Services to Expand Access to Contraception in Ethiopia

BACKGROUND

Increased access to family planning (FP) is widely recognized as central to the achievement of a broad range of health, social, and economic development goals, including improving maternal and child survival. Expanding FP access is also crucial for ensuring the fundamental rights of individuals to decide, freely and for themselves, whether, when, and how many children to have.

During the past decade, the Government of Ethiopia has made remarkable progress in increasing FP access. Between 2005 and 2014, dramatic increases in modern contraceptive prevalence rates (mCPR) have been observed, from 13.9% in 2005 (CSA & ORC Macro, 2006) to 27.3% in 2011 (CSA & ICF International, 2012) and 40.4% in 2014 (CSA, 2014). Use of long-acting reversible contraceptives (LARCs) and permanent methods of contraception (PMs) has increased from 4% to 15% of the method mix since 2005 (CSA, 2014).

Yet unmet need for FP remains high—24.4% among married women (PMA2020 Project, 2014)—and women in the poorest wealth quintile are almost twice as likely as those in the wealthiest quintile to report having unmet need (PMA2020 Project, 2014). Disparities in access also persist: The mCPR is 49% higher among urban women than among rural women (CSA, 2014), and urban women are more than twice as likely to use LARCs and PMs as are their rural counterparts (CSA, 2014). This disparity is even more striking in terms of IUD utilization: Urban women are seven times more likely to use the IUD than are rural women.

THE MOBILE OUTREACH SERVICES PROJECT

Launched in April 2012, with funding from the Merck Company Foundation, the Mobile Outreach Services (MOS) Project aimed to increase access to FP, especially LARCs/PMs, in rural, hard-to-reach communities in the Amhara, Oromia, and Southern Nations, Nationalities and Peoples (SNNP) regions of Ethiopia. The project used a public-to-public mentoring model (see Figure 1), whereby experienced LARC/PM service providers from 23 “host” facilities—all mid-level government health centers—conducted mobile outreach services at 72 peripheral government health sites—i.e., “outreach sites.” Thirteen of these sites focused on delivering PM services and 59 on strengthening sustainable LARC service delivery at outreach sites. The public-to-public mentoring model seeks to strengthen the district health system by providing training and
orientation to service providers and community volunteers and by supporting the gradual transfer of skills among public health facilities and alignment and harmonization of plans, budget, review, and tools into the district health service delivery system, to ensure sustainability of the interventions.

Traditional mobile outreach models generally focus on extending services without attention to building the capacity at lower level facilities. Through the MOS model, on the other hand, lower level facilities’ capacity to provide sustainable services is developed at the same time that services are provided to underserved communities.

Project activities included training LARC/PM service providers, outreach site staff, and community health workers; providing essential equipment; and supporting outreach services provision with regular facilitative supervision, clinical monitoring, and on-the-job coaching. Outreach sessions provided an opportunity for experienced service providers from host facilities to mentor staff at peripheral sites and build capacity to independently provide LARC service. In addition, the project supported training of nearly 600 community-based health extension workers (HEWs) to provide individual and couple counseling during house-to-house visits and to lead community dialogue sessions to raise awareness about and interest in LARCs/PMs and scheduled outreach service sessions.

EVALUATION

A mixed-methods retrospective evaluation was conducted in early 2015 to document project achievements, to identify strengths and limitations of implementation strategies, and to describe lessons for improving program implementation and scale-up. Quantitative data related to service delivery and facility capacity, as well as qualitative feedback from selected project partners and stakeholders (12 service providers and 19 health managers), were collected and analyzed. Endline data from clinical monitoring visits were available for 39 of the 59 LARC outreach sites.

FINDINGS

Increasing access to FP: Over 30,000 clients reached

Between May 2012 and December 2014, the MOS Project contributed to increased FP access by supporting 1,352 LARC/PM outreach sessions—1,307 LARC outreach sessions and 45 PM outreach sessions. Exceeding planned project goals by more than 150%, a total of 31,489 clients were served through these outreach sessions (see Figure 2, page 3), with the majority of clients (92%) receiving LARCs (IUDs and implants). A total of 750 (2%) clients received PMs, and 1,805 (6%) had an implant or IUD removed (i.e., clients whose device was due for removal or who wished to discontinue use).

A small number of clients (227 women) who originally sought female sterilization at PM sites received an IUD or implants, either because their method preference changed or because medical eligibility
criteria suggested they should use another method. The majority (70%) of PM clients were served during outreach sessions at the project’s PM outreach sites; however, in response to client demand, some received PM services at specially arranged outreach sessions held at LARC outreach sites.

Overall, the provision of LARC services through the project represented a large and important increase over previous LARC service provision at the 59 LARC outreach sites. At baseline, only one of the LARC outreach sites had provided any IUDs during the previous six months, serving an average of eight clients per month during the six-month period. Similarly, at baseline, only seven of the 59 sites had served any implant clients during the previous six months (with a total of 496 implant clients served). In contrast, during the last six months of the project, the same 59 sites served a total of 1,652 IUD clients and 4,045 implant clients—more than a 10-fold increase in the number of LARC clients served.

Leaving behind capacity for sustainable FP services
The MOS Project leaves behind the capacity for continued, sustainable services: During the last quarter of the project, 64% of the project-supported LARC sites provided routine IUD or implant services on their own, without support from the host facility team or the project. This result was achieved by focusing not only on training providers, but also on improving whole-site capacity for service provision (including logistics management), achieving stakeholder buy-in, and increasing demand.

Improving provider and facility capacity for FP service provision
First, important improvements occurred in the routine provision of LARC services and in the capacity for sustained service provision without ongoing support from the host facility teams (see Table 1). For example, nearly all evaluated (37 of 39) sites had adequate rooms for counseling and examining FP clients, a 76% increase from baseline. While only four facilities had an adequate sterilization or high-level decontamination mechanism in place at the beginning of the project, 38 (97%) did by the end of the project.

Confirming findings from clinical monitoring visits, key informants at all levels—from heads of Zonal Health Departments to HEWs—reported that providers at most outreach sites

<table>
<thead>
<tr>
<th>Standard of care</th>
<th>Baseline (n=39)</th>
<th>Endline (n=39)</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adequate rooms for counseling and examining FP clients</td>
<td>21 (54%)</td>
<td>37 (95%)</td>
<td>76</td>
</tr>
<tr>
<td>Basic equipment available and functional (e.g., examining table, lamp, trolley, etc.)</td>
<td>7 (18%)</td>
<td>24 (62%)</td>
<td>244</td>
</tr>
<tr>
<td>Infection prevention protocol or wall chart in FP unit</td>
<td>5 (13%)</td>
<td>32 (82%)</td>
<td>531</td>
</tr>
<tr>
<td>Adequate sterilization or high-level decontamination mechanism in place</td>
<td>4 (10%)</td>
<td>38 (97%)</td>
<td>870</td>
</tr>
<tr>
<td>Daily FP register available and correctly used</td>
<td>32 (82%)</td>
<td>37 (95%)</td>
<td>16</td>
</tr>
<tr>
<td>Comprehensive FP method chart in FP unit</td>
<td>4 (10%)</td>
<td>27 (69%)</td>
<td>590</td>
</tr>
<tr>
<td>Referral linkages with other health facilities</td>
<td>12 (31%)</td>
<td>38 (97%)</td>
<td>213</td>
</tr>
<tr>
<td>Referral mechanism with community-based HEWs</td>
<td>15 (39%)</td>
<td>39 (100%)</td>
<td>156</td>
</tr>
<tr>
<td>Provision of referral feedback to HEWs on clients served</td>
<td>0 (0%)</td>
<td>31 (80%)</td>
<td>N/A</td>
</tr>
</tbody>
</table>
have the training and skills needed to provide LARC services on their own, without ongoing support from the host facility teams. In terms of the needed logistics, the MOS Project initially provided essential equipment and supplies to all outreach sites, but by the project’s conclusion, commodities and infection prevention supplies were being supplied regularly through the government procurement system.

Achieving stakeholder buy-in for providing LARCs/PMs

In general, key informants had positive reactions to the project’s operational model and commented that the project had increased health facility staff’s personal commitment to and satisfaction with FP service provision. This buy-in from health managers and providers played a key role in the project’s ability to deliver services and is a foundation for building upon the project’s success.

Ministry of Health partners were universally positive about the project, both as a means to address unmet need for FP in underserved communities and as a strategy for expanding the capacity to provide LARC services at remote health facilities. Partners noted that prior to the project, women and men living in the communities surrounding the outreach sites were obliged to travel to distant facilities that had the capacity to provide LARC/PM service—often a half day’s travel or more from their homes.

Increasing demand for LARCs/PMs

Key informants also universally reported that the project had had a positive impact on overall demand for FP in their communities, as well as for LARCs and PMs in particular. Many of those interviewed commented that prior to the project, some members of the community were resistant to FP, and that demand for LARC/PMs was extremely low because the methods were unknown and misconceptions and myths were pervasive. However, the project’s training of HEWs and their involvement in conducting community dialogues and home visits were widely reported to have catalyzed changes in people’s perceptions about and interest in these previously underutilized methods.

RECOMMENDATIONS FOR FUTURE INTERVENTIONS

Expand and scale up the model to make LARC/PM services available and accessible in other underserved communities. Although the project has ended, services are expected to continue at many supported sites, and in some cases these have been expanded beyond the project’s initial reach. Staff at host sites and mobile outreach sites spoke emphatically about the need to expand services to other sites, and several host facility teams and mobile outreach site staff reported that they had begun providing mobile outreach services at other sites in their respective catchment areas.

Provide essential equipment and materials for infection prevention directly to the outreach sites at the outset of the project. Basic materials should be provided directly to outreach sites, to reduce the logistical burdens placed on host sites and to facilitate the institutionalization of improved infection prevention practices at outreach sites.
Support the selection of appropriate FP focal persons at outreach sites. Clear guidance should be provided to outreach site managers to select and support appropriate focal persons for outreach sessions. For example, site managers should ensure their availability during scheduled outreach sessions and maximize staff opportunities to gain counseling and clinical skills in LARC service provision.

Complement on-the-job skills transfer and mentorship with formal in-service comprehensive contraception training. Several providers emphasized the importance of formal comprehensive contraception training to be able to insert IUDs, noting that without such training, they would have been able to insert implants but would not have been able to independently provide IUD services.

Ensure that outreach sites have adequate space for FP service provision. While the project led to improvements in terms of sites’ setting aside adequate space for FP counseling and service provision, several key informants emphasized the importance of space and reported that ensuring the quality of services had been challenging because of infrastructure gaps.

CONCLUSION
The public-to-public mentorship model that was used by the MOS Project appears to have contributed to a large increase in LA/PM service provision at supported sites and has substantially strengthened the capacity for sustained service delivery, particularly at the LARC sites. It offers a promising way to meet unmet need for FP in underserved communities, while strengthening capacity for sustained service provision—especially for LARCs. The model is an important health systems strengthening approach that can be scaled up in areas with limited service accessibility, particularly in hard-to-reach communities.

REFERENCES

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