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**The RESPOND Project Study Series:
Contributions to Global Knowledge**

Report No. 13

**Approaches to Mobile Outreach Services
for Family Planning:
A Descriptive Inquiry in
Malawi, Nepal, and Tanzania**

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Contents

Acknowledgments	v
Acronyms and Abbreviations	vii
Executive Summary	ix
Introduction	1
Background	1
Methodology	4
Country Case Studies	5
Tanzania	5
Nepal	12
Malawi	19
Discussion	27
Key Considerations for Programming	28
Research Questions	31
References	33
Appendixes	
Appendix 1: Interview Questions: Private Sector	37
Appendix 2: Interview Questions: Public Sector	49

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The RESPOND Project, funded by the U.S. Agency for International Development (USAID) Office of Population and Reproductive Health, undertook this case study to document the important role that mobile outreach services play in fulfilling clients' needs. In conducting the fieldwork, many people from the three countries under review (Malawi, Nepal, and Tanzania) contributed their time, experiences, and insights to help the authors prepare this study. The team had the pleasure of interviewing key informants from ministries of health, development partners, nongovernmental organizations, and private-sector groups in all three countries. We appreciate their time and insights.

The study team also had the opportunity to observe mobile outreach services in action in all three countries, giving us the opportunity to speak with health care providers, volunteers, community leaders, and clients. We thank all those who spoke with us for their candid responses to our many questions. There are so many people to thank it would be difficult to name them all.

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As Dirgha Raj Shrestha (Country Director, EngenderHealth/Nepal), a key informant for this study, noted, “Nepal needs to reach the ‘far hanging fruits’—meaning family planning clients who need assistance due to geographical distance/difficulties in reaching services; poverty; lack of doctors and other service providers. Mobile outreach services are critical for these clients to achieve access to the family planning services they need.”

Acronyms and Abbreviations

ATP	ACQUIRE Tanzania Project
BCC	behavior change communication
BLM	Banja la Mtsogolo
CBDA	community-based distribution agent
CHW	community health worker
CYP	couple-years of protection
DHO	district health officer
DMO	district medical officer
DRCHS	district reproductive and child health section
FCHV	female community health volunteer
FHD	Family Health Division (Ministry of Health and Population, Nepal)
FP	family planning
FPAM	Family Planning Association of Malawi
HSA	health surveillance assistant
IUD	intrauterine device
LA/PMs	long-acting and permanent methods (of contraception)
MCH	maternal and child health
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare (Tanzania)
MST	Marie Stopes Tanzania
NGO	nongovernmental organization
NSV	no-scalpel vasectomy
PHC	primary health care
RCH	reproductive and child health
SPN	Sunaulo Parivar Nepal
SWAp	sector-wide approach
USAID	U.S. Agency for International Development
VSC	voluntary surgical contraception

Executive Summary

Mobile outreach services for family planning (FP) are widely used in the global south to reach underserved, hard-to-reach populations, yet they have been sparsely documented in recent years (Solo, 2010). To address this deficit, the RESPOND Project conducted a study of mobile outreach services, with a focus on long-acting and permanent methods of contraception (LA/PMs) (the intrauterine device [IUD], hormonal implants, vasectomy, and tubal ligation). This inquiry was conducted at the request of the U.S. Agency for International Development (USAID) Office of Population and Reproductive Health's Service Delivery Improvement Division. Fieldwork was conducted in three countries between 2010 and 2012.

In this report, the term “mobile outreach services” refers to mobile teams of trained providers operating in an area with limited or no FP or health services. RESPOND staff observed mobile outreach services at 20 facilities and interviewed more than 150 providers, clients, managers, and policymakers in Malawi, Nepal, and Tanzania, countries with long-established and diverse mobile outreach programs implemented by both the public and nongovernmental sectors.

The purposes of the study described in this report were to:

- Contribute to the body of knowledge about mobile services for FP
- Document case studies from three countries that have considerable experience with providing LA/PMs through mobile outreach
- Highlight, through detailed programmatic descriptions, the realities of planning and implementing mobile outreach services in Sub-Saharan Africa and Asia
- Inform program initiation, replication, and scale-up
- Spur conversation within the international FP community about the importance and role of mobile services, especially in regard to LA/PMs

The three countries studied used a variety of service delivery modalities for mobile outreach services. Tanzania, for example, relies on a strong mix of public- and private-sector mobile services, while Nepal's outreach is provided mainly by the public sector. In Malawi, mobile services offered by nongovernmental organizations (NGOs) focus on FP; by contrast, the government offers both mobile FP services and integrated family health services, including contraception, through mobile outreach. The Tanzanian Ministry of Health and Social Welfare offers routine mobile outreach throughout the year; in addition, it sends out mobile teams during special weeks. In Nepal, government-sponsored mobile outreach is method-specific, focused on either long-acting methods or permanent methods. In Malawi, outreach sometimes includes HIV and AIDS and maternal and child health (MCH) services as well as FP. In the three countries examined, most outreach services (even those offered by 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.

Mobile outreach services have been used to address gaps in FP services for underserved populations for decades in some countries, extending LA/PM access to clients who might otherwise lack it. Mobile services have not been without controversy, as have some clinic-based services. Health advocates have over time expressed concern about the quality of care offered by mobile outreach (especially in the aftermath of documented abuses). On the other hand, supporters of mobile services argue that *all* FP services must pay scrupulous attention to quality, safety, and clients' rights. Because mobile services are often highly visible and typically rely on highly trained, very experienced providers, they may actually offer better quality services than those generally available in rural areas. RESPOND's review of mobile outreach services did not document any serious quality-of-care issues in the three countries studied.

Based on interviews, reports, and observations, the authors offer 10 key programmatic considerations for mobile outreach:

1. When working in less-than-ideal circumstances, program managers and staff must adapt to ensure quality of care.
2. Greater attention must be paid to ensuring the availability of contraceptives, medical equipment, instruments, and expendable supplies for mobile outreach services.
3. Attention to staff planning and innovations in staffing for mobile outreach could improve access to FP, especially LA/PMs.
4. Supervision is an important component of mobile outreach and should be conducted at regular intervals to ensure quality.
5. Mobile services offer opportunities for on-the-job training, coaching, and skills improvement in LA/PMs for new staff and for those needing refresher training.
6. Demand creation that relies on a combination of interpersonal communication and community mobilization is an effective way to reach underserved populations, though these efforts would benefit from greater planning and coordination.
7. Community health workers and/or volunteers play a crucial role in demand creation and community mobilization for mobile outreach and ultimately in improved access for underserved populations.
8. Public-private partnerships are key. District health officials should coordinate all public- and private-sector programs offering mobile services in a district.
9. Improvements are needed in data collection and analysis, including disaggregation of data by mode of service delivery.
10. Governments should ensure that mobile outreach services are free of charge to clients.

The authors also offer the following questions that merit additional data collection and research:

- Does scale-up of mobile outreach services contribute to, or compromise, efforts to build the capacity of hospitals and health facilities to routinely provide LA/PMs?
- To reduce unmet need for FP in general and for LA/PMs in particular, are there criteria that would inform an optimum mix of static and mobile services? What demand "tipping points" would indicate a need to increase, or decrease, the amount of outreach services?

- How do public-sector programs best coordinate both public and private efforts to reach the maximum number of people in remote areas? What methods of data collection and use for decision making and planning foster the best service coverage?
- Are clients satisfied with the quality of mobile outreach services? How do mobile and static services compare in terms of client satisfaction?
- Do hidden client fees in the public and private sectors hinder access to mobile services for FP?
- How important is prescreening in improving quality of care and efficiency of service delivery?
- Do mobile services adequately meet the needs of hard-to-reach men and women?
- In any given country, how cost-efficient and cost-effective are mobile outreach services?
- What is the impact of integrated mobile HIV/MCH/FP services on unmet need for FP? How does this impact compare with that of dedicated FP outreach and method-specific outreach? Are integrated services a “distraction,” or do they reach more FP clients because of the additional services they provide?

Introduction

Mobile outreach services for family planning (FP) are widely used in the global south to reach chronically underserved populations, including those living in hard-to-access geographic areas; however, documentation, especially in recent years, has been sparse (Solo, 2010). The purposes of the study described in this report were to:

- Contribute to the body of knowledge about mobile services for FP
- Document case studies from three countries— Malawi, Nepal, and Tanzania—that have considerable experience with providing long-acting and permanent methods of contraception (LA/PMs) through mobile outreach
- Highlight, through detailed programmatic descriptions, the realities of planning and implementing mobile outreach services in Sub-Saharan Africa and Asia
- Inform program initiation, replication, and scale-up
- Spur conversation within the international FP community about the importance and role of mobile services, especially in regard to LA/PMs

The study was undertaken by the RESPOND Project at the request of the Service Delivery Improvement Division, Office of Population and Reproductive Health, U.S. Agency for International Development (USAID).

This report:

- Describes the history, policies, and experiences that shape mobile outreach services
- Describes how various mobile outreach models are implemented, highlighting different approaches
- Offers programmatic considerations for both the public and private sectors
- Identifies operational or other questions for further research

Background

Programs use different terms to refer to service delivery “beyond the clinic walls.” Examples include *mobile services*, *outreach*, *itinerant teams*, *camps*, and *satellite services*. Most of these terms, however, refer to the delivery of FP services by a mobile team of trained providers in an area with limited or no FP or other health services (Solo, 2010; Campbell & Corby, 2011; Jacobstein et al., 2013). Commonly used approaches for LA/PMs (Thapa and Friedman, 1998; Solo, 2010; USAID, 2010) include:

- Vehicles with staff, equipment, and supplies moving from place to place
- Teams from higher-level health facilities traveling periodically to lower-level facilities to provide services
- Temporary facilities being set up in an area, for a few days or as long as several months
- Services provided in a mobile unit, such as a specially equipped van or tent
- Services provided in community settings, such as schools

A variety of FP services may be offered through mobile services, including short-acting, long-acting, and permanent methods of contraception. Sometimes FP services are combined with other preventive or curative health services.

Governments, nongovernmental organizations (NGOs), donors, and others working in the FP field consider several factors when deciding their level of investment in mobile outreach services, especially for LA/PMs. They ask:

- Are peripheral staff so focused on meeting clients' emergency, curative, and primary health care (PHC) needs that they cannot provide contraception (including LA/PM services, which require more time and resources than other contraceptive services)?
- Do peripheral clinics have trained staff capable of providing LA/PMs?
- Are there breakdowns in the supply chain so that contraceptives (especially hormonal implants and injectables) do not reliably reach peripheral clinics?
- Do peripheral clinics routinely stock sufficient equipment, instruments, and expendable supplies to provide LA/PMs? Are the equipment and instruments in good repair?

Shortcomings in the capacity of low-level health centers and dispensaries might be addressed through intensive, system-wide attention to logistics, human resources, training, quality assurance, and so on. However, governments and others must ask if such attention is a cost-effective solution for small clinics in remote, sparsely populated, and/or disadvantaged areas, especially if these clinics cannot attract and retain qualified health staff. Even when stakeholders institute system-wide improvements or introduce task shifting to allow lower-level providers to offer LA/PMs, these changes take time. In the interim, clients have a right to contraceptive choice and high-quality services. Therefore, mobile outreach services can fill an important need.

History and Concerns

For decades, governments, donors, and the private sector have invested in mobile services, and these services have played an important role in increasing access to FP, including LA/PMs, and expanding contraceptive choice. From the 1960s through the 1990s, investigators described a variety of mobile services in several countries for a range of FP methods, including the intrauterine device (IUD), female sterilization, and vasectomy (Hartman, 1966; IPPF, 1971; Munroe & Jones, 1971; Kim, Ross, & Worth, 1972; Gail et al., 1973; Khairullah, 1988; Coeytaux et al., 1989; Thapa & Friedman, 1998).

Mobile services are not without controversy, however. In the 1970s in India, investigators documented coerced sterilization for demographic reasons, often in mobile camps (Freedman & Isaacs, 1993). Recently, there have been allegations of forced sterilizations provided through mobile services in Uzbekistan (Tynan, 2010; Wickstrom & Jacobstein, 2011). But such abuses have also been recorded in static sites and in FP programs in general (Boesten, 2007; Diamond-Smith & Potts, 2010; Flynn, 2012).

Key informants for this study and others have noted concerns about mobile services, including:

- Disposal of medical waste
- Irregularity of services
- Difficulties with client follow-up and continuity of care after mobile service teams leave a site (especially in hard-to-reach geographical areas) (Eva & Ngo, 2010)

Furthermore, women’s rights advocates, donors, and international NGOs concerned with safeguarding clients’ rights ask how well mobile programs ensure informed and voluntary decision making, especially for tubal ligation and vasectomy (EngenderHealth, 2003).

Supporters of mobile services argue that *all* FP programs must ensure informed and voluntary decision making and offer a range of contraceptive options—and, in fact, mobile services *expand* contraceptive choice by making FP available to those who otherwise lack access (Solo, 2010; Campbell & Corby, 2011; Jacobstein et al., 2013). It is often only through specially organized outreach events that clients are confident that they can obtain their method of choice (Campbell & Corby, 2011). Mobile services further enhance access because they are frequently offered free of charge in communities (Jacobstein et al., 2013); consequently, clients spend less on transportation and take less time away from work and family than they would if they had to travel to static facilities. Thus, while many lower-level facilities cannot routinely offer LA/PMs, bringing mobile FP services to underresourced facilities and communities may be strongly preferable to providing no services at all. At issue is not just the right of individuals and couples to achieve their reproductive intentions, but also the women’s lives that are saved by FP.

As for quality and safety, one key informant for this study, who is a proponent of mobile services, argued that the high visibility of mobile outreach services in the community (compared with that of static services) may make quality of care issues more evident and observable. In fact, quality of care issues are not unique to mobile services. All FP programs must pay strong attention to quality, including:

- *Technical* aspects (e.g., contraceptive security, counseling, infection prevention, performance to standard, client follow-up)
- *Personal* aspects (e.g., client convenience, privacy, informed choice and consent)

When examining female sterilization services in Nepal, Thapa and Friedman (1998) concluded that services provided by mobile outreach and in hospitals were comparable in terms of client screening and quality of care. Mobile services may in fact have the potential to offer better quality services than might otherwise be possible at the peripheral level. Specialist mobile teams, for example, are highly trained as a rule; they often have much more experience with delivering clinical FP methods than do providers at low-level health facilities. Moreover, because mobile services are time-limited and are provided close to the community, there may be greater potential for community scrutiny and oversight. Clients may also feel more empowered to request care or express concerns at their local clinic or dispensary than they might at an unfamiliar district hospital.

Recent Interest in Mobile Services

Drawing upon lessons learned in the past, FP programs have continued to implement mobile services. The international FP community has a growing interest in studying how mobile services can be provided most effectively and efficiently. Mobile services have been identified as a potentially high-impact practice in a comprehensive FP strategy (USAID [no date]).

In 2010, USAID published *Expanding Contraceptive Choice to the Underserved through Mobile Outreach Service Delivery*, a practical programming handbook (Solo, 2010). This work provides guidance for planning, implementing, and scaling up mobile services. In recent years, EngenderHealth’s ACQUIRE and RESPOND projects and Marie Stopes International have all reported on the

successful implementation of mobile services for LA/PMs (ACQUIRE Project, 2008; Bakamjian, 2008; Toth, 2008; Eva & Ngo, 2010; MSI, 2010; Campbell & Corby, 2011; Jacobstein, Wickstrom, & Wachepa, 2011; Jones, 2011; RESPOND Project, 2011; RESPOND Project, 2012; Jacobstein, 2013). Documented unmet need for both spacing and limiting births has supported the use and expansion of mobile services for LA/PMs as well as other contraceptive methods (USAID & FHI, 2007; Al-Attar, 2009; Wickstrom & Jacobstein, 2011; Jacobstein et al., 2013; Van Lith, Yahner, & Bakamjian, 2013).

Methodology

To conduct this study, teams of technical advisors and researchers from RESPOND, working with local staff and/or national counterparts, carried out structured assessments (meetings, interviews, and observations of mobile outreach services) in Tanzania (in December 2010), Nepal (in January 2011), and Malawi (in May 2012). These assessments followed a desk review of the literature for each country.

In Tanzania, fieldwork was conducted in two regions. In Dodoma Region, the team observed outreach services at the Handali Health Center in Chamwino District. In Mwanza Region, the team visited the Ihayabuyaga Dispensary and the Kisessa Health Center in Magu District and the Bugulula and Kagu dispensaries in Geita District.

In Nepal, the team visited nine facilities: a health post, a sub-health post, and a PHC center in each of three districts: Makwanpur, Parsha, and Sindhupalchok. In Makwanpur (in the Hill Zone), the team observed vasectomies; in Parsa (in the Terai Zone), the team observed minilaparotomy under local anesthesia; and in Sindhupalchok (also in the Hill Zone), the team observed both male and female sterilization. The team also visited Chhetrapati Clinic in Kathmandu, Nepal's principal training facility.

In Malawi, the team observed mobile outreach services in Lilongwe, Kasungu, Blantyre, and Thyolo districts, at three public-sector sites and three NGO sites. In Lilongwe, the team visited the Chileka Health Post and the Mlinga Roman Catholic Church site in Mehawa. In Kasungu, the team visited two rural communities and the clinic operated by the Family Planning Association of Malawi (FPAM). In Blantyre, the team visited the clinic operated by Banja la Mtsogolo (BLM), a local NGO, and the Lundu District Health Center in Malume village. In Thyolo, the team visited the Puteni Health Post.

In addition to observing services at these locations, the teams collectively conducted key informant interviews with more than 150 program managers, service providers (surgeons, nurses, counselors, and infection prevention personnel), drivers, clients, Ministry of Health (MOH) personnel, cooperating agency staff, local NGO staff, community leaders, and others, using two structured question guides (see appendixes), one for private-sector providers and one for public-sector providers. These guides covered the organization and management of mobile outreach services, geographic coverage, service frequency, human resources, procurement, supply management, transportation, reporting and information management, community engagement and mobilization, communication with clients, service delivery, quality of care, supervision, and funding. The authors synthesized data from the three countries, identified common themes, and summarized the findings.

Country Case Studies

In selecting countries for review, the study team considered the following criteria:

- Longstanding, well-established national mobile services programs, rather than recently launched successful pilot or small-scale programs
- A variety of mobile outreach models across the countries chosen
- Approaches that offered both LA/PMs and other FP methods through mobile outreach

Together, the three countries chosen—Tanzania, Nepal, and Malawi—met these criteria. Tanzania, for example, relies on a strong mix of public- and private-sector mobile services, while Nepal's outreach is provided mainly by the public sector. In Malawi, mobile services offered by NGOs focus on FP; by contrast, the government offers both mobile FP services and integrated family health services, including contraception, through mobile outreach. The Tanzanian Ministry of Health and Social Welfare (MOHSW) offers routine mobile outreach throughout the year; in addition, it sends out mobile teams during special weeks. Both approaches provide all methods, including LA/PMs. In Nepal, government-sponsored mobile outreach is method-specific, focused on either long-acting methods or permanent methods. In Malawi, outreach sometimes includes HIV and AIDS and maternal and child health (MCH) services as well as FP. In the three countries examined, most outreach services (even those offered by NGOs) are provided at public-sector health facilities. In some cases, mobile teams use community centers, schools, churches, tents, or vans. Tanzania and Nepal rely on physicians to provide permanent contraception. By contrast, Malawi has instituted task-shifting policies for permanent and long-acting contraception, due to staff shortages of physicians; thus, clinical officers serving on mobile teams can perform female sterilizations and nurses can provide implants and IUDs. In all three countries, community health workers or volunteers play a role in educating clients about FP, including LA/PMs, and informing them about the schedule for mobile services.

Tanzania

Mobile outreach health services in Tanzania began in the 1970s, with the MOHSW offering MCH services through periodic outreach. From the early 1990s to 2001, UMATI, the member association of the International Planned Parenthood Federation (IPPF) in Tanzania, provided mobile outreach services for FP, including LA/PMs, with USAID-funded technical assistance and support from EngenderHealth (Pile & Simbakalia, 2006). After 2001, however, funding cuts ended those services. More recently, mobile outreach for FP has regained momentum in both the public and private sectors; it is becoming an important strategy for reaching underserved women and men in rural parts of the country.

Mobile services are well-suited to Tanzania for three reasons:

- Most women live within 10 km of a health facility, but because of poor road conditions and limited transportation, travel is time-consuming, expensive, and difficult.
- Access to contraception is limited. While short-acting methods are more widely available, few MOHSW facilities have the capacity to provide LA/PMs in rural areas, as many are staffed by nurses and midwives not trained in these methods.

- Twenty-five percent of women in the country have an unmet need for FP (16% for spacing and 9% for limiting); these figures are even higher in rural areas (27%; 17% for spacing and 10% for limiting) (NBS & ICF Macro, 2011).

Mobile Outreach Approaches

Tanzania is currently using three mobile outreach approaches in rural areas to increase access to FP services (in particular, LA/PMs). Two of these approaches are managed by the public sector—the MOHSW—and one by the private sector. The MOHSW has offered mobile outreach, with support from the USAID-funded ACQUIRE Tanzania Project (ATP), which was managed by EngenderHealth. Private-sector mobile outreach services are managed by Marie Stopes Tanzania (MST) and PSI.¹

The public sector

Over the last several years, the MOHSW has strengthened mobile outreach for FP and has expanded services to more than 100 districts. The MOHSW uses two distinct approaches:

- **Routine mobile outreach services:** A team of trained providers from a district hospital travels to health centers or dispensaries to provide FP services, including LA/PMs, on a single day or over a few days. Clients are informed in advance when services will be available. Typically, the team returns home at the end of the day and may make additional outreach visits over the course of the next few days to the same locale. After mobile outreach visits, team members resume their normal duties at the hospital.
- **Family Planning Weeks:** During the course of one week, multiple teams of service providers from a district hospital travel to a number of health centers and dispensaries in the district to provide FP services, including LA/PMs. Again, clients are informed in advance that services will be available. During the week, these dedicated teams move from facility to facility to cover as many sites as possible and return to normal duties thereafter.

The MOHSW introduced Family Planning Weeks in 2009 to supplement routine outreach, as a way of reaching distant locations to meet client demand. As they have evolved, Family Planning Weeks have become large, district-wide undertakings; they require considerable advance preparation, both for the deployment of multiple outreach teams and for mobilization of clients. Teams are in the field for a week and work as many hours as are necessary to serve all waiting clients.

Nurses on Three-Wheeled Vehicles

MST recently began a new mobile service pilot in several districts of Zanzibar. Trained nurses drive three-wheeled vehicles called *bajaji* to government health centers and dispensaries. The nurse packs the bajaji with contraceptives, supplies, and instruments needed to provide short-acting methods and to perform IUD insertions and removals.

Both approaches make it possible for clients to access FP services that would not otherwise be available to them.

¹ PSI's mobile services are not reviewed here, because PSI's program was new and limited in scope at the time of data collection.

The private sector

MST, a private NGO, implements Tanzania's third approach to mobile FP services. Fourteen full-time itinerant teams of health professionals circulate in 84 districts across Tanzania, providing services at MOHSW health centers and dispensaries. In late 2012, MST received funding to increase the number of outreach teams to 21. Six of MST's 14 current outreach teams work exclusively on FP services, particularly LA/PMs; the others provide a broad range of reproductive and maternal health services. Each of the six dedicated FP teams usually covers six districts a year, although some cover more, based on district needs and requests from district and regional reproductive and child health (RCH) coordinators. To reach all districts in a team's coverage area, each team is typically in the field for 18 days per month. When they are not in the field, team members compile reports and organize supplies and funds for the next outreach trip; they also work two days per month at one of MST's 14 static facilities.

Management

In Tanzania's decentralized health care system, management of the MOHSW's mobile outreach is the responsibility of the Council Health Management Team—in particular, the district medical officer (DMO) and the coordinator of the district reproductive and child health section (DRCHS). ATP staff in four zonal offices work closely with these district counterparts to organize and provide mobile outreach services.

MST's mobile outreach teams are directed by MST's outreach manager, based in Dar es Salaam, in collaboration with two outreach zonal coordinators, based in Dar es Salaam and Arusha. District MOHSW officials and MST staff expressed the need to continue improving coordination and collaboration between the public and private sectors working on mobile outreach.

Planning

The DMO and/or the DRCHS coordinator decide when and where to offer outreach services and which staff from the district hospital will be assigned to outreach teams.

As a general rule of thumb, mobile outreach sites are chosen based on the following criteria:

- Hard-to-reach location
- Unmet need for spacing and limiting births
- Sufficient FP demand for the methods to be offered
- Suitability of the premises (e.g., adequate room for clients to rest after a clinical procedure, particularly a tubal ligation)

Before providing mobile outreach services, staff from the public or private sector visit potential sites to determine if they meet these criteria. Because client registers at local health facilities can offer an indication of demand, they are important sources of information for planning. If a client is interested in an LA/PM that is not available at the site, a staff member registers her or him. When a facility registers a critical mass of clients, the district organizes mobile outreach services for that site.

Staffing

A severe shortage of skilled human resources in Tanzania limits the availability of health care services. Because of difficult living and working conditions, personnel shortages are especially severe in rural facilities. One report provided an example of the differences between rural and urban areas: One rural district had 0.3 health care workers per 1,000 inhabitants, while one urban district had 12.3 health care workers per 1,000 residents (Munga et al., 2009).

Every day, the few trained staff available in health centers and dispensaries must attend to a large number of clients, including those with emergency and chronic health care needs. Clients seeking nonemergency services, such as FP, often must wait until providers have finished with priority cases; sometimes they are told to go elsewhere for FP care. Given the severe personnel constraints, mobile outreach is an important service delivery mode to provide LA/PMs in areas where they would not otherwise be available.

Also, some clients believe that mobile outreach services are of higher quality than those available at the local facility. Clients interviewed for this study stated that they preferred to wait for an outreach visit rather than obtain an implant or IUD from a local provider; they believed that mobile service providers offer higher quality of care.

MOHSW service teams, whether for routine mobile outreach or for Family Planning Weeks, usually include a surgeon for female sterilization and no-scalpel vasectomy (NSV), an assistant surgeon, a nurse or clinical officer for IUD and implant insertions, an FP counselor, and a driver. The surgeon is the team leader. When the surgeon finishes performing sterilization procedures for the day, he or she inserts and removes hormonal implants and IUDs, as needed. MST outreach teams usually include four staff members: a surgeon, two nurses, and a driver.

During outreach sessions, MOHSW and MST staff provide all FP services, unless the client volume is so large that it is impossible to do so. In such cases, both MOHSW and MST teams may ask local staff to serve clients who wish short-acting methods. Staff from the local health center or dispensary may help the outreach team with counseling, confirmation of informed consent, infection prevention, instrument processing, and client flow; they may also care for clients who come to the facility for other services, such as antenatal care or growth monitoring.

Logistics

Both MOHSW and MST obtain contraceptives and some expendable supplies from the MOHSW's district medical stores. When the district medical stores are out of a particular FP method, contraceptives are requested from zonal medical stores. When district medical stores do not have necessary equipment in stock, both MOHSW and MST purchase equipment, such as portable sterilizers and IUD insertion kits, from local vendors. Larger items, such as exam tables, beds, and instrument trolleys, are already on-site at the facilities and are used during outreach sessions.

MOHSW and MST teams bring to the health centers and dispensaries contraceptives, linens, drapes, gowns, equipment, and the instruments needed to insert and remove IUDs and implants and to perform sterilization procedures. Throughout the day, linens are washed and hung to dry and instruments are processed as needed. On days with significant client interest and demand for LA/PMs, key informants noted that clients may experience delays in services while instruments are being disinfected or sterilized between procedures.

For mobile services to be effective, adequate supplies of contraceptives, instruments, and expendable supplies are essential.

Key informants noted three urgent priorities for both static and outreach services in the Tanzanian national FP program:

- Maintaining an adequate stock of contraceptives
- Having sufficient quantities of medical instruments
- Having sufficient quantities of expendable supplies

With facility stock-outs of injectables (one of the most popular contraceptive methods) and implants (the most popular long-acting method), women are at risk of unwanted pregnancy (NBS & ICF Macro, 2011). While mobile outreach services try to plan for the number of clients per method, stock-outs of implants and shortages of medical instruments were reported.

Demand Creation

Once a date is set for an MOHSW mobile visit, local health center or dispensary staff inform village leaders and village health workers so they can let both registered clients (those on the waiting list for LA/PM services) and any other interested clients know about the upcoming visit. Many health facilities display posters up to a month in advance, and facility staff often inform clients of upcoming outreach days during general health talks or within the outpatient department. Some districts hang posters in busy market areas, giving the time and place of mobile outreach days. Before an outreach event, volunteers often announce it using megaphones, drums, and whistles in areas surrounding the facility. Churches, mosques, ward development committees, and other community groups may also publicize the event. Community mobilization:

- Engages communities in discussing FP
- Informs clients about all methods, including LA/PMs
- Ensures enough of a caseload of LA/PM clients to make the outreach visit worthwhile



Photo: B. Jones/EngenderHealth

Rose was seeking minilaparotomy after bearing eight children, five of whom are still living. Rose had used the pill and Depo-Provera to space her pregnancies, but she decided in 2000 that she did not want any more children. Unfortunately, she had to wait another decade before she was able to obtain sterilization services; during that time, she bore two children that she had not intended to have. When giving birth to her sixth child by cesarean section, Rose asked for a sterilization, but the surgeon was too busy that day to accommodate her.

Rose's story demonstrates how difficult it can be for rural women in Tanzania to access female sterilization services. No woman should have to wait a decade to receive the contraceptive method she prefers, nor should she bear children she did not intend to have. Without mobile services, Rose might have gone on to have other unintended pregnancies.

—Handali Health Center, Dodoma, Tanzania, December 2010

While key informants from MOHSW recognized the importance of community mobilization, they noted that these activities tend to be done on an ad hoc basis and vary greatly by location.

MST uses similar approaches to get the word out about upcoming mobile outreach services. Both the public and private sectors have developed leaflets, brochures, a counseling flipchart, and posters in Swahili. MST also uses diagrams of all methods on a foldable wall chart in Swahili.

Both ATP and MST managers reported that increased demand-generation activities, including use of mass media, are needed to educate prospective clients about FP and to mobilize communities. Informants stated that in recent years, behavior change communication efforts have largely focused on HIV prevention, with much less done about spacing and limiting births.

Community mobilization activities often are done on an ad hoc basis and vary greatly by location.

Quality of Care and Supervision

Tanzanian health care services are grounded in the principles of quality of care, as outlined in national norms, guidelines, and standards (MOH, 2003); these standards apply equally to static and outreach activities. During routine MOHSW mobile outreach services and Family Planning Weeks, regional and district supervisors make periodic visits to ensure quality. The MOHSW often faces shortages of staff and fuel for supervision; however, special funding of mobile outreach services for FP makes it possible for supervisors to visit the periphery and to support all types of health care staff.

Given the large number of LA/PM clients served during mobile outreach services, MOHSW trainers and supervisors focus on monitoring clinical skills and quality of care, reviewing record keeping and adherence to informed consent procedures, and conducting follow-up and support for recently trained staff. Depending on their availability, local staff may help the team with client registration, counseling, and management of clients in recovery. During the outreach session itself, site staff or outreach staff provide additional information and counseling as needed, verify method choice, and give instructions for follow-up care based on the method chosen. Mobile teams usually bring items needed for infection prevention with them.

Trainers and supervisors also take advantage of on-the-job training opportunities during mobile outreach services. With recent policy changes in Tanzania allowing clinical officers to provide sterilization procedures and MCH aides to provide implants at dispensaries, ATP-supported sites use mobile outreach as an opportunity to:

- Provide on-the-job training
- Build dispensary capacity to provide implants and short-acting methods during normal business hours

During Family Planning Weeks, an additional supervisory team—including the DRCHS coordinator, the regional RCH coordinator, an ATP program officer, and sometimes a regional trainer—travel to several sites per day. Depending on the number of clients registered for LA/PMs, the supervisory team may redirect a district team to sites with a higher client load.

Management of complications is an important aspect of quality of care. As part of in-service training, MOHSW LA/PM providers learn to manage complications that may occur during a procedure, and outreach teams carry drugs for use in case of emergency. Clients are instructed to return to the health center or dispensary if they experience problems after a procedure. If site staff cannot manage the problem, they refer clients to the district hospital, using a standard referral form. If a major complication occurs either during or after a procedure, the provider reports details to the DMO, the DRCHS coordinator, and the regional and zonal levels, according to government protocols, and follow-up actions are initiated.

MST follows the clinical standards and guidelines used by all of MSI's country programs; these protocols mainly conform to Tanzania's standards and guidelines, with some slight variations in clinical technique and pain management. MST staff give clients a card with the cellular phone number of a team member whom clients can call if they have a question or problem with their method. At quarterly meetings, MST's Medical Development Team discusses reported complications and reviews records to address problems that may have led to a complication. MST's clinical services manager also conducts an annual quality audit of each outreach team and decides if additional training is needed. In addition, MSI headquarters conducts a quality audit on three outreach teams each year.

MOHSW client record forms are used for both facility-based services and mobile outreach services, regardless of whether the provider is from the static facility or part of a mobile outreach team. Client record forms are kept at the facility and include demographic data, medical history, physical examination findings, procedure notes, and information from the first follow-up visit. For clients who choose a permanent method, the form also includes details about the surgical procedure, the anesthesia used, and (in accordance with national standards) the client's signed informed consent statement.

Both public- and private-sector programs follow the MOHSW system for client records. Therefore, MST teams record services in the local facility's MTUHA book (MOHSW's health information system is referred to by the Swahili acronym MTUHA); service data are reported up the line, ultimately to the DMO. In this way, the district captures all client services. In addition, MST client forms, including medical history and client consent, are completed for MST internal records. MST maintains its own database, using monthly activity reports submitted by its mobile outreach teams for its internal audits. At the request of the MOHSW and to avoid confusion, MST teams use the MOHSW's consent form for clients receiving permanent methods. According to key informants, MOHSW records may be disaggregated in the future by mode of service delivery in the MTUHA books, to better enable reviews of mobile outreach services.

Disaggregated data for static sites and mobile services can enhance supervision and monitoring of each type of service.

Financing

The mobile services described in this report are offered free of charge to clients.

Funding for FP varies by district, depending on the interests of local government authorities and other participating groups, competing health care priorities, and donor-driven activities. To support mobile outreach services, local government authorities are encouraged to allocate sufficient funds in their annual budgets for FP and expend those funds. However, mobile outreach services in Tanzania are funded primarily by USAID through ATP and MST. Additional funding for MST programs comes from other international donors.

Summary

The 2010 Tanzania DHS reported that contraceptive prevalence has increased significantly, from 26% of married women in 2004–2005 to 34% in 2010 (NBS & ICF Macro, 2011). Use of modern methods increased from 20% to 27% of married women in the same time period. According to both MOHSW and MST representatives, mobile outreach has contributed to these increases, although how much is unknown.

Stakeholders agree that mobile outreach is an effective service delivery mechanism to increase the availability and use of FP, especially LA/PMs, among underserved populations. To demonstrate the popularity of mobile outreach, informants reported that several DMOs outside the areas served by ATP-supported teams have organized mobile outreach services using their own district resources.

An important aspect of Tanzania's mobile outreach program is the strong public-private partnership between MOHSW and MST. Nevertheless, key informants stated that coordination among all players could be improved, to enhance efficiency and to avoid overlap at the district level. To improve efficiency, cost-effectiveness, and equity of service delivery for the underserved, two specific areas need improvement:

- Enhanced contraceptive security (in particular, reduction in stock-outs)
- Rationalization of staff

As noted above, disaggregated data are also needed to better reach underserved populations, to inform future investments in mobile outreach services, to reduce unplanned pregnancies, and to improve maternal health.

Nepal

More than one in four married women in Nepal (27%) have an unmet need for FP (MOHP, New ERA, & Macro International, 2012). Twenty-eight percent of rural women, who are the focus of the Government of Nepal's mobile outreach services program, have an unmet need for spacing (10%) or for limiting (18%); these women also have difficulty accessing services because of geographic and transportation issues (MOHP, New ERA, & Macro International, 2012). For example, more than one-third of people in the Hill Zone live more than four hours from an all-weather road (MOHP, New ERA, & Macro International, 2012).

Mobile outreach services have long been a cornerstone of Nepal's FP efforts. With 83% of the population living in rural areas (MOHP, New ERA, & Macro International, 2012), mobile services are critical in hard-to-reach areas, which are characterized not only by poor roads but

also by inadequate health care facilities and inadequately trained personnel. Mobile clinics serve nearly one in seven of Nepal's modern contraceptive users nationwide (MOHP, New ERA, & Macro International, 2012), from the lowlands of the Terai Region to the hill and mountain zones. Mobile services are an important source of permanent contraception in Nepal, accounting for 19% of all female sterilizations and 33% of all vasectomies (MOHP, New ERA, & Macro International, 2012). With new initiatives for long-acting methods being undertaken and scaled up, the Government of Nepal expects to increase the provision of these methods via mobile outreach services and satellite clinics.

Because of weather conditions, Nepal and other countries on the subcontinent can only provide mobile outreach services during the dry season (usually November to February). In Nepal, 60% of the roads, including most rural roads, cannot provide all-weather connections (World Bank, [no date]). During the wet season, roads are impassable in much of the country. In addition, key informants pointed out the traditional belief that the risk of infection increases when any surgery is performed under hot and moist conditions. The Nepal program has tried to address this issue with limited success.

Mobile Outreach Approaches

Mobile services in Nepal have historically focused on voluntary surgical contraception (VSC) (i.e., female and male sterilization). "VSC camps" were introduced in the mid-1970s (the term "camps" communicating the temporary nature of the service sites) and continue to this day. Over the years, the Government of Nepal has used two approaches to provide mobile outreach services for VSC to rural areas of Nepal (MOHP, 2010a):

1. A trained surgical team from outside the district travels to district health care facilities that do not offer VSC to their clients. The team brings with it any equipment and supplies that are unavailable at the local sites.
2. A trained surgical team travels from the district center to areas that do not have VSC services and performs surgery in temporary medical settings, such as schools and community centers. While the team brings with it almost all necessary equipment and supplies, it uses tables, lamps, and other items available at local sites.²

The Government of Nepal recently instituted "satellite clinics" in all 75 districts, a form of mobile outreach that focuses on long-acting methods (hormonal implants and IUDs). Satellite clinics operate either in community settings (e.g., houses, schools) or at clinical facilities (e.g., PHC centers) during special days or weeks. Because long-acting methods do not require the highest levels of clinical emergency care, the government believes that using community sites can be appropriate. In both types of settings, a visiting team offers several methods, including long-acting methods, oral contraceptives, and condoms. Because of the satellite clinics, Indoplant[®] is now available in 20 districts,³ the Jadelle[®] implant is offered in 55 districts, and the Copper T 380A is available nationally (MOHP, New ERA, & Macro International, 2012).

² The government is transitioning away from the second approach and now recommends that male and female sterilization be performed only at health facilities during mobile service delivery. The RESPOND Project team conducting this study did witness female sterilization services delivered in a school setting. The event was well-attended and provided quality services.

³ Indoplant[®] is a two-rod hormonal contraceptive implant lasting up to three years that is manufactured by PT Triyasa Nagamas Farma, Indonesia.

As a result, 9% of all IUD users and 8% of all implant users now obtain their method in a satellite setting (MOHP, New ERA, & Macro International, 2012). Because Nepal's health implementation plan (MOHP, 2010b) calls for IUDs and implants to be available at all health posts and PHC centers by 2015, satellite clinics are considered an interim measure for ensuring access to these two methods.

As noted above, mobile outreach services are a seasonal event throughout the country, giving both providers and clients time to plan. However, since many woman and men do not have access to FP services, especially LA/PMs, during many months of the year, unplanned pregnancies occur. As a result, Nepali FP managers have discussed the appropriate balance between mobile outreach services and static service delivery for many years. In the early 1990s, the MOH's Family Health Division (FHD) and USAID worked to establish year-round routine availability of FP services at fixed facilities in 21 districts. The intention was to move away from mobile outreach services, so that FP services could be available throughout the year. A good degree of institutionalization was achieved in the Terai Zone and the Kathmandu Valley and continues to this day. However, given Nepal's scarce financial and human resources, harsh terrain, and entrenched cultural biases against year-round surgical services, mobile outreach probably will still be needed in parts of the country for many years to come.

The private sector

A private-sector organization, Sunaulo Parivar Nepal (SPN), partners with the government by sometimes providing staff to fill vacancies within governmental mobile outreach. Established in 1994 and working in partnership with MSI, SPN provides a wide range of sexual and reproductive health services, including mobile outreach services targeting underserved, marginalized, hard-to-reach populations and youth. According to SPN's web site, in 2010–2011, SPN provided about 55% of sterilizations in Nepal at their clinics and through their support of the national mobile outreach program (SPN, [no date]). These data are not disaggregated by mobile or static service delivery.



Photo: J. Wickstrom/EngenderHealth

“My name is Bharat Bahader Bholan. I am 38 years old now, married with four children. Since our youngest child is 1 1/2 years, my wife and I discussed the future and decided four children is a good family. We discussed options with our village health worker and that's how I heard about the NSV [no-scalpel vasectomy] clinic today. My wife has some health problems, so I decided to have an NSV today. Sure, I felt a small bit of pain after the NSV procedure, but it was nothing big. I'm ready to go home.”

**—Churemai Sub-Health Post,
Makwanpur District, Nepal, January 2012**

Management

The FHD, part of the Ministry of Health and Population (MOHP), is responsible for managing and planning all mobile outreach services nationwide. The FHD coordinates annual funding for mobile services in the public sector and oversees both public- and private- sector efforts. At the local level, mobile outreach is the responsibility of the district health office, in

consultation with international and local organizations also working on logistics management and FP at the facility level.

Planning

The FHD works with districts to annually estimate the number of expected clients for each contraceptive method, so that planning and budgeting are as realistic as possible. At the district level, the district health officer (DHO) and FP coordinator, along with other staff in the district health office, plan for a district's mobile services season. Every year, before the beginning of the season, the DHO organizes a preparatory meeting with all FP stakeholders in the district from the public and private sectors. All staff (technical and management) involved in mobile services participate; they share information about the program from the previous year and discuss ways to improve service quality. The district team (staff from the public and private sectors) estimates the number of clients per contraceptive method, based on previous experience and local projections. Plans are then made for human resources, logistics, contraceptives, equipment, instruments, expendable supplies, and transportation. If trained service providers are not available in a district, districts request staff from their regional health directorate officer or the FHD at the national level. The RESPOND team noted that Nepal's system of district-wide planning appears to be effective and might serve as a model for other countries.

Staffing

Only 4.2% of all health care workers in Nepal are medical doctors, and only 12% are nurses; nearly half (47%) are paramedics, and almost one-third (28%) are support staff (MOHP, 2010b). Staffing for mobile outreach services thus requires a solid plan to ensure that utilization of trained doctor-nurse pairs is well-coordinated and that staff who travel receive the extra duty salary and per diems needed to support their work in the field. Key informants noted that it has become harder over the years to get doctors to provide tubal ligations in mobile settings because of demands on their time at hospitals. With male and female sterilization a major focus of Nepal's mobile services program, staffing issues need to be addressed urgently, perhaps by task shifting at the local level and by training more doctors.

In Nepal, mobile service delivery for female sterilization and vasectomy is labor-intensive. Most services are conducted by teams that include 10–12 doctor-nurse pairs, assisting nurses, counselors, postoperative staff, and cleaning staff, who travel from their home clinics to offer services at a peripheral site. (To minimize disruption at the home clinic, travel is well-planned, and any service changes that result are communicated to local clients.) The teams are larger than is typically seen in other countries, because of the large tubal ligation caseload. Teams usually remain at a location for several days to meet demand. In general, mobile outreach staff live in the district they serve, though doctors are sometimes seconded from other districts, from private practices in the district, and from SPN. SPN's collaboration with district health offices and local communities benefits clients; key informants noted that support from SPN is especially important due to shortages of medical doctors and other providers of LA/PMs.

Because long- and short-acting methods do not require doctors, only one or two providers (e.g., medical officers, nurses, or midwives) are needed for these methods. The medical officers, nurses, and midwives handle all aspects of service delivery, including counseling and method provision. Cleaning and other support staff are also on hand.

Logistics

On service days, health care teams providing sterilization services arrive via private or public vehicles, mules, or horses, bringing with them all required equipment, instruments, supplies, and medicines provided by the district. Depending upon the geographic location, porters sometimes assist the team. In Nepal's decentralized system, districts provide teams with travel allowances, fuel, and food.

A few staff members arrive early to prepare mobile sites for the expected client load. At both clinic sites and community sites, the team establishes private areas for counseling and preoperative care, cleans and disinfects the operating theater, arranges equipment, establishes high-level disinfection and sterilization stations, and sets up postoperative areas. The RESPOND team visited sites both in clinics and within communities.

As noted earlier, satellite clinics offer long- and short-acting methods at PHC centers and at sites within the community. They follow logistical arrangements that are similar to those of the mobile outreach teams providing female sterilization and vasectomy.

Because of good planning at the district level, there are few stock-outs of the required medical equipment, instruments, expendable supplies, and medications needed for male and female sterilizations in mobile settings. While nationwide stock-outs of contraceptives and supplies occur periodically at lower-level facilities, mobile services rarely face these difficulties, because of the commitment of the government and donors to this type of service delivery.

Demand Creation

Nepal's health care system uses radio, posters, pamphlets, and volunteers to inform potential clients about upcoming mobile services. In many districts, local radio promotion runs a few weeks in advance. As the event becomes closer, trucks with megaphones travel throughout the district announcing the date and time of services and explaining how to get additional information. (This activity is called "miking.")

Before the scheduled services, community health workers (CHWs) and female community health volunteers (FCHVs) increase house-to-house outreach, informing potential clients that there will be focused services for FP at a specific time and date. Both of these cadres of CHWs are the backbone of the FP program in Nepal; they help to increase demand for FP in general (including LA/PMs), provide information, and distribute condoms and pill resupplies. These workers are originally from the communities or currently live in the communities. Interviews with clients in Nepal confirmed that they trust CHWs and FCHVs and have close relationships with them. Many clients praised the workers and volunteers for continuously trying to reach clients in need of services in rural, hard-to-reach areas.

Several weeks before the event, FCHVs begin talking with couples one-on-one about their FP needs. If clients are interested in obtaining an LA/PM, FCHVs often take them to the local health post or subpost where they can get more in-depth information from a trained nurse, CHW, or counselor. In some cases, FCHVs accompany clients from remote areas on the day of the service to assist them in reaching the site. Because the full range of methods is not available during mobile outreach services, prescreening by volunteers helps to ensure that only those wishing an offered method attend on the service day. In Nepal, prescreening is an

important element of quality of care. It meets both clients' and providers' needs, since it helps to ensure that everyone understands what services will be offered on the mobile service day.

In some instances, depending on budgets and the availability of transport, the district may support transportation for women and men who live in very remote areas and want to obtain an FP method.

Quality of Care and Supervision

Since the inception of Nepal's national FP program, international donors, cooperating agencies, local authorities, and health care officials have worked in partnership to continuously improve the quality of care for all services, including those offered in mobile settings. As early as 1997, the FHD, with assistance from EngenderHealth, worked to develop mobile outreach service guidelines for female sterilization and vasectomy in both Nepali and English (MOH, FHD, 1997). All districts now follow the fourth edition of the *National Medical Standards: Volume 1, Reproductive Health* (MOHP, 2010a). This document sets medical criteria and standards for all FP services in Nepal, covering counseling, informed consent, client assessment, method provision, infection prevention, follow-up, management of side effects, medical supervision and monitoring, management, and requirements for facilities and providers. A detailed appendix clearly describes what is required to deliver FP services in mobile settings.

Reference Manual for Management of Emergencies in Family Planning Services in Nepal (JHPIEGO Corporation, 1999) lays out the requirements for managing complications in both mobile and static service delivery. Mobile teams carry all supplies and equipment needed to manage surgical emergencies. In addition, teams have formal relationships with established medical facilities in the areas closest to the mobile sites for client follow-up and care. Clients who need continued medical observation or treatment after emergencies or who develop minor complications after their procedures have a local backup provider who can make a referral or who has the supplies and equipment needed to manage the case. Ideally, most clients from remote areas are visited by their CHW after VSC and are checked for any issues.

To help ensure voluntary choice, CHWs and FCHVs inform clients about available FP methods before the mobile outreach teams arrive. Clients learn where they can obtain short-acting methods in the local area if they are interested. All sterilization clients are fully counseled on the day of service delivery and are told they can still refuse the surgery; if they opt for the procedure, they sign informed consent forms. If a potential client comes on the day of services and was not prescreened, he or she can still be counseled and receive the service. During mobile outreach, clients are provided as much privacy as possible during counseling, service delivery, and recovery.

District health directors supervise mobile outreach services within each district. On-site, senior medical personnel (surgeons for sterilization; medical officers for IUDs and implants) supervise services. To ensure quality of care, FHD and other stakeholder staff conduct regular monitoring and supervision visits using standardized checklists, usually during the early days of a mobile services event. Supervisors offer on-site coaching and feedback when necessary. If a supervisor is unable to solve a problem at a site, he or she refers it to the FHD. Regional staff monitor overall progress and performance at the end of each fiscal year, with a review of service statistics and medical monitoring reports.

Mobile outreach teams use client record-keeping forms; they send reports to the district health office, which are then fed into the national management information system. The system can disaggregate services provided at static and mobile sites. Key informants noted that quality and safety are continuously reviewed, so that issues and challenges related to mobile outreach services can be addressed.

Financing

The Government of Nepal abolished user fees for mobile and other essential health services nationwide in the interim constitution (Interim Constitution of Nepal, 2007), which is still in force. The document states, “Every citizen shall have the right to get basic health service free of cost from the State as provided for in the law” (Interim Constitution of Nepal, 2007, p. 8). As stated in the MOHP’s commodity security strategy (MOHP, Department of Health Services, 2006), contraceptives are provided free of charge through public-sector outlets (hospitals, health centers, health posts, sub-health posts, outreach clinics, mobile services, and FCHVs). In addition, clients can purchase FP commodities such as oral contraceptives, injectables, IUDs, implants, and condoms at private-sector clinics and pharmacies.

In regard to reproductive health, application of the law mandating free services is uneven except for safe delivery services (Witter et al., 2011). During site visits for RESPOND’s study, clients and key informants stated that public-sector services sometimes charge fees for some FP services. The RESPOND team did not witness any collection of user fees during mobile outreach services.

Donor financing of the health sector, including mobile outreach services, is significant. Financing is organized through several forums to coordinate contributions from external development partners, to harmonize efforts, to align plans and programs, and to foster coordination and collaboration between the public and private sectors.

Funding at the national level for mobile outreach services comes from three sources:

1. The “Red Book,” which is the mechanism through which USAID funds FP (Funds are channeled through the Ministry of Finance, which then allocates funds to the MOHP.)
2. USAID’s supplemental workplan, which provides bilateral funding cooperatively designed with the government and transparently shared among donors, government, and projects
3. Other donor funding

Districts receive their budgets from FHD for seasonal mobile services and static facility services throughout the year.

Summary

Quality of care and improved access for underserved and economically disadvantaged populations are the focus of Nepal’s FP program, with strong mobile outreach service delivery as a major component of the program. Mobile outreach services are well-known as a seasonal event throughout the country. However, since many woman and men do not have access to FP services, especially LA/PMs, during much of the year, unplanned pregnancies occur. Because of Nepal’s scarce financial and human resources, harsh terrain, and entrenched cultural biases against year-round provision of surgical services, mobile outreach may be needed in parts of the country for many years to come.

Malawi

Despite severe shortages of health personnel, high rates of poverty, and many competing health and development priorities, Malawi has demonstrated that rapid increases in FP use, including use of LA/PMs, can be achieved. Since 2004, Malawi's positive environment (e.g., supportive government policies, strong donor support, near universal knowledge of FP) has enabled the MOH to make significant advances in improving health service delivery by:

- Investing in human resources and training
- Deploying clinical officers, midwives, nurses, health surveillance assistants, and volunteers to provide services at the community level
- Expanding community outreach and mobile services through public-private partnerships

Between 2004 and 2010, Malawi experienced a 13% increase in modern-method contraceptive prevalence among married women using contraception (from 33% in 2004 to 46% in 2010) (NSO & ICF Macro, 2011). When USAID looked at three high-performing African countries in 2012, it singled out the contribution of Malawi's mobile outreach services, offered by the public sector and by NGOs in cooperation with the public sector⁴: "Affordable and sustainable mobile outreach services provide another common theme in these countries, with the BLM/MSI services in Malawi providing perhaps the best example of a high-functioning public-private partnership for mobile outreach services" (USAID/Africa Bureau et al., 2012, p. 27).

Mobile Outreach Approaches

The vast majority (81%) of Malawians live in rural areas, where they do not have access to the full range of contraception services (USAID/Africa Bureau et al., 2012). One-quarter of Malawian women (26%) have an unmet need for FP (14% for spacing and 12% for limiting) (NSO & ICF Macro, 2011). Public-sector health posts and clinics are not staffed or equipped in rural areas to offer LA/PMs, and there are frequent stock-outs of injectables (USAID/Africa Bureau et al., 2012; MSH, 2011). To meet the need for services in hard-to-reach areas, teams of providers from both the public and private sectors travel to low-level health facilities or community locations on prearranged dates, bringing with them all of the contraceptives, medical equipment, instruments, and expendable supplies they need to provide a set of predetermined services. These services may include FP, MCH care, and HIV prevention services. All teams are qualified to provide long-acting contraceptive methods—methods that lower-level cadres in remote locations are unable to provide. Currently, only NGOs provide female sterilization through mobile outreach, and neither sector offers vasectomy in mobile settings. (Only three surgeons in the entire country are trained to offer vasectomy services.) In 2012, EngenderHealth's RESPOND Project began training MOH trainers and surgeon-nurse teams in the public sector in female sterilization for static facilities. Future planning and programming are needed to add female sterilization to the government's mobile outreach service package.

Because outreach sessions bring in a large number of clients in addition to those seeking routine services, facilities must be reconfigured. Consultation rooms normally used for exams and individual counseling may be turned into LA/PM procedure rooms, with the result that

⁴ Among the NGOs mentioned were BLM, which is the MSI local affiliate, and FPAM.

there are no private areas remaining for exams or counseling. To compensate for this and other infrastructure deficits, some teams transport tents for waiting areas, clean water for washing, autoclaves for sterilization, and generators for electricity. FP procedure rooms are set up, and arrangements are made to ensure client comfort, confidentiality, and infection prevention.

The public sector

Regional and district health authorities establish teams of MOH health care providers to reach underserved populations with two types of mobile outreach services:

- Targeted FP services
- Integrated family health services (also known as “under-5 clinics,” as they serve mothers with children under 5 years of age)

The MOH teams work with community leaders to find suitable locations for services; teams may set up their stations at a community center, school, church, or even a common community area, such as an open field. In many of Malawi’s 28 districts, the district health office provides 4x4 vehicles for mobile services once or twice per month. Currently, the MOH teams focus on all FP methods except male and female sterilization, which are handled by NGOs.

The under-5 clinics provide the following services:

- Health education (including FP)
- FP (only short- and long-acting methods)
- Antenatal care for pregnant women
- Child growth monitoring and immunization
- Integrated management of childhood illness
- Prevention of mother-to-child transmission of HIV, including CD4-count testing and antiretroviral therapy
- Supervision of traditional birth attendants

Public-sector outreach teams visit the same sites regularly, building relationships with local practitioners and communities. At each visit, a team typically spends 3–5 hours per visit providing services. (They do not leave a site until all clients have been counseled and those who wish a contraceptive method have received one.)

The study team observed both types of public-sector outreach, targeted FP and integrated family health. During one integrated outreach visit, the MOH estimated that approximately 200 clients were served. Local nurses reported that they often see up to 400 clients during the integrated under-5 clinics, including clients seeking FP. The nurses did not have service statistics on hand; however, on the day that the RESPOND team viewed the integrated services, the FP section served 75 clients, and FP information was shared in a group setting with approximately 125 women and men.

The private sector

NGOs such as BLM and the FPAM offer outreach services to supplement services in underserved areas provided by public-sector clinical facilities and mobile services. BLM offers the full range of FP services, while FPAM offers short- and long-acting methods.

BLM, the local affiliate of MSI, opened its first clinic in Malawi in 1987 and now operates 33 static clinics in 22 of Malawi's 28 districts. In 27 districts, BLM also provides mobile outreach FP services, in collaboration with the MOH and local communities. In an innovative public-private partnership, BLM provides periodic mobile services for short-acting methods in government health centers, but the organization does not have the trained providers, medical equipment, instruments, and supplies to routinely offer LA/PMs at government centers.

BLM fields two types of outreach teams:

- *Clinic outreach teams* visit five public health facilities per month using an equipped 4x4 vehicle. These teams provide FP services at their home clinic when they are not conducting outreach.
- *Dedicated outreach teams* are on the road 22 days per month in both rural and urban settings. These teams travel with a 4x4 vehicle and a mobile trailer, complete with autoclave, tents, clean water, a generator, and all of the medical equipment, instruments, expendable supplies, and contraceptives needed for that month.



Photo: J. Yanulis/EngenderHealth

Jennifer Nkyayera is 25 years old and has two children. After her first pregnancy, at age 20, she dropped out of school for one year. She had postdelivery problems with her second pregnancy and now wants to delay any future pregnancy. She has been using the pill, but earlier she practiced periodic abstinence.

During a mobile outreach event, she received group counseling and became interested in an implant. When asked if she knew anyone who was using an implant, she said, "No, but I heard about it from a [community-based distribution agent] and wanted to come here today and hear it from the nurses to see if it was true."

After the procedure, Jennifer said: "I am very happy that I do not have to come back to the clinic next month. I walked 10 km to get here."

She said she would tell her friends to not be afraid: "I thought it was a big operation, that they would cut your arm open. But today I see the contrary: it was nothing like that."

FPAM's mobile outreach services provide integrated health services similar to those provided by the public sector (see above), including FP and HIV testing, counseling, and support. FPAM places particular emphasis on reaching youth and young adults. FPAM does not have providers trained to provide female sterilization or vasectomy through mobile services.

FPAM has five static clinics in five districts of Malawi and provides mobile outreach services for short- and long-acting methods in those districts. In three of those districts, FPAM conducts mobile outreach in partnership with the MOH, communities, local leaders, and volunteers. It provides services in rural and periurban areas using equipped 4x4 vehicles to set up their services in the community; the MOH does not currently have mobile services in those districts. At the outreach site, FPAM sets up tents in which to receive clients and to provide group health education. A service site may be a community center, another community area, or even the side of the road near the village. In the other two districts, FPAM has two equipped mobile trailers attached to FPAM 4x4 vehicles that can reach especially remote areas. Each of these “vans” has two private consultation and service provision rooms. For individual counseling, FPAM providers use the private consultation rooms in the van. FPAM staff and clients acknowledged the importance of privacy and confidentiality during counseling and service delivery.

The study team witnessed FPAM providing impromptu services along its route when a community stopped the van, desperate to obtain its services. Such responsiveness, while admirable, can also be problematic, because it causes the team to be late to the intended site and may result in some clients opting out of services.

Privacy and confidentiality are important during counseling and service delivery.

FPAM’s mobile outreach teams serve approximately 60 clients during an outreach event. However, if there is a shortage of Depo-Provera in the public sector, then trained FPAM service providers will offer this method at stations set up under trees. In these instances, FPAM can serve between 100 and 150 clients during a single visit.

Management

Those responsible for coordinating mobile outreach conduct regular supervision and management to ensure quality service provision. Quarterly review meetings are conducted to review progress and identify gaps in service provision (e.g., managing fuel shortages and stock-outs of supplies and contraceptives).

Planning

Each district public-sector outreach team is responsible for planning and coordinating visits to 5–15 communities or facilities every month. The district health office develops a detailed monthly schedule for mobile outreach visits, specifying which communities will receive which outreach services on a given day. The schedule is communicated to each health facility at the beginning of the year. Reminder notifications are given at the end of each month for the following month. BLM and FPAM use similar planning mechanisms, although coordination with the district health office is not as frequent as the office would prefer.

Staffing

In Malawi, significant shifts in policy and deployment of human resources have dramatically improved access to FP methods in the 15 USAID-supported districts (MOH, Department of Planning, 2004). In 2004, the MOH’s six-year emergency human resource plan called for the

training and deployment of lower-level cadres to provide clinical services in the public and private sectors (MOH, Department of Planning, 2004). Specifically, the policy allows clinical officers to perform female sterilization (with the result that most female sterilizations are now performed by clinical officers rather than by doctors) (USAID/Africa Bureau et al., 2012). In 2005, the policy was further revised to allow nurses to provide long-acting methods (i.e., implants and IUDs) (USAID/Africa Bureau et al., 2012).

Integrating Preservice Training into Mobile Outreach

Nursing students from preservice medical training colleges participate in mobile outreach service days to observe community-based service provision, support infection prevention, and provide health education messages to clients attending under-5 clinics.

To further address staffing shortages while bringing services closer to communities, Malawi has conducted widespread training of health surveillance assistants (HSAs) and volunteer community-based distribution agents (CBDAs) to provide a range of health services, including FP information and certain contraceptives. HSAs provide counseling and testing for HIV, health talks, vaccinations, condoms, and oral contraceptives. When mobile outreach teams are not present, HSAs use their bicycles to bring contraceptives and medications from the health posts to which they are assigned to clients in surrounding

communities. HSAs refer clients to health centers; they provide free condoms, pill resupplies, and some noncontraceptive products. Each HSA routinely serves 2–4 villages. In 2008, the MOH allowed HSAs with special training to also provide injectable contraception (i.e., Depo-Provera). The use of HSAs to provide injectable contraception has made a major contribution to improved access (USAID/Africa Bureau et al., 2012).

In Malawi, a typical mobile outreach team for both public and private services includes:

- An FP provider (a clinical officer if permanent methods are offered, and/or a registered nurse if only short- and long-acting methods are offered)
- A community reproductive health nurse or nurse-midwife (for health education and service delivery)
- A community peer educator (for health education, record keeping, and referrals)
- A driver (for condom distribution and site clean-up)

Logistics

For each of the mobile outreach models, teams transport all linens, drapes, gowns, medical equipment, instruments, contraceptives, and expendable supplies in sterilized packages to health centers, dispensaries, or community sites. The quantity transported is based on the number of clients who have registered in advance with their local HSAs, CBDAs, or clinic; in addition, the team takes additional stock for unregistered clients.

There are frequent stock-outs of Depo-Provera, and demand for hormonal implants often outstrips supply; thus, during mobile outreach, FP access can be limited. Mobile outreach teams sometimes face other obstacles, such as a lack of access to autoclaves for sterilizing instruments. Overall, however, key informants stated that because of the organized nature of mobile outreach services, the resources allocated, and the dedication of providers, mobile services improve FP access.

Demand Creation

HSAs, the lowest-level full-time salaried MOH worker, and volunteer CBDAs play an important role in mobilizing and informing communities for both the public and private sectors.

If no health facility is available, HSAs work with their communities to identify suitable sites for mobile services. Before an outreach event, the mobile outreach team shares its schedule with HSAs and relies on them to mobilize community members through house-to-house and group counseling and education sessions; HSAs also post leaflets in the community announcing the date and type of services to be provided. HSAs and CBDAs perform preliminary counseling and inform clients about the modes of action and side effects of various FP methods. They announce that mobile services are offered free of charge, which is the policy for all FP.

As in Tanzania and Nepal, district and NGO personnel make announcements and hang posters in busy market areas. In many cases, a poster is placed at a health center up to a month in advance to inform people when mobile services will be available. Rural and periurban health center staff inform clients during general health talks at reproductive health and outpatient clinics. FPAM staff promote their outreach among teachers and parents at basic education schools (communities served by outreach often do not have secondary schools).

Quality of Care and Supervision

For LA/PMs, public-sector FPAM and BLM providers follow official clinical protocols, guidelines, and procedures to ensure that care is of the highest quality (MOH, 2006). In addition, BLM follows MSI's medical standards of care.

All outreach teams pay careful attention upon arrival to infection prevention during set-up for implants and female sterilizations. In general, medical waste (including sharps) is returned to the hospital or to the FPAM or BLM clinic, where it is incinerated. Other waste is disposed of in rubbish pits at least 50 m from the facility.

HSAs prescreen clients for mobile outreach services before the service provision day. On the service day, clients attend a group health talk; they are then called individually for history taking, counseling, verification of method choice, and, if required, completion of informed consent forms. Once these steps have been completed, clients receive their desired FP method.

Supervisors from the district health office attend regular public-sector outreach sessions to observe counseling and record keeping and to support outreach teams with high client loads.

Information and counseling about complications and referrals vary depending upon facility level. If clients are served at a remote outreach facility, for example, they are told to report complications to the service point within 24 hours, so that a decision about referral to a higher-level facility can be made. Mobile teams also prepare local providers or volunteers to provide basic follow-up care. Local personnel are told to contact the outreach team if any client experiences a problem after a procedure, especially if there are significant complications, such as persistent infection or bleeding.

At some sites observed, space for minilaparotomy and implant insertions was limited and cramped. Staff had a difficult time delivering services in such quarters, raising questions about quality of care.

Mobile outreach teams collect service statistics, which are kept in locked cabinets or boxes and reported to the DHO monthly. According to existing agreements, BLM and FPAM outreach teams are supposed to report mobile outreach services to the DHO to be included in the overall district summary. However, several DHOs reported that they were not consistently receiving NGO reports. This lack of coordination has an adverse effect on overall reporting of district FP data and can lead to inaccurate forecasting and inadequate procurement at the national level, resulting in shortages of contraceptives.

Malawi and Tanzania share a common issue with data collection and analysis. Since the data are not collected and disaggregated by mode of service delivery, it is difficult to determine the extent to which mobile outreach services contribute to the contraceptive prevalence rate, although Malawi's DHS attempts to determine how services were rendered.

Financing

Malawi's reproductive health program is part of Malawi's six-year *Joint Programme of Work for a Health Sector Wide Approach (SWAp)* (MOH, 2004) (renewed for 2011–2016). The purpose of this program, implemented by the government with assistance from development partners, is to establish and deliver an essential health package, including FP, free of charge to all Malawians. Key informants for this study gave high credit to the essential health package for improving access to reproductive health services.

In line with the SWAp, all public-sector FP services are provided free of charge, including mobile outreach services supported by district health office budgets. Clients using BLM's private clinic-based services pay fees, while BLM's mobile outreach services, provided in collaboration with the MOH, are free of charge. FPAM provides short-acting methods free of charge during mobile outreach events and offers a sliding scale of fees for long-acting methods, which as a result are 40–50% less than fees charged at their static facilities. FPAM reports, however, that no client is turned away for lack of funds. Key informants stated that free contraception and low-cost methods offered through NGOs have led to dramatic increases in service uptake, as evidenced by significant contraceptive prevalence increases among married women of reproductive age between 2004 and 2010 (from 28% to 42% of married women) (NSO & ORC Macro, 2005; NSO & ICF Macro, 2011). The UK Department for International Development, which is Malawi's largest donor, provides budget support for the health sector and separate funding as technical assistance (Pearson, 2010).

Summary

Since 2004, the Government of Malawi has made significant advances in improving health service delivery by investing in human resources and training, deploying lower cadres of health professionals (clinical officers, midwives, nurses, health surveillance assistants) and volunteers to provide services at the community level, and expanding outreach and mobile services through public-private partnerships.

Different modes of service delivery have been put into place to realize the goal of making FP accessible and affordable to all Malawian women and men. Between 2004 and 2010, Malawi experienced a 13% increase in modern contraceptive prevalence among married women using contraception (from 33% in 2004 to 46% in 2010) (NSO & ICF Macro, 2011). Mobile outreach is serving as a key strategy toward achieving Malawi's national goals.

Discussion

Successful mobile outreach services for FP respect client choice, provide high-quality services that are close to the client's home, and offer services at no or low cost to clients. As the country case studies illustrate, mobile outreach services are not uniform. The mix of public- and private-sector inputs differs across countries, depending on several factors, including the experience of the public sector and funding streams. The challenge is to effectively deliver the services, using scarce human and financial resources to reach as many poor, underserved women, men, and youth as possible. Approaches to mobile outreach span a continuum of complexity, from the simplest distribution of short-acting methods by village health workers on bicycles to the more complex approaches, such as delivery of LA/PMs or provision of integrated FP/MCH/HIV services. This report has focused on mobile services that deliver LA/PMs at some point during the year, to provide equitable access to these effective methods.

A number of inputs must be considered when planning and implementing mobile outreach services. These include the following:

- Supportive policies that allow for task shifting and the availability of personnel
- Careful management, planning, and coordination among stakeholders
- Systems to estimate the needs for personnel, equipment, instruments, and supplies
- Quality of care (e.g., standards and guidelines, procedures to ensure informed and voluntary decision making, infection prevention protocols, measures to protect client confidentiality and privacy, monitoring, and supervision)
- Scheduling systems that allow collaboration and communication between stakeholders within the health system and the communities to be served
- Mobile outreach teams, including skilled medical personnel as well as staff who drive vehicles, clean and prepare the service delivery site, and keep records
- Local health staff and/or volunteers to perform a number of tasks (e.g., informing and mobilizing the community, registering clients, prescreening clients)
- Appropriate facilities, whether they are health care sites or community sites, such as schools or community centers
- Transport for providers of mobile services (ranging on a continuum from a bicycle at one end to trailers equipped with autoclaves, generators, and clean water on the other)
- Contraceptive security for the methods to be offered
- The necessary medical equipment, instruments, and expendable supplies to provide LA/PM services
- Mechanisms for safely disposing of medical waste
- Procedures for follow-up care, management of complications, and referrals
- Record-keeping mechanisms that feed into existing health information systems
- Disaggregated data for mobile outreach and static services

From the perspective of clients and communities, mobile outreach services differ from routine services in several important ways:

- They are offered only at limited times.
- They may be offered in non–health care settings.
- They may involve providers who are unknown to the community.
- Most importantly, they offer FP methods (e.g., LA/PMs) that may otherwise be unavailable in or near the community, helping to ensure contraceptive choice for clients.

To be successful, mobile outreach services must explain these differences to communities, both to ensure general community support and to help clients who have an unmet need for FP feel safe and comfortable in accessing mobile services. Community engagement, therefore, must involve a wide variety of mobilization, education, and counseling activities.

Key Considerations for Programming

When working in less-than-ideal circumstances, program managers and staff must adapt to ensure quality of care. Quality of care is a cornerstone of mobile outreach program success. Since the inception of mobile services more than 40 years ago, however, programs have faced questions about how they can ensure quality at the periphery, where mobile venues sometimes provide less-than-ideal service settings (e.g., at small, underresourced health posts or at non–health care facilities). Program managers and providers of mobile outreach share a dedication to serving hard-to-reach populations; this can sometimes result in a “take what you can get” attitude related to site selection, privacy, and client waiting times. Clients, meanwhile, seem genuinely glad to receive *any service whatsoever* near their communities.

Organizers of mobile services must know ahead of time what the setting will be and what is needed to ensure quality of care. Managers and staff must pay close attention to the balance between increasing access in underserved areas and ensuring quality of care. For example, because of client load, consultation rooms at a local health facility may need to be turned into LA/PM procedure rooms, leaving no private areas for counseling or preprocedure exams. Settings may lack exam tables, light sources, or water.

To meet quality-of-care standards, mobile teams routinely bring with them not just contraceptives and supplies, but also portable items needed for infection prevention, physical exams, and clinical procedures. Some use tents specifically designed for LA/PM service delivery or trailers that contain everything needed for clinical services. As part of its efforts to ensure quality, Nepal has begun to require that male and female sterilization be performed only at health facilities; however, this study found that community facilities, such as schools and administrative buildings, can be acceptable service delivery sites if they are properly cleaned and prepared.

Greater attention must be paid to ensuring the availability of contraceptives, medical equipment, instruments, and expendable supplies for mobile outreach services. While the availability of LA/PMs was observed to be generally strong in mobile settings, problems with the availability of equipment, instruments, and supplies remain. For example, mobile services sometimes experienced stock-outs of hormonal implants and other methods, possibly

due to an underestimation of need, a lack of funding for higher-cost methods, or countrywide stock-outs affecting all services. While static sites also experience stock-outs, the consequences in outreach settings can be especially problematic: Mobile services are typically offered only occasionally, increasing the risk of unintended pregnancy for clients. Improved planning and better tracking of mobile service requirements would alleviate some of these issues.

Attention to staff planning and innovations in staffing for mobile outreach could improve access to FP, especially LA/PMs. Mobile services require skilled providers who are dedicated to traveling to the periphery. Staffing for outreach services thus requires a solid plan to ensure that dedicated and trained clinical staff are available and sufficiently supported; if team members are temporarily away from their regular jobs at higher level facilities, coverage for them must be arranged. Investments in task shifting and/or training of more clinicians may be required as FP needs increase. Full-time, dedicated teams of professionals whose only job is to provide mobile outreach services can be an effective method of staffing, as demonstrated by the private sector.

Supervision is an important component of mobile outreach and should be conducted at regular intervals to ensure quality. District health officials for the public sector and NGO supervisors in their organizations should be in charge of supervising mobile outreach services within the districts. Senior medical personnel and supervisors are needed to oversee quality of care, especially for clinical services. Regular monitoring and supervision visits, perhaps conducted jointly in the case of public-private partnerships, can provide benefits such as feedback to teams, planning, and coordination.

Mobile services offer opportunities for on-the-job training, coaching, and skills improvement in LA/PMs for new staff and for those needing refresher training. Because mobile services often provide sufficient caseloads for supervised practice, providers who have recently completed LA/PM training can improve their skills during mobile outreach. Mobile services also offer opportunities for on-the-job refreshers. Preservice students, meanwhile, can observe LA/PM service delivery and assist with counseling, infection prevention, and delivery of short-acting methods.

Demand creation that relies on a combination of interpersonal communication and community mobilization is an effective way to reach underserved populations, though these efforts would benefit from greater planning and coordination. Mobile service delivery for FP typically employs multiple communication channels to create demand among potential clients and build community support for services. Adequate client load is important if services are to be cost-effective and, as noted above, clients must clearly understand which methods will be offered. Key informants noted that most clients arrive with a good knowledge of FP; they usually have been prescreened or are prepared to choose a method. Community support, commitment, and interest are important because local leadership must agree to host mobile services, especially if they are delivered in community spaces, such as schools. Demand creation and community mobilization channels include village health workers and/or volunteers (who conduct community talks or make house-to-house visits), loudspeakers in marketplaces, posters, and radio. Key informants noted that demand efforts would benefit from greater planning and coordination.

Community health workers and/or volunteers play a crucial role in demand creation and community mobilization for mobile outreach and ultimately in improved access for underserved populations. Volunteers and/or community health workers are vital to the success of mobile outreach. Trained village health workers and volunteers:

- Counsel and prescreen potential clients
- Inform clients about mobile service schedules and the methods that will be available
- Help clients with transportation
- Follow up with clients after service delivery and refer them if complications arise

Study respondents noted that this cadre, as it creates demand and engages communities, is crucial to the success of mobile outreach.

This report highlights the important work that community-based staff and volunteers do to prescreen clients when a mobile services event offers a limited range of contraceptives (e.g., female sterilization or long-acting methods). Successful prescreening and counseling ensure that clients are prepared to attend mobile services and can expect to obtain their desired method.

Public-private partnerships are key. District health officials should coordinate all public-and private-sector programs offering mobile services in a district. In the three countries examined, public-private partnerships have proved to be essential to well-running mobile outreach services. Coordination of such partnerships, under the leadership of district health officials, is critical to mobile outreach programs, although, in this study, it was not always strong. District health authorities should conduct up-front planning for all organizations offering mobile outreach; Nepal provides an example of how this can be done. Planning and coordination of all mobile services help to prevent duplication of effort and ensure maximum coverage.

Improvements are needed in data collection and analysis, including disaggregation of data by mode of service delivery. Improvements in data collection and analysis, including disaggregation of data by mode of service delivery (static vs. mobile), will help:

- District health officials to plan and coordinate all types of FP services
- National leaders to ensure contraceptive security, plan for human resources, and finance all types of FP services

For example, proactively collecting service statistics from both the public and private sectors provides important data for management and decision making in Nepal. In Tanzania and Malawi, data coordination at the national level between the public and private sectors was less systematic, leading some stakeholders to comment that this is an area needing improvement.

Governments should ensure that mobile outreach services are free of charge to clients. There would be no mobile outreach services without dedicated financing by governments, donors, and NGOs. The purpose of mobile services is to improve access to contraceptive choice among the underserved, who are mostly the rural poor. Mobile services should therefore be provided free of charge into the future. To do so, governments must ensure that

FP-related line items include the funding required for mobile outreach (e.g., for contraceptives, staff, transport, and fuel). Governments could support NGOs that currently charge user fees for mobile services so that all mobile services could be free of charge to clients.

Research Questions

The three country cases in this report, as well as other country examples, have demonstrated that mobile outreach can be an effective service delivery mechanism for increasing the availability and use of FP, especially LA/PMs, among underserved populations. Without these services, women and men in rural and hard-to-reach areas would have limited contraceptive options. Important questions remain, however, that merit additional data collection and research:

- Does scale-up of mobile outreach services contribute to, or compromise, efforts to build the capacity of hospitals and health facilities to routinely provide LA/PMs?
- To reduce unmet need for FP in general and for LA/PMs in particular, are there criteria that would inform an optimum mix of static and mobile services? What demand “tipping points” would indicate a need to increase, or decrease, the amount of outreach services?
- How do public-sector programs best coordinate both public and private efforts to reach the maximum number of people in remote areas? What methods of data collection and use foster the best planning, decision making, and service coverage?
- Are clients satisfied with the quality of mobile outreach services? How does client satisfaction with mobile and static services compare?
- Do client fees, including hidden client fees, in the public and private sectors hinder access to mobile services for FP?
- How important is prescreening in improving quality of care and efficiency of service delivery?
- Do mobile services adequately meet the needs of hard-to-reach men and women?
- In any given country, how cost-efficient and cost-effective are mobile outreach services?
- What is the impact of integrated mobile HIV/MCH/FP services on unmet need for FP? How do integrated outreach services compare with dedicated FP outreach and method-specific outreach? Are integrated services a “distraction,” or do they reach more FP clients because of the additional services they provide?

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Interview Questions: Private Sector

SECTION 1: Organization and Management

A. Governance

1. Does the NGO/private organization have mobile outreach services? **Y or N**
If yes, what services are provided?
 - Family planning
 - HIV/AIDS
 - Sexually transmitted infections
 - Child
 - Maternal
 - Tuberculosis
 - Malaria
 - Male circumcision
 - Eye
 - Other (specify)

2. Does the NGO directly manage the mobile outreach services ? **Y or N**
If yes:
 - What division(s) and unit(s) manage mobile services?
 - **Probe:** If multiple services are provided but managed by a single division/unit, what are training, supervision, quality issues?
 - **Probe:** If multiple divisions/units are involved, how is coordination (of staff, schedules, etc.) managed?If no:
 - Does the NGO have a contract (or other agreement) with another organization (which?) to manage mobile outreach services? **Y or N**
 - If yes:
 - Which organization and type (e.g., MOH, private-for-profit)?
 - If no:
 - Probe** for explanation about how NGO's mobile services are managed.

3. What is the source of funding for the mobile services (and % of total budget)?
 - Government (including SWAp; budget support)
 - NGO (which?)
 - Private-for-profit organization (which?)
 - Donor (which?)
 - Insurance
 - User fees
 - Other (specify)

4. Are mobile services included in national plans as a service-delivery strategy? **Y or N**
If yes:
 - Are there set service targets for mobile outreach services [e.g., x% of national couple years of protection (CYP) or LA/PM CYP, or % of users]?
 If no:
 - Are mobile services seen as stop-gap measure until fixed facilities are built?
 - Donor-supported pilot project
 - National plan developed before mobile outreach services were started
 - Other reason

5. Are mobile service statistics reported to MOH district/regional/national management information system? **Y or N**
If yes:
 - Is reporting to MOH a requirement for operating in the country?
 If no:
 - Are service stats reported to NGO central office or headquarters?
 - How does NGO determine what contribution to national objectives is being achieved?

6. Do government policies exist pertaining to mobile outreach services? **Y or N**
If yes, what is included in them?

B. Coverage

1. What is the geographic area covered by the mobile outreach services?
2. What is the size and location of communities served?
3. How/Why were they selected?
4. Is there a designated target population (e.g., youth, parity, spacers or limiters)?
5. How frequently do the mobile outreach services function?
 - Full-time (i.e., every work day)
 - Part-time (certain days of the week or month)
 - Intermittent (certain times of the year; specify)
 - In-service “after duty hours” or “in-reach” to hospital wards

C. Human Resources (Management, Administration, Operations)

1. What is the management structure of the mobile services program (and what % of time is spent on mobile services)?
 - Executive director
 - Deputy director
 - Director of programs
 - Medical director

- Finance manager
 - Operations manager
 - Procurement and logistics manager
 - Monitoring and Evaluation manager
 - Other (specify)
2. What other operations and program staff work on the mobile outreach services? (and what % of time is spent on mobile outreach services?) (Do not include service providers here.)
- Program officers
 - Accountants, bookkeepers
 - Secretaries, administrative assistants, clerks
 - Drivers
 - Procurement/Logistics staff
 - M&E staff
 - Other (specify)

D. Operations

Procurement and Supply Management

1. Where do mobile outreach services get the following?:
 - Contraceptives
 - Expendable supplies
 - Instruments
 - Medical equipment
 - Essential medicines

2. Are contraceptives, expendable supplies, instruments, equipment, essential medicines included in regular procurement forecasts? **Y or N**
 If yes, are the forecasts prepared by:
 - NGO?
 - National/Regional/District government?
 If no:
 - Is procurement done on an as-needed/ad-hoc basis?

3. In the past year, have there been shortages of any of the following?:
 - Contraceptives (which?)
 - Expendable supplies
 - Instruments
 - Medical equipment
 - Essential medicines

4. How are contraceptives, supplies, instruments, essential medications managed?
 - Are they supplied to and stored at the mobile outreach site?
 - Does the mobile outreach team bring them at the time of the visit?
 - Are they stocked in a special mobile services van?

5. How is equipment maintained and/or repaired?
 - Technicians employed by:
 - NGO
 - MOH
 - For-profit organization
 - Vendor/Supplier of equipment
 - Local mechanic
 - Other
 - None: Equipment is not maintained/repaired.

Transportation and Communication

1. How does mobile outreach team travel to service area?
 - Public transport
 - Personal transport (or at personal cost for reimbursement)
 - Vehicle (car, van, SUV, truck, motorcycle, bicycle)
 - Equipped van
 - Other (specify)
2. How is lower-level health facility or non-health facility notified of upcoming visit?
 - Telephone, e-mail, text in advance (specify from whom to whom)
 - Established schedule (e.g., every Wednesday)
 - Other (specify)
3. How is community notified of upcoming mobile team visit?
 - Public radio announcement
 - Telephone, e-mail, text to community liaison
 - Community meetings or via village health committee
 - Other

Reporting and Information Management

1. Where are client records kept?
2. Is there a client register? **Y or N**
If yes:
 - Is it kept at the lower-level facility?
 - Is it kept by the mobile team and brought along at time of visit?
3. Are MOS statistics reported for district/regional/national databases?

How is “credit” for services/users handled in cases of public-private partnership for mobile outreach services?

Mobile Outreach Services Setup and Breakdown

What tasks are required for setup and breakdown? (Questionnaire guidelines provided illustrative task lists.)

E. Community Engagement

1. Are there community liaisons/representatives for mobile outreach services (or other health services)?

Y or N

If yes:

- How are they selected and by whom?
 - Are village health committees involved?
 - What is role of community liaison before, during, after mobile team visit?
 - Do they receive remuneration?
 - If yes, how much (cash) or what (in-kind)?
 - Who provides the remuneration?
 - Are they given training or orientation for their mobile outreach role?
 - If yes, who provides the training or orientation?
 - Who supervises them?
2. What level of contact and frequency do community liaisons maintain with mobile outreach services organizers?
 3. How are communities informed and mobilized for mobile outreach?
 - Announcements by local radio, posters, flyers, newspaper, etc.
 - Phone, e-mail, text notice to designated community liaison who notifies community members or village health committee or health workers
 - Phone, e-mail, text notice to provider at lower-level facility who notifies community members
 - Other (describe)
 4. What mechanisms exist for communication and interface between mobile outreach team, lower-level providers, and community representatives?
 5. How do communities participate in the organization and management of mobile outreach services?
 6. Are community engagement strategies in place? If so, describe them.

What participatory approaches/tools are used to mobilize communities?

7. Are there feedback mechanisms from the community to the mobile team about client satisfaction, problems, desired services, etc.? **Y or N**
 - If yes:
 - How do they work?
 - What issues have been raised?

8. Are there client information and behavior-change communication (BCC) materials available **between** mobile outreach visits? **Y or N** (verify if there are any available)

Are there client information and BCC materials available **during** mobile outreach visits? **Y or N** (verify if there are any available)

9. Are any job aids available for use by mobile team providers?
10. Given your experience, what have been the most useful channels of communication for reaching potential clients for mobile outreach services?
11. Have there been any BCC campaigns for FP or LA/PMs in the last year?
12. What is typical demand like during mobile outreach service days following community engagement and communication activities?
13. What are the most common FP methods obtained during mobile services?
14. What are some of the questions or issues raised by clients pertaining to the various FP methods offered during mobile services?
15. Do most clients come with their husbands/partners?

If not, do you think that husbands/partners are aware that their wives/partners are seeking FP services?

16. How far, on average, do you think clients are traveling for mobile services?

Do clients travel out of their immediate area to ensure confidentiality or to keep FP use secret from their husbands?

17. What do you see as some of the biggest barriers to meeting demand?

- Perceptions of methods
- Spousal opposition
- Religious opposition
- Distance from service
- Cost
- Other (specify)

18. Do you find clients well informed about the various FP methods? LA/PMs?

19. Do you think that clients coming for mobile services are satisfied with the quality of FP and LA/PM services provided through static services? Why or why not?

SECTION 2: Service Delivery

A. Service Venue

1. What type of service site is used for mobile outreach services?
 - Lower-level health facility
 - Non-health stationary facility (e.g., school, church, community hall)
 - Temporary tent or other shelter
 - Equipped van
 - Other (specify)
2. What is the schedule/frequency of mobile outreach visits?
 - Weekly
 - Monthly
 - Every two months
 - Quarterly
 - Twice per year
 - Once per year
 - For special events (e.g., National Immunization Days)
 - Other (specify)
3. How many days do most mobile outreach services last?
 - 1 day
 - 2–3 days
 - 1 week

B. Services

1. What services are provided by the mobile outreach teams?
 - Family planning
 - Counseling
 - Method provision
 - Maternal health
 - Antenatal care (what is included?)
 - Postnatal care (schedule?)
 - Nutrition supplementation (iron, folate, vitamin A, other)
 - Child health
 - Postnatal care
 - Growth monitoring
 - Immunization
 - Nutrition supplementation
 - Treatment of childhood illness
 - Deworming
 - Sexually transmitted infections, HIV/AIDS
 - Counseling
 - Testing
 - Antiretrovirals

- Malaria
 - Tuberculosis
 - Other curative/Emergency services
2. Which family planning methods are provided?
- Lactational amenorrhea method
 - Fertility awareness methods
 - Emergency contraception
 - Condoms
 - Male
 - Female
 - Pills
 - Combined oral contraceptive
 - Progestin-only pill
 - Injectables
 - Monthly
 - 2-month
 - 3-month
 - Implants
 - Norplant
 - Jadelle
 - Sino-implant
 - Implanon
 - IUD
 - CuT 380A
 - Levonorgestrel IUD
 - Sterilization
 - Male
 - No-scalpel vasectomy
 - Vasectomy
 - Female
 - Minilaparotomy
 - Laparoscopy
3. When and by whom is client counseling about family planning done?
- Before the mobile outreach services
 - By provider at lower-level facility
 - Other (specify)
 - During the mobile outreach services visit
 - By member of mobile outreach services team
 - By provider from lower-level facility
 - Other (specify)

4. Are there written and signed consent forms used for female sterilization and vasectomy? (obtain the form used for this purpose)
If yes:
 - Where are the forms kept?
 If no:
 - How is informed consent verified and documented?
5. Are any lab tests done during mobile outreach services visit? **Y or N**
If yes, specify.
6. How are clients notified about the date of the mobile outreach services visit?
 - Announcements by local radio and newspaper
 - Phone, e-mail, text notice to designated community liaison who notifies community members, village health committee or health workers
 - Phone, e-mail, text notice to provider at lower-level facility who notifies community members or village health committee
 - Other (describe)
7. After the mobile outreach services visit, how is client follow-up handled for the following (specify where, when, by whom)?
 - Routine return visit
 - Method resupply
 - Side effect or complication management
 - Implant or IUD removal
8. Are FP contraceptives and/or supplies left behind if a static facility was used during mobile outreach services?
9. Are mobile outreach services targeted on special days (e.g., immunization days) to maximize reach and client numbers?

C. Mobile Outreach Service Staff

Mobile outreach services *staff* refers to team members who travel to outreach services sites; includes clinical staff and non-clinical staff (e.g., drivers, assistants).

1. What is the composition of the mobile outreach service team (i.e., number and cadre of all team members, clinical and non-clinical)?
2. What is the employment status of mobile team members?
 - Full- or part-time
 - Staff or contract worker
 - Public-sector staff seconded to NGO
3. Are mobile team members assigned exclusively to a mobile team?
 - Yes, work assignment is exclusively for mobile outreach services.
 - No, mobile team members are also on staff of fixed facility.

4. If mobile team members are also assigned to fixed facilities, how are services provided at fixed facility when staff leave for mobile outreach service visits?
5. Is the composition of the mobile team always the same (i.e., are the team members always the same individuals)?
 - Yes, the team is always the same individuals.
 - No, the same individuals are not always on the team.
 - There is rotation among staff of fixed facility for team.
 - There is a pool of staff who shift teams depending on need.
 - Other explanation
6. In addition to salary or daily fee, do team members receive any of the following?
 - Other allowances
 - Per diem
 - Overtime or extra duty pay
 - Other (specify)

If yes:

 - Who pays the allowance, overtime, per diem, etc.?
 - NGO (which?)
 - MOH
 - Technical assistance project (which?)
 - Donor (which?)
 - Other (specify)
7. Is there orientation or training specific for mobile outreach that team members receive? **Y or N**

If yes:

 - Who organized and paid for the training?
 - Who conducted the training?
 - What topics were included in training?
8. Are mobile outreach services staff included in periodic in-service and refresher trainings? **Y or N**

If yes:

 - What trainings/updates have been conducted in last 12 months?
 - Which mobile staff attended the training?
 - Who organized and paid for the training?
 - Who conducted the training?
9. If training is given by mobile outreach service team, is certification done as well? **Y or N**
10. How are mobile outreach service teams supervised?
 - By whom?
 - How often?
11. What are the roles and responsibilities of health staff at the lower-level facility before, during, and after the mobile outreach visit?

D. Quality of Care

1. What service guidelines and protocols are used by mobile outreach services?
 - MOH guidelines
 - NGO guidelines
 - Other guidelines (which?)
 - No guidelines are used.
2. Does the mobile team have a copy of guidelines and protocols? **Y or N**
If yes, verify
3. What procedures are in place for management of complications?
 - Does the mobile team have emergency medications and equipment at the time of the visit?
 - Are members of the mobile team trained to manage complications?
 - Do lower-level health staff have training for complication management when the mobile team is not present?
 - Are medicines and supplies available at lower-level facility or outreach site?
 - Are referral mechanisms (communication, transportation, cash) in place?
 - Where is the closest referral facility?
4. Are adverse events reported? **Y or N**
 - To whom and by whom?
 - How?
 - Written report
 - Telephone call or e-mail
 - Other
5. Are post-procedure instructions given to clients?
 - Yes, verbally
 - Yes, written (verify and obtain a copy if possible)
 - No
6. Are clients who receive services during mobile outreach services followed up? **Y or N**
If yes:
 - When, where, and by whom?
7. What infection prevention procedures are in place?
 - Instrument processing
 - Where is it done and by whom?
 - Medical waste disposal
 - Where is it disposed? By whom?
8. Supervision
 - How is the mobile team supervised?
 - How often and by whom?
 - Are there written supervision reports? (If yes, where are they kept?)
 - Does the supervisor discuss observations and recommendations with mobile team?

Mobile Outreach Services Personnel

Cadre	No.	Employment Status			Time		Comment
		Staff	Contract	Seconded	Full	Part	
MD (specialist)							
Clinical officer							
Registered nurse							
Midwife							
Nurse/midwife							
Auxiliary nurse							
Technician							
Social worker							
Record keeper							
Pharmacist							
Driver							

Interview Questions: Public Sector

SECTION 1: Organization and Management

A. Governance

1. Does the Ministry of Health have mobile outreach services? **Y or N**
If yes, what services are provided?
 - Family planning
 - HIV/AIDS
 - Sexually transmitted infections
 - Child
 - Maternal
 - Tuberculosis
 - Malaria
 - Male circumcision
 - Eye
 - Other (specify)

2. Does the MOH directly manage the mobile outreach services? **Y or N**
If yes:
 - What division(s) and unit(s) manage mobile services?
 - **Probe:** If multiple services are provided but managed by a single division/unit, what are training, supervision, quality issues?
 - **Probe:** If multiple divisions/units are involved, how is coordination (of staff, schedules, etc.) managed?
If no:
 - Does the MOH have a contract (or other agreement) with another organization (which?) to manage mobile outreach services? **Y or N**
 - If yes:
 - Which organization and type (e.g., NGO, private-for-profit)?
 - If no:
 - Probe** for explanation about how MOH's mobile services are managed.

3. What is the source of funding for the mobile services (and % of total budget)?
 - Government (including SWAp; budget support)
 - NGO (which?)
 - Private-for-profit organization (which?)
 - Donor (which?)
 - Insurance
 - User fees
 - Other (specify)

4. Are mobile services included in national plans as a service-delivery strategy? **Y or N**
If yes:
 - Are there set service targets for mobile outreach services (e.g., x% of national CYP or LA/PM CYP, or % of users)?
 If no:
 - Are mobile services seen as stop-gap measure until fixed facilities are built?
 - Donor-supported pilot project
 - National plan developed before mobile outreach services were started
 - Other reason

5. Are mobile service statistics reported to district/regional/national management information system? **Y or N**
If no:
Probe for explanation of how MOH knows how well (or poorly) mobile services are functioning.

6. Do government policies exist pertaining to mobile outreach services? **Y or N**
If yes, what is included in them?

B. Coverage

1. What is the geographic area covered by the mobile outreach services?
2. What is the size and location of communities served?
3. How/Why were they selected?
4. Is there a designated target population (e.g., youth, parity, spacers or limiters)?
5. How frequently do the mobile outreach services function?
 - Full-time (i.e., every work day)
 - Part-time (certain days of the week or month)
 - Intermittent (certain times of the year; specify)
 - In-service “after duty hours” or “in-reach” to hospital wards

C. Human Resources (Management, Administration, Operations)

1. What MOH staff have management responsibilities for mobile services (and what % of time is spent on mobile services)?
 - Regional or district levels
 - Director of health
 - Division/Department/Unit director
 - Chief medical officer
 - Finance manager
 - Operations manager
 - Medical stores manager
 - Information/Statistician
 - Other (specify)

2. What other operations and program staff work on the mobile outreach services? (and what % of time is spent on mobile outreach services?) (Do not include service providers here.)
 - Program officers
 - Accountants, bookkeepers
 - Secretaries, administrative assistants, clerks
 - Drivers
 - Procurement/Logistics staff
 - Data entry staff
 - Other (specify)

D. Operations

Procurement and Supply Management

1. Where do mobile outreach services get the following?:
 - Contraceptives
 - Expendable supplies
 - Instruments
 - Medical equipment
 - Essential medicines

2. Are contraceptives, expendable supplies, instruments, equipment, essential medicines included in regular procurement forecasts? **Y or N**
 If yes, are the forecasts prepared by:
 - National/Regional/District government?
 - NGO, international NGOs (if involved with management of MOH mobile services)?
 - For-profit organization (if involved with management of MOH mobile services)?
 If no:
 - Is procurement done on an as-needed/ad-hoc basis?

3. In the past year, have there been shortages of any of the following?:
 - Contraceptives (which?)
 - Expendable supplies
 - Instruments
 - Medical equipment
 - Essential medicines

4. How are contraceptives, supplies, instruments, essential medications managed?
 - Are they supplied to and stored at the mobile outreach site?
 - Does the mobile outreach team bring them at the time of the visit?
 - Are they stocked in a special mobile services van?

5. How is equipment maintained and/or repaired?
 - Technicians employed by:
 - MOH
 - NGO, international NGO
 - For-profit organization
 - Vendor/Supplier of equipment
 - Local mechanic
 - Other
 - None: Equipment is not maintained/repaired.

Transportation and Communication

1. How does mobile outreach team travel to service area?
 - Public transport
 - Personal transport (or at personal cost for reimbursement)
 - Vehicle (car, van, SUV, truck, motorcycle, bicycle)
 - Equipped van
 - Other (specify)
2. How is lower-level health facility or non-health facility notified of upcoming mobile outreach services visit?
 - Telephone, e-mail, text in advance (specify from whom to whom)
 - Established schedule (e.g., every Wednesday)
 - Other (specify)
3. How is community notified of upcoming mobile outreach services visit?
 - Public radio announcement
 - Telephone, e-mail, text to community liaison
 - Community meetings or via village health committee
 - Other

Reporting and Information Management

1. Where are client records kept?
2. Is there a client register? **Y or N**
If yes:
 - Is it kept at the lower-level facility?
 - Is it kept by the mobile team and brought along at time of visit?
3. Are mobile outreach service statistics reported for district/regional/national databases?

How is “credit” for services/users handled in cases of public-private partnership for mobile outreach services?

Mobile Outreach Services Setup and Breakdown

What tasks are required for mobile outreach services setup and breakdown? (Questionnaire guidelines provided illustrative task lists.)

E. Community Engagement

1. Are there community liaisons/representatives for mobile outreach services (or other health services)?

Y or N

If yes:

- How are they selected and by whom?
 - Are village health committees involved?
 - What is role of community liaison before, during, after mobile outreach services visit?
 - Do they receive remuneration?
 - If yes, how much (cash) or what (in-kind)?
 - Who provides the remuneration?
 - Are they given training or orientation for their mobile outreach services role?
 - If yes, who provides the training or orientation?
 - Who supervises them?
2. What level of contact and frequency do community liaisons maintain with mobile outreach service organizers?
 3. How are communities informed and mobilized for mobile outreach?
 - Announcements by local radio, posters, flyers, newspaper, etc.
 - Phone, e-mail, text notice to designated community liaison who notifies community members or village health committee or health workers
 - Phone, e-mail, text notice to provider at lower-level facility who notifies community members
 - Other (describe)
 4. What mechanisms exist for communication and interface between mobile outreach team, lower-level providers, and community representatives?
 5. How do communities participate in the organization and management of mobile outreach services?
 6. Are community engagement strategies in place? If so, describe them.

What participatory approaches/tools are used to mobilize communities?

7. Are there feedback mechanisms from the community to the team about client satisfaction, problems, desired services, etc.? **Y or N**
 - If yes:
 - How do they work?
 - What issues have been raised?

8. Are there client information and BCC materials available **between** mobile outreach visits? **Y or N** (verify if there are any available)

Are there client information and BCC materials available **during** mobile outreach visits? **Y or N** (verify if there are any available)

9. Are any job aids available for use by mobile outreach service providers?
10. Given your experience, what have been the most useful channels of communication for reaching potential clients for mobile outreach services?
11. Have there been any BCC campaigns for FP or LA/PMs in the last year?
12. What is typical demand like during mobile outreach service days following community engagement and communication activities?
13. What are the most common FP methods obtained during mobile outreach services?
14. What are some of the questions or issues raised by clients pertaining to the various FP methods offered during mobile outreach services?
15. Do most clients come with their husbands/partners?

If not, do you think that husbands/partners are aware that their wives/partners are seeking FP services?

16. How far, on average, do you think clients are traveling for mobile outreach services?

Do clients travel out of their immediate area to ensure confidentiality or to keep FP use secret from their husbands?

17. What do you see as some of the biggest barriers to meeting demand?

- Perceptions of methods
- Spousal opposition
- Religious opposition
- Distance from service
- Cost
- Other (specify)

18. Do you find clients well informed about the various FP methods? LA/PMs?

19. Do you think that clients coming for mobile outreach services are satisfied with the quality of FP and LA/PM services provided through static services? Why or why not?

SECTION 2: Service Delivery

A. Service Venue

1. What type of service site is used for mobile outreach services?
 - Lower-level health facility
 - Non-health stationary facility (e.g., school, church, community hall)
 - Temporary tent or other shelter
 - Equipped van
 - Other (specify)
2. What is the schedule/frequency of mobile outreach visits?
 - Weekly
 - Monthly
 - Every two months
 - Quarterly
 - Twice per year
 - Once per year
 - For special events (e.g., National Immunization Days)
 - Other (specify)
3. How many days do most mobile outreach services last?
 - 1 day
 - 2–3 days
 - 1 week

B. Services

1. What services are provided by the mobile outreach services?
 - Family planning
 - Counseling
 - Method provision
 - Maternal health
 - Antenatal care (what is included?)
 - Postnatal care (schedule?)
 - Nutrition supplementation (iron, folate, vitamin A, other)
 - Child health
 - Postnatal care
 - Growth monitoring
 - Immunization
 - Nutrition supplementation
 - Treatment of childhood illness
 - Deworming
 - Sexually transmitted infections, HIV/AIDS
 - Counseling
 - Testing
 - Antiretrovirals

- Malaria
 - Tuberculosis
 - Other curative/Emergency services
2. Which family planning methods are provided?
- Lactational amenorrhea method
 - Fertility awareness methods
 - Emergency contraception
 - Condoms
 - Male
 - Female
 - Pills
 - Combined oral contraceptive
 - Progestin-only pill
 - Injectables
 - Monthly
 - 2-month
 - 3-month
 - Implants
 - Norplant
 - Jadelle
 - Sino-implant
 - Implanon
 - IUD
 - CuT 380A
 - Levonorgestrel IUD
 - Sterilization
 - Male
 - No-scalpel vasectomy
 - Vasectomy
 - Female
 - Minilaparotomy
 - Laparoscopy
3. When and by whom is client counseling about family planning done?
- Before the mobile outreach services visit
 - By a provider at a lower-level facility
 - Other (specify)
 - During the mobile outreach services visit
 - By a member of the mobile team
 - By a provider from a lower-level facility
 - Other (specify)

4. Are there written and signed consent forms used for female sterilization and vasectomy? (Obtain the form used for this purpose.)
If yes:
 - Where are the forms kept?
 If no:
 - How is informed consent verified and documented?
5. Are any lab tests done during mobile outreach services visits? **Y or N**
If yes, specify.
6. How are clients notified about the date of the mobile outreach services visit?
 - Announcements by local radio and newspaper
 - Phone, e-mail, text notice to designated community liaison who notifies community members, village health committee or health workers
 - Phone, e-mail, text notice to provider at lower-level facility who notifies community members or village health committee
 - Other (describe)
7. After a mobile outreach services visit, how is client follow-up handled for the following (specify where, when, by whom)?
 - Routine return visit
 - Method resupply
 - Side effect or complication management
 - Implant or IUD removal
8. Are FP contraceptives and/or supplies left behind if a static facility was used during mobile outreach services?
9. Are mobile outreach services targeted on special days (e.g., immunization days) to maximize reach and client numbers?

C. Mobile Outreach Service Staff

Mobile outreach service *staff* refers to team members who travel to outreach services sites; includes clinical staff and non-clinical staff (e.g., drivers, assistants).

1. What is the composition of the mobile outreach service team (i.e., number and cadre of all team members, clinical and non-clinical)?
2. What is the employment status of mobile team members?
 - Full- or part-time
 - Staff or contract worker
 - NGO staff seconded to public sector
3. Are mobile team members assigned exclusively to a mobile team?
 - Yes, work assignment is exclusively for mobile outreach services.
 - No, mobile team members are also on staff of fixed facility.

4. If mobile team members are also assigned to fixed facilities, how are services provided at fixed facility when staff leave for mobile outreach service visits?
5. Is the composition of the mobile team always the same (i.e., are the team members always the same individuals)?
 - Yes, the mobile team is always the same individuals.
 - No, the same individuals are not always on the mobile team.
 - There is rotation among staff of fixed facility for mobile team.
 - There is a pool of mobile outreach service staff who shift teams depending on need.
 - Other explanation
6. In addition to salary or daily fee, do mobile team members receive any of the following?
 - Other allowances
 - Per diem
 - Overtime or extra duty pay
 - Other (specify)

If yes:

 - Who pays the allowance, overtime, per diem, etc.?
 - MOH
 - NGO (which?)
 - Technical assistance project (which?)
 - Donor (which?)
 - Other (specify)
7. Is there orientation or training specific for mobile outreach that team members receive? **Y or N**

If yes:

 - Who organized and paid for the training?
 - Who conducted the training?
 - What topics were included in training?
8. Are mobile outreach service staff included in periodic in-service and refresher trainings? **Y or N**

If yes:

 - What trainings/updates have been conducted in last 12 months?
 - Which mobile outreach service staff attended the training?
 - Who organized and paid for the training?
 - Who conducted the training?
9. If training is given by the mobile team, is certification done as well? **Y or N**
10. How are mobile teams supervised?
 - By whom?
 - How often?

11. What are the roles and responsibilities of health staff at the lower-level facility before, during, and after the mobile outreach visit?

D. Quality of Care

1. What service guidelines and protocols are used by mobile outreach services?
 - MOH guidelines
 - NGO guidelines
 - Other guidelines (which?)
 - No guidelines are used.
2. Does the mobile team have a copy of guidelines and protocols? **Y or N**
If yes, verify
3. What procedures are in place for management of complications?
 - Does the mobile team have emergency medications and equipment at the time of the visit?
 - Are members of the mobile team trained to manage complications?
 - Do lower-level health staff have training for complication management when the mobile team is not present?
 - Are medicines and supplies available at lower-level facility or outreach site?
 - Are referral mechanisms (communication, transportation, cash) in place?
 - Where is the closest referral facility?
4. Are adverse events reported? **Y or N**
 - To whom and by whom?
 - How?
 - Written report
 - Telephone call or e-mail
 - Other
5. Are post-procedure instructions given to clients?
 - Yes, verbally
 - Yes, written (verify and obtain a copy if possible)
 - No
6. Are clients who receive services during mobile outreach followed up? **Y or N**
If yes:
 - When, where, and by whom?
7. What infection prevention procedures are in place?
 - Instrument processing
 - Where is it done and by whom?
 - Medical waste disposal
 - Where is it disposed? By whom?

8. Supervision

- How is the mobile team supervised?
- How often and by whom?
- Are there written supervision reports? (If yes, where are they kept?)
- Does the supervisor discuss observations and recommendations with mobile outreach services team?

Mobile Outreach Services Personnel

Cadre	No.	Employment Status			Time		Comment
		Staff	Contract	Seconded	Full	Part	
MD (specialist)							
Clinical officer							
Registered nurse							
Midwife							
Nurse/midwife							
Auxiliary nurse							
Technician							
Social worker							
Record keeper							
Pharmacist							
Driver							