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Expanding Contraceptive Choice to the Underserved Through Delivery of Mobile Outreach Services

A HANDBOOK FOR PROGRAM PLANNERS

About This Handbook

Expanding Contraceptive Choice to the Underserved through Mobile Outreach Service Delivery: A Handbook for Program Planners provides general guidance on how to design and implement mobile outreach family planning services, and should be adapted to each country's context.

Whether your organization is the Ministry of Health (MOH), a service-delivery nongovernmental organization (NGO), or a community-based organization (CBO), mobile outreach can be an important addition to your program.

We look forward to hearing your comments and suggestions on how to improve all the parts of this handbook.

Contents

Acknowledgements

This handbook was prepared by Julie Solo, by modifying an earlier draft developed by Linda Bruce.

While little has been written about mobile outreach service delivery for family planning (FP), there are many exciting programs that are being implemented around the world. The authors are extremely grateful to the program implementers, who generously shared their ideas and expertise to inform this handbook, to Victoria Graham at the U.S. Agency for International Development (USAID), and to Mia Foreman at ICF Macro for providing the technical direction for the content of this manual.

We sincerely appreciate the valuable technical guidance of Lynn Bakamjian and John Pile at EngenderHealth. Heidi Quinn at Marie Stopes International (MSI) shared the extensive and impressive experiences and lessons learned from MSI's work. Kate Rath at International Planned Parenthood Federation (IPPF)/Western Hemisphere Region (WHR) provided important lessons learned from their work in several Latin American countries. Our gratitude also goes to the following people for their extremely useful input and field perspective on mobile outreach service delivery in their respective countries: Carlos Bauer, Asociación Pro Bienestar de la Familia de Guatemala [Association for the Well-Being of the Family, Guatemala] (APROFAM); Jennifer Louks, Cooperative for Assistance and Relief Everywhere, Inc. (CARE)/Madagascar; Ronald Quintana, Program for Appropriate Technology in Health (PATH) Foundation Philippines, Inc.; and Dario Merlo, Jane Goodall Institute/ Democratic Republic of Congo program. Patricia MacDonald at USAID provided insightful comments in reviewing a draft of the handbook.

We also wish to thank the U.S. Agency for International Development/ Bureau of Global Health/Service Delivery Improvement Division for identifying a need for this handbook. We hope it will be a helpful addition to expanding access to high-quality FP services to the many women and men in need of such services.

Acronyms

APROFAM	*Asociación Pro Bienestar de la Familia de Guatemala* (Association for the Well-Being of the Family, Guatemala)
BLM	Banja la Mtsogolo
CBD	Community-based distributor
CBO	Community-based organization
CHW	Community health worker
CPR	Contraceptive prevalence rate
CYP	Couple-years of protection
EMI	Extra Mile Initiative
FP	Family planning
IEC	Information, education and counseling
IPPF	International Planned Parenthood Federation
IUD	Intra-uterine device
LA/PMs	Long-acting and permanent methods
MMU	Mobile Medical Unit
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSI	Marie Stopes International
NGO	Nongovernmental organization
SDC	Social Development Committee
USAID	United States Agency for International Development
VSC	Voluntary surgical contraception
WHR	Western Hemisphere Region

An outreach worker providing sexual and reproductive health information in rural Bolivia.

An outreach nurse from Banja La Mtsogolo visiting her patients.

I. WHY: The Importance of Mobile Outreach

A. Too many women lack access to contraceptive choice

Unmet need for FP is high in many parts of the world, particularly for poor, rural populations. Even where FP methods might be available for hard-to-reach populations, contraceptive choice is limited. For example, community-based distributors (CBDs) and other community health workers (CHWs) offer only pills, condoms, fertility awareness methods, and sometimes injectables. The capacity to offer a range of methods to women is a fundamental aspect of quality of care; it also increases use and improves continuation rates, thereby improving women's health. Yet, access to long-acting and permanent methods (LA/PMs) remains particularly limited; mobile outreach service delivery can effectively meet this need.

B. What is mobile outreach service delivery

The delivery of mobile outreach services is a way to provide a full range of FP methods to underserved communities. For the purposes of this manual, mobile outreach service delivery is defined as FP services provided by a mobile team of trained providers, from a higher-level health facility to a lower-level facility, in an area with limited or no FP or health services. In some cases, services are actually provided in the mobile unit.

Mobile outreach services can be provided at lower-level health facilities or locally available community facilities that are not used for clinical services, such as schools, health posts, or other community structures. The mobile outreach team brings any equipment and supplies that are unavailable at the local area. The team may also upgrade the lower-level facilities and train the local staff in FP to sustain these services after it has left the community (Thapa and Friedman, 1998).

From communities displaced by guerrilla activities in Colombia to the isolated Mayan rainforest of Guatemala, staff from IPPF/WHR member associations set out in vans, canoes, and even small planes to provide education, supplies, and services (IPPF/WHR, 2005).

One of the important aspects of mobile outreach services is the emphasis on both supply and demand. As described by a service delivery expert, "mobile services are successful because they go out and advertise; they don't sit and wait for clients. There is built-in demand creation." Program implementers emphasize the importance of coordination and scheduling in making mobile outreach services work; this is discussed in detail in the planning and implementation phases of the handbook.

Mobile outreach can also be an important intervention in light of the human resources crisis in the health sector. In many African countries, for example, this approach is used in settings where there are not sufficient personnel to staff static facilities. The experience of EngenderHealth's work in India highlights the potential efficiency of this approach, as it found that it is often better to train 1 provider who does 100 procedures than 20 providers who only do 5 each (Bakamjian, 2008). Such an approach is also an opportunity to provide on-the-job training and

coaching to providers, as shown by Pathfinder International's work in Ethiopia (Pathfinder International, 2007) and the ACQUIRE Tanzania project (ACQUIRE, 2008). In this way, mobile outreach can also contribute to building capacity and can leave something behind after the team departs.

It should be noted that there is a wide range of community outreach programs using CBDs, CHWs, health extension workers, etc. These health workers provide information, pills, condoms, and in some cases, injectables. This handbook focuses on mobile outreach, with an emphasis on long-acting and permanent methods of FP and how to increase access to this broader range of methods. While this handbook does not focus on all the efforts of CHWs, these efforts are a key part of mobile outreach in terms of creating demand, helping to understand community needs, generating interest, providing information to clients, and assisting with referral and follow-up.

C. Mobile outreach makes a difference

Mobile outreach has been successful in a number of settings, using a variety of models and often making a significant contribution to national FP programs. Marie Stopes International uses this approach in 18 countries. As a result, in 2008, 73 percent of 1.1 million LA/PM[1] services provided by MSI in these countries were delivered by clinical mobile outreach (MSI, 2009). In the first year of the ACQUIRE Tanzania project, 60 percent (94,264) of clients served received services via outreach (ACQUIRE, 2008).

Throughout this handbook, we highlight some examples of successful programs. In addition to representing different regions, these three mini case studies show a difference in scale—from large (Malawi and Nepal) to small (Guatemala), a difference in main implementing partners—with either an NGO (Malawi and Guatemala) or the MOH (Nepal) leading the effort, and a difference in models—including bringing staff to rural MOH facilities (Malawi) and providing services in NGO or community facilities (Guatemala). While we describe the potential impact of mobile outreach in the handbook, we also explain the challenges of implementing this model of service delivery and explore possible ways to deal with these challenges.

[1] LA/PMs are defined by MSI as including IUDs, implants, tubal ligations, and vasectomies.

GUATEMALA

MOBILE MEDICINE MATTERS

APROFAM, the IPPF affiliate in Guatemala, provides roughly one-third of FP services in the country. In order to reach poor rural populations who cannot come to its clinics, APROFAM operates five Mobile Medical Units (MMUs). Three of these MMUs provide services and two focus on education and referral. Interestingly, the three MMUs provided more implants (5,399) and female sterilization (5,379) in 2008 than did the 28 static clinics (3,874 and 4,094, respectively) (Couple-years of protection [CYP] data for fiscal years 2007 and 2008).

Each mobile unit has a team of qualified professionals (one OB/GYN doctor, one general doctor, two auxiliary nurses, and one driver) for the provision of integrated primary-level health care services, with an emphasis on sexual and reproductive health. The services provided include family planning (Intra-uterine devices [IUDs], injectables, implants, and male and female sterilization), OB/GYN services (pre- and post-natal, pap smear), general medicine, pediatrics, and sale of basic medicines and FP methods. The team travels in a vehicle equipped with high-technology medical and surgical equipment, and the necessary medicines to provide services. Services are provided in lower-level health facilities or community buildings.

One month prior to a trip by the MMU, activities take place in the communities to promote the services. The permanent availability in the communities of field personnel from APROFAM's Rural Development Program has allowed community members continued access to FP services in their own communities and has assured the success of these services (APROFAM, 2009).

An outreach nurse discussing family planning options with a Bolivian woman.

Mobile outreach can be initiated by CBOs that decide to bring mobile services to their program area. CARE did this in Madagascar with the Extra Mile Initiative (EMI), which aims to bring FP education and services to six remote communes. The EMI project helped a Social Development Committee in one commune to create a partnership with Marie Stopes International. MSI then traveled to the commune seat with its surgical teams, equipment, and generators to offer IUDs and surgical sterilization (CARE, 2008).

II. HOW: Making Services a Reality

Mobile outreach can be an extremely effective approach to increasing access to and use of FP. There are many different models of providing these services, depending on the particulars of each setting. This handbook describes the steps for a program to follow to put these services into action. We divide these steps into three main categories: 1) Planning, 2) Implementation, and 3) Scale Up. While the specifics will vary by setting, these general steps will be appropriate in most cases.

A. Planning

1. Needs Assessment: Do we need mobile outreach, and if so, where?

First, your program staff should answer the following questions:

- Are there underserved populations in your program area (national, regional, community-level), and if so, where are they located?
- If yes, what are the main barriers to services for these populations?
  - Is there a lack of access to health services?
  - Is there a lack of trained providers to offer a choice of FP methods for these populations?
  - Is there minimal demand for FP services?
  - Is there limited awareness and knowledge of FP?
  - Are there myths or misperceptions about FP?
- Is mobile outreach possibly an effective way to address these barriers and reach these populations?

Ideally, this assessment can be done with minimal new data collection. Efforts should be made to use available data—such as the most recent Demographic and Health Survey (DHS), government Management Information System (MIS) data—to look at contraceptive prevalence rates (CPRs), use of methods by type and by, levels of unmet need for spacing and limiting, and mapping of health facilities (using Geographic Information System data, if it is available). In addition, it will be helpful to talk with health providers and CBOs to better understand the needs to different communities.

If you decide that mobile outreach could be an effective and feasible strategy for your program, then you need to see what resources you will need for this program.

2. Identification of Resources: What resources are available and what resources do we need to find?

There are a number of resources needed for mobile outreach services; it is important to see what is available, what is needed, and based on this, which model of mobile services makes the most sense for your setting. Such resources include

trained staff; commodities; transport; infrastructure at lower-level facilities; information, education and counseling (IEC) materials; and funding. This step of identifying resources is important for calculating program costs.

SITE SELECTION. Will mobile outreach services be provided at lower-level health facilities? Are such facilities available and accessible to the populations you want to reach? Are they adequately equipped? If not, what would it take to equip them to provide services safely? If there are no facilities available, are there other community buildings that can be used? What supplies and equipment are needed to make the site a temporary site for service delivery? Or should the program try to equip a mobile unit that can provide services?

TRANSPORT. Transport needs will depend on the model of mobile outreach. If your program decides to send trained staff to lower-level facilities, then transport can even be done by motorbike (see photo below from Bangladesh). If services will actually be provided in the mobile unit, clearly this is a more expensive form of transport. Vehicle needs will depend on the distance traveled and the condition of the roads, the number of staff being transported, and the equipment that they need to bring with them. In the MSI outreach program in the Philippines, most IUDs were delivered by paramedics taking public transport (buses and/or boats) to rural areas (Pernito et al, 2009). You should also explore the possibility of combining mobile outreach services transport with other functions, such as supervision or commodity delivery.

METHODS AND COMMODITIES. Which methods will be provided? This is a key question to figure out the commodities and staff skills that will be needed. LA/PMs are not all equal in terms of how to manage quality of care. While the provision of all methods requires paying attention to infection prevention, with female sterilization, opening the abdominal cavity requires a level of asepsis that is potentially harder to maintain. Outreach in Nepal has focused on sterilization, but a recent technical brief recommended that the program expand to a broader range of FP services, including implants and IUDs. It is worth repeating the importance of choice, that women are offered and have access to a range of methods; it is recommended that if feasible, your program offers as wide a range as possible. Many mobile outreach efforts have focused on LA/PMs such as implants, IUDs, and sterilization; but many women lack access to other methods, including injectables. There are increasing efforts to add injectables to CBD programs, but this is still not the norm in many programs. This handbook focuses on provision of FP, but it should be noted that some mobile health services, for example in Bolivia, focus on a broad range of RH and other health services, including pap smears. Several MSI programs have added male circumcision to their outreach efforts.

Marie Stopes Clinic Society's Roving Team[2]
Mobile doctors travelling to reach patients in rural Bangladesh.

[2] From "Bangladesh team reaches out to the unreachable." 3/16/09. Retrieved from www.mariestopes.org.

NEPAL

MOVING SERVICES TO THE MOUNTAINS

Nepal is widely known for its stunning mountains. While its landscape attracts tourists, it greatly complicates the improvement of access to health services. The delivery of mobile outreach services delivery of FP to remote areas of Nepal has been an integral component of the MOH's national FP program for 40 years. It is focused on providing sterilization services to mountainous regions, where routine services do not exist. The MOH has developed specific service delivery guidelines for mobile services, which cover the following: planning, budgeting, staffing, equipment and instruments, commodity supplies, IEC, medical screening, introductory workshop on FP, preparation of sterilization, camp location, involvement of NGOs, and clients follow-up (Family Health Division, MOH/Nepal, 1997).

Mobile clinics are a significant source of contraception in the country. The 2006 DHS found that government mobile clinics were the source of contraception for roughly one-fifth (21.6 percent) of all users of modern methods, more than one-third (35.3 percent) of female sterilization, and almost half (47.7 percent) of male sterilization (MOHP [Nepal] et al, 2007).

Female sterilization is the most commonly used method among currently married women in Nepal; it is used by 18 percent of women. Because of the high number of women receiving this service from mobile units or "camps," there has been some concern about the quality of care. An analysis of the 1996 DHS found that the mobile services provided equally careful screening and high-quality care as hospitals do, and that they were an important way to meet demand in areas without access to health services (Thapa and Friedman, 1998). The 2006 DHS asked about regret, as an indication of service quality. The survey found that 6 percent of women who were sterilized or whose husbands were sterilized regretted the operation. In most cases (two-thirds of those expressing regret) this was due to side effects. It should be noted that this is half the rate of regret indicated in the 1996 DHS.

TRAINED STAFF. It is important to look at the availability of trained staff, both in terms of clinical skills and community mobilization experience. Are there trained staff with the necessary clinical skills who can travel to provide these services? Is it feasible for them to leave their places of work for brief periods for this work? Who will pay them? Will the program hire full-time staff for mobile services, or will it have existing staff dedicate some days each month to mobile services?

Team composition must also be considered. As noted above, APROFAM's team consists of one OB/GYN doctor, one general doctor, two auxiliary nurses, and one driver. MSI described a team of four to five people, including one surgical provider for tubal ligations and vasectomy (it may be a doctor, an assistant medical officer, or a clinical officer), one nurse assistant, one nurse for counseling and post-procedure care, and one driver. The teams might also include CHWs onsite, MOH staff onsite, and community volunteers (Hovig and Quinn, 2009).

At the community level, does your program have CHWs? If not, are there CBOs and health workers you can partner with to conduct the community education and mobilization activities? Will the program need to pay these workers? How well are the CHWs linked to the community health facility, and does the training need to strengthen these linkages?

What kind of training will you have to conduct as part of these services, including training of staff at lower-level health facilities and training of CHWs? At the community-level facility, are there providers who can be trained to provide these methods? Is there adequate demand (case load) to train providers on the job? Will your outreach team be able to provide the training while providing services, or do they need additional skills in how to train others?

JOB AIDS AND IEC MATERIALS. Are job aids available? If not, they will need to be developed and staff will need to be trained in their use? (Both steps will need to be included in an action plan.) You will also need a monitoring tool to collect services statistics. This is important to know how the program is working, to be able to plan for supplies and commodities and to ensure mechanisms for follow-up. There will also be a need to develop materials for community mobilization or to modify existing materials for this use. For all of these materials, you should first try to see if there are materials already available that you can adapt and use before using resources to create all new materials.

GUIDELINES AND POLICIES. All countries should have FP service delivery guidelines that can be used for service delivery issues. It will also be important to look at whether existing policies support or hinder mobile outreach services. If it is the latter, there will be a need to advocate for policy changes. Guidelines for the delivery of different FP methods, including which staff can offer these methods and where and how they can be offered, can affect what can be done via mobile outreach.

FUNDING. How will your program fund these services? Possible sources of funding could include a) funds from other services provided by your organization, b) cost sharing by the government or other organizations, c) fees for services, or d) donor support.

a. Is there money from other programs that can be allocated to this; for example, if you are an NGO that charges for clinical services at health facilities, can some of this money go toward covering the costs of outreach? MSI has taken this approach to cover some costs; in 2001 and 2002 it started using its United Kingdom clinic surplus to increase investments in rural clinical outreach and to launch efforts in many countries.
b. Is it possible that other organizations, including the MOH, will share the costs? In Malawi, the MOH has contributed some of its funds to the NGO Banja la Mtsogolo (BLM), thereby acknowledging the importance of BLM's contribution to the national FP program through its extensive mobile outreach program (see case study in Section C on scale up). This is an important model from which other NGOs can learn. Such sharing of costs, either in cash or in kind, should be discussed in planning meetings.
c. Will you charge clients for services? In many cases, it will be necessary to follow government policy regarding fees for service. Given the target population for these services, most organizations do not charge clients in mobile outreach programs. MSI rarely charges clients for clinical outreach services, since it acknowledges that rural Asian and African women cannot afford the full cost of an LA/PM. Similarly, IPPF/WHR explains that given the populations served by their mobile health units, they will not look at user-fees as an approach to financial sustainability, but they will look at alternative financing strategies (IPPF, 2008).
d. Are there donors who can provide support?

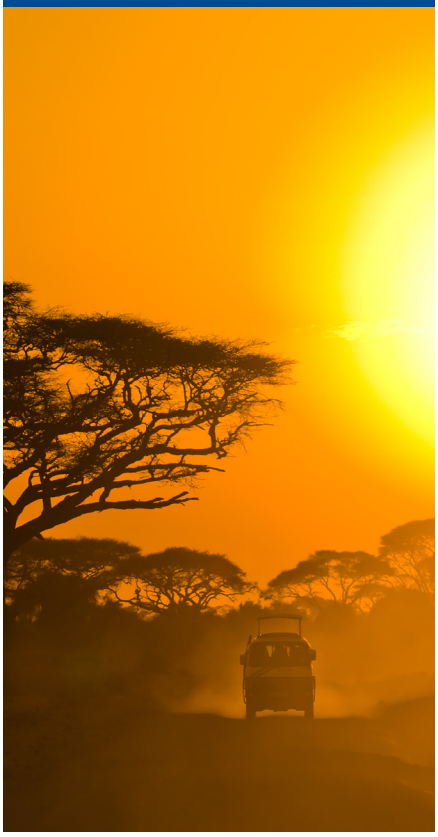
If you have decided on your model and identified the resources needed, it is time to conduct a cost analysis.

3. *Cost Analysis: Is this approach feasible from a cost perspective?*

Along with the identification of resources described above, a cost analysis will help your program decide whether mobile outreach is a feasible approach and what level of funding you will need to implement these services. Given the potential high costs of this intervention, it is good to consider if this is the most cost-effective means to reach the underserved populations in each particular context. The details of this type of cost-effective analysis are beyond the scope of this handbook, but a program might consider conducting such an analysis if the resources and technical skills necessary to do so are available.

The following potential costs should be estimated—consider these costs in light of the funding possibilities you identified in the previous section on resources to help determine the feasibility of conducting mobile outreach:

- Clinical staff time
- Transportation: vehicle, fuel, driver
- Commodities, supplies, and equipment, including contraceptives



- Upgrading lower-level health facilities
- Training lower-level health workers
- Compensating CHWs and CBDs, if they are paid
- Planning meetings (use of space, refreshments, etc.)
- Developing, printing, and potentially broadcasting IEC messages and materials.

In order to cost out the delivery of services, you will need to consider the timing of service provision; for example, will it occur once a month, every other month, quarterly, etc.? This will depend on demand for services and other factors; so it is probably best to look at costs for different potential schedules.

Costs will also depend on the scale of your program. It is recommended to start with only a few sites to work out all the logistical issues. If this pilot is successful, and if funds are available, the program can then consider scaling up.

If you decide that from a cost perspective this appears to be a feasible approach for achieving your program goals, then the next step is to identify and meet with partners for the project.

4. *Building Partnership: Who are the key stakeholders and how can we best plan and work together?*

Coordination is key to the success of mobile outreach. Therefore, identifying and meeting with partners is an essential step in setting up and implementing these services and ensuring that they can run smoothly. This includes initially identifying and sensitizing partners, planning meetings, and developing memorandums of understanding (MOUs).

IDENTIFY NATIONAL, DISTRICT-LEVEL, AND COMMUNITY-LEVEL PARTNERS. Successful mobile outreach services have involved both district- and community-level partners. Thus, program planners will want to identify partners from the MOH, government and private health facilities, local and international NGOs, CBOs, local health centers, community outreach workers, and community leaders to support mobile outreach services. Involving a wide range of partners in the process, especially local service providers and community members, helps build ownership and sustainability of community FP services.

HOLD PLANNING MEETINGS WITH PARTNERS. This could include both larger meetings to bring all partners together to discuss general issues, as well as smaller meetings—for example, just between and NGO and the MOH—to talk about specific details. It is important to always involve collaborating partners and other stakeholders in the planning and implementation process. You will need their support to promote mobile outreach services, link them with community mobilization activities, and address any challenges that arise.

DEVELOP MOUs BETWEEN KEY PARTNERS. It is recommended that programs develop MOUs between partners to clearly define roles and responsibilities.

MSI describes the partnership that its affiliates create with governments in many countries as being "contracted in" by the MOH to provide clinical FP services (Hovig and Quinn, 2009). In these public-private partnerships, the government's contribution can include the following (such details should be worked out in MOUs between partners):

- Contraceptives and other surgical commodities and supplies
- Physical infrastructure
- Community health workers to assist with sensitization, counseling, and logistics
- Counseling of clients by government health workers supporting the outreach team
- Other health services that attract additional clients
- Provision of short-term methods (condoms, pills, injectables) along with the LA/PMs provided by the mobile outreach team
- Follow-up services.

As mentioned earlier, in some cases the government supports some of the costs of mobile outreach. In the case of MSI's work, this has happened on a large scale in Malawi, Tanzania, and in South Asia, and on a small scale in Uganda and Kenya.

The next step is to translate the discussions with partners and the ideas from planning meetings into a concrete and specific action plan.

5. Developing an Action Plan: What are the key steps to starting and implementing the program, and who will be responsible for each step?

The following is a list of topics that should be included in an action plan, with questions to consider for each to work out details for your particular program.

LOCATION OF MOBILE OUTREACH SERVICES. Where and at which level will you provide outreach services? Often services are provided at lower-level health facilities such as health centers or health posts, or sometimes they are provided in community buildings, with some inputs to make them suitable for service provision. MSI is experimenting with providing services in tents to take the service one step further than the reach of health posts.

FREQUENCY OF MOBILE OUTREACH SERVICES. Because outreach service delivery depends on a mobile team traveling to rural and often remote and hard-to-reach communities, program planners should decide the best time to provide mobile outreach services. Some options to consider:

- During a certain season of the year (i.e., dry season) when roads are hard and dry, thus more accessible

MALAWI

DEVELOPMENT OF A PUBLIC-PRIVATE PARTNERSHIP

Before embarking on the Community Outreach Clinic Initiative, Banja la Mtsogolo (BLM) held a series of discussions with Ministry of Health and Population officials before the initiative was finalized. The various services under this initiative are provided in rural government-owned health centers, and where necessary, BLM embarks on rehabilitation works of the service room to make sure that it meets desired high-quality standards. In addition, the provision of the services in the various health centers is done at times jointly by BLM and Ministry of Health officials.

From: http://www.banja.org.mw/communitr.htm

Providing advice to a mother and child in Malawi.

Providing a Zimbabwean man with family planning information.

- During specific holidays or specific times of year that lend themselves to the situation, such as immunization campaigns or cultural events, or that need to be avoided so as not to conflict with cultural festivities
- When a reasonable number of clients have been identified
- When services are needed. For example, with hormonal injectables, mobile outreach services should be provided every two to three months for women to get their next injection.

COMPOSITION OF MOBILE OUTREACH SERVICES DELIVERY TEAM. The clinical team providing mobile outreach service delivery should be trained and well versed in the provision of FP, including LA/PMs. The mobile outreach teams can consist of —

- Health providers from a higher-level health facility
- Health providers from lower-level facilities who have been, or are able to be trained by a clinical mobile outreach team
- Health providers from NGOs.

TYPE AND NUMBER OF TRAINING ACTIVITIES. If training is a large component of the mobile outreach program, decide who needs training and how often training will take place. For example—

- How many lower-level facility staff need to be trained in FP and/or service provision?
- How many community outreach workers need to be trained in FP?
- Will there be refresher training for health facility staff or community outreach workers, and if so, how often?

SUPPLY OF FP METHODS. Family planning supplies and equipment are needed for outreach visits. Also, if lower-level facilities will be trained to provide FP services; thus ensuring a steady supply of FP methods is critical for continuing these services. When planning for supplies, consider the following:

- Can you work within the existing supply management system (governmental or nongovernmental)?
- Who is in charge of distribution and how can linkages be made with supplier?
- How can you ensure accurate forecasting and timely orders of supplies at regular intervals to avoid stock-outs?

WAYS TO PROMOTE FP IN THE COMMUNITY. It is important to create a demand for the mobile outreach services, inform the community about FP, and combat any misinformation and rumors about certain methods abound. Family planning can be promoted through community outreach workers and IEC campaigns, as well as through confidential information sources such as hotlines and

provider counseling. Make plans to ensure that your community outreach workers are well trained. Also, plan for the development IEC materials and/or media campaigns to further promote mobile outreach services.

FOLLOW-UP AND CONTINUITY OF CARE ACTIVITIES. One of the challenges of mobile outreach services is the lack of continuity of care once the mobile team has left a community. Program planners should plan how continuity of care will be handled, especially for—

- Re-supply of methods
- Side effects management
- Post-op care and support, including how to handle complications and how the client will be transported if necessary to a referral center
- Implant or IUD removal
- A mechanism for the community-level providers to contact the mobile outreach team, if needed.

FUNDING PROGRAM COSTS. Collaborating partners should cover the costs of delivering the mobile outreach services. Different partners may be able to cover the different costs and leverage existing program funds for the mobile outreach services. Identify gaps in funding and where additional support can be acquired, such as within the partner community, from an outside donor, or within the community itself.

AGREE ON ROLES AND RESPONSIBILITIES AND FINALIZE MOUs. Once a plan has been formulated, agree on who is responsible for the different tasks. MOUs developed during the partnership-building phase will inform who is responsible for each action.

And now, it's time to turn that plan into action.

B. Implementation

1. Main steps

a. **SCHEDULE SERVICES.** This should include locations, dates, staffs for each visit, commodities needed. Make sure to schedule community mobilization activities during the weeks BEFORE the mobile team visit. Also make sure you have approval from all relevant local health authorities (an issue that should have been covered in planning meetings).

b. **PREPARE SITES FOR SERVICE DELIVERY.** Coordinate with service delivery locations, whether services will be provided at a health facility, or another location in a community, or within the mobile health unit itself, ensure that you will have what you need at each location in terms of staff, equipment, infection prevention, etc.

c. **INFORM CLIENT BASE.** Conduct community mobilization and information activities. This can include a mass media campaign, dissemination of printed materials such as posters and brochures, and convening community meetings.

CHECKLIST

FOR MOBILE OUTREACH TEAM MEMBERS BEFORE THEY TRAVEL TO COMMUNITY SITE

- ✓ They have coordinated with local partners in the target community.
- ✓ There is sufficient demand for services.
- ✓ A health facility or community structure has been identified; it offers sufficient space to counsel clients on FP and provide services.
- ✓ Team member's workload and clinic duties at the home facility are covered while they are away.
- ✓ Transportation to and from mobile outreach site is arranged.
- ✓ They have all the necessary supplies, including FP supplies, medical supplies, equipment, pre-operative protocols, consent forms, infection prevention equipment, and medical waste containers needed for mobile outreach service delivery.
- ✓ There are generators and fuel for providing clinical methods, if needed.
- ✓ Emergency provisions are available in the event that there are complications during any of the clinical insertions or procedures.
- ✓ Determine how clients will receive post-operative care and support, especially if the mobile outreach team does not plan to return to the outreach site
- ✓ If training lower-level facility staff to provide FP during the mobile outreach visit, curricula, training materials, and supplies are available.
- ✓ IEC materials on FP methods and post-procedure follow-up care are available for clients.

REMEMBER

Client follow-up is very important in a mobile outreach program. For this, the information related to clients should be recorded accurately and clearly during registration.

The mobile outreach services do not end with the completion of the service; rather, it ends when every client has completely recovered from their procedures.

—Adapted from VSC Mobile Outreach Services—Guidelines, Nepal, 1997

d. **CREATE MONITORING PLAN.** Make sure to collect program data regularly and submit weekly/monthly to headquarters. Mobile teams must have a form to complete during each visit, on which they note the number of clients, demographic data for each (age, parity), the methods chosen and provided, etc. This will enable the program to monitor key indicators, namely the number of clients served by location and by method, and total CYP provided by the program. Collecting such data is also essential for follow-up.

e. **PLAN FOR FOLLOW-UP.** Set up systems for follow-up and continuity of care—if qualified providers are only available on an intermittent basis, how will you address complications, side effects management, and implant removal? With MSI's programs, they advise clients to return to the site where they received the services, if they experience specific symptoms or complications.

f. **ENSURE THE QUALITY OF SERVICES**. Program implementers identify this as an extremely important part of mobile outreach services. As one implementer explained, if you go into a community and something goes wrong, you could be kicked out—"the impact is swift." Some of the key issues to monitor are listed in the box below.

g. **HOLD REGULAR PROGRESS MEETINGS WITH PARTNERS.** These meetings will serve to—
   - Ensure smooth implementation of the project
   - Discuss and address any problems or challenges
   - Provide refresher training and updates.

2. Main challenges and suggestions on how to address them

a. **TRANSPORT DIFFICULTIES**. This includes poor road infrastructure in most rural areas, which is especially a problem during rainy seasons. In Nepal and other places, political unrest also led to difficulties in providing outreach services, which leads them to work to increase the use of static services.
   - Schedule outreach visits during non-rainy seasons.
   - In the case of political instability, there might be a need to focus more on static services rather than outreach, at least temporarily.

b. **FINANCIAL CONSTRAINTS, INCLUDING DIFFICULTIES IN COVERING THE COSTS OF VEHICLES AND THEIR MAINTENANCE AS WELL AS FUEL COSTS.**
   - Look for cost-sharing arrangements with partners and with other programs (i.e., HIV/AIDS, immunization, malaria, vitamin A) when integrated services are provided.

c. **INADEQUATE DEMAND.**
   - Ensure that community mobilization occurs, along with a range of methods to advertise services, including posters, radio, and word-of-mouth.
   - Conduct more participatory educational activities. IPPF/WHR staff highlight the innovative efforts in Colombia, which often involve men and youth, and include games and role-playing.

d. **FOLLOW-UP CARE AND SUPPORT.**
   - Work with CHWs to assist with follow-up of clients.

e. **COMMODITY LOGISTICS.** No product or program remains a fundamental truth in FP programs.
   - When possible, explore government partnership for the provision of contraceptive methods.
   - Keep good records to ensure proper forecasting and planning for the number of methods needed.

f. **BREAKS IN SERVICES AT MOBILE TEAM'S HOME CLINIC.**
   - Try to involve providers from adequately staffed clinics so they are able to function without some of their staff.
   - Consider hiring staff to work full-time on mobile outreach, although this will depend on the details of your program and whether it can support full-time staff.

In the Philippines, MSI manages follow-up through a combination of regularly scheduled visits and cell phone communication with village contacts (Pernito et al., 2009). Given the ever-increasing reach of cell phone networks, this could become an increasingly important way to facilitate follow-up.

It is important to keep in mind that it can take time for an outreach program to gain momentum. MSI gives the example of Kenya, whose outreach program began in 1997, but did not take off until 2004. "Outreach is difficult to launch, it requires strong government relationships, focused attention on clinical quality of care and intensive demand creation." (Hovig and Quinn, 2009); but patience and hard work paid off. In 2008, 14 percent of modern method CPR in Kenya was provided by MSI, mostly through outreach.

C. Scale up

If initial efforts are successful, you might want to consider expanding the services to more sites, provided that there is a need and you have the resources. In order to scale up, it will be crucial to have good program data—both in terms of inputs and their costs, and of outputs and impact—thus highlighting the necessity to include strong monitoring and evaluation into the program from the beginning.

Scale up will also require partnership. If you wish to have a national-scale program, the MOH is an essential partner. The story of scale up in Malawi is described below; it highlights the importance of a strong public-private partnership for a program to have a national impact.

MSI's experience in the Philippines also highlights how partnership and collaboration are key to success and scale up. MSI launched an innovate IUD outreach program in 2005, which has led to a tenfold increase in IUD insertions in just three years, from roughly 10,000 in 2005 to 100,000 in 2008. MSI estimates that it provides more than one-third (34 percent) of IUDs in the country: "The key to MSI's IUD outreach success stems from its commitment to a collaborative and coordinated approach, linking up with rural village governing councils and local

IMPORTANT

REMINDERS DURING DELIVERY OF MOBILE OUTREACH SERVICES

- ✓ Use good counseling techniques.
- ✓ Ensure informed choice for all FP clients.
- ✓ Ensure privacy and confidentiality while counseling on family planning and providing contraception.
- ✓ Perform clinical procedures in clean and aseptic environment.
- ✓ Make sure sharps and medical waste are disposed of properly.
- ✓ If the mobile team cannot stay in the area or cannot return after several days to provide follow-up care for the clients who have had a clinical procedure, then train local service providers and/or community outreach workers to provide 1) post-procedure care and support and the handling or referral of complications, 2) side effects management, and 3) removal. (Hovig, D and H. Quinn. 2009. Marie Stopes International Mobile Choice Outreach Programme Overview.

MALAWI

A POWERFUL PARTNERSHIP WITH NATIONAL REACH

With 83 percent of its population living in rural areas, access is a key challenge for FP in Malawi. Banja la Mtsogolo—an independent NGO affiliated with MSI—implements the Community Outreach Clinic Initiative, working jointly with the MOH. Trained staff from BLM clinics travel to MOH facilities to provide clinical FP services that are not available at these facilities. The network of community outreach clinics now totals 307 sites, a threefold increase from the 102 sites included in 2004. BLM provides more than one-third (35 percent) of contraceptive services in the country, with a significant proportion through outreach.

Through this initiative, BLM is able to provide services to people who cannot afford transport costs because of high poverty levels and poor road infrastructure. The importance of this initiative has been acknowledged by the MOH—particularly for permanent FP methods—to the point where they even provide some funding to BLM.

By also going into communities to provide free services under the Community Outreach Clinic Initiative in over 200 sites, BLM has assisted Government in scaling up in provision of services in the Essential Health Package. The services provided to communities in the remote and hard-to-reach areas are making a difference to the poor and vulnerable people. Since last year, BLM has been funded by my Ministry in recognition of its contribution to Government efforts. BLM is a high-capacity institution. With only 5 percent of the health infrastructure, they provide over 42 percent of all permanent family planning methods in Malawi per the 2004 DHS report."

—Speech by Khumbo Kachali, Minister of Health, June 24, 2008 (Government of Malawi, 2008)

health committees (often by mobile phone) in advance of delivering IUD insertion services" (Pernito et al., 2009).

Mobile outreach can either be a stopgap measure or a permanent part of your program (Bakamjian, 2008). If it is the former, then scale up might not necessarily be the goal for your program.

Finally, mobile outreach can be either part of a national program or of a project in one community. The scale of the program will depend on the needs of the communities you serve.

III. Conclusion

Mobile outreach can be an important addition to an FP program. Whether it is a big program with national coverage or a small program in one community, this can be an important way to give women access to a full range of FP options.

We hope that this handbook can help your program if you decide to make mobile outreach part of your work. If you do, please share your experiences and stories with us so we can continue to improve this handbook.

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Appendix 2: Tools

Tool #1: Managing an Outreach Program (from MSI)

Background

Marie Stopes International (MSI) is in the midst of tremendous growth. With this growth comes the opportunity to establish minimum guideline for managing outreach programs. There are several documents within the partnership at the program level addressing managing outreach program. This document is the collaboration and synthesis of best practices at several of these programmes. Major programs that contributed to this document are Sri Lanka, Kenya, Pakistan and Uganda.

Contents

A. Establishing A New Outreach Site

1. Confirm support from MSI program/regional director
2. Confirm adequate financial support

Confirm Adequate Support for a New Outreach

1. Desk Study—To get the demographics
   - Map—Identify cities/towns
   - Collect Statistics—Regarding target population
   - Identify gaps between demand and supply of services
   - Develop a list of names and contact information of important people
   - Identify local health facilities for complication management backup
2. Field Study—Visit the potential site
   - Ask clients at MSI centres and existing outreach programs where they live and open site where there is a high demand
   - Ask MSI centre staff where there is A need for outreach
   - Meet with—
     * Government officials
     * Medical community
     * Women's groups
     * Other NGOS—Identify what services they provide
   - Assess the accessibility for clients—Proximity to public transportation
   - Assess whether outreach site is at an appropriate distance from MSI centre
   - Evaluate the feasibility of refurbishment
   - Appropriate facility

Decide Which Services to Provide

1. Permanent Procedures
   - MSL
   - MSV
2. Temporary Services/Procedures
   - Condom distribution
   - Oral contraceptive pill distribution
   - IUD insertion
   - Implants
   - Injections

Establish a Schedule

1. Negotiate with stakeholders; e.g.,
   - Government officials
   - Motivators
   - Health workers

Establish a Schedule — *continued*

2. Choose the duration of the outreach
    - One day
    - Two day overnight
    - One week
3. Establish the dates (frequency of visits)
    - Start with every eight weeks
    - Make schedule quarterly
4. Establish the first day of the outreach
    - Will need at least one month to prepare

Day Before Outreach

Example of Ideal Outreach Day

- Prepare instruments and supplies

Outreach Day

- Pack vehicle using outreach checklist
- Depart for site
- Arrive at site
- Clean room to MSI protocol, unpack vehicle
- Counsel clients and obtain consent
- Set up instruments in a sterile corner and room
- Bring first client into room
- Do Family Planning talk and answer any questions
- Arrange next date for visit and put up posters
- Inform mobilizer and health facility
- Usher last client out of the room
- Clean up room and pack up

B. Supplies and Equipment

Non-Clinical Supplies Checklist

1. Location
   - Water supply
   - Electricity—if possible
   - Generator—backup
2. Building
   - Washable floor, good ceiling
   - Need at least three rooms
     * Procedure room
     * Recovery room
     * Working/Counselling room
3. Transportation for the Surgical Team
   - Vehicle
     * Station wagon or van
     * Funds for adequate fuel/per diems/referral incentives
4. Client Record Forms
   - Registration
   - History
   - Informed consent forms
   - Discharge instructions
5. Payment Forms
6. Client Service Satisfaction Survey
7. Complication Reporting Forms

Outreach Supplies *(for more details please see Outreach Supplies Checklists)*

- Completes medication
- Emergency supplies
- MSL procedure
- MSV procedure
- Family Planning
- STI screening and treatment
- Infection prevention

C. Outreach Team Members

Essential members

1. (1) Service Provider
2. (1) Assistant
3. (1) Nurse for counselling and recovery care
4. (1) Driver
5. (1) Vocal Local—ideally, sometimes the driver takes on this role
6. (1) Volunteer—ideally a nurse from the local health centre

Recruitment

1. Recruit from MSI centres
2. Makes sure team members are able to possibly stay overnight at an outreach site
3. Ideally recruit individuals who are enthusiastic about outreach and have the skills to perform multiple roles
4. All team members should be able be trained in sterilization techniques

D. Sustainability

Cooperation with, and acceptance by, the local community

1. Community Sensitisation
2. Proper information dissemination at site community
   - Announce opening date of outreach

Communication of complication

1. Client instructed to return to the location where she had the surgery
2. Health provider (ideally a nurse who helped on the day of outreach)
   - Makes an assessment and decides if she need to be referred to Hospital
   - Reports complication to the doctor who did the surgery
3. Doctor nearest to the MSI centre who did the procedure
   - Visits client
   - Decides if care is appropriate
   - MSI pays for patient's hospital care
4. Any minor complications hears about at next outreach visit is documented and the appropriate follow-up is arranged (e.g., Having patient come to the outreach site for a follow-up visit)

Client satisfaction

- Survey

Follow-up services available to give advice to those clients with post-MSL queries

Outreach Supply Checklist—Emergency Supplies

Emergency Supplies (Updated April 2008)		
Observation Item	**Quantity**	✓
Emergency Equipment	1	
1. Ambu bag and mask	1	
2. Oral airway (sizes 3 and 4)	2	
3. Latex gloves	4	
4. Adhesive tape	1	
5. Bottle spirit and cotton or alcohol swabs	1	
6. Foley catheter and urinary bag	1	
7. Suture (0 chromic for cervical, 2.0 or 3.0 chromic for bladder repair, 2.0 or 3.0 silk for bladder repair)	1 of each	
8. Suture needles: small, atraumatic	1	
9. Roll of gauze	1	
10. Sterile gauze pack	4	
11. Butterfly needle (22 and 24 gauze)	1 of each	
12. Standard infusion needle (16,18, 20 gauge)	1 of each	
13. Syringes (1,5 and 10ml)	1 of each	
14. Ault IV—IV administration set with tubing	1	
15. IV fluids normal Saline lactate Ringers	2	
16. Haemaccel (colloid plasma expander)	2	
17. Oxygen cylinder (at least half full)	1	
18. Blood administration sets	1	
Emergency Medications (team familiar with use of each, indications and dosages)		
1. Adrenaline1mg/ml 1:1000		
2. Chlorpheniramine (or equivalent)		
3. Hydrocortisone		
4. Diazepam (Valium) 10mg injections		
5. Inhaler (bronchodilator)		
6. Aminophyiline		

Outreach Supply Checklist—Procedure Checklist

Marie Stopes Ligation (MSL) (April 2008)		
Standard Procedure Stage	**Quantity**	✓
Informed consent		
1. Informed consent form		
Client screening and assessment		
1. History form (prior contraception/obstetric history/previous surgery/bleeding disorders/BP)		
Aseptic technique		
1. Sterile gloves		
2. Sterile drape		
3. Antiseptic		
Local anaesthetic (LA)		
1. 21 gauge needle, 1.5 cm		
2. One 20 cc syringe, with 1.5 inch No. 20 (or smaller) needle for infiltration of local anaesthetic		

continued on next page

Procedure		
MSL Kit		
1. Tubal Hook 26 cm w/flat serrated		
2. One No. 3 scalpel handle		
3. Metzenbaum scissors b		
4. Iris Scissors str 11.5 cm		
5. Standard tissue forceps 1		
6. Four mosquito forceps		
7. One pair Army-Navy retractors		
8. Mayo Hegar needle holder 16 cm		
9. Two Babcock tissue forceps		
Not in the MSL Kit		
1. One sponge holding forceps with gauze swabs		
2. Small bowl of antiseptic solution for skin preparation		
3. One No. 10 blade		
4. 0 plain suture, if possible Ethicon round needle 35 mm half circle (J&J) alternatively cutting needle		
5. Drapes		
Recovery and discharge		
1. Written discharge instructions for MSL given (wound care, activity level, warning signs)		
2. Client satisfaction form		

Outreach Supply Checklist—Family Planning Checklist

Family Planning		
Standard Procedure Stage	**Quantity**	✓
Combined pills		
1. History form with screening (age, smoking, history)		
Medications **Oral contraceptives**		
1. Progesterone only		
2. Combined estrogen and progesterone		
Intrauterine contraceptive device (IUD)		
1. UCG (pregnancy) test		
Insertion equipment		
1. Beta-dyne cervical preparation		
2. Device to sounds uterus		
3. Stopes forceps		
4. Scissors to cut thread		
5. Speculum		
IUD		
1. Cooper T		
2. Gyne-fix		
3. Mirena		
Patches—Evra patch		
Injections		
1. Depo-Provera injections		
Condoms: male and female		
Implants		

Emergency contraception (OCP)		
1. History and screening form—Eligibility/Timing (72 hours post-unprotected sexual intercourse)		
2. Written client instructions—(With food/if vomits/future unprotected sexual intercourse/starting regular contraceptive method)		
Emergency contraception		
1. Combined: 2 x 50 mcg 12 hourly or 4 x 30 mcg 12 hourly or		
2. Progesterone-only pill Postinor 1 x 750 mcg 12 hourly		

Outreach Supply Checklist—Sexually Transmitted Infectioin (STI) Checklist

STI Screening and Treatment		
Standard Procedure Stage	**Quantity**	✓
Written information/Pamphlets on—		
1. Syndromic approach for risk assessment		
2. Treatment regimens follows local Ministry of Health requirements		
3. Prevention counselling is included in all STI consultations		
4. HIV/AIDS prevention counselling offered to all customers		
5. HIV testing material		
6. IEC		
Antibiotics		
1. Flagyl (Metronidazole 400 mg)		
2. Doxycycline 100 mg		
3. Erythromycin 250 mg		
4. Ciprobay 500 mg		

Outreach Supply Checklist—Infection Prevention

Marie Stopes Infection Prevention (MSIP) (March 2008, page 2 of 3)		
Observation Item	**Quantity**	✓
Steam sterilisation (autoclave)		
Chemical sterilisation		
• CIDEX (Gluteraldehyde 2x)		
Disinfection		
Boiling		
☐ Stove (gas or electric)		
☐ Boiling pot with lid		
Chemical HLD		
☐ CIDEX		
☐ Chlorine		
Handling and storage		
☐ Sterile drums		
☐ Box or bag (waterproof) for sterile packs		
Equipment cleaning routine		
☐ Procedure table/cover is wiped with a chlorine or disinfectant solution between clients.		
☐ Procedure room is damp dusted.		
☐ All surfaces coming into contact with blood or other body fluids are disinfected immediately.		

Infection Prevention Checklist		
Standard Procedure Stage	**Quantity**	✓
1. Hep B. vaccine		
2. PEP policy		
3. Toilet facilities		
4. Hand-washing facilities		
5. Sharps container (puncture resistant)		
6. Bin liners (colour-coded for waste disposal)		
7. Incinerator or deep pit		
8. Utility gloves		
9. Detergent		
10. Soft brush or sponge		
11. Water-proof apron		
12. Timer		

General Equipment		
Items	**Quantity**	✓
Containers and cleaning supplies		
1. Peddled buckets		
2. Lidded buckets		
3. Tapped buckets		
4. Mop and container		
5. Measuring jar		
6. Compartmentalized box		
Stationary		
1. Client's record form		
2. Consent forms		
3. Follow-up card		
4. Stamp pads		
5. Medicine envelopes		
6. Marker pens		
7. Writing pens		
10. Banners—Marie Stopes International branded		
General clinical equipment		
1. BP machine		
2. Stethoscope		
3. Stop watch/Kitchen clock		
4. Sanitary pads		
Linen		
1. Sterile gowns and towels		
2. Sterile drapers with peritoneal hole		
3. Linen bag		

Tool #3: Partner Agreement (from MSI)

Introduction

Marie Stopes International (MSI) is pleased to enter into this agreement with the District health team. This partnership is established to provide high-quality family planning (FP) and male circumcision (MC). MSI looks forward to working together with the Lusaka District Health Management Team (LDHMT) to develop a successful programme and form a strong public private partnership with the Ministry of Health.

This Partner Agreement is a statement of the relationship between MSI and the Lusaka District Health Management Team with regard to the provision of sexual and reproductive health services in Lusaka. It serves to provide a framework clarifying this relationship and the responsibilities agreed upon by both parties.

By signing this agreement, both MSI and the Lusaka District Health Management Team agree to adhere to the terms of this agreement.

1. Commencement and Term

This agreement shall commence on the 15th of May 2009 and shall continue in force thereafter unless and until determined in accordance with its terms for an initial term of one (1) year subject to the right of renewal contained in the next following clause.

2. Renewal

Subject to the provisions of this, the agreement may at its option be renewed at the expiration of the said initial term for a further term of one year.
The renewal shall only be effective provided that:

- The partner has throughout the initial term properly observed and performed all its obligations under this agreement and is not at the expiry date in default under any such obligation.
- MSI and the LDHMT shall indicate their readiness to renew the agreement at least one month prior to the expiry date and shall, where required, execute a new agreement in the form then used by MSI, which new agreement may differ from the terms of this agreement.

3. Scope of the Agreement

MSI will provide support to the LDHMT with regard to the provision of sexual and reproductive health services in Lusaka.

MSI wishes to assist the LDHMT with the provision of long-term family planning methods (LTM FP), Bilateral Tubal Ligation (BTL) and Male Circumcision (MC) services. The following assistance will be provided to the below-mentioned health centers under the auspices of the LDHMT:

- BTL, MC, and LTM FP in—
  - Matero RC
  - Chelstone
  - Chilenje
- BTL and MC in—
  - Kanyama

Mobile services through outreach activities for Chawama and Kalingalinga MoH sites will be evaluated and implemented if at all possible. Other MoH sites may be added to this agreement by written agreement of the LDHMT.

NB: MSI will make no charge for the provision of these services.

4. Commitments of MSI

Section 4.1: Technical Assistance

MSI agrees to provide technical assistance to the LDHMT by—

1. Training and upgrading health centre staff's knowledge in the standards, procedures, techniques and methods including follow-up training, in—
    - Providing high-quality male circumcision procedures
    - Providing high-quality reproductive and sexual health counseling
    - Providing high-quality family planning services, including tubal ligations
    - Other training as considered appropriate.
2. Monitoring and supervising the programme to ensure that a high-quality service provision of MC and FP is maintained.
3. To provide advice, know-how and guidance relating to data collection, stock management, and other management information systems.
4. To provide additional staffing during MC, BTL, and FP outreach service days.

Section 4.2: Supplies, Materials, and Equipment

MSI will ensure provision of—

1. Supply of furnishings, equipment, and instruments. The need will be established based upon a site assessment.
2. MSI shall support the MoH Health Centre to ensure regular and accurate ordering on a monthly basis to enable the MoH site to maintain a regular supply of consumables and FP stock. MSI shall supplement consumables and FP methods, as far as their resources allow, in the event of a stock-out.
3. Educational documents and promotional materials.
4. Manuals setting out technical protocols for all procedures and counseling.

Section 4.3: MSI Logo

MSI will provide a poster signboard, which will announce the availability of these specific SRH services at the premises in partnership with MSI. This signboard will be displayed for the duration of this agreement.

Section 4.4: Promotion of Services

MSI will develop information and educational campaigns through various media channels to create awareness of, and interest in, the services provided. MSI shall make available to the partner information and education materials including posters, leaflets, and flyers, etc.

Section 4.5: Refurbishment

MSI will refurbish ads and when it becomes necessary to permit the partner to operate and promote the services, according to the guidelines of the Ministry of Health and the terms of which shall be deemed incorporated into and shall form part of this agreement.

5. Commitments of LDHMT and the Respective Health Centres

Section 5.1: Maintain Quality Standards

The objective is to provide high-quality MC and FP. The MSI logo symbolizes to clients that the partner provides such quality services in the areas of sexual reproductive health. MSI seeks to protect the image of LDHMT and the respective Health Centres and ensure a standardization of the above-mentioned health services to clients at a minimum level. For this reason, MSI requests that each partner complies with the following expectations:

1. **Provision of quality services in terms of technical standards.** During training, correct procedures are discussed for each service. In the area of male circumcision and family planning, the partner agrees to provide high- quality services, based on the elements presented in the training sessions and to maintain basic privacy during counseling and service delivery.
2. **Trained and qualified staff member.** Any staff member who has not undergone training or been so approved to perform the specified services should not be permitted to perform any such service and/or procedure.
3. **Location requirements.** Services should not be operated at any location other than the premises and/or rooms specifically dedicated for such service.
4. **Maintenance and cleanliness of the facility.** Partners are to ensure that the interior and exterior of the premises are kept in good condition and to the highest standard of cleanliness.
5. **Compliance with MSI standards for quality of care.** The partner permits MSI and its representatives without any further authority, save that hereby irrevocably given at reasonable times and upon reasonable notice, to enter upon the Premises for the purposes of ascertaining whether the provisions of this agreement are being complied with.

Section 5.2: Service Delivery

The partner agrees to be responsible for all service delivery and to ensure appropriate staffing and scheduling of services. In addition, the partner commits itself to conducting all follow-up consultations and to maintaining an adequate referral system for emergencies and in cases of management of complications. MSI will work with and support the Partner to ensure that these systems are in place.

Section 5.3: Provision of Adequate Space

The partner agrees to provide adequate space for service delivery.

Section 5.4: Recording and Reporting Requirements

Partners are required to keep accurate and confidential client records for **each client** and maintain the monthly consultation records form on a daily basis. In addition, monthly stock reports are to be maintained. Monthly records should be filled out correctly, completely, and be ready to be collected **by the 5th of each month.**

Section 5.5: Service Pricing

MSI will provide services free of charge. Notwithstanding this, each Health Centre has the prerogative to establish service fees. Standard fees for services are developed to make sure appropriate levels of cost-recovery are made; yet services remain affordable to low-income clients. Service fees are mutually agreed upon between the LDHMT and the health centre management. Income from service fees will be accounted for and used for the procurement of consumables and/or instruments needed to perform the above mentioned services.

Section 5.6: Promotion of Services

The partner will co-operate with MSI in any special community sensitization, promotion or other special activity.

Section 5.7: Monitoring and Evaluation

MSI shall conduct monitoring and evaluation activities. These activities will be conducted for the purpose of showing overall program improvements. This includes any operational research and/or client satisfaction interviews.

Section 5.8: Equipment, Furnishings, and Instruments

It shall be the duty of the Partner to maintain and safeguard the equipment and instruments. The Partner is not to sell, assign, transfer, charge or sub-license the equipment, furnishings and instruments without the prior consent of MSI.

It shall be lawful for MSI to remain the sole owner and repossess all equipment, furnishings and instruments delivered to the Partner in case of breach and/or annulment of the agreement.

6. Amendment and Termination

This agreement will take effect as soon as both parties sign it. The time period of the agreement is one (1) year; beginning the date it takes effect.

1. The agreement may be amended or extended at any time in writing as agreed upon and signed by the authorized representatives of the two parties.
2. Each party may terminate the agreement at any time, provided that it informs the other party in writing of its decision one month in advance.
3. Either party may terminate the agreement at any time before its expiration date if the clinic fails to comply with any of its obligations specified in this agreement and if it fails to correct the failure after an initial verbal warning and a subsequent written letter notifying the Partner of the failure.
4. MSI may terminate the agreement at any time if MSI experiences an interruption or decrease in funding. Notwithstanding this, MSI will endeavor, through its fund-raising efforts, to ensure a continuation of funding is secured to allow planned activities to proceed. Regular updates with the partner will be held every quarter, minimally.
5. If this agreement expires or is terminated the Partner will return to MSI or otherwise dispose of as MSI shall direct; all signs, advertising materials, forms, and all items of equipment, instruments and supplies. All records will remain the property of the DHMT. MSI shall make copies or duplicates as necessary with full awareness of the DHMT.

7. Entire Understanding

This agreement embodies the entire understanding between the parties and supersedes all previous understandings, commitments, agreements whether oral or written relating to the agreement. This agreement shall be governed and interpreted in accordance with the laws of the Republic of XXXXXXXXXX.

IN WITNESS whereof the parties hereto have hereunto set their hands and names the day and year first above written.

Signed/Dated:
District Health Management Team

_____

Name:

Position:

Signed/Dated:
In the Presence of

_____

Name:

Position:

Signed/Dated:
MSI

_____

Name:

Position: Country Director

Signed /Dated:
In the Presence of

_____

Name:

Position:

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