Use of Facility-Based In-Reaches as a Catalyst for Expanding Access to and Uptake of Family Planning Services in Delta State

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Background

Despite concerted efforts to satisfy contraceptive needs among women in Delta State, Nigeria, several challenges still prevent women and men from tapping into the huge benefits of family planning. These challenges include minimal awareness of the benefits of family planning and where one can access services, absence of functional primary health facilities, shortage of trained service providers, user fees for accessing service and misconceptions about family planning. These challenges all contribute to poor utilization of family planning services in Delta State.

According to NDHS 2018, 23.7% of women of reproductive age in Delta State desire to space their pregnancies or limit the number of pregnancies but are not using any form of contraception to do so, which reflects the high unmet need for family planning. Delta State government is committed to drastically reduce the burden of unmet need and eliminate barriers to access and utilization of family planning services, and, as a result, sought The Challenge Initiative's (TCI's) technical support. This document highlights how the use of facility-based in-reaches has proven to be an easy-to-implement and cost-effective approach for addressing unmet need and driving family planning uptake in Delta State.

What Are Facility-Based In-Reaches?

Facility-based in-reaches describe the provision of family planning services to clients mobilized from the community to a particular facility, usually a primary health center (PHC), on designated days of the week. It is a client-centered approach to utilizing the health facility in providing multiple opportunities for the client to access quality family planning services and a comprehensive package of other health services or interventions in a convenient and cost-effective manner. The facility-based in-reach strategy is aimed at improving access to and utilization of family planning services by potential clients in a chosen health facility. A team of trained providers – comprising the LGA Reproductive Health (RH) Supervisor, outsourced service providers from within the LGA and the facility-based service provider – provide family planning counseling and methods to clients mobilized through social mobilization efforts at the identified in-reach facility on the scheduled days of the in-reach.

The facility providers where in-reaches occur work closely with the community social mobilizers in order to synchronize mobilization days to clinic days for seamless service provision.

Criteria for selecting facilities for in-reaches include low uptake of family planning services, inadequate provider capacity to provide long-acting reversible contraceptive (LARC) services and a high unmet need for family planning in the community. The approach offers the advantage of creating community awareness of available health services rendered at health facilities in a cost-effective manner. It strengthens community-facility linkages including integration of family planning into other maternal and child health services. It also fosters communication between the community and health facility staff, thus promoting community actions directed towards creating an enabling

environment towards family planning. As a result, client turnout on in-reach days far exceeds the usual attendance observed on normal service delivery days.

What Are the Benefits of the Approach?

TCI's introduction of facility-based in-reaches in Delta State have been beneficial in many ways:

- Underserved populations in greatest need for family planning services have been reached with family planning information, counseling and method provision as close to their communities as possible at no additional cost.
- Contraceptive use has been successfully improved particularly in areas where geographical, cultural and socio-economic barriers have limited service uptake in the past.
- The capacity of more health care providers has been built and strengthened to provide a broader range of methods. Specifically, providers' knowledge and skills related to LARCs has increased, expanding the method mix available in these geographies.
- High quality contraceptive care is now integrated into other existing Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services, such as cervical cancer screening, antenatal care, immunization services, etc.

TCI's Use of the Approach

Prior to the emergence of TCI in Delta State, the family planning situation deteriorated with the withdrawal of support from a number of donor organizations. A business unusual model was presented by TCI where the State and LGAs mobilized its own local resources, taking ownership to lead implementation of TCI's high impact approaches. Relevant family planning stakeholders in the State were also engaged to identify existing State structures to drive family planning program implementation. The reproductive health (RH) coordination structure at the LGA level was identified as a vital existing structure. As a result, all 25 LGA RH Supervisors in Delta State were introduced to the high impact service delivery approaches, including facility-based in-reaches and their capacity was built to implement them so that they could be assured results.

Based on the evidence that facility-based in-reaches have significantly increased uptake of family planning services elsewhere, TCI introduced this approach to Delta State. The remarkable outcomes from the first batch of in-reaches gained the buy-in and commitment of the State to fund this approach, so that it is now implemented across all 25 LGAs on a monthly basis. Of the total number of facility-based in-reaches implemented, 70% were fully funded by the State through its Saving One Million Lives Program for Results (SOML PforR). In addition, TCI is providing some financial support along with technical assistance in the form of information sharing on the methodology for the in-reaches. This technical assistance support ranges from guidance on the selection of facilities to the sourcing of trained service providers from nearby facilities, onsite/virtual coaching of service providers during the in-reach and distribution of SBCC/IEC materials by TCI-trained social mobilizers. The TCI State Technical Support Team also provides technical assistance to the RH unit to document, analyze and disseminate results from the in-reaches to key state actors in an effort to promote accountability and garner greater resources to support interventions that work.

Facility data from February to September 2019 shows that **1,912** women and men took up various family planning methods – **1,165** LARCs and **747** short-acting methods – from 25 facility-based in-reaches conducted over a 1- to 2-day period in 13 LGAs of Delta State.

Steps in Implementing the Approaches

The steps to implementing the approach can be viewed in three phases.

Phase I: Planning Phase

- Hold a planning meeting at the state level where the LGA RH Supervisors lead the discussion on the modality of implementation of the activity and agree upon criteria for the selection of facilities, and frequency of implementation of the in-reaches among others.
- Map the geographical area, noting health facilities that meet the selection criteria. This should be done in collaboration with the LGA RH Supervisors who are familiar with the geographical terrain.
- Assess the sites that meet the selection criteria for cleanliness, safety, privacy and availability of family planning commodities.
- Identify trained service providers from nearby health facilities within the same LGA that can be sourced, verifying availability, to support the facility-based provider and the LGA RH Supervisor in counseling and provision of services.
- Make sure that family planning commodities and consumables are made available by the State to the facility prior to the facility-based in-reach.

Phase II: Community Engagement & Mobilization

- Provide women and children who come into contact with the facility for antenatal, immunization and post-natal clinic days with family planning information, methods and referrals.
- Leverage community dialogues focusing on other program areas such as malaria, nutrition and immunization to sensitize community members on family planning and refer them to the facility for services during the in-reach.
- Where indications arise, refer women who intend to take up a family planning method to other services, such as cervical cancer screening, treatment of reproductive tract infections and STCI counseling, screening and treatment.
- Three to five days preceding the in-reach and on the in-reach day, the LGA Health Educator and TCI-trained social mobilization teams should conduct a door-to-door campaign using local town announcers to sensitize the community, sustain awareness creation and mobilize potential clients to the chosen facility. Referral cards are issued to potential clients in the community with the aim of tracking the number of potential clients reached, number referred and the number completing referrals.
- In LGAs without TCI-trained social mobilization teams, the social mobilizers for other program areas are oriented and utilized to disseminate family planning information to potential clients in the communities with referrals to the health facility for uptake of different family planning methods.

Phase III: Day of the In-Reach

- On each day of the in-reach, one of the service providers leads the group counseling sessions. Individual counseling follows with the service provider discussing all method options while guiding the clients in choosing the method best suited to their needs.
- After counseling and method choice, clients are screened for pregnancy where necessary then directed to the private procedure area for service provision.
- Following the procedure, service providers give clients detailed instructions on care of the insertion site if injectable was the chosen method, back-up contraception where required and schedule a follow-up visit.
- Lastly, data of clients that assessed family planning services during the in-reach is collated by method and recorded in the facility FP Register and also reported separately as in-reach data to the State.

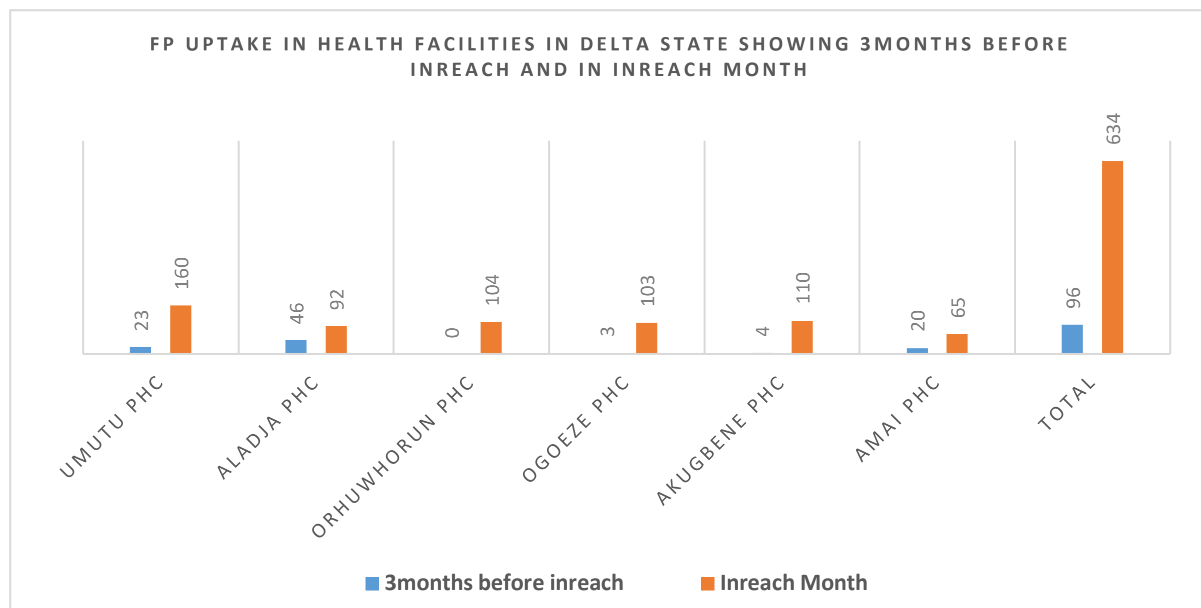
Key Learnings from the Approach

- Demand for family planning services can be particularly overwhelming during an in-reach; thus, substantial quantities of commodities and consumables must be made available to ensure there are no stock-outs during the in-reach.
- Advocacy and demand generation efforts have the potential to increase support and community awareness, paving the way for rapid uptake of family planning at the in-reach service delivery points.
- Many women who are initially hesitant are likely to take up a method after hearing a satisfied client share her experience.
- In-reaches can meet the growing needs for family planning of underserved populations and poor couples of child bearing age, including the marginalized and vulnerable groups.
- In-reaches provide a cost-effective, practical approach to on-the-job training and skill reinforcement of service providers avoiding the huge cost incurred with formal classroom trainings.
- In-reaches can expand method choice, especially in health facilities without trained service providers to render LARCs.
- Due to free FP services of all methods provided during the in-reaches, women and men were seen to respond easily to social mobilization efforts and there was an increase in number of completed referrals being recorded for the community.

Challenges

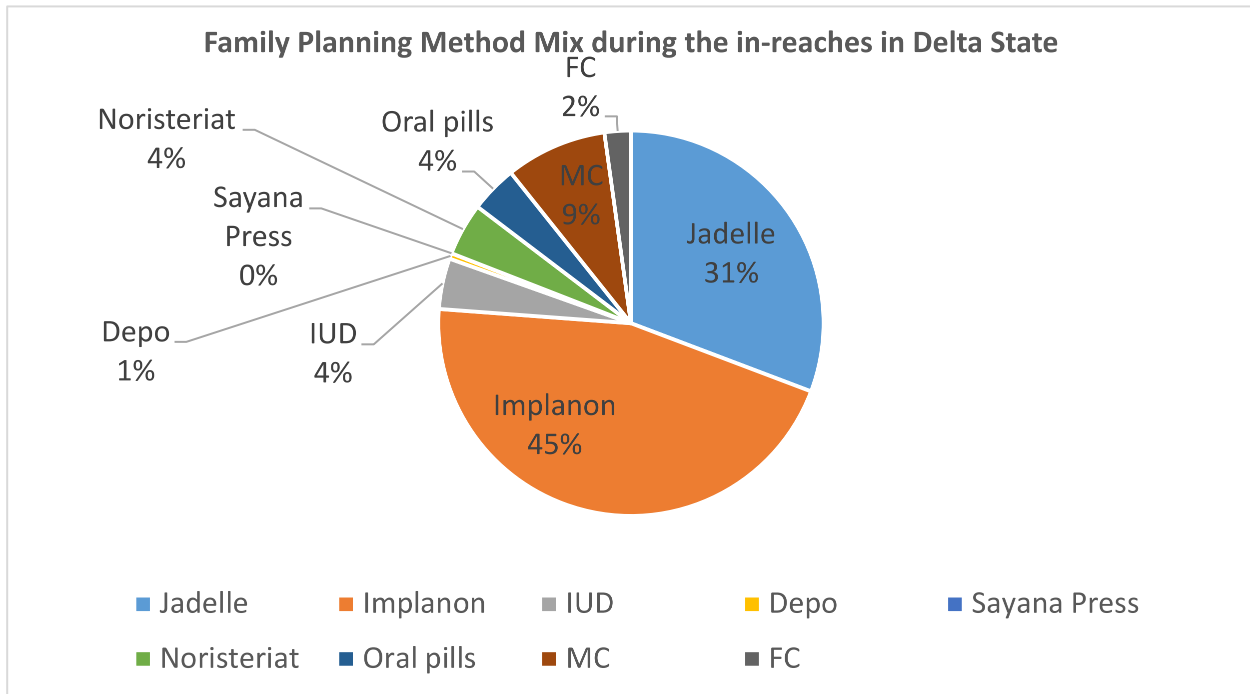
- The demand for services was particularly high during the in-reaches in some health facilities, overwhelming the available workforce and commodities and consumables provided.
- Poor inclination and bias towards family planning in some communities still affect utilization of family planning within those communities.
- Ineffective social mobilization and sensitization ahead of the in-reach affected the turnout of clients for the in-reach in some facilities.

Supporting Evidence



Source: PMIS, 2019

The chart on the previous page shows the uptake of family planning services for new acceptors before and during the in-reach in health facilities in Delta State. The uptake for the immediate 3-months before the in-reach were summed up to give the before data. This shows clear increase in the number of new acceptors in all facilities during in-reaches.



Source: PMIS, 2019

The pie chart above depicts the percent contribution of each method to the uptake of family planning services during in-reaches in Delta State. Implanon had the highest demand with 45% uptake, followed by Jadelle with 31% while Sayana press, Depo-Provera and female condom contribute the least with 0%, 1% and 2%, respectively.