

Mobile Outreach Services

Multi-Country Study and Findings
from Tanzania



THE
respond
PROJECT

Managing Partner: EngenderHealth; Associated Partners: Cicatelli Associates Inc.; Family Health International; Futures Institute; Johns Hopkins Bloomberg School of Public Health Center for Communication Programs; Meridian Group International, Inc.; Population Council

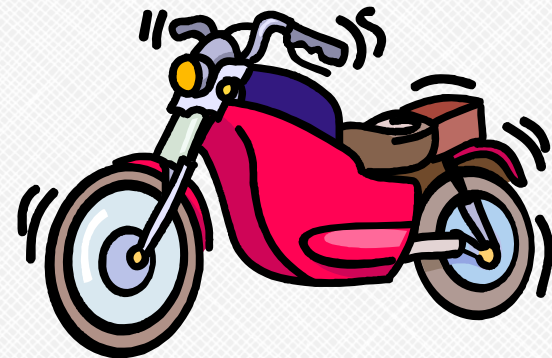
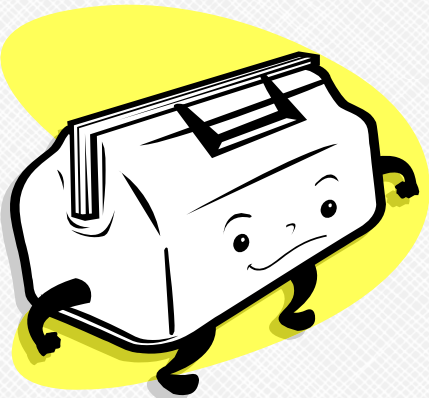


USAID
FROM THE AMERICAN PEOPLE

- Information about the RESPOND multi-country study
- Findings of the Tanzania study
- Lessons Learned for Remaining Country Studies



- Tanzania
- Nepal
- Mali or Ethiopia



- To add to the general body of knowledge about mobile outreach services:
 - Rationale
 - Organization
 - Characteristics
 - Cost

- To produce practical analyses of the models and their efficiency and effectiveness that decision makers can use to plan for expansion and replication of different mobile service models.

- Management and Oversight
- Funding and Revenue Sources
- Human Resources
- Logistics
- Services
- Quality of Care
- Reporting and Information Management
- Community Engagement

Tanzania is first country where study has been conducted



- Literature review
- Discussions and interviews with key stakeholders
- Review of records
- Site visits and observation
- Provider and client interviews



■ High fertility:

- Mainland Urban 3.7 TFR
- Mainland Rural 6.1 TFR
- Zanzibar 5.1 TFR

■ High unmet need for FP: 22%

- almost one-fourth of women reported that their last pregnancy was unwanted or mistimed
- more than two-thirds of women wanted to delay their next birth or stop childbearing altogether.

Sources: Preliminary TDHS 2010 and TDHS 2004-2005



- Shortage of health staff in government facilities was 65% in 2006
- Disparities in distribution of health personnel ranging from:
 - 0.3 health workers per 1,000 inhabitants in a rural district to
 - 12.3 health workers per 1,000 inhabitants in an urban district
- Majority of the population lives within 10 kms of a health facility



Public Sector

- Ministry of Health and Social Welfare (MOHSW) supported by
 - ACQUIRE Tanzania Project (ATP) and USAID

Private Sector

- Marie Stopes Tanzania (MST)

Model Similarities: Provider Teams Travel to MOHSW Health Centers and Dispensaries



Similarities: Health Talks & Client Registration

- Clients are put on waiting list, i.e., “registered” and notified when outreach date is scheduled
- Health talks given at start of the day as a way to inform all clients
- Very little national promotion of FP for a decade
- Some basic IEC/BCC materials available



Similarities: Other Services Continue During Outreach



■ MOHSW:

- Outreach services are provided in MOH Health Centers and Dispensaries
- Teams of trained providers travel to the HCs and Dispensaries
- DMOs communicate with HCs and Dispensaries re: outreach schedule and client mobilization
- # of expected clients communicated to DMO and in turn to **ATP**
- Client counseling done by HC & Disp staff in advance of outreach
- MOH provides commodities, expendable supplies
- No charge for services

■ MST:

- Outreach services are provided in MOH Health Centers and Dispensaries
- Teams of trained providers travel to the HCs and Dispensaries
- DMOs communicate with HCs and Dispensaries re: outreach schedule and client mobilization
- # of expected clients communicated to DMO and in turn to **MST**
- Client counseling done by HC & Disp staff in advance of outreach
- MOH provides commodities, expendable supplies
- No charge for services

■ MOHSW and ATP

- Objectives
 - > Increase use of modern contraceptive methods
 - > Strengthen the capacity of the MOH to provide LA/PMs
 - On-the-Job Training
 - Supervision
- Team coverage: Teams work within their own district and are away from normal duty station for either 1 day (mobile outreach) or 5 days (FP week)
- Mobile outreach in > 90 districts of the country

■ MST

- Objective
 - > Increase the use of modern contraceptive methods
- MST staff provide all FP services unless client volume too great.
- Team coverage: 14 outreach teams* cover 6-9 districts and are continuously on the move, i.e., 18-20 days/month
- Mobile outreach in 94 districts

■ MOHSW: 2 models

Team(s) of providers from district hospital travels to lower level facilities then returns to regular assignment at district hospital

- Outreach: 1 team/1 site/1 day
- FP Week: multiples teams/multiple sites/multiple days

■ MST: 1 model

Teams of providers work FP on outreach traveling throughout the month to different lower level facilities

- Outreach: 1 team/1 site

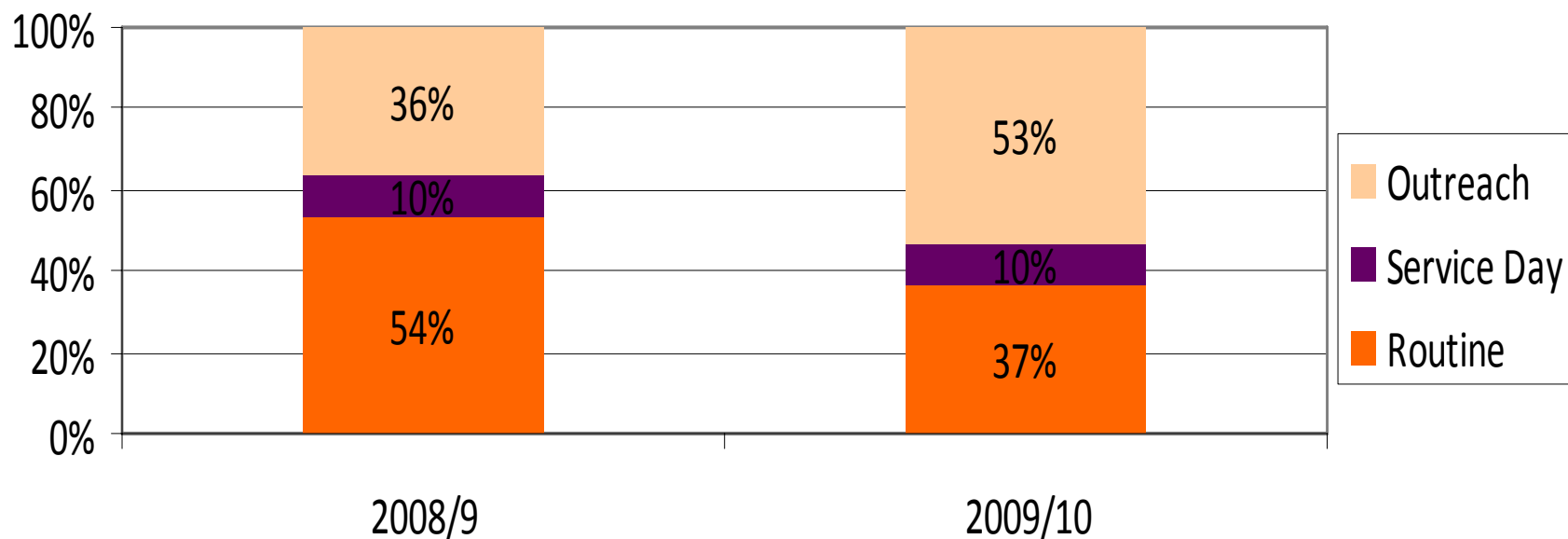
■ MOHSW

- Providers are employees of MOH assigned to higher level MOH facility, i.e., District Hospital
- Teams vary somewhat depending on whether HC or Disp has providers trained for LAs
- MOH standards & protocols, client record forms used
- Client consent for PMs
- Outreach focused on LA/PMs but all methods are provided

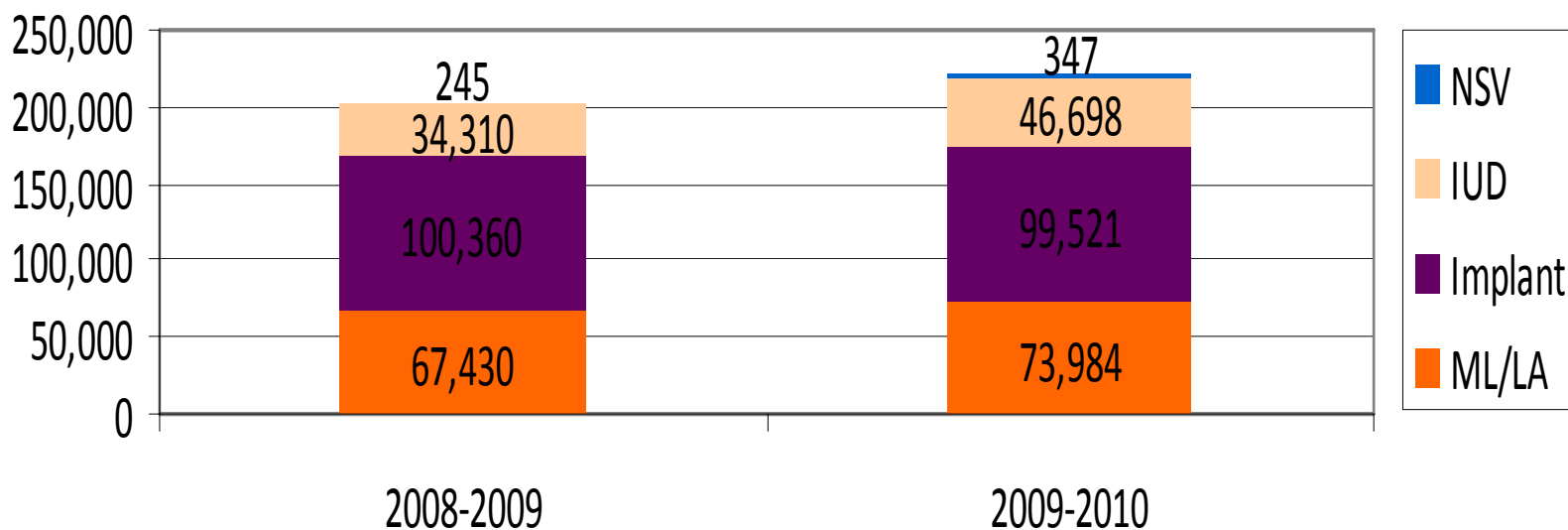
■ MST

- Providers are employees of MST assigned full-time to mobile outreach team
- Teams include surgeon, 2 nurses, driver
- MST standards & protocols *
- MOH client record forms used *
- Client consent for all LA/PMs *
- Outreach offers all FP methods

Percent of Services Provided through Each Mechanism



Change in Total Method Provision between 2008/9 and 2009/10



- Shortages of contraceptives (especially injectables and implants)
- Shortages of expendable supplies
- Shortages of instruments and equipment (MOHSW)
- Overlapping coverage areas
- Limited national IEC and BCC activities for past decade

■ Infrastructure & Space, Lack of Privacy



- Integrated services mean lots of people waiting



- Theory versus reality
- Standards and guidelines for mobile outreach have not yet been developed by MOHSW
- MIS not set up to track service statistics by service delivery mechanism
- Data may not be organized in ways that are easily accessible for the purpose of the study
- Organizations may be hesitant to collaborate and provide information



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