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INREACH: REACHING POTENTIAL FAMILY PLANNING CLIENTS WITHIN HEALTH INSTITUTIONS

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SUMMARY

Many women and men all over the world want to delay their next child or do not wish to have any more children. Some do not know about family planning. Of those who ***do,*** *many do not know how to get services, where and when services are available, what contraceptive methods are offered, or how much services cost. Also, some women and men who do have this information about family planning and want to get services, do not seek out services or initiate discussions with a health worker. Family planning providers usually try to reach these potential clients through outreach strategies, which have been valuable in encouraging the use of services.*

However, by concentrating its energies in outreach activities, family planning has failed in many ways to reach potential clients ***within*** *the health facilities themselves. This paper discusses a strategy to reach these potential clients: the concept of* ***inreach.*** *Inreach focuses on the tens of thousands of service providers, patients, and visitors who spend time in hospitals and clinics every day. Although many of these people would like family planning information and services, opportunities for informing these potential clients are often missed. By orienting all of a health facility's staff to family planning and by creating linkages between family planning and other departments, family planning providers could use a minimum of effort and a few additional resources to reach these clients with information and the offer of services.*

A combination of inreach and outreach activities can give family planning providers an effective program for informing potential clients and directing them to service-delivery points.

BACKGROUND

Outreach—accessing the community through community health programs, mass media, information and education (I&E) activities, and home visits by field workers—has been important in the expansion and development of family planning programs in Africa, Latin America, and Asia. These strategies have helped inform people about family planning, helped them think about family size, and encouraged family planning use.

By the end of 1991, Demographic and Health Surveys had been conducted in 25 developing countries around the world. In more than half of these countries, over 80% of women surveyed were aware of at least one family planning method (Rutenberg et al. 1991). However, despite increased awareness of family planning, there seems to be considerable unmet need for services in Africa, Asia, and Latin America for the purposes of spacing births and limiting family size. Levels of family planning use

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Many people in a hospital for other reasons could benefit from greater access to family planning

remain far below the expressed level of need in many of these areas (Westoff 1991; Dixon-Mueller and Germain 1992; Sinding 1992).

Why is there this unmet need? Through the implementation of AVSC's self-assessment intervention, called COPE (client-oriented, provider-efficient), some possible components of the problem at the site level began to emerge. COPE, a technique developed by AVSC in Africa, enables health workers to identify and find solutions to the family planning service-delivery problems in their facility (Dwyer et al. 1991). The findings from this assessment, along with other interventions, provided a framework for addressing these problems.

Missed Opportunities

Every day, tens of thousands of men and women visit service-delivery points, hospitals, and clinics. These people include service providers, inpatients, outpatients, visitors, and family planning clients.

Because family planning services are usually exclusively located in the family planning clinic, clients must actively seek out information and services. However, many people who are in a hospital for other reasons could benefit from greater access to family planning information and services. These are *missed opportunities*. In the family planning context, missed opportunities are just that: opportunities to provide family planning information or services that are not taken advantage of. With a minimum of effort and few additional resources, family planning providers could reach these people with information and the offer of services.

Missed opportunities are particularly striking in the case of postabortion and postpartum clients, who may be most interested in family planning messages. In many parts of the world, a woman's contacts with the health care system may be limited to coming to a facility to deliver a baby or to receive gynecologic services related to abortion. A six-country study of the perspectives of postpartum women and service providers showed that the majority of the women interviewed believed that providing family planning information to women during the prenatal period and immediately postpartum (before discharge from hospital) is appropriate and desirable. Service providers also believed that women want and should get family planning information and services during the same periods (Landry et al. 1992). Furthermore, a 1992 study in Kenya revealed that although family planning providers were willing to provide information, they rarely did so (Bradley et al. 1993). The majority of postpartum and postabortion women interviewed in this study were interested in using family planning services and in

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obtaining information while in the health facility, but few received either.

Inadequate Linkages

Few facilities adequately link units and departments. Instead, they are frequently designed and run as vertical programs: maternity is separate from family planning, which is separate from gynecology, and so on. Many health care workers do not know how to refer their patients for these services within their own facility. Often, the staff working in one part of even a small hospital knows nothing about family planning services available in another part of the hospital. For example, in the 1993 Bradley et al. study in Kenya, no maternity ward staff knew that the progestin-only pill is the oral contraceptive breastfeeding women can take. There was little exchange of information, collaboration, or teamwork between departments, which limited the effectiveness of the facility's referral system.

DEVELOPMENT OF INREACH

From these and other studies and observations, AVSC developed a concept called *inreach*. Inreach takes as its basic premise that potential clients within health care delivery sites are interested in family planning but do not know how to access information to services. Inreach can be defined as a strategy for addressing missed opportunities and establishing internal linkages for referring potential clients from within health care sites to family planning services—using resources already available, where possible. Inreach complements other family planning, I&E, and community outreach programs. Using this concept, AVSC developed interventions to put the strategy into operation.

The staff identified problems and made an action plan to address them

INREACH PILOT STUDY

Working with counterparts in the Dominican Republic, Kenya, Nigeria, Tanzania, and Uganda over the past five years, AVSC has developed inreach approaches to family planning service delivery. In Kenya, AVSC is currently supporting a pilot project to test the applications of the inreach concept at five service sites that represent different health and family planning organizations.

Two of these sites, a government and a mission hospital, were selected as inreach study sites for formal research activities. Before the inreach interventions were implemented, researchers undertook a baseline study to examine the attitudes of staff and potential clients toward family planning and to discover the missed opportunities for providing information and services. Sixty-nine service providers and more than 1,000 women were interviewed for the study. The clients interviewed were visiting the prenatal clinic (400 women), visiting the child-welfare clinic (400 women), leaving the maternity ward after delivery (200 women), or leaving the gynecology ward after an abortion (20 women). Table 1 shows that

Table 1 Who Respondents Think Are Interested in Family Planning, by Percentage

	Prenatal clients (N=400)	Post-partum clients (N=200)	Post-abortion clients (N=20)	Child-welfare clients (N=400)	Staff (N=69)
Think pregnant women are interested	67	60	55	61	70
Think women in maternity wards are interested	93	93.5	90	95	70
Think postabortion women are interested[a]	—	—	80	—	72
Think women at child-welfare clinics are interested	95	96	90	97	99

SOURCE: Bradley et al. 1993.

NOTE: Combined results from two inreach study sites in Kenya.

[a] This question was asked of staff and postabortion respondents only.

The orientation also addressed some prevailing rumors about contraceptive methods

both staff and potential clients thought that pregnant, postpartum, and postabortion women and women attending child-welfare clinics would be interested in receiving family planning information. By comparing the number of women who said they wanted to speak to a family planning provider with the number of those who actually did so, the missed opportunities for giving family planning information in different parts of the hospital were made obvious (Table 2).

Once these baseline data had been obtained, AVSC joined with the Ministry of Health at the public sector site and the Christian Health Association of Kenya (CHAK) at the mission hospital to facilitate a COPE exercise.

Using this exercise, the staff identified problems in the site and made an action plan for interventions to address them. In both sites, staff identified lack of family planning services in the wards, inadequate referral systems, and lack of interdepartmental cooperation as obstacles to the provision of quality services. The types of intervention introduced at each site addressed problems and recommendations identified by the hospital's staff.

INREACH INTERVENTION STRATEGIES

Hospital-Wide Family Planning Committee

Neither site had a family planning committee before the inreach intervention. As a result of the COPE exercises, staff at each hospital decided to form a committee as a forum for discussing family planning issues to improve interdepartmental linkage, to develop teamwork, and to limit obstacles to services within departments. Staff members felt that having this committee would improve both the cooperation between departments and the communication system as a whole. For this reason, the members of the committees represented a wide range of ward and clinic staff and administrators.

The committees held regular meetings to present and discuss problems with the family planning system. For example, maternal and child health (MCH) and family planning services at the government hospital, although supposed to be integrated, were physically far apart, and it was difficult for clients to receive child-welfare and family planning services during the same consultation. The committee members discussed this problem and decided to relocate both services so that MCH and family planning would be housed under one roof, making access to family planning easier for women who come for MCH services. The committee allowed MCH and family planning staff, other outpatient department staff, and hospital administrators to work together to make this happen.

On-Site Orientation

An orientation was held at each hospital to address the problems of missed opportunities and lack of interdepartmental linkage. The orientation sessions were designed so that all clinical staff in contact with potential clients (for example, nurses, doctors, and clinical officers) would either have the knowledge and confidence to talk about family planning or would at least have

Table 2 Missed Opportunities for Providing Family Planning Information, by Percentage

	Prenatal Clients (N=400)	Post-partum Clients (N=200)	Child-welfare Clients (N=400)
Wanted to speak to a service provider	51	77	45
Spoke to a service provider	6	18	33

SOURCE: Bradley et al. 1993.

NOTE: Combined results from two inreach study sites in Kenya. Data for postabortion clients not shown because of the small number of clients interviewed.

some basic facts and know where to refer clients for further information.

Every employee at a service-delivery site can be a source of health information: potential clients may look to any level of staff for advice and guidance. For this reason, nonclinical staff were also given an idea of how to refer clients for information or services, even if they could not give comprehensive information about contraceptive methods. For example, guards and doormen at hospitals and clinics are literally the gatekeepers of family planning and other services and direct many visitors to the departments they want. Similarly, many clients may be shy or may think nurses are too important or too busy to be asked about problems. These clients may turn to other staff, such as receptionists, for advice.

The orientation sessions were conducted by staff members themselves and included a discussion of basic facts about family planning, the methods available at the site, and how to get family planning at the site. They also addressed some of the prevailing rumors about contraceptive methods. The aim of the sessions was to orient all staff members to family planning services and to make staff aware of the potential opportunities for letting clients know about them.

During the orientation sessions, the staff at each site discussed and agreed on a referral system for family planning within the hospital. The family planning staff presented members of other departments and units with a schedule listing days and times of operation and agreed to send one staff member to the postnatal and gynecology wards every day to give a short talk on family planning methods and availability. The ward staff discussed the possibilities of implementing family planning initiatives in their departments, including rotating ward staff through the family planning clinic, making some contraceptive methods available in the wards, and developing ways to identify potential family planning clients.

Conducting the orientation on-site had many advantages. First, the sessions included nonclinical staff who would not normally attend an off-site training. Second, every area of the hospital could be reached with minimal resources. Third, the training was practical and related directly to work at the site. Finally, bringing all staff together in this way helped develop a "team spirit" and informed everyone of the hospital administration's commitment to improving family planning services.

Promoting the Use of I&E

I&E materials are important in addressing missed opportunities. However, from the COPE exercise and committee meetings, staff discovered that clients and potential clients often did not receive existing I&E materials, either because the materials were not produced in sufficient numbers or because distribution systems were inadequate. Staff therefore attempted to acquire larger supplies of I&E materials, to distribute them more freely, or to develop simple materials themselves. In one site, staff of the gynecology ward, which had previously had no I&E materials, made wall charts displaying available methods.

At both sites, staff members were giving health talks to patients in some waiting areas, especially in the MCH and family planning areas, before the intervention took place. The orientation helped to reinforce and improve these talks by focusing on updated family planning information and by encouraging staff to present clear instructions about how to access the services. Also, family planning talks were started in all the wards and in other areas where patients wait.

Encouraging Health Workers to Be More Proactive

Service providers often assume that if women want family planning information or services, they will ask for them. This is not always true (Bradley et al. 1993). In the baseline study, staff were asked why, although they recognized the need and desire for family planning information among clients, they did not provide the service. Although nearly all staff interviewed felt that providing family planning information was part of their job, and most were willing to provide the services, they also acknowledged that they often did not provide them. The nurses on the wards, few of whom are trained in family planning, felt constrained by their lack of knowledge,

The training was practical and related directly to work at the site

Health workers decided that they need to be more proactive

although they generally felt that the wards would be an ideal place to discuss family planning. The trained nurses in the clinics, on the other hand, cited lack of time and lack of privacy as barriers to addressing the family planning needs of clients. Health workers decided that they needed to be more proactive, to identify women who might be interested in family planning and to provide them with basic information, even if service provision might be delayed.

Signs

In many sites (perhaps including the majority of family planning sites in Africa), there are no signs that direct clients to the family planning clinic, that list the clinic's hours of operation, or that explain how much services cost. The staff at both sites decided to post these kinds of signs.

SHORT-TERM EVALUATION STRATEGIES

Four months after the initial COPE exercise and immediately following the inreach interventions mentioned above, AVSC, the Ministry of Health, and CHAK conducted a repeat of the COPE exercise at the two sites to determine which of the initial problems had been addressed (whether successfully or not). In addition, a limited version of the client survey was repeated six months after the intervention at both sites to determine whether the unmet needs of clients and previously identified missed opportunities had been addressed (Bradley 1993).

Responses indicated that the hospital-wide orientations in family planning methods and services had increased knowledge and awareness among providers of curative services and MCH and family planning services. The staff reported a closer working relationship between departments that clearly affected the ward staff's ability to initiate family planning activities.

Preliminary results showed that there had been an increased sensitivity to clients' and potential clients' need for information and assistance in obtaining family planning. More women heard family planning talks, saw family planning posters and leaflets, and were individually counseled than before the interventions. Table 3 shows the increase in the number of women who received family planning information in the maternity ward and the prenatal and child-welfare clinics. For example, combined data from both sites show that the number of women in the maternity wards who received family planning information in a group talk increased from 20% to 65%. The number of women who received individual counseling about family planning increased from 6% to 29% in the prenatal clinics and from 8% to 27%

Table 3 Percentage of Clients Who Received Family Planning I&E and Services before and after the Inreach Intervention

	Prenatal Clients		Postpartum Clients		Child-welfare Clients	
	Before Inreach	After Inreach	Before Inreach	After Inreach	Before Inreach	After Inreach
Had an individual discussion	6	29	18	25	8	27
Heard a lecture	8	17	20	65	7	16
Saw a poster	54	74	56	77	52	76
Received a leaflet	7	19	4	12	4	14
Received a contraceptive method before discharge	—	—	2	15	—	—

SOURCES: Bradley 1993; Bradley et al. 1993.

NOTE: Combined results from two inreach study sites in Kenya. For "before inreach" columns, Ns = 400 prenatal clients, 200 postpartum clients, and 400 child-welfare clients. For "after inreach" columns, Ns = 200 prenatal clients, 142 postpartum clients, and 200 child-welfare clients. Data for postabortion clients not shown because of the small number of clients interviewed.

in the child-welfare clinics. The number of maternity ward patients who received a contraceptive method before discharge increased from 2% to 15%.

CONCLUSION

It is clear that there is an unmet need for family planning in many developing countries. AVSC believes that by providing a framework for addressing the missed opportunities for extending family planning programs and uptake *within* service-provision sites, inreach could partially address this problem.

Inreach and outreach activities complement one another as approaches to reaching and referring potential clients. Inreach activities that address issues of interdepartmental linkages and missed opportunities need be neither costly nor time consuming, since they rely to a large extent on the capabilities of the staff at each site. In general, inreach solutions will differ from site to site according to circumstances and needs.

Preliminary results from the AVSC pilot sites are encouraging; by providing on-site orientations to staff about family planning, by posting signs, by establishing committees which will pay attention to the issues of improving family planning services, and by providing more I&E materials for clients, staff using inreach have exposed more women to family planning information, and, in the case of postpartum women, more have received family planning services.

There will be further data collection at one year postintervention (June 1994) in the two inreach pilot sites, and more extensive studies in collaboration with the Population Council are planned for the future. If these studies confirm the positive findings mentioned here, AVSC plans to extend the inreach approach to other sites and to introduce it to other family planning organizations with which we work.

When this paper was first published, Pamela Lynam, M.D., was AVSC's senior advisor for medical and client-centered quality of care. Joseph Dwyer was the director of AVSC's Regional Office for East and Southern Africa, based in Nairobi. Janet Bradley was a consultant for AVSC.

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