



**Evidence
and Insights**

Version 2

Powered by Evidence

MSI Reproductive Choices is committed to supporting the reproductive choices of everyone, wherever they are, by delivering the highest quality of care to our clients. We aim to do this in an effective, equitable, and transformative way. Given the complexity of sexual and reproductive healthcare, it is vital that we use evidence to track best practice and ensure resources are used efficiently to maximise our impact.

There are more than 600 dedicated research and impact team members across the MSI partnership who work hand-in-hand with our country operational teams, governments, and other organisations to gather quantitative and qualitative data. This allows MSI and our partners to better understand the needs of our clients; to evaluate and improve our services; to increase access where unmet need is highest; and to use evidence to improve policies and practice where choice is limited.

Two important drivers for us in achieving these goals are:

1 Our Evidence and Impact strategic pillars, which have guided our work to:

- Facilitate access to user-centred operational data that drives evidence-based decision-making and offers insights relevant for our programmes
- Undertake rigorous research and generate evidence that improves client experience and access to SRHR services for a wider population, particularly those with highest need
- Create a learning organisation where best practices are shared internally and externally, effectively and efficiently

2 The depth of learnings and information MSI has built through delivering on the frontline to millions of clients:

- No amount of discussion, theory, or modelling can replace being in the field, intimately understanding the needs and desires of communities and the barriers they face. Whether through listening to clients about the social norms restricting their choices or our teams figuring out how to deliver care to the last mile, no matter how difficult the context, this constant engaging with those we aim to serve and learning through doing continually yields invaluable insights.
- Blending delivery at scale with our evidence focus has powered the development of rich client-level data sources. Over the past decade, we have spoken to over 160,000 clients about what they value in sexual and reproductive healthcare and the barriers they face. Our client-level routine data systems capture hundreds of millions of data points annually, providing real-time information on who we are reaching and informing what works to reach key populations. MSI has been at the forefront of leveraging client insights and data to drive service adaptation and effective delivery. I am pleased to share that an upgrade to our data system will begin to deliver even greater insights in the year ahead.

As part of our 2030 strategy, MSI is committed to sharing our insights, quality assessment and strengthening tools and models. We continue to work with and learn from grassroots, local, national, and global partners to shape SRHR policy and remove barriers to access. Whether as part of FP2030, IBP, WHO working groups, or through our own SafeAccess hub, we ensure that our insights are disseminated as widely as possible to partners, implementers and policy makers.

This compendium illustrates the diversity of our evidence work and the results we can achieve when powered by data, as well as our experience of delivering services in some of the world's most challenging environments. We hope this will be a useful contribution as we continue to work together to deliver for women and girls across the world. Enjoy it and let us hear your thoughts!



Anisa Berdellima
Global Director of Evidence and Impact

MSI Reproductive Choices is a global organisation providing reproductive healthcare, including contraception, safe abortion and post-abortion care in

37
countries

Over 17%
of our clients
are aged 15-19

Supporting **350K**
girls to continue
their education



It costs just £6 for us to provide someone with life-changing contraception for an entire year

We partner with governments to strengthen the capacity of

5,200 facilities
10,000 providers



Contributed to 10 changes in policy, regulation and health financing expanding access to sexual and reproductive health and rights

34.3

million women and men around the world are using contraception provided by our partnership

Our services averted an estimated

14.1m
unintended pregnancies

6.6m
unsafe abortions

and saved **£670m**
in direct healthcare costs



Evidence and Insights Index

5

MSI's evidence ecosystem: turning data into insights into action

Infographic

6

La Famille Ideale: Engaging husbands and communities to improve access for adolescents in the Sahel

Burkina Faso

8

Convenient, discreet, easier: client feedback on telemedicine medical abortion in England

England

10

Enabling SafeAccess: A collaborative platform to eliminate unsafe abortion

Global

12

Provider perspectives inform SGBV basic care training package and enablers for sustainable, client-centered SRHR integration

Multi-country

14

The role of VCAT workshops in addressing provider stigma and expanding access to safe abortion services

Ethiopia

17

Choice on wheels: How a mobile bus expanded contraceptive access through COVID-19 lockdown in Madagascar

Madagascar

19

Nothing About Us Without Us: designing services for and with people with disabilities

Sierra Leone

22

How can we reach more clients effectively while maintaining quality and cost efficiency on Outreach?

Multi-Country

24

Combi-packs and contact centres: supporting safe self-care

Bangladesh

26

Putting marginalised voices at the centre of cervical cancer screening and prevention

Bangladesh

28

Taking care of our clients and staff: delivering excellent client-centred care

Zambia

30

Supporting community conservation efforts through increasing access to contraception in Zambia

Zambia

32

Empowering adolescent girls as peer advocates for family planning: The design of a peer referral program in Uganda

Uganda

34

The Abortion Quality Index: A new metric to monitor programme quality

Global

37

What does it take to achieve a balanced method mix?

Zambia

39

A cross-sector partnership to improve menstrual health and increase awareness and uptake of SRH services

Timor-Leste and Papua New Guinea



Improving ACCESS & EQUITY

Who are our clients?

160,000+ **exit interviews** and **service use data** covering 160 million visits help us understand our clients and their experiences with us

What are the barriers to care?

Market insights surveys, client feedback surveys and **rapid insight gathering** allow us to lower barriers to service delivery

33 **contact centres** and C3 digital platform support more than 300 agents to address the gap in information for more than 2.7 million people through different social mediums



Are we serving those in need?

Innovative **poverty metrics** and **geospatial mapping** to determine where to reach the most vulnerable

Granular data and metrics to track performance used to close gaps in access for adolescents, people living with disabilities, those in extreme poverty, by gender, and other under-served demographics

How do we engage communities?

Handheld mobile data capture and support tools empower community-based mobilisers and providers to drive a shift from **awareness to intention to use to uptake**, improve **pre-service counselling quality**, and provide **real-time data visibility** to drive performance management



Raising the standards on QUALITY

Do we deliver quality care?

Client exit interviews, mystery clients and **routine client feedback** monitor client experience and quality of care

Client Centred Care framework and metric underpinned by organisational culture, protocols, staff wellbeing ensures positive client experience

MSI Abortion Quality Index helps us understand the safety and quality of our abortion and post-abortion care in every channel

How do we assure clinical quality?

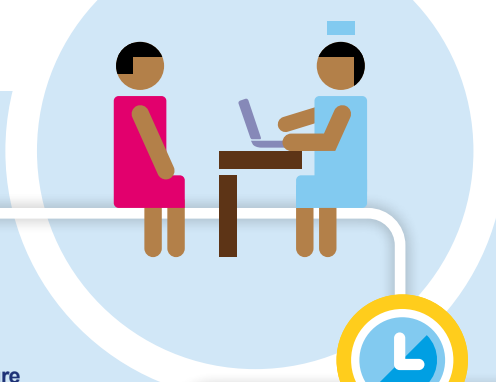
Quality technical assistance **audits**, clinical **incident systems**, provider competency databases and clinical quality scores keep us on track

How can we assure product quality?

Tools test, track and assure the quality of our products before use in our services and being sold externally

How can we support health systems strengthening?

Monitoring of public and private partners using our bespoke **DHIS2 platform** to customise support
Support **government HMIS systems** to capture relevant SRH indicators, improve quality of data and use it to make evidence-based decisions



Doing more with less to drive EFFICIENCY

How do we know what works?

300 million annual client-level data points used to continuously iterate and improve our programming

Can we do more with less?

A unified **global accounting system** and use of our **cost calculator** empowers MSI to understand and manage cost drivers

How do we improve productivity?

Performance dashboards for providers, centres, outreach teams, vehicle tracking maximise our effectiveness and productivity

Our **Global Data Warehouse**, a cloud-based central location for all MSI data that allows end users easy, on demand access to reporting through a new business intelligence platform



What is our impact?

Harnessing the power of our evidence ecosystem: we continuously test the effectiveness of our approaches to better serve those in need and share insights with others.

We use innovative modelling (our **Impact 2** tool) to estimate the wider health and demographic impacts of our service delivery.

TURNING DATA

INTO INSIGHTS

INTO ACTION

MSI'S EVIDENCE ECOSYSTEM

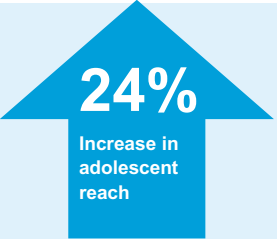
We continuously test the effectiveness of our approaches to better serve those in need and share insights with others.

La Famille Ideale: Engaging husbands and communities to improve access for adolescents in the Sahel

KEY LEARNINGS

La Famille Ideale is a human centred design (HCD) approach which focuses on working with young women and key influencers, like husbands and in-laws.

When piloted in Burkina Faso, we noticed an improvement in adolescent reach from 15.8% to 19.6% at outreach sites during the pilot.



THE CHALLENGE

Reaching newly married adolescents

The Sahel remains a region with high levels of unmet need for family planning, partly driven by major social and cultural barriers.

According to PMA 2020, contraceptive use among married women aged 15–19 is currently 19% compared to 29% among married women aged 19–49.

19% aged 15–19

29% aged 19–49



WHAT WE DID

Human centred design puts family planning in context

La Famille Ideale is a suite of participatory tools for MSI community-based mobilisers, who help create community awareness and build an enabling environment in advance of the arrival of MSI's mobile outreach teams.

The tools (including a game and conversation-starting cards) aim to open-up conversations and encourage support for adolescent rural mothers to access family planning.

MSI outreach teams then deliver a full range of contraceptive methods for free at a nearby site to improve access.



Exploring family planning in the context of life aspirations, like education and financial security, helps create the positive community dialogue and male engagement required to support adolescent access to services.



WHAT WE FOUND

A positive impact on adolescent access

La Famille Ideale was piloted across all eight of MSI Burkina Faso's (MSBF) mobile outreach teams for nine months during 2019/ 2020. The participatory tools were used by two of the four Social Marketing Agents (AMS) working with each outreach team.

Results

A difference-in-difference analysis showed statistically significant increases in the number of adolescent clients served where *La Famille Ideale* was being used in two of Burkina's outreach teams as indicated from the graphs below. There was variation in impact between different AMS, indicating some were able to put them to better effect than others.

Qualitative feedback indicated that *La Famille Ideale* enabled the AMS to open-up conversations about family planning in a unique and impactful way. The community dialogue supporting the role of women in family planning decision-making, helped participants to see how using contraception could play a role in the future of their family. The evaluation also revealed some challenges with integrating *La Famille Ideale* into existing ways of working and opportunities to strengthen its use.

For example, during the pilot, the AMS were not always using this approach with the hardest to reach groups in the community (e.g. husbands). This was despite *La Famille Ideale* being regarded as effective with these audiences. Teams are now exploring how to support AMS to use *La Famille Ideale* most effectively with men.

■ Pre-pilot ■ Pilot

La Famille Ideale sites

Non-intervention sites (control)



% of clients served by MSI Burkina Faso's outreach teams who were adolescents (under 20)
Source: routine service data

WHAT THIS MEANS

Getting the most out of HCD

The evaluation is providing useful insights to support scale-up and sustained use of *La Famille Ideale* across our Sahel programmes. It also provides recommendations for using human centred design (HCD) most effectively:

Recognise and utilise existing know-how within programme teams during formative insight gathering.



Before bringing in external HCD expertise, engage internal stakeholders to ensure there is time and capacity to manage and support the process.



Pay attention to context: if there are issues with an existing system or way of working, or insufficient thought is given to how to integrate a new approach, a new intervention may not be able to overcome this.



Use HCD to support adaptation of interventions from one context to another: in 2019, MSI Senegal adapted the tools for their context using HCD, and in 2020 further versions were under development in Niger and Mali.



“They [the AMS] had two challenges (before *La Famille Ideale*) – firstly to have a dialogue with target groups and secondly they did not have good tools. So this is a tool to have a dialogue with the community.”



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoices.org.
Alternatively, visit our website: www.msichoices.org.

Convenient, discreet, easier: client feedback on telemedicine medical abortion in England

KEY LEARNINGS

In response to COVID-19, on 30th March 2020, the English government approved home use of both stages of medical abortion (MA), using mifepristone and misoprostol under 10 weeks' gestation. MSI Reproductive Choices UK (MSI UK), one of the largest providers of abortion services in England, launched a fully remote telemedicine MA pathway on 6 April 2020.

A sample of all MSI UK's telemedicine MA clients between April and August 2020 responded to an opt-in follow-up call to answer clinical and satisfaction questions.

Clients receiving these routine follow-up calls reported high confidence in fully remote telemedicine abortion services and high satisfaction with the privacy, convenience and ease of this pathway.

2/3

of telemedicine abortion patients reported they would choose this pathway again in future, demonstrating that it should remain available after the COVID-19 pandemic.



WHAT WE DID

Client feedback on telemedicine



In MSI UK's telemedicine pathway, eligibility for MA is assessed (according to [national guidelines](#)) during the client's initial call with a health advisor, and a full phone consultation with a nurse is scheduled. Clients are given the choice to receive MA medication by post or to pick it up with minimal contact from their nearest MSI UK clinic. All clients have access to a 24-hour aftercare line and comprehensive online information.

Between April and August 2020, telemedicine clients were invited to opt-in to a post-procedure phone call with a care assistant, in which they were asked a set of multiple choice and open-ended questions about their service. In total, 2,704 clients (29.9% of all 9,049 telemedicine clients) opted-in to a follow-up call and 1,243 (13.7% of all telemedicine clients) calls were completed. Calls were completed approximately five days after their early medical abortion (EMA). The demographics of the cohort in the follow up sample were compared to the overall telemedicine EMA cohort to check representativeness and were found to be broadly similar.

In total,
2,704
clients opted-in to a
follow-up call and
1,243
calls were completed.



THE CHALLENGE

Restrictive policies on medical abortion

Until 2018, government policy required both stages of early medical abortion to be administered in a government-approved clinic or hospital in England, despite [international evidence](#) showing it is safe and effective for these medications to be administered at home. Requirements for in-clinic visits made it [difficult](#) for many clients to access care due to long distances, work and childcare commitments, and stigma or privacy concerns. In response to the COVID-19 pandemic, professional bodies in the UK advised the use of telemedicine to ensure abortion access was safeguarded. The English government announced temporary approval for both stages of MA to be administered at home, enabling MSI UK to develop a fully remote care telemedicine pathway from 6 April 2020.

WHAT WE FOUND

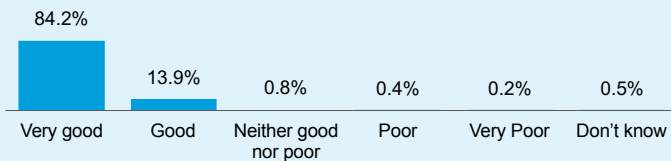
Telemedicine is an acceptable, convenient method of care

Overall, telemedicine EMA clients felt that:

- During the consultation, 1,185 (95.3%) clients felt able to talk privately, but 57 (4.6%) clients had to take action (e.g. to get childcare, go to the car). No clients reported that they were completely unable to talk privately.
- Almost all (1,234, 99.3%) clients felt they had the opportunity to ask questions during their consultation. Many clients preferred having the consultation over the telephone as it removed the stress of visiting a clinic and fear of being judged.
- Almost one-third (391, 31.5%) of clients chose to pick up their medication from a clinic, while 846 (68.1%) chose postal delivery.
- The majority (1,148, 92.4%) of clients reported that they “definitely” had enough information to take the medications by themselves and 68 (5.5%) reported “somewhat”.
- Most (1,086, 87.4%) clients had no concerns about the safety of taking the medication by themselves
- Most reported being able to manage pain either “effectively” (1,093, 87.9%) or “somewhat effectively” (103, 8.3%) during their MA.

For more information, including information on sample validity and demographic sub-group analyses of these findings, please read the full peer-reviewed paper at <http://dx.doi.org/10.1136/bmisrh-2020-200954>

% follow up sample rating their experience of telemedicine EMA



WHAT WE FOUND



The majority – 1,035,

83.3%

– of clients said they would **not** have preferred to have seen a doctor or nurse in-person with this abortion, as the telemedicine pathway suited them.

However, **208** (16.7%) would have preferred a **face-to-face** pathway for this abortion or were not sure, mainly citing a desire for the emotional and practical reassurance of an interpersonal interaction.

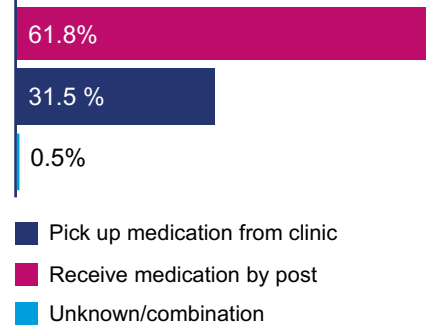
When asked about future abortion preferences post-COVID-19, 275 (22.1%) would prefer face-to-face care, mainly for interpersonal contact and reassurance, while **824 (66.3%) would choose telemedicine again.**

WHAT WE FOUND

Conclusion

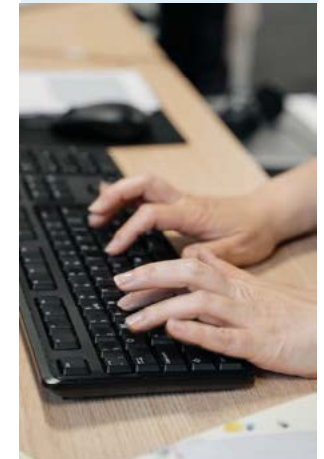
Research has also demonstrated that this new model of care in England is safe and **effective** and improves **access** to care. This analysis shows that telemedicine is a convenient and accessible option that is highly acceptable for clients seeking a medical abortion, especially those for whom in-clinic visits are logistically or emotionally challenging. The telemedicine pathway would be first choice for two-thirds of these clients again in future, demonstrating that it should remain available after the COVID-19 pandemic.

% follow up sample by method of receiving medications



"I hope this carries on [as] it helps people like me with children. The 24-hour helpline was so helpful. From start to finish...it has been amazing."

MSI UK telemedicine client feedback



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoice.org.
Alternatively, visit our website: www.msichoice.org.

Enabling SafeAccess: a collaborative platform to eliminate unsafe abortion

KEY LEARNINGS

There is still much work to be done to increase access to safe abortion. Whether it's a lack of trained providers or clarity over what's permitted, barriers continue to force women to turn to unsafe abortion.

To ensure that frontline practitioners have the tangible guidance needed to deliver safe services, and policy influencers have the evidence needed to remove unnecessary barriers, MSI Reproductive Choices and partners – IPPF, PSI, Safe Abortion Action Fund and Ipas – launched SafeAccess: a digital platform sharing quality resources on safe abortion and post-abortion care.

Almost half of all abortions this year will be unsafe.

That's an estimated

35 million

THE CHALLENGE

35 million unsafe abortions annually

7 million women and girls suffer devastating injuries each year due to unsafe abortion and over 22,000 women and girls lose their lives.

According to the World Health Organisation, almost every single one of these deaths could be prevented. With sexuality education, contraception, and the provision of safe, legal abortion and post-abortion care, no woman or girl should die for the right to determine her own future.

However, frontline practitioners often lack the tangible guidance and resources needed to expand access to abortion.

WHAT WE DID

Providing the evidence for safe care

Our approach to building frontline knowledge on safe abortion provision is simple: we increase the accessibility of sector knowledge with evidence-based, practical guidance for providers and policy-makers. As implementing organisations, we share our own lessons on what works and what doesn't, with the hope that those on the frontline can use these learnings to expand access to life-saving services.

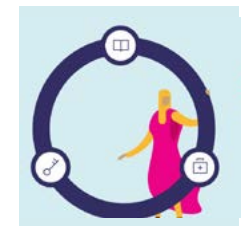
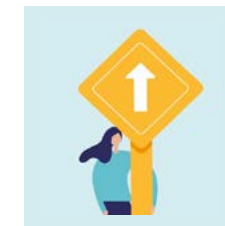
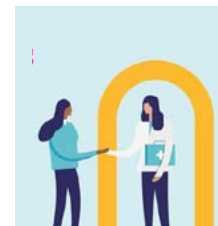
Launched in June 2019, SafeAccess currently houses over 70 multilingual and high-quality resources, submitted by organisations across the sexual and reproductive health sector. In collaboration with partners, we are building a one-stop-shop for frontline implementers looking to expand access to client-centred safe abortion and post-abortion care.

www.safeaccesshub.org



Providing guidance on:

- **Expanding access to safe services**
- **Raising awareness and reducing stigma**
- **Clinical quality in safe abortion and post-abortion care**
- **Removing policy barriers to safe services**



WHAT WE FOUND

Meeting a need in Francophone Africa

In Francophone Africa, the lack of guidance around safe abortion and post-abortion care is even more acute. To meet this need, we translated key resources into French and partnered with la Dialogue pour l'Avortement Sécurisé en Afrique Francophone to share the SafeAccess platform and resources with grassroots organisations in the region.

One organisation was l'organisation Solidarité des Femmes pour le Bien Être Social et le Progrès in Burundi (SFBSB-Burundi), who advocate to expand access to sexual and reproductive healthcare and rights for young women in Burundi. This includes working to prevent unsafe abortion.

In Burundi, abortion is only legal to save a woman's life, meaning unsafe abortion is common and access to high-quality post-abortion care is vital. To support this, SFBSB-Burundi were searching for guidance on how to destigmatise survivors of unsafe abortion, and post-abortion care providers. This is when the team found SafeAccess. They used evidence from the Mon Corps, Ma Voix report to demonstrate how common abortion is worldwide, and used the guide to talking about abortion with rights-based language, to help deconstruct stigma.

Jean Nkeshimana, Coordinateur des projets at SFBSB-Burundi, shared:

"In Burundi, we have many difficulties in challenging abortion stigma. I think it is important to share our experiences with other activists, through projects like SafeAccess, to discuss them and find possible solutions together."

SafeAccess has had a hugely positive impact on our team at SFBSB-Burundi. We are using the resources to raise awareness and advocate for post-abortion care. Thanks to SafeAccess, we have improved our capacity to deliver services to the young women in our community."

We are proud to be supporting quality safe abortion and post-abortion care programming via SafeAccess.

WHAT THIS MEANS

Partnering to scale SafeAccess

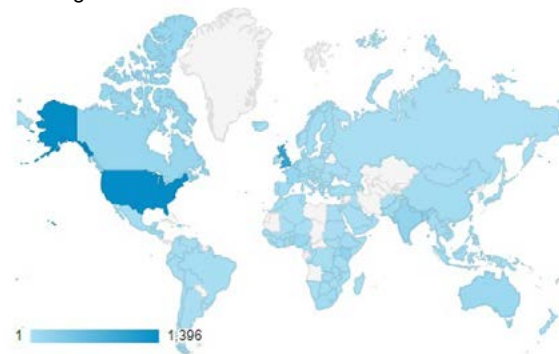
With the aim of reaching frontline implementers, policy influencers and grassroots organisations worldwide, we are pleased to share that:



SafeAccess resources have been accessed over 17k times so far, across 145+ countries.

To remain in-the-loop as we publish new resources each month, readers can subscribe to the SafeAccess newsletter.

Now that SafeAccess is successfully launched, MSI Reproductive Choices is committed to ensuring the platform is as useful as possible and frequently utilised, continuing to expand access and knowledge to implementers worldwide. Through continued cross-sector partnership, we believe we can get there.



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoice.org.
 Alternatively, visit our website: www.msichoice.org.

Provider perspectives inform SGBV basic care training package and enablers for sustainable, client-centered SRHR integration

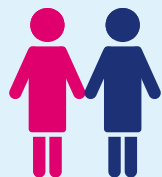
KEY LEARNINGS

MSI Reproductive Choices (MSI) providers participated in individual semi-structured qualitative interviews to better understand the current approach to and existing gaps in gender-based violence (SGBV) provider training and provision of SGBV basic care. These learnings, – along with the contextual issues and challenges that must be considered – informed the development of a provider training package for SGBV basic care provision. Providers outlined the individual, organizational and contextual enablers and barriers to SGBV service integration and provided recommendations. Their recommendations provided a starting point and roadmap for a more sustainable approach to provider training and sustained SGBV service integration – leveraging existing strengths and organizational good practices.

THE CHALLENGE

Quality, sustainable SGBV integration

MSI's 2030 vision demands a bold comprehensive client-centered SRHR care strategy, including SGBV basic care, given the tremendous scale of SGBV among women of reproductive age.



The global prevalence of violence for women of reproductive age can be as high as **1 in every 2** women in low and lower-middle income countries^[1],

which has been further compounded by the COVID-19 pandemic; in turn SGBV contributes to COVID-19 community spread and vulnerability^[2]. Well capacitated and supported front line SRHR providers hold a unique potential to facilitate access to basic SGBV care. They are also best positioned to inform strategies for sustainable SGBV integration.



WHAT WE DID

Seeking provider perspectives

In order to understand and inform the development of a training package that is relevant in various MSI contexts, we invited MSI providers from four MSI Country Programmes to share perspectives about current approaches, training, issues and challenges that would need to be considered for SGBV training and integration. Fourteen participants, including service providers, gender specialists and program management leads from MSI Ethiopia, Zimbabwe, Timor-Leste and Cambodia volunteered for semi-structured one hour long remote qualitative interviews. They shared perspectives on past or current SGBV training; current approaches to SGBV basic care provision; perceived needs and gaps, as well as priority competencies, information and capacity needed to advance SGBV care in their programme.

What providers need to deliver SGBV care

- Training on SGBV concepts and terms
- Survivor centered care components
- Challenging personal bias and attitudes through values clarification exercises
- Confidence building using scenarios to practice
- Strong referral system linkages and pathways
- Improved understanding of country specific legal and policy context
- Internal and external communication approaches aligned with survivor centered care

“SGBV is very big because it is happening every day. MSI cares... and because we work in SRH [already] we have knowledge... to build on”

WHAT WE FOUND

Quality client-centered care

Providers are motivated to deliver and be accountable for high quality, client-centered SGBV basic care that leverages their core SRHR counseling and service provision skills. They identified training needs and outlined a roadmap for expanding client-centered SRHR care to increase confidence in their ability to deliver high quality SGBV basic care.

In addition to content, respondents volunteered their perspectives on how training might be most effectively delivered. The providers emphasized skill building and practice during the training using real life scenarios. They also stressed the need for a comprehensive (4–5 days) hands on, practice oriented, discussion heavy training that would enable them to learn from colleagues and solve practical challenges. Respondents advocated for the inclusion of all staff, referencing the need to ensure that survivors could interact positively with any staff member on site and that a blended e-learning approach might facilitate access to refresher modules and tailored learning required for distinct roles.

Beyond a stand-alone training package to increase knowledge and skills, providers described organizational enablers that would be needed to support the effectiveness of the training. One of the most promising recommendations was to integrate into the training an opportunity to learn from colleagues – to hear from them directly about what they are doing that is working to build on existing good practices.

Leveraging organisational good practice

- 1 Memorandums of understanding and referral maps readily available on site strengthen multisectoral coordination
- 2 Internal and external sexual exploitation and abuse and SGBV hotlines enhance access for client-centred care
- 3 Measuring awareness of harmful gender and social norms among providers motivates efforts to address personal bias
- 4 Partnering with public and private sector partners for training strengthens overall care
- 5 Appointing in-house SGBV champions harnesses commitment, capacity, and motivation to improve overall services
- 6 Learning from other countries and colleagues maximizes resources, enhances relevance and sustains training investments

WHAT THIS MEANS

Implications and recommendations

Motivated to deliver quality client-centred SGBV care and referrals, providers outlined actionable steps to strengthen skills and organizational systems. Providers' strengths-based recommendations leverage organizational and personal assets and enablers that would facilitate and sustain training:

Integrate SGBV basic care skills into existing full trainings, refresher trainings and provider competency assessments

Support a culture of dignified care for survivors by ensuring all staff participate SGBV basic care training, including values clarifications and attitudes transformation for SGBV

Enhance staff resources to provide supportive supervision

Establish referral partner agreements and systems, facilitated by job aids such as posted referral contacts

Develop and use SGBV care quality indicators

Ensure sufficient resources – personnel and training budget – are allocated to teams to integrate this new service.

Providers recognize the need for – and are motivated to engage with – an SGBV basic care package linked to supportive organizational actions that will set them up for success in delivering high quality SGBV client-centered care and referrals.



Fear of being blamed can prevent survivors from reporting incidents.

“For us to intervene in cases like this we must be able to identify the problem and once we can identify [a case of SGBV] we need to know how to handle it.”

“We need to ensure [we are] consistently embedding SGBV into our package of SRHR care...and that every provider is able to respond to SGBV... Training builds confidence.”

MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoices.org.
 Alternatively, visit our website: www.msichoices.org.

The role of VCAT workshops in addressing provider stigma and expanding access to safe abortion services

KEY LEARNINGS

The liberalization of Ethiopia's abortion law in 2005 has expanded access to abortion. However, a significant proportion of abortions still occur outside of facilities with mild to severe complications. Barriers to accessing safe abortion care include limited knowledge of services and legality and abortion-related stigma.

Research has documented how stigma and social norms around abortion influence the likelihood of clinicians to provide abortion services.

Values clarification and attitude transformation (VCAT) workshops are widely used globally by a wide range of organisations to address negative provider and staff attitudes around abortion and other sexual reproductive health (SRH) services and catalyse more empathetic service delivery and advocacy around abortion.



In partnership with Ibis Reproductive Health we undertook a study to evaluate the impact of VCAT workshops on service provision, client-centred care, and provider attitudes and knowledge in Marie Stopes Ethiopia's (MSIE) private socially-franchised facilities.



Understanding whether and how VCAT workshops work to dismantle provider stigma and impact service provision can inform how VCAT workshops should be scaled and expanded.

THE CHALLENGE

Addressing provider stigma through VCAT

Non-judgmental, respectful care is particularly important in safe abortion services and SRH services given that social stigma around abortion and other SRH care is pervasive in most countries, regardless of the legal environment.

A VCAT workshop aims to help participants increase their awareness and comfort with the provision of comprehensive, non-stigmatizing person-centred abortion care through exploring, questioning, and affirming their values and beliefs about abortion and sexual and reproductive health.

Despite widespread use, there is little research documenting the way in which VCAT workshops impact workshop participants over time or the way in which they ultimately impact the care provided to clients.




WHAT WE DID

A mixed-methods evaluation

One hundred and one socially-franchised facilities within the MSIE BlueStar network in the regions of Addis Ababa, Amhara, Oromia, SNNPR, and Tigray were randomized into one of two arms for the study:


- 1) the control group that did not participate in a VCAT workshop
- 2) an intervention group that was invited to participate in a VCAT workshop

Randomization was stratified by facility client volume. Approximately two healthcare providers per facility in the intervention group were invited to participate in a VCAT workshop. Seven 2-day VCAT workshops were held in January – February of 2020.

-  The evaluation used routine service statistics to assess the impact of VCAT on the volume of clients served.
-  Provider surveys pre-training, immediately post-training and 6 and 11 months after the training to understand the effect of participating in a VCAT workshop on provider knowledge, attitudes, and service provision.
-  In between the final two surveys with providers, we also conducted in-depth interviews with a subset of 30 providers split between the intervention and control groups (October – December 2020).

"What helped me is to understand problems of others as my own and to be in the shoes of other people.

It helped to be more understanding with clients and never judge about it."



– Private provider & VCAT participant, Oromia

WHAT WE FOUND

Encouraging shifts in private provider knowledge, a greater willingness to provide safe abortion services and indications of expanded access.

Ensuring participants have a clear understanding of abortion law and practice in their context is a key part of VCAT and a first step in transforming attitudes. We found that knowledge about abortion law and practice increased moderately among the private providers participating in VCAT. We used eight questions to assess correct knowledge of abortion laws and practice. Providers in the intervention group saw a 1 unit increase in knowledge compared to a 0.4 unit increase in the control group on the knowledge scale (p=.075). As time passed after the workshop, knowledge decreased.

Our results suggest it is likely that providers were not serving some clients prior to participating in VCAT based on a discomfort or potential conflicting values around abortion. We found that providers held mixed opinions about whether it was appropriate for clients in less severe circumstances (clients who were older, who were married, or whose lives were not imminently in danger) to seek abortion care. These attitudes resulted in providers acting as gatekeepers, judging the acceptability of the reasons the client stated for seeking abortion and sometimes trying to convince her to change her mind even in cases where the client would qualify for legal services.

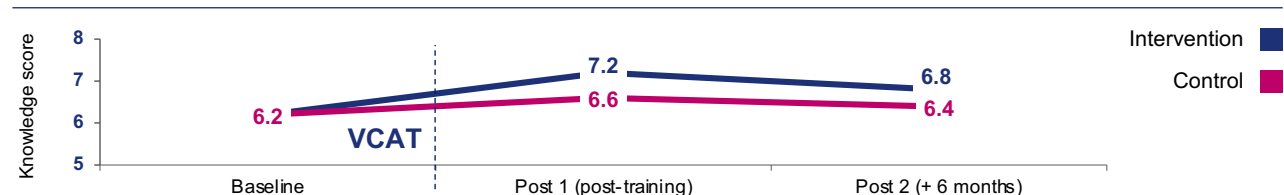
VCAT explores these individual beliefs and social norms that influence attitudes towards abortion. As with knowledge, we used a set of questions in pre/ post workshop surveys to understand any changes in participant attitudes towards abortion. Supportive provider attitudes increased among the private providers who participated in VCAT; however, few individual attitudes were influenced to an extent that we could detect statistically significant differences between baseline and post 1 comparing intervention and control providers.

However, we did observe an impact on some specific attitudes, including the response to the statement **"I feel comfortable performing a safe abortion procedure for anyone who requests it regardless of the reason."** Among the intervention group, agreement with this statement increased from 60% at baseline to 84% following the workshop (p=0.02). A greater comfort with performing a safe abortion procedure for anyone who requests it was also reflected by the increased number of providers self-reporting to provide abortion services to minors (a group who often face greatest barriers to accessing safe abortion care).

Some providers felt their attitudes changed through participation in the VCAT workshop, explaining that: it increased the empathy they had for clients; emphasized their professional duty to serve clients; and articulated the role providers play in saving lives. However, while providers were more positive about promoting broader access to safe abortion they did not always recognise the importance of access to safe abortion for specific groups (e.g. married women). Providers also linked the change in their attitudes around abortion to improved client experience. Despite increases in supportive abortion attitudes and an increased understanding of the importance of abortion care, insights suggest providers still play a significant role in deciding whether a client should be able to access abortion care.

Reported expansion of abortion services was reflected in client volumes. For each month following the VCAT workshop, the number of abortion clients served in intervention facilities was 1% higher than control facilities (p=0.013), translating to a difference of 14% over the course of a year (95% CI: 3%–26%). This effect decreased over time.

Provider knowledge about safe abortion laws and practice



WHAT THIS MEANS

A need for continued intervention to overcome provider stigma and expand access

These findings underscore the importance of addressing provider attitudes and stigma to improve access to safe abortion and quality of care.

VCAT can play an important role in opening up the conversations necessary to achieving this. To realise a sustained impact on quality of care and access to services, VCAT should be used as part of a suite of interventions designed to support providers as well as efforts to advocate for full implementation of abortion laws where laws are permissive.

Key recommendations:

VCAT content



Use what is known about existing provider knowledge and attitudes to frame and target the content of VCAT workshops. Ensure workshop content is linked back to the national and local context, drawing on national guidelines and policy.



Implement a broad rights-based framing to VCAT workshops that emphasises the need for abortion in a range of circumstances, reinforces the comprehensive nature of the WHO definition of 'health', and centres the autonomy of people seeking abortion care (rather than primarily leveraging the justification of the provision of life-saving care).



Include a greater emphasis on implementing client-centred care during the provision of abortion into VCAT workshops. Use role plays to make the link between values, attitudes, and behaviours towards clients.

Implementing VCAT



Plan to implement frequent refreshers and follow-up VCAT workshops as well as using other complementary provider support approaches, such as Provider Share Workshops so that these interventions help to create a pro-choice organisational culture and are not one-off interventions.



Implement VCAT workshops with a greater range and number of team members involved in providing family planning and safe abortion care and staff within facilities, including receptionists, guards and community-based promoters.



Prioritise future research to understand the impact of VCAT on client-centred care and client experiences.

“If they come and they need my help I will do it. I won't look back. I will help them whatever age they are.”

– Private provider & VCAT participant, Addis Ababa



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoices.org.
Alternatively, visit our website: www.msichoices.org.

For more information on Ibis Reproductive Health, please contact:
T +1 617 349 0040
admin@ibisreproductivehealth.org
Alternatively, visit www.ibisreproductivehealth.org

Choice on wheels: How a mobile bus expanded contraceptive access during the COVID-19 lockdown in Madagascar

KEY LEARNINGS

With a national lockdown restricting movement, barriers to sexual and reproductive healthcare have increased due to the COVID-19 pandemic. To ensure clients could continue to access essential services, MSI Madagascar started to deliver contraceptive services using a bus which travelled across cities to offer services on demand. This supported clients by maintaining existing access to family planning and by expanding contraceptive access for new users, as well as access to general health services. This innovative model safeguarded access through service disruptions. Ensuring clients have a choice in how to access services is critical.



THE CHALLENGE

COVID-19 and new barriers to care

The COVID-19 pandemic has devastated lives and communities across the world and has impacted access to essential sexual and reproductive healthcare due to lack of information, supply chain disruptions and restrictions on travel. It is estimated that 1.9 million fewer women were served by MSI programmes due to COVID-19-related disruption from January to June 2020.

In March 2020, three major cities in Madagascar – Antananarivo, Toamasina, and Fianarantsoa – went into partial lockdown. The Ministry of Health declared sexual and reproductive healthcare as essential during the lockdown, and MSI Madagascar wanted to ensure continued access, despite restrictions on movement and fear of infection.

WHAT WE DID

A new mobile service

MSI Madagascar deployed the new service from March to September 2020, using three mobile buses that travelled across cities to ensure clients could access essential sexual and reproductive healthcare.

While it was critical for MSI centres to stay open during this time, the buses were able to operate as an extension to MSI's usual services.

This addressed new access barriers created by COVID-19, safeguarding access for clients who were unable to visit our centres.



To access the mobile bus services, clients called MSI's contact centre or sent a Facebook message to book an appointment.



The bus also served "walk-in" clients they encountered on their journeys.



The COVID-19 pandemic has devastated lives and communities around the world and has impacted access to essential sexual and reproductive healthcare.

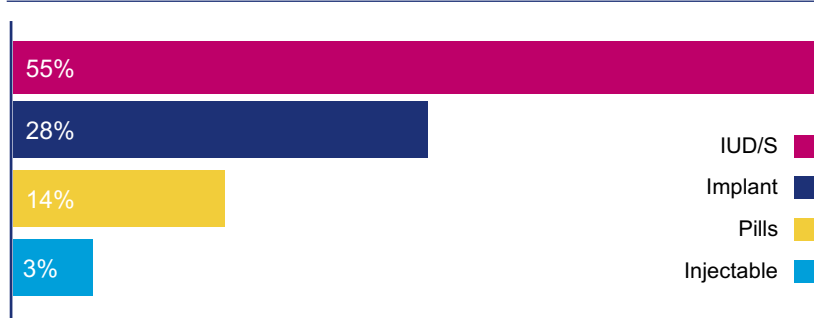
WHAT WE FOUND

Serving a new client base

Analysis of available data for the period June to September 2020 shows that during this time, 264 clients accessed sexual and reproductive health services from the mobile buses. The booking system through the contact centre proved to be effective, with an estimated 77% of booked clients keeping their appointments.

Of the clients served on the buses, 94% were new users of MSI services. The clients also tended to be older and more educated than MSI's fixed centres' client base, with over half having completed university education and only 8% under 20 years of age. The bus was also reaching 'adopters' – 3 out of 4 clients had not used a method of contraception in the past 3 months which may reflect intention to delay pregnancies during the pandemic.

% of FP clients' method of choice



By offering integrated services, the buses also increased access to a broader range of essential health services.

77% of clients who accessed services from the buses also received a general health consultation, and 66% purchased other health-related products.

This is not surprising as access to private and public health services were more restricted during the lockdowns. By bringing services to the doors of clients, the buses offered choice to those who may otherwise not have had access.

However, we found that for the service to be sustainable in the longer-term, it would need to run for fewer days and serve more clients per day.

WHAT THIS MEANS

Innovating through disruption

During the COVID-19 pandemic and resulting movement restrictions, this mobile bus service complemented the static centres network and increased access for new users.

The service identified new areas with high demand for MSI's services, increased access to integrated health services, built a new client base, and provided an innovative way to safeguard access when usual services were disrupted.



Around the world, lockdowns led to curfews, transport blocks, and the cancellation of market days, which would usually provide a cover for clients wanting to access MSI services discreetly.

By adapting rapidly, MSI Madagascar has worked to **ensure clients who cannot access static health facilities were still able to access essential sexual and reproductive healthcare.**



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoice.org.
 Alternatively, visit our website: www.msichoice.org.

Nothing About Us Without Us: designing services for and with people with disabilities

KEY LEARNINGS

Prototype interventions to increase disabled people's access to sexual and reproductive healthcare were designed using Human Centred Design principles. Survey data indicates an increase in reaching clients living with a disability from 1.2% to 6.1% in 2021 in our outreach operations.

The expertise and experience of people with disabilities is a crucial part of the overall design process.

6.1%

Of outreach clients are living with a disability



THE CHALLENGE

People with disabilities face unique barriers to accessing services

People with disabilities can be among the most marginalised groups in any society, with often insurmountable barriers to accessing sexual and reproductive healthcare information and services¹, such as physical accessibility, communication barriers or lack of access to cash or transport solutions. In Sierra Leone, where estimates suggest more than 93,000 people² have a disability, negative stereotypes of disability and sex are pervasive across communities (e.g. that disabled women cannot or should not have children), and are often used by healthcare staff as well. Healthcare workers also often lack the confidence to appropriately serve clients with disabilities.

At MSI we are committed to creating an environment where all people can easily access high quality services free of stigma; everyone has equal right to reproductive choice and a healthy, pleasurable and safe sex life. MSI worked with Leonard Cheshire the Sierra Leone Union on Disability Issues (SLUDI) and design agency ThinkPlace as part of the Women's Integrated Sexual Health (WISH)³ programme to design interventions to make our service delivery more inclusive.

In Sierra Leone, estimates suggest more than **93,000** people have a disability



WHAT WE DID

1. Using human-centred design to develop interventions

Partners embarked on an inclusive human-centred design (HCD) project to develop some responsive interventions to improve access to our services, ensuring people with disabilities were involved in all stages of design.

An 'observation' and consultation phase closely informed by SLUDI found that three key challenge areas for people with disabilities in accessing services were:

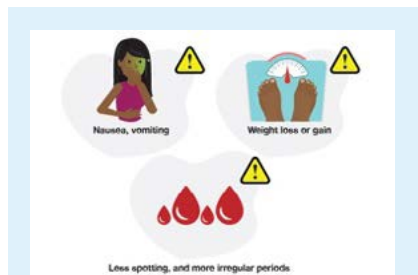
- The experience of being judged
- Lack of empowerment
- Limited disability-specific information.



WHAT WE DID

1. Using human-centred design to develop interventions

Ideas were generated to counter each challenge area and specific opportunities to make an impact were prioritised. ThinkPlace rapidly generated concepts for immediate testing and the three prototypes most successful at this stage were:



Choice Pic: series of visuals for providers to use in counselling to help clients with communication/hearing impairments understand their choices (targeting focus area 3)



Inclusive Services Guide: handy booklet for providers with easy-to-implement guidance on how to better prepare for and tailor services for clients with different disabilities (also targeting focus area 3).

Rumour Cards: set of cards comprising misinformation about people with disabilities and sex for stimulating discussion with the community and dispelling myths. It aims to counter negative stereotypes and foster a more accepting environment for people with disabilities accessing SRH services (targeting focus area 1). The sessions also planned to challenge stereotypes by how they were facilitated (e.g. SLUDI members as active facilitators where possible) (targeting focus area 2).



In October 2020 a team of MSI Sierra Leone and SLUDI members shared the prototypes with people with disabilities and used their feedback to refine them, ensuring they met the needs of potential clients with disabilities.

2. Piloting and refining the prototype interventions

These refined prototypes were piloted with MSI outreach teams in Freetown, Moyamba and Kenema districts over February–March 2021, including visiting 10 communities of people with disabilities twice during the period.

A mix of mechanisms including feedback forms, WhatsApp groups and supervision calls was used to garner ongoing feedback from outreach teams on their experience of using the prototypes. This was key: early on we identified that teams needed more support with the Rumour Cards prototype. We refined our approach and staggered the roll-out of the three prototypes to allow time for extra training on using the Rumour Cards.

We gathered end-line feedback from our teams in an end-of-pilot session in the head office in Freetown, and from clients with and without disabilities in a separate qualitative study conducted immediately afterwards⁴.

WHAT WE FOUND

What was the experience of our outreach teams?

- **Choice Pic resulted in high engagement:** the Choice Pic really engaged clients with disabilities and resulted in a lot of questions and clearly filled a gap in accessible information. However, this sometimes meant a counselling session could take approx. 90 minutes instead of 45 minutes
- **Community-based mobilisers (CBM) most benefitted from Inclusive Services Guide:** despite it being designed with providers in mind, CBMs may not have necessarily received prior training on disability inclusion; they found it particularly useful in informing them how to select appropriate locations for the outreach team to serve people with disabilities
- **Rumour Cards required further training to increase knowledge and confidence:** as the most complex prototype demanding the ability to talk about disability inclusion from a rights-based perspective, further training was required. Specific Rumour Cards generated a lot of engagement – promising for the ongoing conversation with communities that will hopefully shift attitudes in the longer term.



“People with disabilities were meaningfully consulted on the design and nature of these interventions.”



WHAT WE FOUND

What impact did these interventions have?

Qualitative feedback from clients with disabilities suggested that the interventions had the intended effect of enabling clients with disabilities to access our services, feel informed about their choices and receive respectful care:

“I think this service has improved a lot. I was counselled and given good information on the side effects of all the commodities”

“I feel the treatment is just the same for both persons with disability and able – bodied... I think it is easy speaking to the staff. I was able to tell the staff all my problems and they also gave me good advice and encouragement”.

Given that disability assessment tools are more suited to surveys than routine data collection⁵, we could not quantitatively measure the change in attendance of clients with disabilities over the pilot period. However, we estimate the percentage of clients with a disability in our annual client exit interview survey at the end of the year.

Given the focus on accommodating clients with disabilities in our Sierra Leone programme and the wealth of technical support given by Leonard Cheshire, it is promising to see that within our outreach teams,

the estimated percentage of clients with a disability rose from 1.2% in 2019 to 6.1% in 2020.



WHAT THIS MEANS

Adapting and refining continues

The nature of human-centred design means that we will continue to refine and adapt the interventions in response to client / team member feedback, as this is what makes the interventions even more effective and future-proof. Following the pilot, all outreach teams now identify potential sites which are accessible for clients with disabilities as part of their monthly scheduling.

Learnings to take away

- Specific and deliberate efforts to accommodate potential service users with disabilities can really support them to access services, and dramatically improve the experience for returning users
- It is crucial to have ongoing communication and coordination with Organisations of Persons with Disabilities (OPD) during piloting to ensure trust by members
- The design team included people with disabilities, and their expertise and experience was a crucial part of the design process
- More complex community sensitisation interventions may require lengthier training, starting with disability inclusion and human rights principles, for the team members who will be facilitating sessions (including the opportunity to practise/role play)
- In services where the user is required to make choices, the team may need the flexibility to allow for longer sessions with clients with disabilities or communication barriers, as it may take them longer to feel informed on all their choices.

Practical guidance on developing meaningful partnerships with OPDs and conducting community engagement workshops with people with disabilities is available on Leonard Cheshire's website.

FOOTNOTES

1. Ganle, J. K., Baatiema, L., Quansah, R., & Danso-Appiah, A. (2020). Barriers facing persons with disability in accessing sexual and reproductive health services in sub-Saharan Africa: A systematic review. *PLoS one*, 15(10)
2. Sierra Leone 2015 Population and Housing Census Thematic Report on Disability: <https://sierraleone.unfpa.org/sites/default/files/pub-pdf/Disability%20Report.pdf>
3. WISH is the UK Foreign Commonwealth and Development Office's flagship programme to scale up support to integrated SRH services to expand access for marginalised people across 12 countries in West and Central Africa. Through WISH, MSI works in partnership with IPPF, Ipas, ThinkPlace, DKT, Leonard Cheshire Disability and Options Consultancy
4. Further insights on clients with disabilities' experience in accessing services and their recommendations for more inclusive services will be included in a forthcoming peer-reviewed paper authored by Leonard Cheshire as part of WISH
5. Implementation Guidelines: How to use the WG questions <https://www.washingtongroup-disability.com/implementation/implementation-guidelines/>



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoices.org.
Alternatively, visit our website: www.msichoices.org.

Leonard Cheshire Links:

- [Community engagement for inclusive sexual and reproductive health](#)
- [Working together for inclusive sexual and reproductive health](#)

How can we reach more clients while maintaining quality and cost efficiency on outreach?

KEY LEARNINGS

A multi-country analysis of split teams was conducted for Nigeria, Zambia, Tanzania, Burkina Faso and Mali. Days where split teams were operational saw client visits double per day compared to classic outreach days.



The increase in productivity comes at an additional **£110** per day making the model very cost-effective.



MSI is committed to expanding access to and reaching the most underserved communities with safe sexual and reproductive healthcare (SRH) as well as creating a sustainable pathway to public sector ownership. A “split outreach team” (where outreach teams work in partnership with government nurses to double their coverage) model is one approach to help meet these commitments.

However, implementation lessons reveal that split teams must be carefully planned and implemented.

THE CHALLENGE

Expanding access to quality care

Over 218 million women and girls in low – and middle-income countries have no access to modern contraception and in remote rural communities, the unmet need for reproductive healthcare and family planning remains persistently high. Public healthcare facilities in these regions can be scarce and many are unable to meet the needs of all clients because of staff and commodity constraints.

To bridge these gaps, by 2030 MSI is committed to reaching at least 54 million clients and expanding access to regions with the highest unmet need, as well as supporting a sustainable pathway to public sector ownership. To meet these commitments several of MSI’s country programmes have been using a “split outreach team” model as a way to increase access in more remote areas, expand choice to more women with unmet need and build government providers’ capacity.

WHAT WE DID

The Split Team model

A split team model means that a classic Outreach team is split into two sub-units, with sub-units visiting two different facilities on the same day. Each sub-unit is supplemented with one or more government providers, who usually receive travel and food allowances as well as a per diem payment. The inclusion of government providers means this approach can facilitate a sustainable transition to public sector ownership through embedded capacity building. Split team model logistics and set-up vary between country programmes and contexts.

To assess the impact of split teams, descriptive analysis of routine client data from January to December 2020 for Nigeria, Zambia, Tanzania, Burkina Faso and Mali was undertaken.

A split team model enables two-sub-units to reach two adjacent facilities in the same day, with support from government providers.

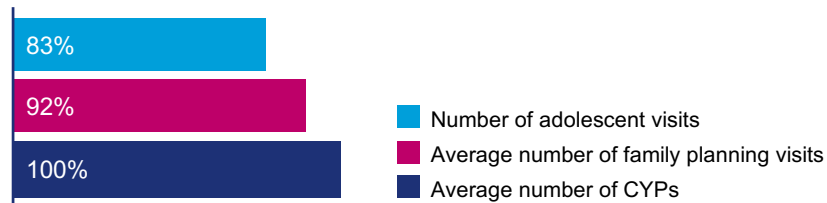


WHAT WE FOUND

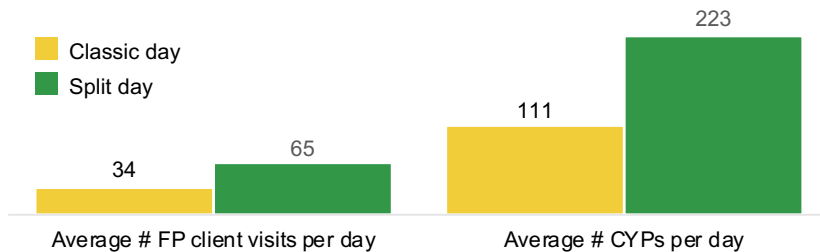
Daily productivity can almost double when using split teams

Across the seven country programmes, teams were using a split model just over a third of the time. A split model approach saw the average number of family planning visits and the average number of CYPs per day increase by 92% and 100% respectively. While the number of adolescent visits per day also increased by 83% for split days, the proportion of clients that were adolescent remains similar to classic outreach days (13% split vs 14% classic). This is also true of visits where a LARC method was taken up (61% split vs 58% classic) – indicating that equity and method mix do not substantially change between the models. These impacts come at an additional cost of £110 per day, or an additional £2 per client – making the model extremely cost effective.

Split model approach per day increase



Average Daily Productivity for Split vs Classic Outreach days



Although this increased productivity and reach is impressive, a split team model requires ongoing investment in capacity strengthening, engagement with government, and logistical planning.

WHAT THIS MEANS

Careful planning is critical before implementing this approach

Split teams can offer a cost-effective approach to almost doubling outreach productivity and can facilitate the transition to public sector ownership. However, this approach is not a quick win and must be carefully planned and coordinated:

Agreement with government on sites

Decide site selection jointly with the government. Be fact based; use data to show where the need is highest.



Staff availability and selection

Ensure government providers are well trained and competency assessed.



Upfront costs

For additional equipment (laptops for data entry) and commodities; double everything!



Data capturing

Accurate data entry when split teams are operating will help to measure impact. Ensure all sub-teams have their own laptops and are trained properly.



Plan accordingly

Sites visited by split teams should be planned like any other site visit: negotiate with the government, mobilise in advance, plan a return visit.



Quality of care/continuum of care

Determine frequency of revisits, set up referral networks for clients to access after-care support and share the contact centre number. Collect client feedback where possible, either directly or through community mobilisers.



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoices.org.
 Alternatively, visit our website: www.msichoices.org.

Combi-packs and contact centres: supporting safe self-care

KEY LEARNINGS

To support the safe self-administration of menstrual regulation (MR) pills, MSI Bangladesh analysed over 280,000 calls made to their contact centre – a phone line that provides information to menstrual regulation users and providers.

The data from these calls demonstrate the essential role of contact centres and hotlines in safe self-management of mifepristone and misoprostol – the drugs used for menstrual regulation in Bangladesh. The findings also show how combination packs (combi-packs) of these medications, with packaging that includes clear instructions and a contact number, can support safe access to essential reproductive healthcare.



THE CHALLENGE

Enabling safe menstrual regulation

In Bangladesh, menstrual regulation was introduced as a method to establish non-pregnancy in the 1970s.

Menstrual regulation services can include manual vacuum aspiration or medical methods (mifepristone and misoprostol, or misoprostol alone). Pregnancy is not confirmed before a procedure or medications are administered.

The medications mifepristone and misoprostol in a combination pack (combi-pack) is often available in pharmacies in Bangladesh. These medications can be safely self-managed and evidence suggests that pharmacy provision of the medications is safe and effective. However, it is important for women to have access to accurate information about how to use the medications, and pharmacy staff do not always provide advice on the correct regimen, or how to manage unexpected side effects.

WHAT WE DID

Analysing over 280k client calls

In 2010, MSI Bangladesh established a contact centre, staffed by mid-level health care providers who can provide advice and information to support menstrual regulation self-management.

Between 2012 and 2016, over **280,000** calls were made to the contact centre

We analysed data from these calls to find out who was calling, the reason for their call and how contact centre use changed as new products became available.

“By raising awareness of contact centres and hotlines through combi-pack product packaging, we can support women in accessing the safe and informed care they need and deserve.”

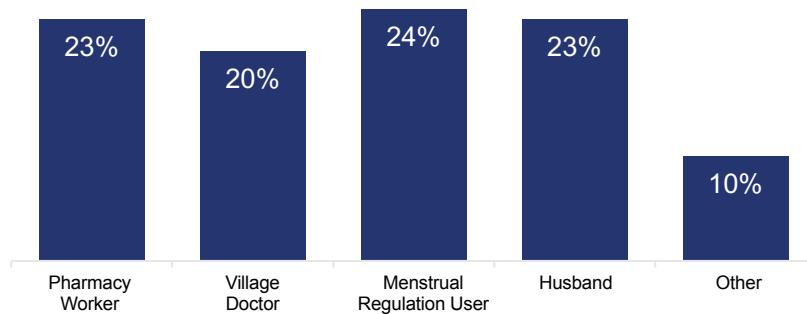


WHAT WE FOUND

Over four years, the use of the contact centre steadily increased from 2,429 per month in July 2012 to 8,700 per month in August 2016.

Calls were from menstrual regulation users, their husbands, pharmacy workers and village doctors, and a high proportion of callers had previously used the contact centre. Most menstrual regulation calls were related to the use of misoprostol. However, after the more effective combi-pack was introduced to the market in 2014, a growing proportion of calls were about the combi-pack regimen, and more calls were from MR users who had taken the complete regimen and wanted to know about side effects or pain medication, with fewer calls asking about dosages.

Profile of Callers



“By raising awareness of contact centres and hotlines through combi-pack product packaging, we can support women in accessing the safe and informed care they need and deserve.”

WHAT THIS MEANS

The role of combi-pack, clear packaging and onward support

The high and increasing volume of calls suggest the contact centres are meeting an unmet demand for information about menstrual regulation medications, and that contact centres can provide an accessible way to deliver this support.

The findings also highlight the value of printing a contact centre number on menstrual regulation medication packaging. When MSI Bangladesh started printing their contact centre number on their own product packaging, there was a substantial increase in calls about the product. There was a similar increase when the contact centre number was printed on another company’s product, too. By maximising visibility of the contact centre, MSI Bangladesh increased access to information and support.



Finally, the study highlighted the impact that combi-pack products can have on access and ease of use. After the combi-pack entered the market, fewer people called to ask about dosages, which may reflect that the combi-pack is easier to use.



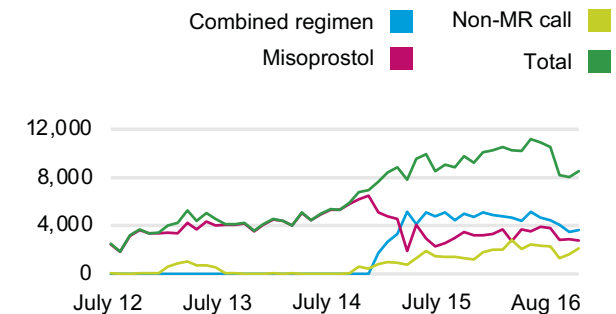
Enabling a continuum of care

In short, the findings support the importance of combi-pack availability, including clear, user-centred instructions on the packaging. The findings also highlight the value of ensuring that there is onward support for combi-pack users, in the form of a contact centre or hotline, to provide the information and support needed for safe menstrual regulation.

By raising awareness of contact centres and hotlines through combi-pack product packaging, we can support women in accessing the safe and informed care they need and deserve.

Access the [full journal article online](#).

Contact Centre Call Volume



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoice.org.
 Alternatively, visit our website: www.msichoice.org.

Putting marginalised voices at the centre of cervical cancer screening and prevention

KEY LEARNINGS

Cervical cancer is the second most commonly diagnosed cancer amongst women in Bangladesh, with 8,000+ new cases reported in 2018. In response, MSI's programme in Bangladesh (MSB) implemented a GSK-funded project to provide cervical cancer screening & preventative treatment plus HPV vaccinations in Dhaka.

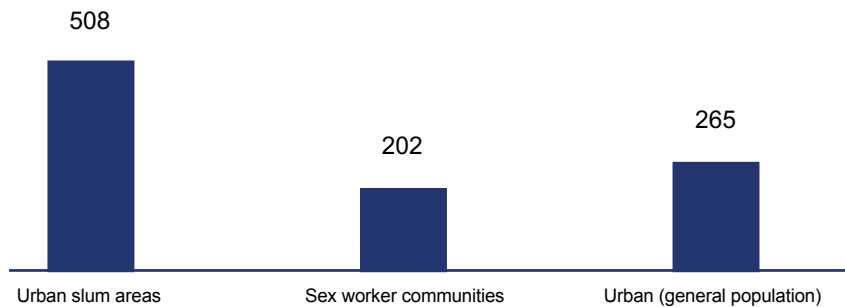


31% of 'slum-dwelling' women and 50% of sex workers screened were found to have precancerous cervical lesions.

Of these, 3% of women were referred to tertiary facilities for higher level treatment and 97% were referred for cryotherapy, to freeze off lesions. This study aimed to understand how to better meet the needs of these clients with the aim of improving our services and increasing access.



Number of women tested for cervical lesions



THE CHALLENGE

Overcoming barriers to safe services

Across Dhaka, nearly 1,000 women were tested for precancerous cervical lesions. Women in poor areas of Dhaka, including sex workers and women living in slums, were found to be at particularly high risk, with a third of women living in slums and half of sex workers testing positive for lesions and receiving follow-up treatment, including cryotherapy. WHO guidelines state that to allow the cervix to heal, women should be abstinent for at least 4 weeks following cryotherapy, or at least use condoms, but for many women, this is not possible. We wanted to find out: how can we make treatment as safe as possible for these clients?

WHAT WE DID

Understanding our client experience

To better understand how our clients experienced our cervical cancer screening services including their motivations and barriers to accessing health services, we asked them directly. We wanted to know, would a period of abstinence be possible for sex workers, and for women living in slums whose husbands may not be understanding of their need for a period of abstinence?

To find out, between October - November 2018, we interviewed 47 clients who had been treated with cryotherapy to learn more about their experiences with the screening camps, their ability to adhere to the abstinence guidelines, their contraceptive preferences, and their approach to seeking and receiving care for Menstrual Regulation.

WHAT WE FOUND

Centering marginalised voices

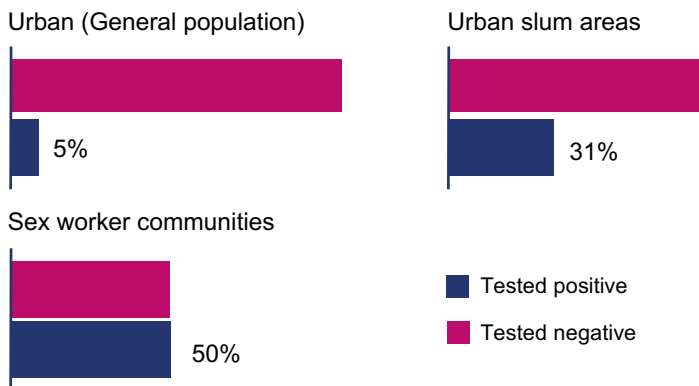
The women and girls we talked with shared that they valued the services and respectful providers, but were often fearful of the procedures involved, due to a lack of awareness of what to expect. Sex was a daily occurrence for many women, either for their work or within their relationships, meaning abstinence and condom-use were challenging.

Our research showed that effective contraceptive use was rare. Both sex workers and women living in the slums predominantly reported using short-term methods, and discontinuation was high due to side effects.

Concurrently, most participants reported at least one unintended pregnancy and use of menstrual regulation to manage pregnancy was extremely common and often unsafe.

Finally, several sex workers were unable to access sexual and reproductive health services, either due to concerns from brothel leaders about certain methods of contraception, rules around condom use or barriers at a service-provision level, including being turned away by providers due to prejudice. The clear lesson was the need to tailor sexual and reproductive health and rights programmes to ensure they are accessible to marginalised women, many of whom face multiple levels of discrimination and stigma, and to put their needs and voices firmly at the centre of programme development.

% of women testing positive for cervical lesions



WHAT WE FOUND

How to deliver tailored programming

Based on the findings, our recommendations include:

- Deliver community-based sessions and quality counselling to ensure clients and partners have a clear understanding of cervical cancer risks and what procedures involve.
- Ensure guidelines on abstinence and condoms are shared with clients, and involve partners in follow-up care and visits, to help negotiate guideline adherence.
- Deliver Values Clarification for Action and Transformation training to providers, to ensure non-judgmental and accessible services for sex workers.
- Tailor programmes to meet the most marginalised, for example, through building referral networks with community-based organisations, implementing single provider models, and partnering with sex worker communities to support sexual health access and safe provision.



“Those who have money and wealth, they can follow these rules.

There are many people here who have support from their mother, sister or family. They can follow the rules without doing the work.”

– client in Dhaka



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoice.org.
Alternatively, visit our website: www.msichoice.org.

Taking care of our clients and staff: delivering excellent client-centred care

KEY LEARNINGS

In 2019, MSI Zambia undertook a holistic approach to delivering client-centred care by implementing the *Client-Centred Care Package*, a global suite of tools that support country programmes to evaluate and improve the client experience.

This new approach highlights that to deliver excellent care, we need to walk in the shoes of our clients to truly understand their needs, worries, and preferences in accessing safe sexual and reproductive health services.

However, we can only deliver consistent, high-quality care if our frontline staff, including non-medical providers, feel they are supported, recognised, and encouraged to deliver their best.



THE CHALLENGE

High-quality client experiences

At MSI, the aim of our client-centred care philosophy is to put the client's interests first and respect the role of our clients as active partners in their own care. High clinical standards are not enough to ensure client-centred experiences of care. Clients' needs and life choices must be clearly understood to ensure an informed choice of health care. If a client feels they are not treated with respect and dignity, this can lead to mistrust, poor health outcomes, and pursuit of unsafe care elsewhere.

WHAT WE DID

A holistic client-centred approach

In 2019, MSI Zambia (MSZ) implemented the Client-Centred Care Package in their centres. This package contains a suite of tools that support programmes to deliver client-centred care services. It includes training modules for frontline staff, an observational client experience checklist, routine client feedback tools, and action planning guidance to help staff and supervisors implement improvements.

Using MSI's annual Client Exit Interviews, we measured the impact of MSZ's client-centred care activities on client experience, including satisfaction with the service environment, interpersonal care, and quality of service delivery.

WHAT WE DID

A holistic client-centred approach

The Client-Centred Care Package helped MSZ's frontline staff to view the care they provide through their clients' eyes. Using the package, MSZ focused on **three key strategies** that led to notable improvements in client experience (see graphs on Figures 1 and 2 on the next page):

Improving key client touchpoints. MSZ identified waiting times, privacy and counselling quality as key areas of focus, and implemented targeted interventions to optimise client flow and improve privacy features and job aids.



Responsive to client feedback. Centre teams reviewed and actioned client feedback daily and as part of monthly performance reviews. Actions taken were displayed using "You Said, We Did" boards in waiting rooms.



Sharing client insights across the client journey. As the Contact Centre has direct conversations with clients, MSZ held meetings for these insights to be shared with centre staff.



WHAT WE FOUND

To take care of our clients, we need to take care of our staff

To sustain client-centred care behaviours, MSZ's management team prioritised creating an enabling environment for staff to deliver excellent care by:

Taking the time to mentor and develop team members.

Supervisors initiated honest two-way conversations to better understand each team member's strengths, as well as development needs.



Championing peer-to-peer support.

Staff members were encouraged to share best practice tips with each other, which improved staff engagement and strengthened support networks.



Giving space for reflections. Service providers can sometimes be faced with challenging cases and giving them the space to share this with colleagues helped reduce their stress and increase motivation.

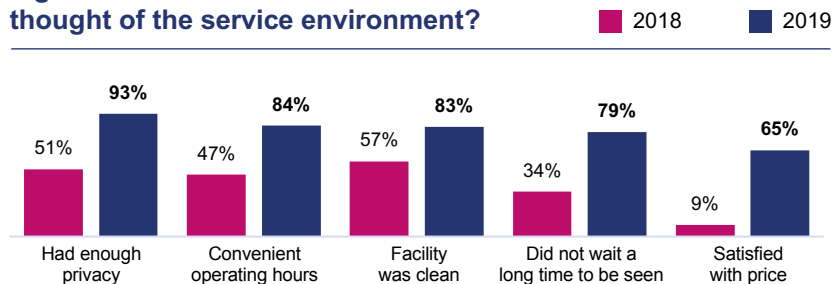


Recognising team achievements, however small.

Management strived to recognise all team members who were actively putting clients at the heart of what they do.



Figure 1. What MSZ centres' clients thought of the service environment?



% strongly agreeing, from MSI Client Exit Interview Data

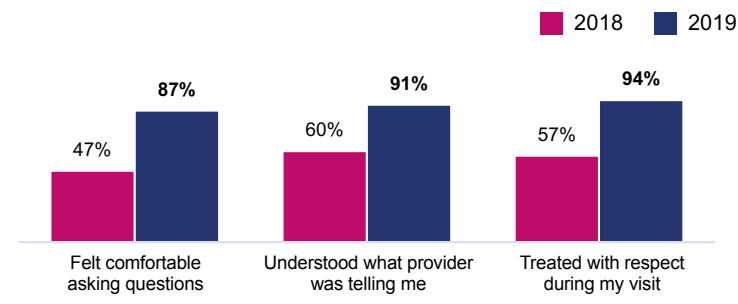
WHAT THIS MEANS

The power of empathy and support

A holistic approach to delivering client-centred care is key to ensuring all clients have access to and receive high-quality sexual and reproductive health services. Word of mouth referral is the most common way clients with unmet health needs hear about MSI, so delivering a client-centred experience for our clients is crucial in increasing access.

Training frontline staff, responding to client feedback, sharing insights across the client journey, while motivating and recognising staff success can drive organisational behaviour change to embed the client-centred care values of empathy and support.

Figure 2. What MSZ centres' clients thought of their interaction with their MSI provider?



% strongly agreeing, from MSI Client Exit Interview Data

Our clients are experts in their own experience, and we must serve them with dignity and respect, and ensure they are always in control of their care without judgement or discrimination.



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoice.org.
 Alternatively, visit our website: www.msichoice.org.

Supporting community resilience on the frontline of the climate crisis in Zambia with reproductive choice

KEY LEARNINGS

Communities in Zambia are already impacted by and responding to the effects of climate change. To support those on the frontline of the climate crisis in the North Luangwa and Nsumbu National Parks to adapt, MSI Zambia’s Mpika outreach team worked in partnership with the Ministry of Health and Frankfurt Zoological Society to expand contraceptive access in these communities.

By working closely through existing community structures and a team of community mobilisers, 9,600 clients accessed contraceptive services from the Mpika outreach team in 2020, and MSI Zambia strengthened capacity in public health facilities in the area through training and supportive supervision.

9,600

clients accessed contraceptive services from the Mpika outreach team in 2020



THE CHALLENGE

Adapting to climate change impact

Climate change is the biggest global health threat of the 21st century.



Zambia is already experiencing the adverse impacts of climate change – including an increase in frequency and severity of seasonal droughts, increased temperatures in valleys, flash floods and changes in the growing season.

The country is responding by developing sustainable and resilient programmes for crops and livestock. MSI Zambia is supporting these efforts to adapt and mitigate the effects of climate change by providing SRHR, which helps empower communities to participate more effectively in climate change planning and natural resource management.

WHAT WE DID

Integrating SRHR into conservation

In partnership with the Ministry of Health and Frankfurt Zoological Society (FZS), MSI Zambia began working with communities and conservation projects in the North Luangwa and Nsumbu National Parks, providing contraceptive services through the Mpika outreach team.

MSI Zambia worked through existing community structures supported by FZS, including Village Action Groups (VAGs), Community Resource Boards (CRBs) and Game Scouts to mobilise and educate communities on sexual and reproductive health and rights (SRHR).

SRHR activities were integrated into conservation programmes, providing an opportunity for collaboration between conservation officers and public health teams.

WHAT WE FOUND



Addressing challenges

The programme faced some challenges, including poor road networks, nationwide commodity shortages, and communication challenges. These challenges were navigated by procuring a Land Cruiser to navigate rough terrain, and using the radio system of FZS to communicate between teams and mobilisers for planning purposes.



Additionally, the costs of serving clients in very disconnected and remote parts of the country were significantly higher than in other rural areas, made more challenging by increases in costs attributed to COVID-19.

WHAT WE FOUND

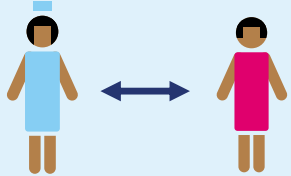
Sustainable access

This mobile service improved access for people who would otherwise have very limited access to care. In game management areas, women would otherwise walk for three hours or more to reach a facility for their preferred method of contraception.


The outreach teams provided services to

9,775

clients in 2020...

...adapting to COVID-19 with new social distancing measures.



72%

of clients were switching from short-term to long-acting methods, and 17% were adopters of contraception.


Community-based mobilisers play an important role in raising awareness about contraception, with 99% (9,662) of clients served by the Mpika outreach team hearing about our services through these mobilisers. Working with FZS's community structures also enabled our teams to deliver community mobilisation and awareness-raising sessions.

MSI Zambia also trained 30 public providers from the area in post-abortion care, contraceptive provision, medical emergency management and infection provision. The outreach team has supported ongoing skill retention for these public providers through on-site supervision and mentorship. Going forward, MSZ intends to train Provincial and District Health Administrators to ensure that they can support facilities in the game management areas with ongoing supportive supervision while securing contraceptive commodities for these vulnerable communities.

WHAT WE FOUND

Aligning with climate change priorities

Through this project, MSI Zambia has changed the way we think about communities and climate resilience, highlighting the interdependency of people and the environment. MSI Zambia has also started working to reduce the organisation's carbon footprint by improving how we operate and using more environmentally sustainable forms of energy and power.



"I have had 10 pregnancies and 8 children. Today I am so happy that I have finally accessed a method of my choice. I shall be a role model and tell everyone in my village about this service."

– Catherine

"MSI Zambia sought to support efforts to adapt and mitigate the effects of climate change."



Two Community Resource Board Members inspect a Copper-T IUCD during a training session



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoice.org.
Alternatively, visit our website: www.msichoice.org.

Empowering adolescent girls as peer advocates for family planning: a peer referral program in Uganda

KEY LEARNINGS

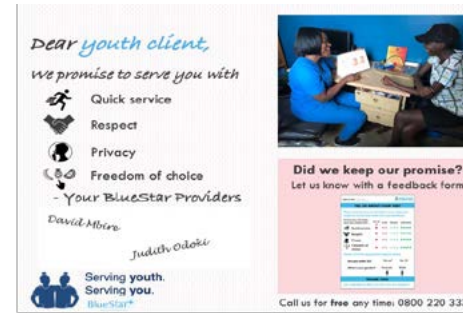
There is a high unmet need for family planning services among Ugandan adolescents. Social norms, stigma, and limited agency in decisions about sex limit access to reproductive healthcare services. Ideas42, MSI Reproductive Choices, and Marie Stopes Uganda (MSUG) partnered to design and test a behavioural science intervention to support uptake of modern contraceptive methods among adolescents aged 15–19.

This project leveraged MSUG-supported providers and community mobilisers, who introduced a refer-a-friend program to girls who had received FP methods or counselling,

coupled with youth-friendly materials and training to create a welcoming environment at the participating clinics.

The intervention resulted in positive impacts, with an average 45% increase in adolescent clients (about 5.4 more per clinic per month), and an average increase in the proportion of adolescent clients by 5.3%.

This suggests that nearly 2,000 adolescents became new FP users as a result of the intervention, with many more being empowered and counselled, during the six months of implementation.



THE CHALLENGE

Reaching adolescents in need

Adolescents bear a disproportionate burden of sexual and reproductive health risks compared to any other age group in Uganda.

In Uganda, 25% of girls aged 15–19 have begun childbearing, with nearly half reporting these pregnancies as mistimed or unwanted. Adolescents also have the highest rate of abortion, which are frequently unsafe. **Of the 2.5 million adolescent girls in Uganda:**

26% are sexually active and do not want a child for at least two years.

39% use modern FP, leaving 61% with an unmet need.

Through interviews with adolescents, mobilisers, and providers, a number of behavioral barriers for adolescent FP-uptake were identified, even when affordable services are available, including:

- Lack of prompts to **make decisions** about FP or **overweighing FP health risks** compared to unplanned pregnancy risks
- Intangibility of losses** from unintended pregnancy
- Focusing on condoms** as the primary method of FP
- Failing to **follow through with taking up a contraceptive method** even if intending to

WHAT WE DID

Removing behavioural bottlenecks

To address these complex behavioural bottlenecks, a peer-referral intervention was designed. Adolescents who had used FP or had received counselling were invited by a mobiliser or MSUG BlueStar provider to give a “Refer-a-Friend” (RAF) card to a friend that was not using FP.

The card creates space for adolescents to discuss FP – sharing information, advice, aspirations, and prompting the recipient to visit a BlueStar clinic that had been outfitted with youth-friendly materials and training.

The peer endorsements encouraged those who might have felt uncomfortable speaking to a mobiliser or provider to seek services, and when a girl endorsed FP to a friend as an “expert”, it built her confidence and intention to use FP.



When a girl redeems a RAF card, she is given two friendship wristbands – one for her and one for the friend who referred her. These wristbands are a small token to motivate girls to make referrals and to follow through on visiting the clinic.

If a girl receives FP counselling or services after redeeming her RAF card, she receives a new card to give to another friend, becoming an advice-giver herself. In addition to providing an incentive, the wristbands signal that MSUG is a place where adolescents belong, and that using FP is a desirable and accepted behaviour.

WHAT WE FOUND

Empowered peers provide effective pathways to care

Using a randomised controlled field trial (RCT), MSUG BlueStar clinics were randomly assigned to a *control* group (offering standard services), a *core* group (implementing the RAF program and clinic materials), or a *core+* group (RAF program, clinic materials, and youth-friendly service training). The clinics implemented the intervention for six months in 2020, interrupted mid-way for 3 months due to COVID-19.

The impact of the intervention was measured on 1) the number of adolescents aged 15-19 receiving FP services; and 2) the proportion of FP clients who were adolescents. Both were measured monthly at the BlueStar clinic level.

Results showed statistically significant (p<.01) positive impacts of the intervention on both outcomes – an average 45% increase in the monthly number of adolescent clients (about 5.4 more per clinic), and an average increase in the monthly proportion of adolescent clients by 5.3%. Nearly 2,000 adolescents became new FP users as a result of the intervention during the six months of implementation.

The effects were marginally stronger with the more intensive Core+ package:

62% relative increase in monthly clients (7.4 more per clinic) compared to a 26% increase (3.2 adolescents per clinic) when the intervention was implemented without the YFS training.



The average increase in the proportion of adolescent clients (5.4 and 5.3 percentage points, respectively) was more consistent between intervention groups.

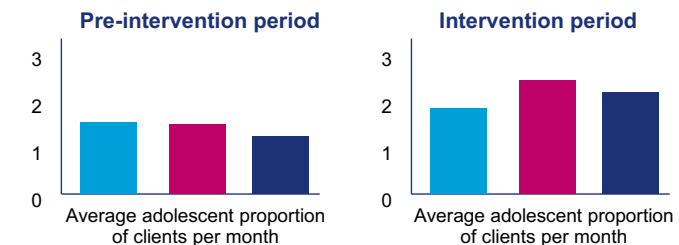
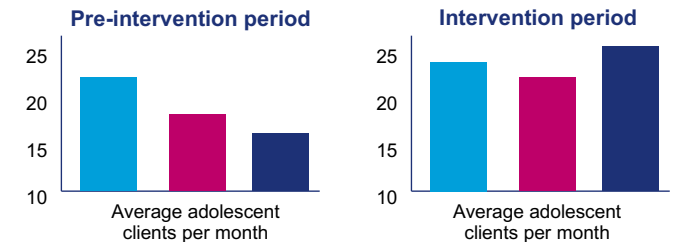
This underscores the importance of addressing barriers across touchpoints. The programme was most effective when it included the YFS training component that built providers’ skills, knowledge, and intention to offer youth-friendly care, in addition to the adolescent-friendly clinic materials and RAF cards.

WHAT WE FOUND

Refer-a-friend, begin their journey

The number of redeemed RAF cards also offered insight into the reach of the programme among adolescents who visited a clinic but opted not to take up FP. Interviews with providers suggest that virtually all girls who redeemed a RAF card chose to receive free FP counseling and according to provider reports, a minimum of 5,477 RAF cards were redeemed during the study period.

As a greater number of adolescents received FP counseling only, this shows that adolescents visiting the clinics did not feel pressured to take up a method and were supported in accessing information. Although this number is a conservative estimate, it suggests that for every adolescent who took up FP (~2000), another two may have received FP counseling to support them in making an informed choice in the future.



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:

T +44 (0)20 7636 6200 • evidence@msichoices.org.

Alternatively, visit our website: www.msichoices.org.

The Abortion Quality Index: A new metric to monitor programme quality

KEY LEARNINGS

The MSI Abortion Quality Index (MS AQI) was developed with the aim of measuring the quality of MSI’s programmes for safe abortion and post-abortion care globally and to drive continuous quality improvement.

The MS AQI recognises five key components that are needed no matter how clients access care or the method of abortion they choose. The metric was informed by WHO definitions of abortion safety and quality, and developed through a review of existing indicators and consultation across teams and functions.

Between 2018 and 2020, MS AQI scores were generated in 31 MSI programmes where safe abortion and/or post-abortion care is provided, in Africa, Asia and Latin America. Since launching, we have seen significant improvements in scores across our programmes, including due to greater adherence to new product quality assurance standards for self-testing, and through new continuum of care mechanisms.



THE CHALLENGE



Measuring quality across diverse models of care

Access to high quality, client-centred abortion care is a fundamental human right. Globally, MSI programmes increase access to high quality care, and we use a range of monitoring tools to ensure service quality. There is variation in the [indicators](#) used to measure quality in abortion care across the sector, but we wanted to develop one simple tool that could be used to measure and motivate a culture of continuous quality improvement across our global partnership.



At the same time, it is increasingly common globally for medical abortions (MA) to be self-managed outside of facility settings via a pharmacy. Growing [evidence](#) is showing that pharmacies can provide safe and effective pathways to care. However, we know that not all women receive adequate advice and support when accessing medical abortion via a pharmacy. We sought to include the quality of self-managed MA from pharmacies within our global quality metrics.

WHAT WE DID



Development of a simple metric: the MS AQI

MSI has developed the Abortion Quality Index (MS AQI) - a metric to monitor the quality of care across all our programmes and models of care. The metric was developed in 2018 based on WHO definitions of safety and quality, a review of existing monitoring tools and quality indicators, consultation across different teams, and through a process of ongoing feedback across the partnership. To ensure the metric could be rapidly and efficiently rolled out, we focussed on using indicators that could be readily extracted from our existing monitoring systems.



Data were extracted for the first time in 2018 and the MS AQI was calculated for each country and region, and for the global partnership. Results were reviewed by each country or regional team, and an interactive dashboard of results was developed for annual updates. The MS AQI has been integrated into our annual performance review processes.

WHAT WE FOUND

The key components of care

The MS AQI recognises five key components that are needed across different types of care or method of abortion. AQI indicators measure whether MSI programmes meet the following standards:

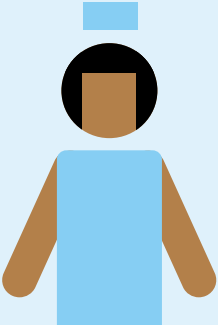

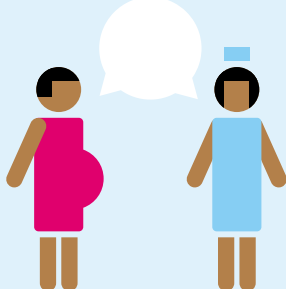

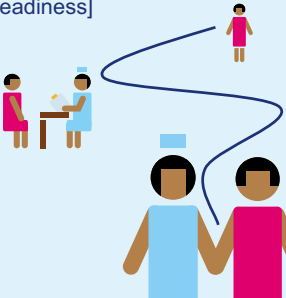
<p>Competent provider [% of providers meeting MSI's Level 1]</p> 	<p>Quality products [QARMA approval and shelf-testing status]</p> 	<p>Client-centred services [service quality audit score]</p> 
<p>Accurate information [a multi-pronged assessment of how the programme ensures women self-managing MA have access to comprehensive information through a contact centre, user-friendly instructions, or other client- or pharmacy-facing mechanisms]</p> 	<p>Continuum of care through follow up mechanisms [as assessed by service quality audits and/or contact centre readiness]</p> 	<p>Indicators vary by location and type of safe abortion or post-abortion care service (see Figure 1), but each type of abortion is assessed by three of these indicators. For example, the quality of surgical safe abortion or post-abortion care service delivery is measured by provider competency, service quality, and the continuum of care. Medical abortion that may be accessed from a pharmacy is monitored in terms of product quality, availability of information, and the continuum of care.</p>

Figure 1

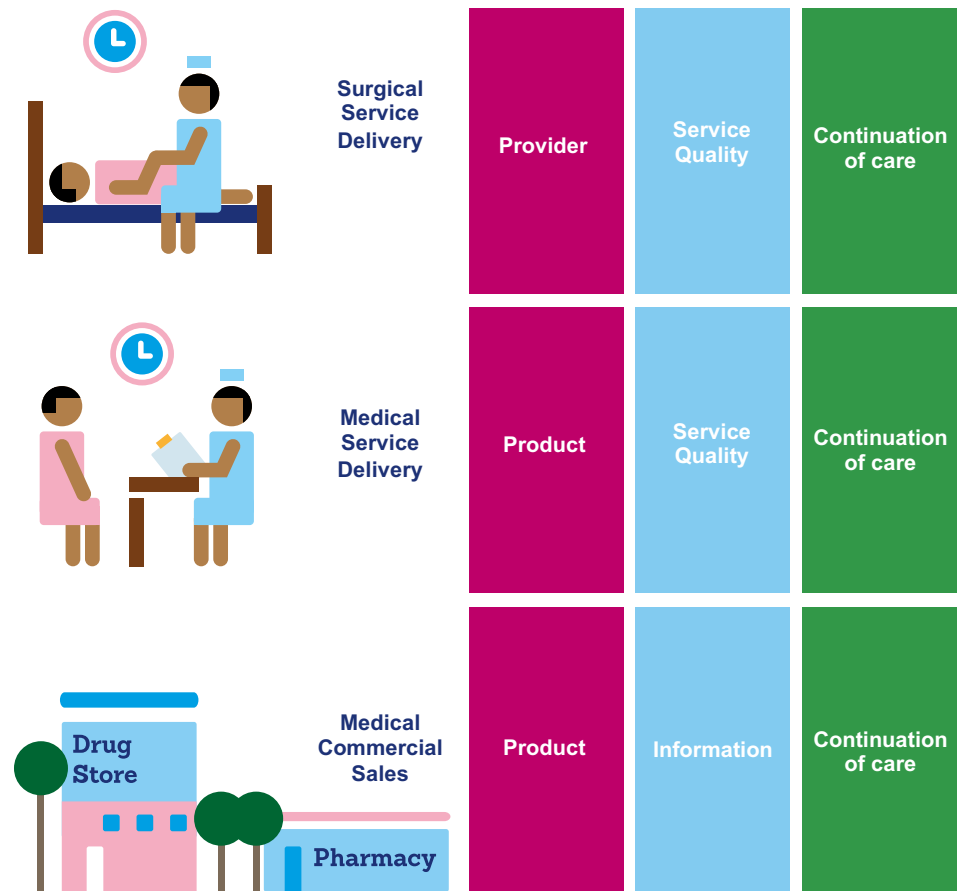


Figure 1: The MSI AQI measures three indicators for each type of CAC/PAC

WHAT WE FOUND

A measure of programme quality

The MS AQI is a measure of overall programme quality, rather than the quality of one individual service or client experience. To enable effective implementation, indicators are drawn from MSI's existing systems, including clinical quality audits, provider competency assessments, contact centres data systems, and product quality trackers.

By categorising each indicator at a value between 0 and 3 (from 'safe' to 'gold standard'), we generate overall standardised scores from 0-9 for each type of abortion (see Figure 2). These scores are then weighted by the number of services provided through each model of care in a country or region.

The metric enables MSI programmes to closely monitor their overall performance and strive towards the 'gold standard' in quality.

Figure 2



Figure 2: The maximum score is 3 out of 3 per indicator, and 9 out of 9 per service delivery type.

WHAT WE FOUND

Driving quality improvements

Between 2018 and 2020, MS AQI scores were generated in 31 MSI programmes where safe abortion and/or post-abortion care is provided. From 2018 to 2020 we noticed significant improvement in scores, mainly due to greater adherence to new product quality assurance standards for shelf-testing and improvements in continuum of care mechanisms.

In 2020, **MSI Mongolia** experienced the greatest improvement in score from the previous year and achieved a gold standard of quality across the programme. Driven by the guidance of the AQI standards, the country programme was able to make improvements in all 5 standards of quality, in accordance with the regulatory requirements. This improvement was driven by ensuring that a client phone line was included in MA product packaging, developing a new script to provide advice on safe abortion or post-abortion care provision via the phone line and appointing 24-hour focal points to answer client calls. In addition, knowledge and skill sharing for provider competency-based training was adopted from the MSI Nepal programme, helping MSI Mongolia to increase the proportion of their providers that are competency assessed at Level 1 (meaning they do not require direct supervision).

As standards improve, we are also able to shift the goal posts, ensuring a culture of continuous quality improvement across our global programmes.



Above: contact centre staff in Mongolia provide advice to clients over the phone



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoice.org.
 Alternatively, visit our website: www.msichoice.org.

“We wanted to develop one simple tool that could be used to measure and motivate a culture of continuous quality improvement across our global partnership”



What does it take to achieve a balanced method mix?

KEY LEARNINGS

MSI strives to provide full choice in contraceptive methods to every client. This requires not only ensuring clients are well informed on the range of methods suitable for them, but also that providers are competent and confident to provide the full range of methods.



In 2018, our programme in Zambia (MSZ) found that their providers were not confident to provide intra-uterine devices (IUDs) in their mobile outreach channel. This meant that method choice was limited, and during periods of method scarcity such as national implant stock-outs, options for long-acting forms of contraception were restricted.

MSZ invested in a comprehensive approach to supporting provider confidence, client-centred counselling and provision of contraception to ensure that clients were always counselled on a full range of possible methods, even when facing product stock-outs.



THE CHALLENGE

Ensuring a balanced method mix

To support women to make an informed choice about which method is right for them, it is essential providers feel confident to counsel clients on a full range of contraceptive options. This is especially important during periods of method scarcity, such as national stock outs of popular methods such as implants, which are becoming increasingly common.

In 2018, MSZ found that many of their providers lacked confidence in inserting intra-uterine devices (IUDs), which meant that during implant stock outs, options for long-acting forms of contraception were limited.

WHAT WE DID

Investing in provider confidence

MSZ invested in clinical trainings on IUD insertion, however they found that the group nature of these trainings made providers uncomfortable admitting they wanted more support, so MSZ introduced one-on-one clinical supportive supervision to further improve their skills and confidence.

They also increased the number of female providers/female chaperones available for clients, and embedded a client-centred approach to counselling (i.e. starting with client aspirations and needs, and tailoring counselling on methods to that, rather than just running through the pros and cons of all methods, as they had previously).



One-to-one supportive supervision builds provider confidence in counselling on all methods

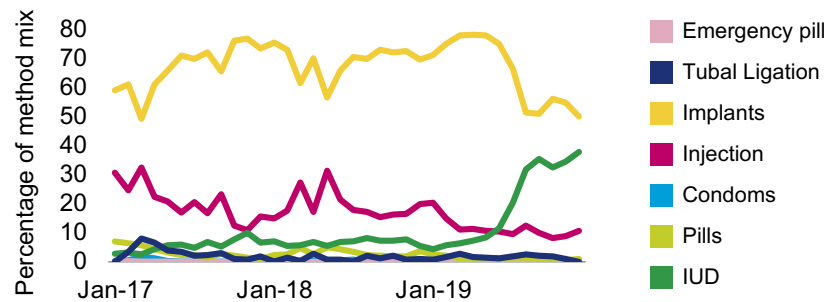
WHAT WE FOUND

A long-term, effective alternative

This approach saw MSZ's rate of IUD uptake triple from 7% in 2018 to 22% in 2019 – aligned with the MSI global average method mix for our mobile outreach channel.

The absolute number of IUD insertions also increased six-fold from 6,324 in 2018 to 40,919 in 2019.

Method mix in outreach by month



MSZ's investment in building provider confidence and ensuring client-centred counselling and provision meant that in 2019, when MSZ was affected by national implant stock outs on an unprecedented scale, IUDs were available as another option for clients who wanted long term effective protection.

2019 client exit interview data showed that clients in outreach:

85% felt comfortable asking questions to the provider

99% felt treated with respect by the provider

94% understood what the provider was explaining during counselling

WHAT WE FOUND

The right method for the client

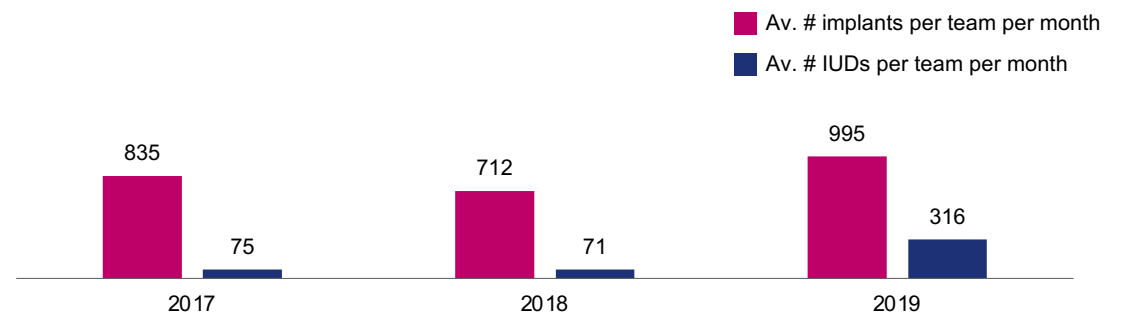
MSZ's experience suggests that IUD uptake is influenced by factors such as how counselling is tailored, as well as provider confidence and client comfort with the IUD insertion process.

MSZ's concerted effort to address these barriers meant not only a steady trend in IUD uptake, but that when Zambia was affected by national stockouts of implants in 2019, they saw an increase in the proportion of their method mix from IUDs, as an effective long-term alternative to the implant.

In the context of method-scarcity, it is more important than ever that providers are confident in providing all possible methods and that every effort is made to match clients with a method that meets their needs.



Average LARC insertions per team per month



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
 T +44 (0)20 7636 6200 • evidence@msichoices.org.
 Alternatively, visit our website: www.msichoices.org.

A cross-sector partnership to improve menstrual health and increase awareness and uptake of SRH services

KEY LEARNINGS

From 2017–2020, Marie Stopes International Australia (MSIA) and WaterAid (WA) worked in partnership to deliver the ‘Keeping Girls in School through Improved Reproductive and Menstrual Health’ project. The project was a cross-sector approach to holistically improve menstrual health and increase awareness and access to sexual and reproductive health (SRH) services in Timor-Leste and Papua New Guinea (PNG).

An independent evaluation was undertaken in late 2020, involving stakeholder interviews, and found the intervention was effective in building effective partnerships with schools and enabling adolescents to apply the skills and knowledge learned via education sessions to better manage their menstruation at school.



A NEED TO WORK ACROSS SECTORS

Reaching newly married adolescents

Collaboration between partners working in SRH and water, sanitation and hygiene (WASH) to improve menstrual health is a relatively new development. SRH and menstrual health are intrinsically related and yet sexuality education delivered in schools often misses the opportunity to speak about both topics. Traditional sexuality education may provide basic biological knowledge about the reproductive system but there is rarely any guidance on how students can practically apply this information to manage their menstruation or their SRH.

Globally, menstrual health studies have repeatedly pointed out that **a cross-sector approach is needed** to properly address the complex issues involved in improving adolescent girls’ menstrual health.

WHAT WE DID

A first-of-its-kind partnership

In response to this need, MSIA and WaterAid partnered to design and deliver the ‘GAP Project’, funded by the Australian Government. The first of its kind in the Pacific region, the project focused on adolescent girls and their communities to address the interrelated issues of unwanted pregnancy and menstrual health. There were three outcome objectives:

1. Increased awareness and use of SRH services and menstrual health practices among adolescent girls through improved access to girl-friendly facilities, education and services.



2. Improved availability of appropriate and affordable menstrual products through strengthened sustainable business models for local women-led entrepreneurs.



3. Strengthened knowledge of and attention to the importance of SRH and menstrual health in Timor-Leste, PNG and Asia Pacific more broadly through cross-collaboration, learning and an established community of practice.



WHAT WE FOUND

Effective entry into schools

Providing WASH facilities alongside discussions of menstrual health also proved to be **an effective way to develop partnerships with schools**.

The approach allowed for the strategic introduction of topics that tackled myths, taboos and misinformation pertaining to menstruation and SRH including fertility awareness.

Interviews with teachers from three schools in PNG highlighted that the **integration of WASH, SRH and menstrual health helped teachers to introduce sexuality education into the curriculum**. All the teachers interviewed believed that young people really needed comprehensive sexuality education and benefited from the education sessions.

Developing education materials in partnership with the government was shown to be an effective strategy to ensure public ownership and context-appropriate materials that can be used in the long term.



WHAT WE FOUND

The cross-sector approach works

By aligning shared challenges and shared goals, the cross-sector approach between WASH and SRH proved a valuable way to holistically improve menstrual health within the project areas.

Shared Challenges	Shared Goals
Difficulties in shifting gender and social norms and attitudes	Educating young people on taboo topics
Challenges in engaging men and boys on taboo topics	Keeping girls in school
A need to reach girls out of school	Improving health outcomes and delivering essential services

The project combined improvements to WASH facilities at schools alongside the delivery of SRH and menstrual health education sessions. Interviews with stakeholders revealed that **this approach was effective in enabling adolescents to apply the skills and knowledge learned via education sessions to improve their ability to manage their menstruation at school**. Although it was beyond the scope of the evaluation to measure impact on menstrual health outcomes, stakeholders interviewed as part of the evaluation all agreed that integrating WASH and SRH was essential as a means of improving menstrual health.



“The project was a good way to get SRH into schools, as prior to the GAP Project sex education wasn’t allowed in schools. Improving the WASH infrastructure was also a good way to introduce the topics of SRH and MH softly.”

– Project Staff Member, PNG

WHAT WE FOUND

Investing in partnership is critical

Partnership is crucial for the integration of WASH and SRH. Menstrual health projects will have greater impact by working with partners to implement innovative solutions.

The partnership between WaterAid and MSI was an integral component of the project. Interviews with project staff revealed a strong partnership in Timor-Leste from the outset due to an existing relationship between the organisations. As a result, staff worked collaboratively to deliver some of the education sessions and activities jointly.

“The partnership with WaterAid is good for our mission at MSI and for improving WASH at health facilities, at houses and in communities.” - Project staff member, Timor-Leste.

The evaluation found the partnership was open, transparent and harnessed the strengths of each organisation to deliver the project.



The project showed however, that time and investment is needed to establish strong working partnerships. Both organisations also had to adapt their business model to work in partnership and integrate the GAP Project within their ‘core’ functions.



“I think it is vital to integrate the topics of SRH and menstrual health. This was an eye-opening experience in breaking down some taboos.

When talking about sexual health in the classroom, we can see the students opening up and understanding the issue and respecting each other.”

– **Government Representative, Department of Health, PNG**



MORE INFORMATION

For more information on MSI Reproductive Choices and the work that we do, please contact:
T +44 (0)20 7636 6200 • evidence@msichoice.org.
Alternatively, visit our website: www.msichoice.org.

Where can I find more information?

For more information on MSI Reproductive Choices and the work that we do please contact:

T +44 (0)20 7636 6200 • evidence@msichoices.org

Alternatively, visit our website: www.msichoices.org

Registered charity number: 265543

© MSI Reproductive Choices, 2022