



Evidence and Insights

Powered by Evidence



At Marie Stopes International, our mission is what drives us. We believe that all women should be able to determine their own futures, whoever they are and wherever they live in the world. In every country I visit I see the importance of our services to the women and girls who would otherwise have no access to contraception or safe abortion, and what it means when they are given the opportunity to take control of their lives.

I am particularly proud of the technical expertise we have built up over 40 years of delivering reproductive health and rights programming and advocacy. Evidence is integral to our programmes because it informs everything we do. Our research and impact teams work hand-in-hand with our country programmes, governments and other organisations to gather quantitative and qualitative data 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.

As part of our renewed commitment to sharing our expertise with the wider world I am delighted to introduce this compendium of some of our most recent evidence and insights. This work illustrates the diversity of our approach and the results we can achieve when powered by data and 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.

Simon Cooke
CEO

Marie Stopes International is a global organisation providing personalised contraception and safe abortion services to women and girls in

37
countries

In 2017 we doubled the number of adolescents we served

Over 10%
of our clients are aged 15-19



We change lives, one woman at a time. We support women and girls to take control, empowering them to choose if, and when, to have children.



26.9
million women and men around the world are using contraception provided by us

Our services last year averted 5.4 million unsafe abortions and saved £337 million in direct healthcare costs



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Improving ACCESS & EQUITY

Who are our clients?

100,000+ **exit interviews** and **service use data** covering 140 million visits help us understand our clients and their experiences with us

What are the barriers to care?

Market and client surveys, complemented by systems data on vouchers and subsidies, help us to price fairly and never turn a woman away

Data from 29 **contact centres** (call hotlines) help us address information and service gaps



Are we serving those in need?

Innovative **poverty metrics** and **geo-mapping** enable us to reach the most vulnerable

How do we engage communities?

Handheld mobile data capture plus support tools empower our community-based providers



Raising the standards in QUALITY

Do we deliver quality care?

Exit Interviews, **mystery clients** and **routine feedback** allow us to monitor client experiences

How do we assure clinical quality?

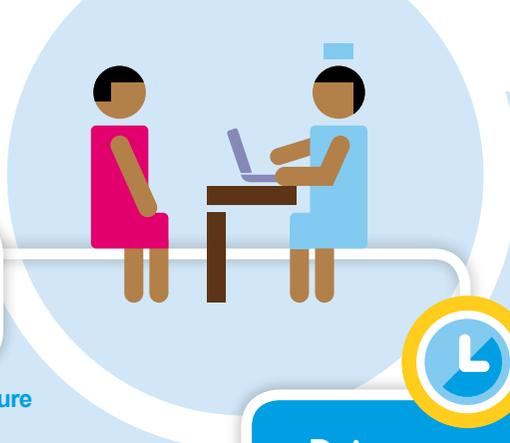
Quality technical assistance **audits**, **clinical incident systems**, and provider **competency databases** keep us on track

How can we assure product quality?

Our tools **test, track and assure** the quality of our products used in our services and sold externally

How can we prevent stock-outs?

Our end-to-end **logistics management system**, gives full visibility of supply chain (*coming soon*)



Doing more with less to drive EFFICIENCY

How do we know what works?

Client-level data for over 3 million clients across 22 countries, allows us to continuously iterate our programming

Can we do more with less?

Commodity use, costs and income captured through a **global accounting system** and analysed through our **cost calculator** empowers us to manage cost drivers

How can we support health systems?

Our bespoke **DHIS2 platform** allows us to customise support to public and private partners

How do we improve productivity?

Performance dashboards for providers/centres and outreach teams, plus vehicle tracking and more, maximise our productivity



What is our impact?

We harness the power of our evidence ecosystem and use our innovative **Impact 2** modelling tool to estimate the wider health and demographic impacts of our service delivery.

MSI'S EVIDENCE ECOSYSTEM

TURNING DATA INTO INSIGHTS INTO ACTION

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

No quick fix: finding the right recipe to reach young women in need

IN BRIEF

In 2017 Marie Stopes International began a concerted effort to reach more adolescent women. Within a year we almost doubled client visits in this age group – going from a historical average of about six per cent to almost 12 per cent by December 2017.

But the new initiative also revealed that there was no “one size fits all” approach.

Ongoing data monitoring and adaptive programming leveraging different service delivery channels to reach different groups is essential to continue to build on our success.

THE CHALLENGE

Reaching those in most need

An estimated 23 million adolescent women (aged 15-19) in low- and middle-income countries need better access to modern contraception. Meeting that need could help reduce unintended pregnancies in this age-group by 6 million annually, averting 2.1 million unplanned births, 3.2 million abortions and 5,600 maternal deaths each year.

As part of our ‘Scaling up Excellence’ 2020 strategy, MSI committed to reaching more marginalised populations by 2020, putting young people at the heart of our programmes for the first time. This started us on a journey throughout 2016-2018 towards invigorating MSI’s approach to reaching adolescents.

WHAT WE DID

Finding the right blend

We identified eight ‘building blocks’ that played a critical role in our journey (see overleaf for details):

- | | | | |
|---|---|---|---|
| Central and in-country resources.
1 | Cross-organisation youth working group set.
2 | Situational analysis of internal and external evidence.
3 | Adapted global data systems.
4 |
| Adolescent Strategy and best practice operational guidance.
5 | Adolescent reach indicators embedded.
6 | In-depth quantitative analysis triangulated.
7 | Facilitating cross-country communities.
8 |



We have developed programmes that are starting to deliver – supporting these young people to step forward and make choices to define their own future



WHAT WE DID

Finding the right blend

We identified eight ‘building blocks’ that played a critical role in our journey:

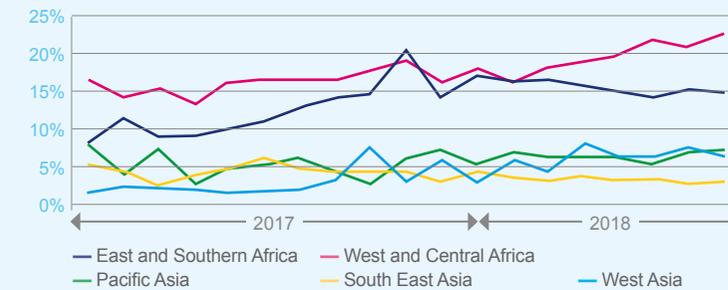
- 1 Central and in-country resources were appointed to focus on adolescent work; with global and national youth leads to help drive the agenda.
- 2 Cross-organisation youth working group established to gain buy-in, pool expertise and disseminate learnings.
- 3 Situational analysis of internal and external evidence – to build our understanding of the evidence base and outstanding gaps. We also analysed Demographic and Health Survey data to segment the adolescent ‘market’, looking at the demographic and geographical distribution of adolescent unmet need for contraception.
- 4 Adapted global data systems for greater visibility over adolescent reach.
- 5 Adolescent Strategy and best practice operational guidance launched, such as how to leverage our range of channels, including static urban clinics, rural mobile outreach teams, private socially-franchised providers, and community-based ‘Marie Stopes Ladies’ to reach different segments by providing the kind of services that suit them. For example, our mobile outreach channel mostly reaches rural, childbearing adolescents by overcoming the cost and distance barriers to care, while our static clinics can reach more urban, pre-childbearing adolescents by providing discreet, youth-friendly care.
- 6 Adolescent reach indicators embedded into performance management processes. We developed an interactive dashboard to help give managers immediate performance trends on client visits, broken down by age, channel and country, compared with regional performance. We also looked at contraceptive method mix by age and marital or childbearing status, where possible.
- 7 In-depth quantitative analysis triangulated with consumer-led insights to understand ‘what good looks like’ and build our evidence base.
- 8 Facilitating cross-country communities of practice and peer-to-peer knowledge sharing between marketing and youth leads to share successes.

WHAT WE FOUND

Doubling our reach

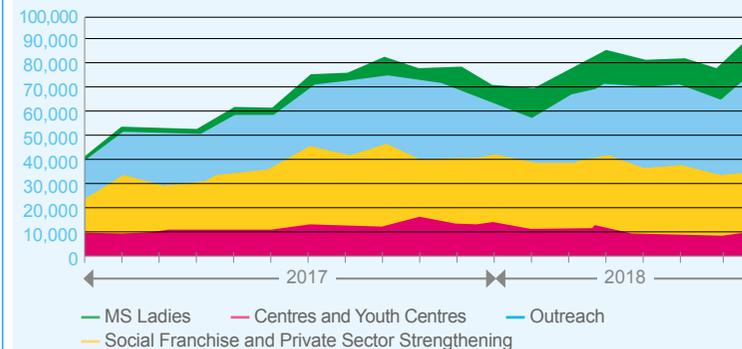
The difference in 2017 alone was remarkable: from a historical annual average of 6.3% between 2012-2016, we managed to double the proportion of global client visits from girls and women aged 15-19 to 11.8% by December 2017, driven by growth in our African programmes and our outreach and MS Ladies channels (see Figures 1 and 2).

Figure 1: Proportion of core service* visits by adolescents (<20 years), by geographical region



Proportion of core service* visits by adolescents (<20 years), by geographical region. Data source: MSI financial data system

Figure 2: Number of core service* visits by adolescents (<20 years), by service delivery channel



Number of core service* visits by adolescents (<20 years), by service delivery channel. Data source: MSI financial data system

We also increased the number of adolescent client visits by 73% in 2017 – from 41,000 in January to 71,000 by December. These positive trends continued into 2018, and by March 2018 we had seen over a million visits by clients aged under 20 in the space of just 15 months.



WHAT THIS MEANS

Listening and learning to deliver better

While there’s no quick fix, the combination of adequate resources, visibility of key indicators and organisational buy-in has helped transform our programming. We still have a lot to learn. However, by listening to adolescents, being willing to invest, to take risks and to fail, we have developed programmes that are starting to deliver – supporting these young people to step forward and make choices to define their own future, for themselves, their families and their communities.

*Core services include family planning counselling and provision, safe abortion and post-abortion care services.

Where can I find more information?

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Human-centred design: putting people at the heart of our work

IN BRIEF

The Marie Stopes team in Burkina Faso are trialling a creative approach to get the message across, based on human-centred design.

It's all about building a deep empathy with the people we're aiming to help – and tailoring solutions to their needs.

By immersing ourselves in their lives we're able to move beyond data and demographics and unearth new ways to target those in need of reproductive health services and support real change.

THE CHALLENGE

Giving young rural women a voice

Life for teenage girls in rural areas of Burkina Faso is extremely tough. Marriage at a young age is the norm and there's huge pressure to produce a baby within the first year.

This makes running family planning campaigns tricky. We can't talk to unmarried girls because 'they aren't having sex'. And childless newly-weds HAVE to produce a first child. Sexuality is a taboo topic in Burkina Faso and the country lies at 185 of 188 on the gender inequality index. The result is that most young women find they have no decision-making power when it comes to family planning.

We can talk to them when they've had that first baby – but it's still an extremely hard group to reach. So any discussion on contraception needs to engage the broader community and be framed around the overall wellbeing of the family and household, with a focus on the economic impact, rather than health.

WHAT WE DID

Putting people at the centre of our work

The human-centred design (HCD) initiative was developed in partnership with IDEO.org with funding from the Hewlett Foundation. The team in Burkina Faso were working towards three aims:

- 1 Increase uptake of family planning services by rural, married 15-19 year-olds who already have one child
- 2 Increase family and community acceptance of adolescent sexual and reproductive health
- 3 Increase capacity to use the HCD process in project design and implementation – and share across MSI



Through this we were able to gather better insight into the social and cultural factors that impact family planning decisions

WHAT WE DID

Putting people at the centre of our work

The project began with a desk review and brainstorm and progressed, through a two week design research phase involving the team becoming immersed in the target communities, using individual and group interviews and observations as well as some initial prototyping of intervention ideas.

Using insights from the design research, IDEO.org prepared initial prototypes and an approach for how to test them. During a second visit to target communities the various prototypes were tested in different settings and in various combinations – with several of the more promising ones iterated and tested again.

WHAT DID WE LEARN?

We conducted in-depth, in-context, qualitative interviews and discussions with a range of community members. Through this we were able to gather better insight into the social and cultural factors that impact family planning decisions, including:

1. Children are the ultimate symbol of wealth.
2. Women are property with a depreciating value.
3. A need for change is recognised – as long as it doesn't threaten men's status.

Individual and group interviews



WHAT WE FOUND

“Babies cry inside me. You need to let them out.”

Through our initial research, interviews and testing we were able to identify behavioural ‘archetypes’, which help us see and understand the people we seek to serve beyond simple demographics. By focusing on people’s needs, aspirations and values, behavioural archetypes unveil new, often ignored, user segments.

From all the archetypes identified, we saw the most potential to change behaviour and attitudes if we designed initiatives around these segments:



The Hindered-Female

Some understanding of the benefits of family planning but lacking support



The Novice-Female

Engaged with the benefits and open to family planning use with a husband who is on board



The Conflicted-Male

Positive about the benefits but unsure about next steps



The Silent-Male

Accepting of his wife’s use as long as it stays between them

These four archetypes also highlighted the importance of getting the whole community on board. We wanted to get people talking, empower people – both men and women – to think about their future, and create family planning advocates.



WHAT THIS MEANS

La Famille Idéale

Marie Stopes’ global adolescent engagement strategy has been mostly targeted at young women. To create the change we want to see in Burkina Faso, we need to widen the conversation. Demand for family planning is already bubbling under the surface there. Many young women understand the benefits, but their husbands, the gatekeepers, and the broader community remain barriers to access. Inviting Burkinabe men into the conversation paves the way to greater gender equity.

During 2018 we began live prototyping with a human-centred design initiative: La Famille Idéale. We learned that couples barely talk to each other about sex, and wives often could not articulate the benefits of family planning to their husbands. We made space for conversations at multiple levels—from a game in public forums to a facilitated private dialogue between husband and wife. We brought in a trusted figure, a Community Based Mobiliser (CBM), to moderate these conversations.

In our initial pilots, the strategy worked! Many couples decided to take up services after the conversation. Ongoing monitoring and evaluation of this initiative will show us the longer-term impacts.

La Famille Idéale celebrates the beauty of every Burkinabe family and each couple’s potential to shape their own lives. This human-centred design system paves the way to service uptake.

Where can I find more information?

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Who pays for family planning? Taking a step towards national health insurance coverage

IN BRIEF

Family planning is often forgotten when countries develop their national health insurance systems.

In Ghana, provision was made for “any relevant FP packages” in the 2012 revised National Health Insurance Authority (NHIA) act – but it has never been implemented.

So Marie Stopes Ghana has been running a pilot to demonstrate how it is possible to integrate family planning into the existing National Health Insurance Scheme.

It will run for two years but early results are already shedding light on how best to implement similar approaches in the future.



THE CHALLENGE

Getting family planning in national health insurance

In Ghana the NHIA is working with GHS and private providers to make services available to the whole population, but FP is not included in the package of services on offer and there is no clarity on how to pay providers to make it available.

Marie Stopes International's experience of financing and delivering family planning services has shown that, for effective provision of family planning to happen, those financing services need to take into account the 4 Ps of:

-  People (who is included)
-  Provider (which are financed)
-  Package (is each FP service addressed?)
-  Payment (how are services paid for)

WHAT WE DID

Integrating paid family planning

We are gathering valuable lessons on how to integrate family planning into national insurance schemes to test the effective integration of paid family planning services into the primary health care package.

The pilot aims to demonstrate how best to integrate case-based payments into existing systems, with a particular emphasis on long acting reversible contraceptive (LARC) services.



We are gathering valuable lessons on how to integrate family planning into national insurance schemes



During the development phase we wanted to know:

- 1 Which FP methods should be included in the National Health Insurance package?
- 2 What should be integrated in the case-based reimbursement tariff?
- 3 How do we ensure contraceptive commodity security?
- 4 How do we avoid perverse effects? (e.g. providers leaning towards provision of short term methods for financial gains)
- 5 How do we ensure contraceptive choice for clients?

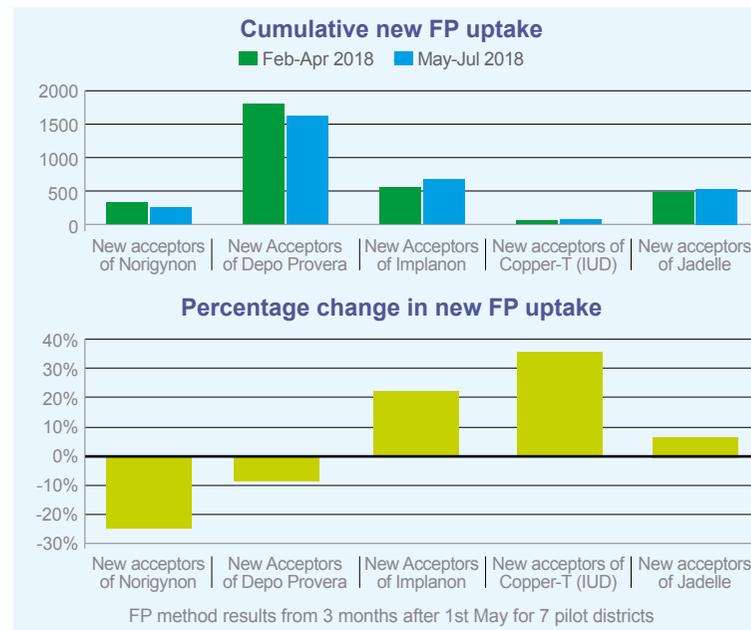
Participating public and private providers are reimbursed through the NHIA payment system for each implant, IUD or injectable service provided – including payment for comprehensive FP counselling and provision of the chosen method.



WHAT WE DID

The early results

Although it is too early to address the overarching questions this pilot attempts to answer, a monitoring team made up of NHIA, GHS, Population Council and MSIG has identified some interesting initial findings. The pilot covered all NHIA accredited service providers and payments are made for all contraceptive methods requiring clinical delivery. Participating public and private providers are reimbursed through the NHIA payment systems for each implant, IUD or injectable service provided. After just three months, we've seen a net positive increase in uptake of long term methods. Clients choosing these more effective methods over short-term methods, which have decreased in the same period.



Although 3 months data is very early days yet to make any conclusive inference, it does point to a shift from short acting methods (Norigynon and Depo Provera) to long-acting reversible contraceptives (LARC) – even though the case-based tariffs for injectables serve as an incentive for providers to learn towards its provision. It further supports our assumption that the removal of out-of-pocket cost will shift FP uptake from cheaper but less effective methods (short acting methods) to expensive but more effective methods (LARCs). However, with some of the challenges in the start up it is too early to draw definite conclusions from this.

WHAT THIS MEANS

Where do we go from here?

The FP pilot experienced some initial operational challenges, but there have been enough positives and gained insights that will help shape a national roll-out.

We have seen that you need to have innovative approaches in order to reach the poor with contraceptive services. In addition to the early results described above we've learned some valuable lessons about the 'how' of doing this type of work, such as:

- **Include contraception from the start** – to successfully integrate family planning into a benefits package, the 'how' of including contraception should be thought through very carefully by applying the 4Ps mentioned above at the design stage.
- **Understand stakeholders' views** – to help anticipate potential stakeholders interests and responses and strategise on whether and how to address them.
- **Be patient** – the complexities of family planning, particularly any cultural barriers, are not always understood so a level of learning should be integrated as part of the pilot to inform the national scale up plan.
- **Be flexible** – key elements of a pilot project may not be fully defined upfront; changes will continue to be made as new information comes in.

This pilot still has some time to run before delivering the answers to the questions it set out to address which, we hope, will help shape the NHIA's decision on formally integrating FP into the NHIS package. In the meantime we hope that lessons learned in Ghana can inform similar decisions that are being made as health insurance packages are developed in countries across the region and beyond.

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Routine poverty measurement: an innovative approach to drive equity

IN BRIEF

Women in extreme poverty are one of the most underserved groups in sexual and reproductive healthcare. But identifying this group and tracking reach is difficult.

Unlike age or marital status, you cannot accurately assess wealth with a tick box. Usually we gather this kind of information through multiple questions in client surveys – but these take time and that limits where and when we can collect data.

So we set out to test an approach using just 1 to 2 questions that could be included in a routine service delivery setting to see if we could get accurate information on poverty on a daily basis.

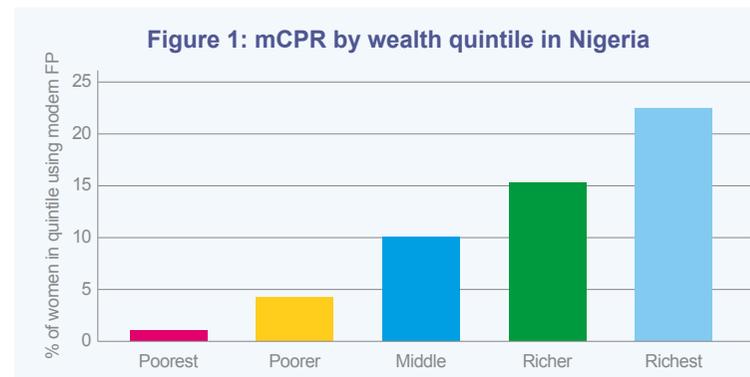
THE CHALLENGE

Getting an accurate picture of clients' wealth

Those with the greatest unmet need for family planning are often the poorest (Figure 1). We need to understand how effective our programmes are in terms of reaching those most in need. And that means getting an accurate view of the wealth of clients and programme recipients in the areas we work.

But the way we've traditionally measured poverty makes it difficult to understand how successfully we're serving the poor. The standard tools to assess poverty are lengthy questionnaires and are therefore only usable in surveys.

So assessing how effective a programme is in reaching those in poverty is typically carried out on a programme-wide level, usually on an annual or less regular basis, and yielding results with wide margins of error.



We've developed a new, easy way to assess poverty on a routine basis. It gives us a reliable measure of relative wealth without putting additional strain on service delivery staff, or the clients themselves.

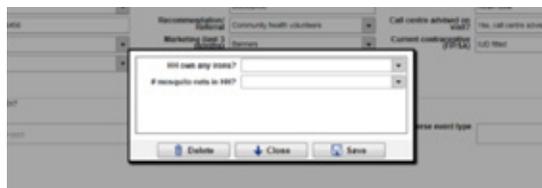
WHAT WE DID

Integrating paid family planning

We wanted to know if a new measurement approach to capturing information on client wealth through routine data collection would be easy to implement and give an accurate assessment of the average wealth of groups of clients for each site where we work. We set up two pilot projects to capture poverty data routinely.

The first, testing in Ghana and Uganda, utilised the single Demographic and Health Survey (DHS) wealth index question most strongly associated with being in the bottom 2 wealth quintiles, but unfortunately proved too weak in predictive power. But the second approach, piloted in Burkina Faso and Kenya, is proving very successful to date. The key innovation with this approach is to use all of the questions of an existing, validated wealth index, but only two per client. Questions come from Scoros' Simple Poverty Scorecard (SPS) and Innovations for Poverty Action's Poverty Probability Index (PPI), and two are used per client to ensure sufficient accuracy even with small client numbers.

These questions are predetermined by MSI's client-level management information system, so staff won't need to keep track of which set of questions to ask each client. Once recorded, registration proceeds as normal. A pop-up with two wealth questions appears when staff save a new client visit record.



Service delivery staff reported that it was easy to implement and – when we prefaced the question with an explanation for why such questions were being asked – acceptability and response rates were high.

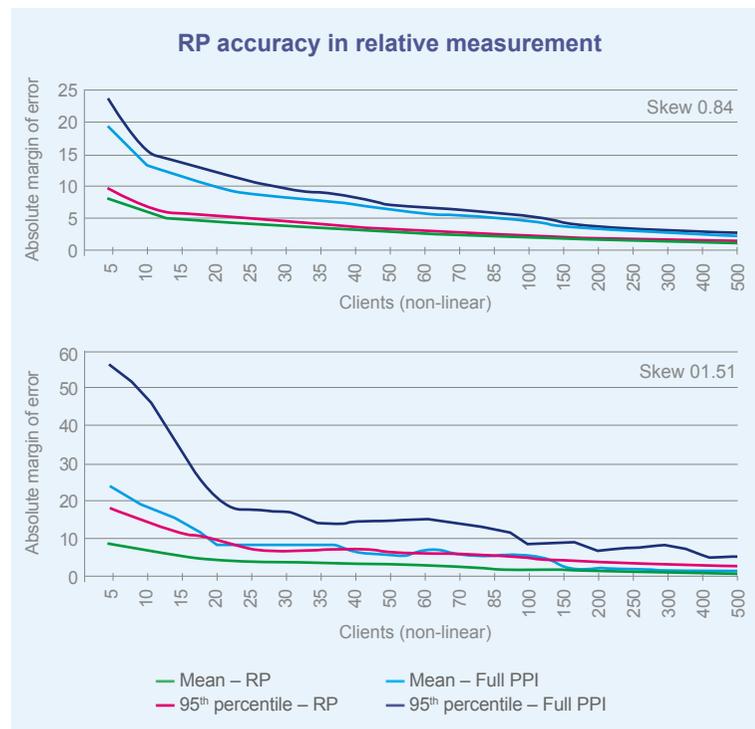
WHAT WE DID

Routine measurement of poverty: a new way to gauge relative wealth

We ran hundreds of thousands of simulations with full data to test for bias and to check the relation of accuracy to respondent numbers. Over the past year, we collected routine poverty data on over 105,000 clients from the two pilot countries and we're using three methods to test how accurate the data was:

- 1** Mathematical simulations using existing population and client data
- 2** Existing geo-spatial data on poverty in catchment areas of each site
- 3** Comparisons against full poverty assessment surveys

When measuring the relative poverty of different sites where we serve our clients, the margin of error was under 10% with 20 respondents and under 5% after 75.



Can we accurately measure absolute poverty?

While no bias was introduced in relative poverty measures, mapping poverty scores to absolute PPI or multidivisional-poverty Index values can potentially result in bias. Further analysis will confirm this possibility

WHAT THIS MEANS

Driving equity and transforming lives

We've developed a new, easy way to assess poverty on a routine basis. It gives us a reliable measure of relative wealth without putting additional strain on service delivery staff, or the clients themselves. And while there's potential for bias when measuring for absolute poverty in populations with extremely high wealth inequity, it's still more accurate than very large surveys in most scenarios.

Routine Measurement of Poverty facilitates the transition from survey to routine assessments of wealth. This methodology can help organisations see the relative wealth of clients in each location they work every day, to help identify the teams or sites that perform better in reaching the poor.

And we can now quickly evaluate the impact of changes in service delivery, demand generation, voucher targeting and other activities on reaching the poorest and most vulnerable in the communities where we work.



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Future Fab: Helping the next generation of Kenyan girls have a fabulous future

IN BRIEF

In Kenya, nearly half of all women have given birth by the age of 20. When girls have children before they're ready, it can drastically reduce their chances of finishing school and achieving their life goals.

Aiming to increase adolescent attendance at its 23 static clinics across the country, Marie Stopes Kenya introduced Future Fab – a new holistic and human-centred approach to raise awareness and align modern contraception with the aspirations of urban, pre-childbearing women under 20. The project had a huge impact, with ten times more visits to clinics by this age group than before.

THE CHALLENGE

Finding a better way to reach teens

Marie Stopes Kenya (MSK) has been providing sexual and reproductive health services across the country since 1985. Taking a holistic approach, Future Fab reached out to adolescents in Kenya with youth-friendly contraception and sexually transmitted infection (STI) services. The programme was built on four key strategies:

- 1 Aspirational design – demand generation campaigns and messaging to link contraceptive use to girls' aspirations and dreams
- 2 Community buy-in – involving parents, community leaders and county governments
- 3 Discreet, friendly and convenient services – with free, specialised teen services both in clinic and at pop up events
- 4 Interpersonal mobilisation – through a broad support network of community-based mobilisers, such as Future Fab Ambassadors and Diva Connectors

WHAT WE DID

Evolving our approach as we learned

Future Fab evolved into two phases. The initial implementation phase focused on engaging girls through large scale events, and smaller sensitisation meet-up events with young people and their parents – aiming to 'activate' and 'engage' the target audience.

This was refined in phase 2 ("refinement") with the balance shifting from teen and parent meet-ups to pop-up outreach service delivery to 'deliver' and make the most of the awareness generated in phase 1. This evolution was part of a commitment to make sure the Future Fab model was responsive, cost-effective and sustainable.



Future Fab led to a ten-fold increase in adolescent visits at Marie Stopes clinics

Demand generation process

1. Activate

Build excitement and acceptance in the community



Community dialogues



Future fab events

2. Engage

Educate about sexual health and contraception choices



Parent meet ups



Teen meet ups

3. Deliver

Provide access to safe and friendly services for young people



The diva experience



The diva space

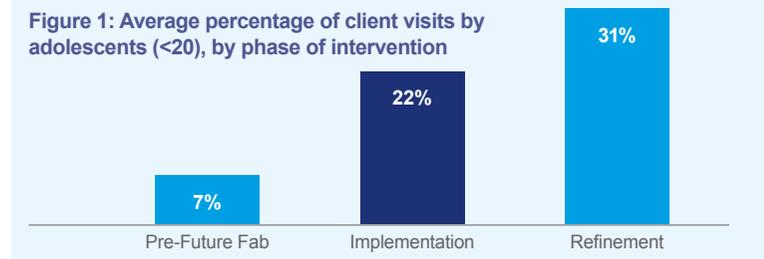
Demand generation process of Future Fab. The implementation phase focused on Activate and Engage and refinement phase focused on Deliver.

WHAT WE FOUND

Effective targeting boosts results

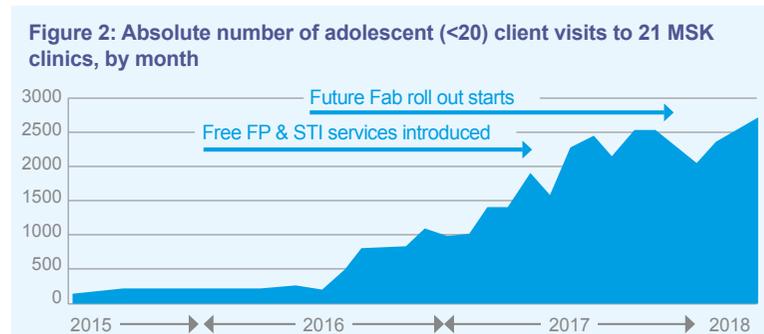
Future Fab had a huge impact on adolescent contraceptive uptake, particularly use of contraceptive implants. Each clinic saw a step-change in the number of adolescents attending right from the start.

In fact, there were ten times as many visits on average to each clinic per week, rising from about 2.5 before the project started to 26 during the refinement phase. At the same time the proportion of client visits by adolescents more than quadrupled between the pre-Future Fab period and the refinement phase (Figure 1), suggesting effective targeting of the adolescent age group.



Average percentage of FP/STI client visits by adolescents (<20) in 21 MSK clinics with data, by intervention phase. Data source: MSI electronic client record system (CLIC)

In total, from the start of Future Fab to end of March 2018, MSK saw around 35,000 client visits by clients under 20 across the 21 clinics that could provide data. And over three-quarters of adolescent clients had had some contact with either a Future Fab event or a Future Fab mobiliser.



Absolute number of adolescent (<20) client visits to 21 MSK clinics with data, by month. Data source: MSI electronic client record system (CLIC)



Large scale Future Fab event aiming to 'activate' the brand and the discussion.

A smaller 'teen meet up' aiming to 'engage' the target audience and continue the discussion.

'Pop up' discrete outreach services by MSK clinic staff, aiming to 'deliver' services on girls' terms.

Photo credits: IDEO.org



WHAT THIS MEANS

"I own my own future!"

It's clear from Figure 2 that making family planning and STI services free at MSK clinics at the start of 2016 was not enough – it was only when the full demand generation intervention began in mid-2016 that adolescent numbers started to increase. Future Fab involved a big investment at the start, but the cost per CYP came down dramatically over time, as the project was refined.

Future Fab had most success with urban, unmarried, pre-childbearing adolescent women. This is a difficult group to reach in Kenya and they face enormous stigma in accessing sexual and reproductive health services. But reaching this group has a massive long-term impact – preventing teenage pregnancy frees girls to finish school, take on careers and improve their chances of reaching their life goals.

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Increasing access to modern contraception: could task-sharing be a cost-effective solution to health worker shortages?

IN BRIEF

Nigeria has one of the fastest growing populations in the world. Low uptake of contraception plays a big part in this, particularly in rural areas. The government aims to scale up access to modern contraceptives to reach a target of 27% by 2020.

One of the biggest barriers to increasing uptake is the shortage of trained providers, in particular in Nigeria's northern states.

But task-sharing the provision of long-acting reversible contraceptives with community health extension workers (CHEWs) could provide a cost-effective way to rapidly reach more people with highly effective methods.

THE CHALLENGE

Getting the right people with the right skills in the right place

When it comes to tackling Nigeria's unmet need for contraception, one of the most important shortages is of trained providers, particularly in rural areas where coverage is the lowest. In Nigeria's northern states, many communities lack providers equipped and trained to deliver a full basket of contraceptives, in particular those who can provide the long-acting and reversible implants and IUDs.

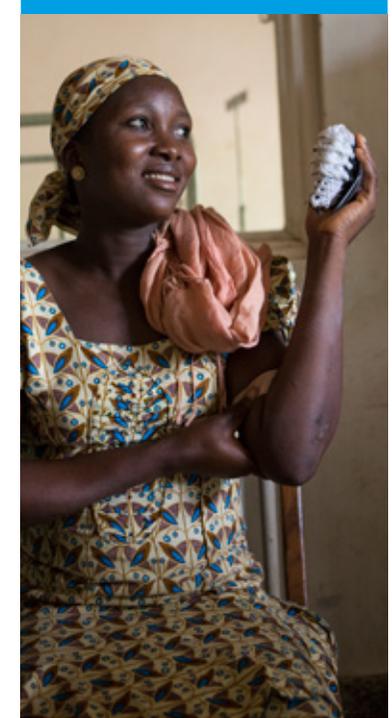
Community health extension workers (CHEWs) are a potential cadre to which to task-share contraceptive implant provision, which traditionally have been provided by nurses or midwives.

But while the benefits of task-sharing are becoming more apparent, concerns on the cost of training and scaling such interventions can hinder ongoing commitment in this area.

Who are Nigeria's CHEWs?

Community Health Extension Workers have three years' training and usually work alone in primary health posts, or support nurses and midwives in larger urban clinics.

They outnumber nurses by 3:1 and are required to spend 30% of their time away from the clinic in the community. From 2017 all newly qualified CHEWs get pre-service training on the insertion and removal of implants and IUDs.



Community Health Extension Workers have three years' training and usually work alone in primary health posts, or support nurses and midwives in larger urban clinics.

WHAT WE DID

Modelling the impacts of training CHEWs to deliver implants

We looked at the potential efficiency gains associated with CHEWs taking on contraceptive implant provision in Nigeria. We were able to build up an accurate picture by working through the results of a recent task-sharing study supported by Marie Stopes International Organisation Nigeria (MSION) which provided training and supervision and demonstrated the feasibility of public sector CHEWs – in terms of safety, quality and client satisfaction – to provide contraceptive implants.

	Cost of training	Number of women served with implants
1 CHEW	\$650	1500
3000 CHEWs*	\$1.9m	4.5m

*Note: 3'000 is the additional number of CHEWs that need to be trained to get to 10% of total CHEWs capable of providing FP by 2020. Estimates assume that a working life of a current CHEW is an average 15 years and each year they provide 100 implants

Based on this, we could estimate the number of implant services each CHEW delivers every month. We then looked at the cost of training and supervising a CHEW until they are fully competent. Using government records and MSI's Impact 2 model, we estimated the health impacts of training 10% of Nigeria's eligible CHEWs to provide implants. We assumed that:

- 1 CHEWs deliver 8 implants a month (as shown in our clinical study)
- 2 Each trained CHEW works for a 15 year career
- 3 CHEWs deliver services to only those with unmet need for family planning (i.e. not currently using a method but not intending to get pregnant within two years)

We used population projections and data on current unmet need for family planning to estimate the impact the resulting increase in service delivery would have in reducing unmet need.

WHAT WE FOUND

The cost, benefits and impact of training

As of January 2018, 2.8% of all Nigeria's CHEWs were trained to provide long acting reversible contraception methods. If 10% of CHEWs are trained by 2020, we estimate that 14% of Nigeria's total unmet need for family planning could potentially be met. Given that 65% of CHEW implant clients in our study were family planning (FP) adopters, the contribution to Nigeria's overall modern contraceptive prevalence rate would be even more significant.

In-service training to CHEW to provide and remove implants costs \$650 per CHEW. This could enable each CHEW to serve at least 1,500 women with implants over 15 years of their working life – so about training costs of \$0.40 per women reached with an implant service.

The impact would be particularly strong in under-served areas where barriers to access are greater. CHEWs represent about 80% of rural healthcare providers.

<p>If 3,000 CHEWs are trained and each provides 1,500 implant services over 15 years, targeting only women with unmet need, this would result in:</p>		<p>4.5m women would be provided with an implant</p>
<p>14% of total unmet need would be met</p>	<p>4.8m unintended pregnancies would be averted</p>	<p>23,000 maternal deaths would be averted</p>
<p>1.7m fewer abortions</p>	<p>The potential cost savings to families and the health care system would be at least \$175 million over 15 years.</p>	<p>Source: Impact 2 (v4), Marie Stopes International, 2016, www.mariestopes.org/what-we-do/our-approach/our-technical-expertise/impact-2/</p>

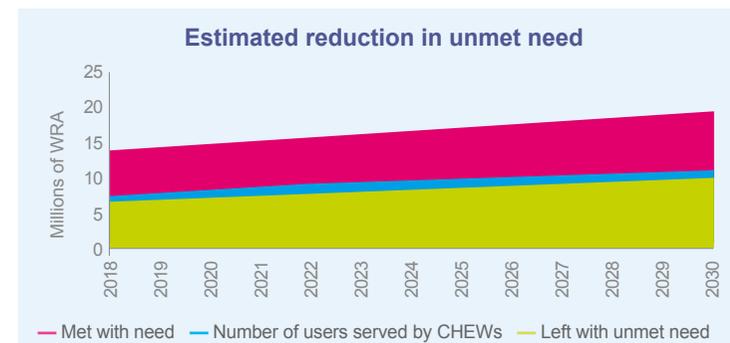
WHAT THIS MEANS

A cost-effective way to tackle unmet need

With CHEW salaries currently about 80% of those of nurses and midwives, investment in this cadre could be a very cost-effective approach. Task-sharing can help increase access to services, improve equity of provision and sustain quality of service. It would also free up time for nurses, midwives and doctors to concentrate on other health services.

In fact, a nurse could have an additional 300 minutes each month to focus on other service delivery needs if implant provision is fully done by CHEWs. With an investment in the next few years towards training currently active CHEWs as well as new cohorts of CHEWs currently in schools, Nigeria can make significant strides in increasing mCPR.

Indicator	2018	2019	2020
Number of CHEWs	43,000	43,000	43,000
Proportion of CHEWs trained and providing implants	5%	7%	10%
Implants provided per year per CHEW	100	100	100
Total implants provided	215,000	301,000	430,000



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Judging the nudge: applying behavioural economics to promote post-abortion family planning in Nepal

IN BRIEF

Studies show that half of all pregnancies in Nepal are unintended, and almost half of these are with women using some sort of contraception. Women attending Marie Stopes clinics in the country say they want to delay their next pregnancy but contraception take-up rates post-abortion have remained low.

We wanted to see if we could boost the uptake of more reliable, longer-acting reversible contraception methods among this client group. So we collaborated with *ideas42* to help develop an intervention based on behavioural economics, which focuses on understanding why people choose and act as they do – and then designing small ‘nudges’ to effect change.

By the end of the trial period, overall LARC uptake increased from 23% to 30%, mostly reflecting a shift away from short-term methods.

THE CHALLENGE

Changing attitudes to contraception

Sunaulo Parivar Nepal, an implementing partner of Marie Stopes International, provides about 40,000 safe abortions each year, with 36 clinics across the country.

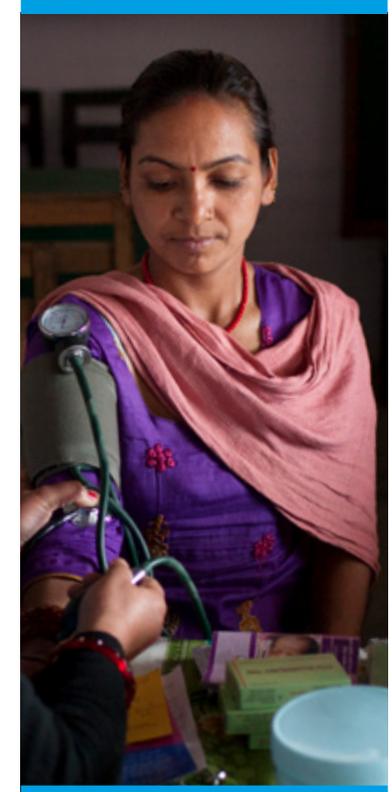
Over half of the women attending clinics for abortions say they want to delay their next pregnancy by at least two years. Long-acting reversible contraceptive (LARC) methods, such as IUDs and implants, are widely available, relatively cheap and close to 100% effective. But uptake is low. As of July 2016 only one in four safe abortion clients took up a LARC. We wanted to know why – and see if we could change this behaviour in the context of a service offering fully informed choice.

WHAT WE DID

From observation to action

Findings from our initial interviews and observations revealed that providers did not consistently counsel women on LARCs after abortion, missing opportunities to increase uptake. Evidence from other areas suggests campaigns around awareness and client-centred counselling can help boost LARC uptake rates.

Focusing on provider-side behaviour, we designed and evaluated the effectiveness of a clinic peer-performance comparison through a step-wedged cluster randomised controlled trial. This involved sending monthly posters to each clinic highlighting LARC uptake rates and how well they were doing compared to similar clinics.



Behavioural interventions like this offer a low-tech and cost-effective solution to programmes



WHAT WE DID Finding the right blend

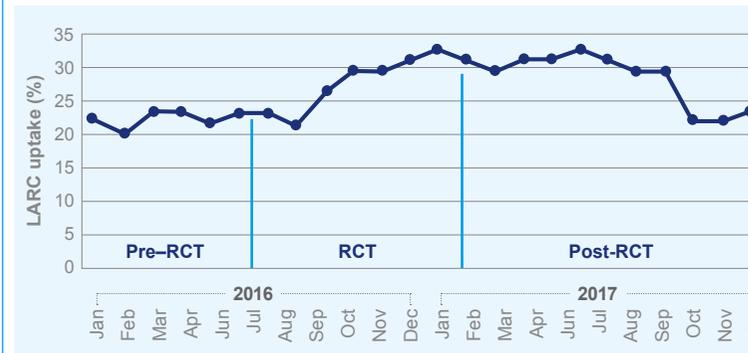
As part of the study design, all 36 clinics were assigned to one of four randomisation clusters, with nine clinics in each cluster. After two months with all clinics in the control group, one cluster at a time was randomised to begin receiving the posters in each subsequent month.

Depending on the current clinic status, the posters would suggest ways to improve or commend high-performing centres. We monitored performance using MSI's routine service statistics.



WHAT WE FOUND Improving LARC uptake

By the end of the trial period, after taking into account differences in clients (age, type of abortion, urban/rural) and the usual time trends occurring in the clinics, overall LARC uptake among abortion and post-abortion clients increased from 22.6% to 29.6%, with the change reflecting a move from short-term methods, which declined during the study. There was also no evidence that the intervention crowded out other services. Our study was one of few randomised control trials aiming to increase contraceptive uptake among post-abortion women.



Results

- Baseline LARC uptake was 23% (vs 53% short-term)
- After adjustment, the intervention increased LARC uptake by 7%
- This change occurred by switching from short-acting to long-acting methods (short-term use decreased by 6%)
- Improvements occurred in all types of clinics but was highest in 'high' clinics (8.7% vs 5.3% in 'lowest')
- Improvements started one month before poster roll-out, suggesting training also had a motivating effect.



Note: Cluster 1 began receiving posters September 1, cluster 2 began October 1, cluster 3 began November 1, and cluster 4 began December 1.



WHAT THIS MEANS Changing attitudes on both sides

We were keen to see how staff responded, as seeing your performance publicised as "low" may have been demotivating, while being "highest" could trigger complacency. But the results show a similar uptake increase across all clinics at different levels – and post-campaign interviews suggest the posters helped service providers change their behaviour and focus on post-abortion family planning.

Despite the study coming to an end, the clinics are continuing to generate and use the posters. Behavioural interventions like this offer a low-tech and cost-effective solution to programmes. So it's encouraging to see it being embraced internally and scaled up across the entire network of SPN clinics in Nepal.

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Changing attitudes to modern contraception in rural Pakistan: Three-step participation programme gets the message across

IN BRIEF

Despite universal awareness and decades of investment to promote family planning, only 25 per cent of women in Pakistan use modern contraception methods.

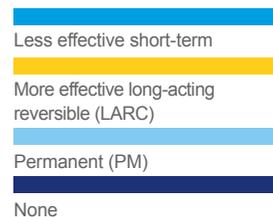
So a new Marie Stopes Society (MSS) project set out to combat some of the main barriers to adoption – from concerns about side effects to low perceived agency among women – and test whether a more active participatory approach could be more effective in changing people’s behaviour than a traditional “information giving” programme.

THE CHALLENGE

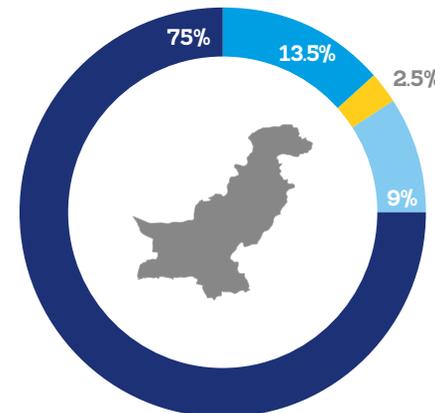
How do you change people’s attitudes?

Changing people’s beliefs, attitudes and behaviour is difficult. Cultural and religious values as well as socio-economic factors need to be considered. As part of an initiative to increase low rates of adoption of more effective long-acting reversible contraception (LARC) in rural Pakistan, Marie Stopes Society developed a behavioural change programme with a communications strategy built on principles of participation and reflection, called IRADA – Improving Reproductive Health Through Awareness, Decision and Action.

Informed by Islamic scholarship and jurisprudence, IRADA, an Urdu word which means Intention, was developed to support MSS delivery functions in Pakistan. By addressing the psycho-social determinants which influence women’s family planning decision-making, IRADA is aimed at enabling women to identify and seek to reduce the contextual and demand-side obstacles to care which occur at all levels of society. Specifically, IRADA is aimed at reducing concerns about side-effects, increasing perceived utility of modern contraception, and increasing women’s perceived agency to navigate various societal barriers to adoption of modern contraception.



Contraceptive method mix in Pakistan



The participatory approaches we used engaged women and encouraged them to critically analyse their lives

WHAT WE DID

A three-step programme: from advice to action

The programme was set up across six districts of Punjab and focused on women aged 15-49 who hadn't used family planning for at least three months before the trial. It had three steps:

<p>Mohalla (neighbourhood) meetings with field health educators (FHEs)</p> <p>To encourage women to reflect on their own lives and choices</p> <p style="font-size: 2em; font-weight: bold; text-align: right;">1</p>	<p>Mashvara (advice) meetings with providers</p> <p>To address concerns about side-effects, dispel myths and increase familiarity and comfort</p> <p style="font-size: 2em; font-weight: bold; text-align: right;">2</p>	<p>Door-to-door client visits by the FHE</p> <p>To help women take control, promote critical thought and allay normative pressures from husbands and mothers-in-law.</p> <p style="font-size: 2em; font-weight: bold; text-align: right;">3</p>
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Changing behaviour: the personal approach

Steps one and two involved FHE-led interactive workshops with small groups of 15-20 women. The activities included photo discussions to promote self-reflection on critical life-choices, using a timeline to help women understand their life-course and daily routines; drawing body maps to understand their own bodies and role of contraception; and social maps to identify environmental barriers to women's mobility.



The women were encouraged to share their own experiences and questions and to take part in activities to explore the impact of childbirth and birth control on the overall quality of life and family well-being.



WHAT WE FOUND

A positive result: the dose effect

We used a pre- and post-test quasi-experimental design to evaluate the IRADA intervention. We conducted a baseline survey in January 2016 and an endline survey after three months, at the end of it. We recruited women who had not recently been using family planning into the study.

The results showed that the more a woman is exposed to behaviour change activities, the more likely she will be to adopt a modern family planning method. They also revealed that a more engaging, participatory workshop approach worked better than the traditional, lecture-based programmes.

Compared to women not exposed to any behavioural change activity, those exposed to the programme were:

- **3 times more** likely to adopt modern family planning if they attended a Mohalla or Mashvara meeting
- **5 times more** likely if they attended a neighbourhood meeting and an advice meeting
- **10 times more** likely if they attended both meetings and received a client visit.

One of the key differences was that women on the participatory programme were much more likely to opt for more effective, longer-acting reversible methods than those in the traditional programme.

Of all the women who adopted LARCs in the study, 70% were women exposed to the IRADA approach, while 30% were exposed to a traditional approach.

1 Dose:
Mohalla or
Mashvara
meeting:

IRADA's participatory approach: **5x** more likely to adopt modern FP than unexposed

MSS traditional approach: **2x** more likely to adopt modern FP than unexposed but this effect was not statistically significant*

2 Doses:
Mohalla and
Mashvara
meeting:

IRADA's participatory approach: **9x** more likely to adopt modern FP than unexposed

MSS traditional approach: **4x** more likely to adopt modern FP than unexposed

3 Doses:
Mohalla and
Mashvara
meeting and
Client visit:

IRADA's participatory approach: **12x** more likely to adopt modern FP than unexposed

MSS traditional approach: **11x** more likely to adopt modern FP than unexposed

The participatory approaches we used engaged women and encouraged them to critically analyse their lives, allowing a deeper understanding of how these less-known methods could help them achieve their fertility goals. Our findings also confirm that behaviour change processes are improved by repeat doses of communication and engagement, which yield exponentially higher impacts than a single intervention.

*Results were statistically significant at p<.05

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Reframing the conversation and removing barriers: what makes a promotional campaign on contraception a success with urban youth?

IN BRIEF

Sierra Leone has a young population, with nearly a quarter of the population aged between 10 and 19, and a high adolescent birth rate.

Over the last two years, Marie Stopes Sierra Leone (MSSL) has coordinated a series of successful campaigns to promote contraceptive use by youth in their static urban clinics.

The results show a big rise in contraceptive uptake at clinics among the adolescent age group during promotional campaigns. Due to this approach in clinics, combined with MSSL's strong adolescent focus in their outreach channel, Sierra Leone was the highest performing country for reaching adolescents in the global MSI partnership in 2017 (see Figure 2). So could this approach help other countries target adolescent girls more effectively?

THE CHALLENGE

Reaching those in most need

Teenage pregnancy rates in Sierra Leone are high – and soared during and after the Ebola outbreak of 2014-15. MSSL is well-established as a leading contraceptive provider, with nine clinics, 10 mobile outreach teams and around 100 community based mobilisers across the country.

While the clinics usually charge fees for services, prices are kept as affordable as possible and women who can't pay the full price are not turned away. Nevertheless, we know that many adolescents do not have access to disposable income and that fees, however small, can be a deterrent.

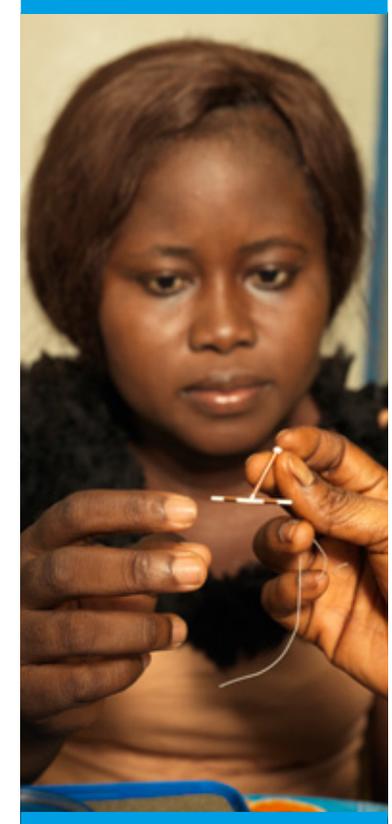
WHAT WE DID

Tailoring messages to different groups

In response to the rise in teenage pregnancies after the Ebola outbreak, MSSL developed a youth strategy that segmented adolescents into different user profiles – helping to tailor messaging according to their distinct needs.

One of the key target segments was the “Education Queen”: girls who attend and aspire to finish school. It's this group that have responded best to the promotional campaigns in urban clinics, as the campaigns frame contraception as a means to delay first pregnancy and stay in school.

Promotional months include free contraception services for all clients on the back of significant marketing and demand generation activities, including radio discussions, social media blasts, news conferences, talks held in slum communities, health talks in schools and colleges, interpersonal sensitisation by their community based mobilisers, and working with youth, community- and faith-based organisations.



**Over 90% of
adolescents
attending during
promotion
months were
students**

WHAT WE FOUND

The benefits of a tailored campaign

Tracking our client numbers through MSI’s electronic information system (CLIC) we found that while promotion months increased access to family planning for all age clients, they had the most impact on adolescent clients.

Between June 2016 and June 2018, MSSL ran a total of six month-long promotion campaigns. Analysing the trends at each clinic using interrupted time series modelling, we saw that adults attended at a 40% higher rate during promotion months compared to their rate of attendance during non-promotion months on average, but adolescents attended at almost double their normal rate.

This translated into a significantly higher proportion of adolescents during promotion months compared to non-promotion months (see Figure 1). Over 90% of adolescents attending during promotion months were students.

Proportionately more adolescent clients at clinics were recommended to attend by an MSI community-based mobiliser (community health promoter) or clinic staff member (at, for example, a school talk) during promotion months, highlighting the importance of interpersonal engagement.

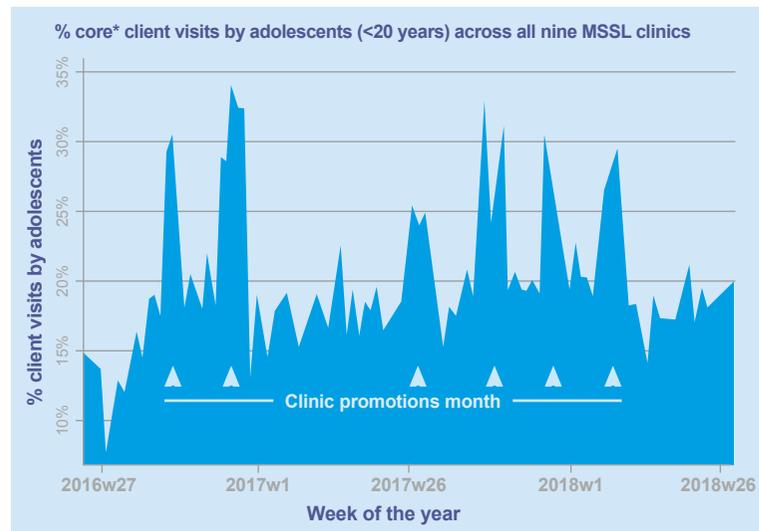


Figure 1. Percentage of core* client visits by adolescents (<20 years) across all nine MSSL clinics. Data source: MSI Client Information Centre (CLIC) electronic data system

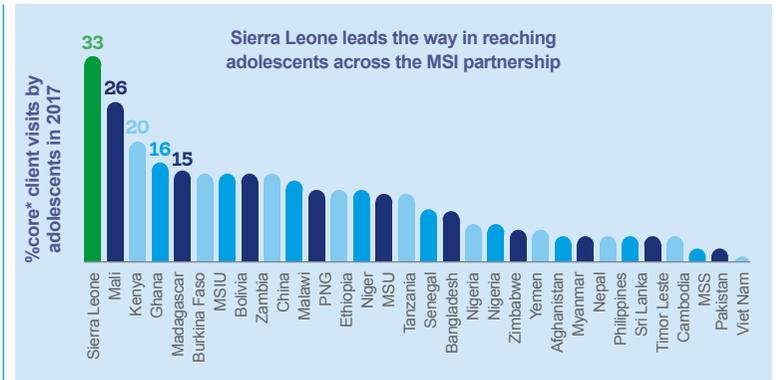


Figure 2. Sierra Leone leads the way in reaching adolescents across the MSI partnership in 2017. Data Source: MSI financial data system

WHAT THIS MEANS

The impact of free provision and tailored messaging

The results show that the combination of free contraceptive provision and adolescent-tailored demand generation is an effective way to reach adolescents. Messaging that resonated with the aspirations of a particular adolescent segment, in this case messaging around using contraception to stay in school and achieve academic potential targeting the values of the urban ‘Education Queens’, was particularly effective.

The involvement of MSSL’s clinic staff in demand generation and the ongoing strong partnerships of their community-based mobilisers with local communities, schools, colleges and youth, community- and faith-based organisations were also key factors in the success of the campaigns.

*Core client visits includes visits for family planning counselling and provision and post-abortion care

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The journey to self-injection: what works and what challenges lie ahead?

IN BRIEF

Sayana Press is a new injectable contraceptive method which lends itself well to self-use because of its unique design. But how willing and able are health providers and women to take this on? Feedback from clients and providers following the introduction of the product in Madagascar found some reluctant to support it being offered for self-use.

A Marie Stopes International study in three Sahel countries (Burkina Faso, Niger and Senegal) further explored the benefits of – and barriers to – expanding the offer of self-injection.

The findings from both show that education, training and support will be vital if this method is to become a viable option for women in these countries and beyond.

THE CHALLENGE

Pilot in Madagascar: some important barriers exposed

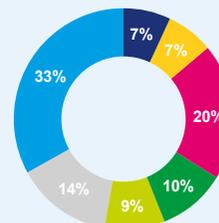
Marie Stopes Madagascar (MSM) received funding from the Children's Investment Fund Foundation (CIFF) to introduce provider-administered Sayana Press as a family planning option in 2017. It was made available in 22 regions, with training provided to 1,200 health providers. At the end of the introduction phase in September 2017, we conducted a survey among 514 women and 87 providers to understand experiences of the product and gauge reactions to the option to offer Sayana Press for self-injection.

Clients in the study were relatively young (40% were under 24 years old). Although almost half (48%) reported some side-effects, the vast majority (98%) were either satisfied or very satisfied with their experience of Sayana Press. Nearly all providers (98%) said they were confident administering Sayana and that it was easy to use. Given all this, it was surprising to find that 80% of clients (411) and 81% of providers (70) were not favourable towards the possibility of offering Sayana Press for self-injection.

Among clients the reasons for opposing it were related to a lack of confidence (including fear of the procedure, potential pain and complications) and the feeling that a trained health provider should carry out injections. Providers raised concerns about clients' competency and their missing follow-up health checks.

Provider reasons for opposing self-injection

- Client competency
- Clients missing follow-up health checks
- Waste management standards
- Risk related to storage
- Concerns about losing clientele
- Injection by trained health provider only
- Other



Data from provider survey in Madagascar, 2017, among the 70 (81%) opposing self-injection"

It was also felt that training could be challenging, particularly for low literacy clients, to ensure infection prevention and appropriate waste management. Providers were also concerned about losing clientele.



“Yes, I prefer to inject at home, at the hospital you lose all day queuing, I often finish around 4pm. If you can do it at home, you can easily do it alongside your activities without pressure.”

Female client, Burkina Faso



“Among ourselves, health providers, there are some who have not mastered the injection of Sayana Press, they make mistakes, first we need to be well trained, so that we can explain to women when they come for (self) injection”

Health provider, Burkina Faso

WHAT WE DID

Study in the Sahel: a positive reaction to self-injection

With funding from the Bill and Melinda Gates Foundation, we set out to assess the market for a self-injection product, with a qualitative study of potential users, family planning decision-makers and private sector providers in Burkina Faso, Niger and Senegal.

We chose up to seven sites in each country, a mix of rural and urban, and worked with local contacts to recruit participants. We then conducted in-depth interviews with 141 women of reproductive age and 18 focus groups with husbands and older female family members, as well as in-depth interviews with 13 key informants and 36 health care professionals.

Generally, people reacted positively to the idea. It was clear that self-injection could help:

- save women time and money by not having to travel to a health centre
- provide discretion by injecting at home
- empower women to take control (notably this was not felt to be the case in Niger)
- free up time for health providers to do other tasks

There were also some specific advantages for having a discrete, time-saving option available for some women, including key target groups such as adolescent girls and those with poorer access to health services.

Self-injection is clearly an appealing option, but the study also revealed a number of hurdles before it can be widely introduced. Some potential users and providers were unsure women would be able to fully master some aspects of self-injection – such as knowing how and where to administer the injection. There were also concerns about storage and disposal of syringes and the training and support required to make sure women could do it safely at home. Providers pointed out that some among them have not fully mastered the administration of Sayana Press and there was a perception that training women may need costly, extended support.

Overall, the current level of understanding of the product was varied – some prior experience with Sayana Press and exposure to the self-injection of other medical treatments influenced how positively women, and particularly providers, felt about the potential to offer Sayana for self-use.

WHAT THIS MEANS

Where do we go from here?

While the levels of overall support for the introduction of the option for women to self-inject Sayana Press varied across the two studies, both raised similar considerations in terms of the types of support that both providers and women will need to ensure a successful roll-out of self-injection.

In the Sahel, the general support for this option but lower awareness and existing use of the product means we're aiming to increase overall use of the method, especially among youth, and find opportunities to promote acceptance of self-injection. In Madagascar, more preparatory work is advisable to ensure women can reap the benefits of this option. This may require greater investment in education, sensitisation and training.

It's clear that the successful introduction of self-injection relies on systems being in place that enable providers to effectively train women to confidently and safely administer the product. Small-scale operational pilots in Burkina Faso, Madagascar and Niger, starting 2018, will offer valuable insight into how this can be best implemented in Marie Stopes' service delivery.



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