Clinical Quality Report 2025

INNOVATIONS IN CARE

SUPPORTING COMMUNITIES WITH QUALITY CHOICES

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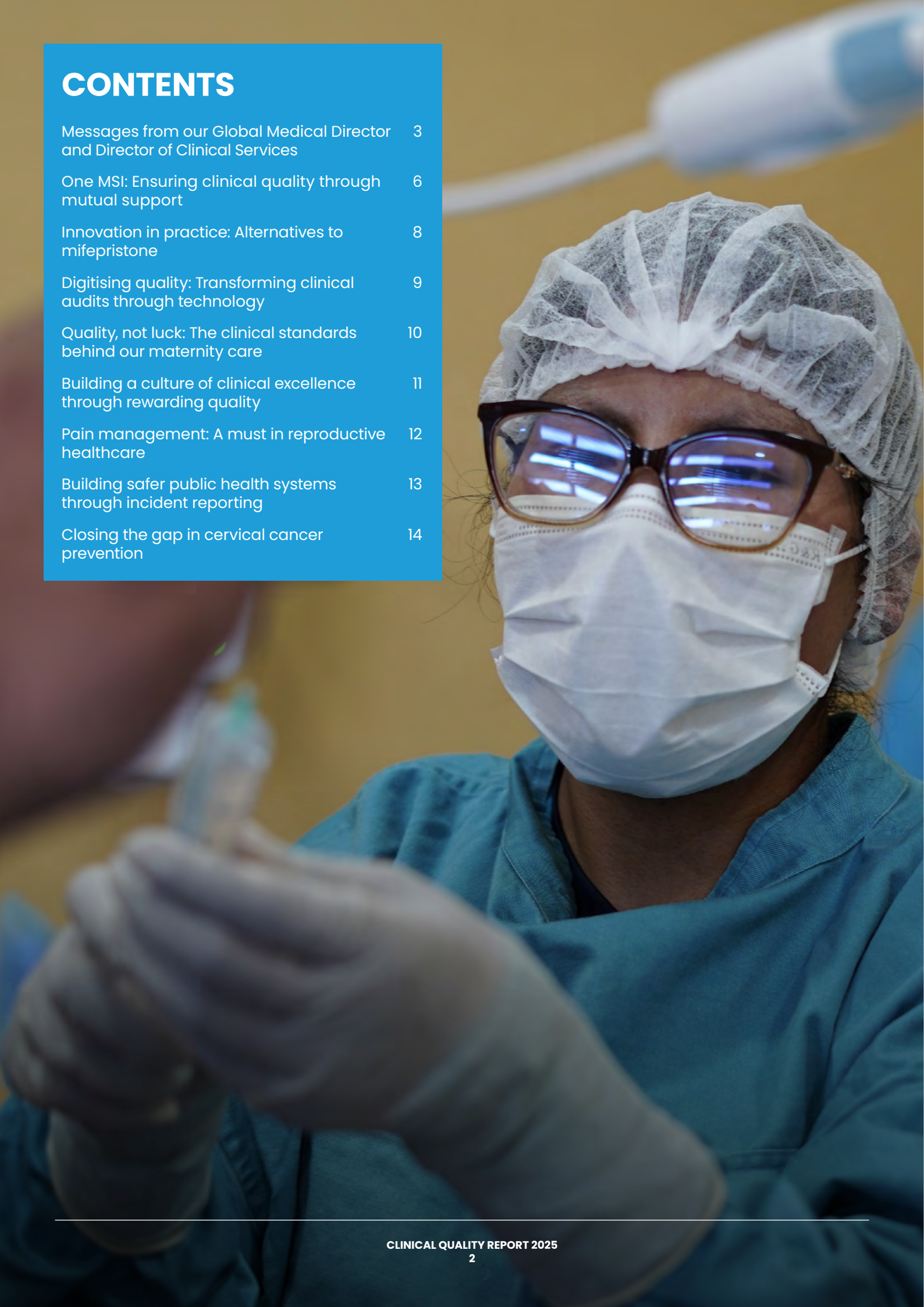


Message **from our Global Medical Director**

When it comes to clinical governance and client safety, innovation is not always found in shiny new technology or groundbreaking discoveries. More often it's the quiet discipline of noticing where harm might enter and closing that door.

It's the courage to ask not only what medicine can do, but what sort of care our clients are experiencing. Whether they're in the procedure room, counselling, or waiting for results, is their care safe, tailored, respectful, and compassionate?

In this report, you'll learn how MSI is moving beyond the familiar limits of healthcare to build systems and standards that would be respected anywhere in the world. In our work, digital quality audits, rigorous competency assessments, external reviews, pharmaceutical quality assurance, peer assessments, no-blame incident management, and targeted reinvestment in excellence are not abstract concepts. They are continuously embedding quality at every stage of a service, ensuring it's never left to chance.

Every woman should be able to give birth knowing she will be listened to, treated with dignity and supported to make choices about her care. That's why we invest in obstetric emergency training, simulations and audits alongside the clinical standards that ensure safe, respectful care. Sometimes the most important intervention is a skilled person that can act decisively and provide a calm explanation of what is happening and what to expect.

The same principle applies to pain management. Pain can leave a lasting memory, and so can the way it is managed. By strengthening pain relief practices, including the use of analgesia and paracervical blocks, for example in Nepal and Ethiopia, we are helping prevent and relieve unnecessary pain. Every woman's comfort, dignity and experience matters. Better pain relief is not just better medicine but is also an act of respect.

Our cervical cancer prevention work carries forward the same spirit. It is not acceptable for preventable cancer to end lives. Moving from less effective approaches to HPV vaccination, HPV DNA testing and timely treatment, means we're placing modern prevention within reach of women who may otherwise have been excluded.

I am equally proud of our less visible innovations: the digitisation of audit tools so we can improve services faster; the strengthening of incident reporting and learning in the public health system; and our 'one MSI' model that shares expertise across borders through standardised external clinical quality audits, training and peer learning.

In many places, an incident report is still feared, but at MSI we are trying to make it a doorway to accountability. Nearly one fifth of critical incidents reported to MSI last year came from supported government facilities. This suggests that partners increasingly see reporting not as blame, but as a way to protect the next client.

Our clinical teams are often unseen. They check, teach, review, test, travel, listen and improve. Their outputs are captured in numbers, but the true impact is a client who feels less afraid, a provider who is better prepared, and a life-threatening complication that is recognised and managed in time.

I am proud that MSI continues to keep the promise at the heart of healthcare: when someone comes to us, we will be ready and we will care.

Dr Dhammika Perera
Global Medical Director

"I am proud that MSI continues to keep the promise at the heart of healthcare: when someone comes to us, we will be ready and we will care."

A message from our Director of Clinical Services

Recently during a visit to MSI's programme in Bolivia, I sat in on a counselling consultation where a client was discussing her contraceptive options. She appeared comfortable. Nothing in her words suggested concern. But there were subtle signs of unease, and the MSI provider was paying close attention.

The provider paused and gently asked whether something no longer felt right. The client seemed surprised. When asked, she explained that she was worried about the pain associated with some of the methods being discussed.

That moment opened the door to a new conversation – certain procedures were explained in more detail, and together they reviewed the options available to prevent and manage her pain. At no stage did the provider say: "Don't worry, you won't feel pain." She did not dismiss her fear, nor lie, but support.

This encounter reflects something I believe with my whole heart: that good healthcare starts with creating the conditions for a woman to express what matters to her and then listening. Listening so that we understand what matters to the person in front of us, and can then provide the information, care and choices that allow women to make informed decisions.

I recognise that this is not always a woman's experience. I have felt frustration myself and heard similar versions from many women. Different countries, different cultures, different health systems, but often a similar experience of being talked at rather than listened to.

For centuries, our symptoms, pain and experiences have been minimised, normalised or brushed aside. "It's simply part of being a woman!" we've been told. When I trained as an obstetrician and gynaecologist, I was taught that women did not feel pain in the cervix so didn't need specific pain management. I beg to differ.

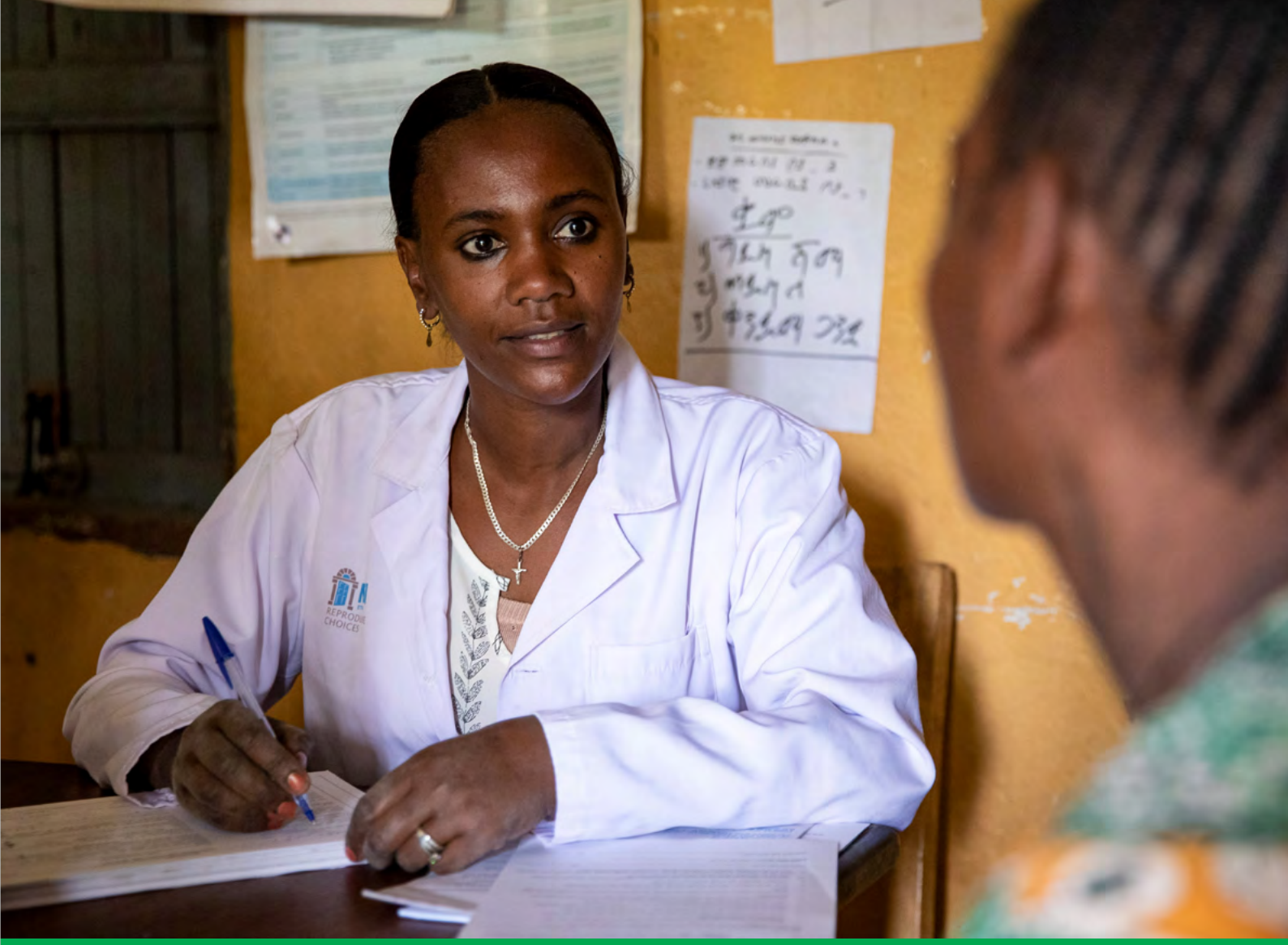
Fortunately, medicine evolves, although not quickly enough. Many of the changes we're now seeing didn't start because healthcare professionals suddenly recognised a problem. Women kept insisting that something was wrong, advocating for themselves. And those voices did not come from one country, one culture or one socio-economic group. Women in rural communities, city hospitals, social movements and advocacy groups across the globe were raising these concerns long before they appeared in clinical guidelines or research agendas.

A powerful example is respectful maternity care. For too long women across the world have been describing experiences of neglect, humiliation, procedures performed without consent, and a lack of dignity during childbirth. They brought this into public debate, and obstetric violence became recognised within human rights discussions which pushed respectful maternity care onto international clinical agendas. Listening more carefully would have allowed this to happen earlier.

The stories in this report are about innovation, quality assurance and clinical excellence. But at their heart they are about listening to women. That is what quality means to me. And it is the principle that runs through every effort made by MSI teams around the world.

Dr Patricia Lledo Weber
Director of Clinical Services

"The stories in this report are about innovation, quality assurance and clinical excellence. But at their heart they are about listening to women."



2025 IN NUMBERS

27.8m
Client visits (including social marketing)

116,001
Competency assessments carried out

126
External clinical quality assessments conducted

15,824
Providers competency assessed in every service

8,965
Internal clinical quality assessments conducted

48
Abortion medication samples tested for quality assurance

ONE MSI: ENSURING CLINICAL QUALITY THROUGH MUTUAL SUPPORT

64 INTERVENTIONS IN 2025

We are harnessing internal expertise to improve clinical quality, through Peer-led Quality Technical Assistance (QTAs), Clinical Audio and Video Assessments (CAVAs) and peer to peer trainings. **In 2025 we ran 30 QTAs, 22 CAVAs, 9 training workshops and 3 peer support sessions .**

Nelson Musonda - Zambia to Ethiopia

This was my longest and first CAVA since completing the 2025 Peer Assessor Training, and although demanding, it was an exceptionally rewarding experience. Assessing 20 sites in Ethiopia allowed me to learn from a context very similar to Zambia's and to observe diverse provider experiences. The added daily pre-sessions and reflection meetings were valuable for improving our assessment approach and I gained best practices that I have already applied in Zambia.

Mavis Mabedhla - Feedback from the Zambia programme on public sector QTA

The assessor conducted the QTA with exceptional professionalism and integrity. Her objective and supportive approach created a positive atmosphere for learning and improvement across all assessed sites. She provided clear, constructive, and actionable feedback, both during site visits and in the debrief. Her guidance helped us reflect critically on our processes and identify practical ways to strengthen service quality.

KEY

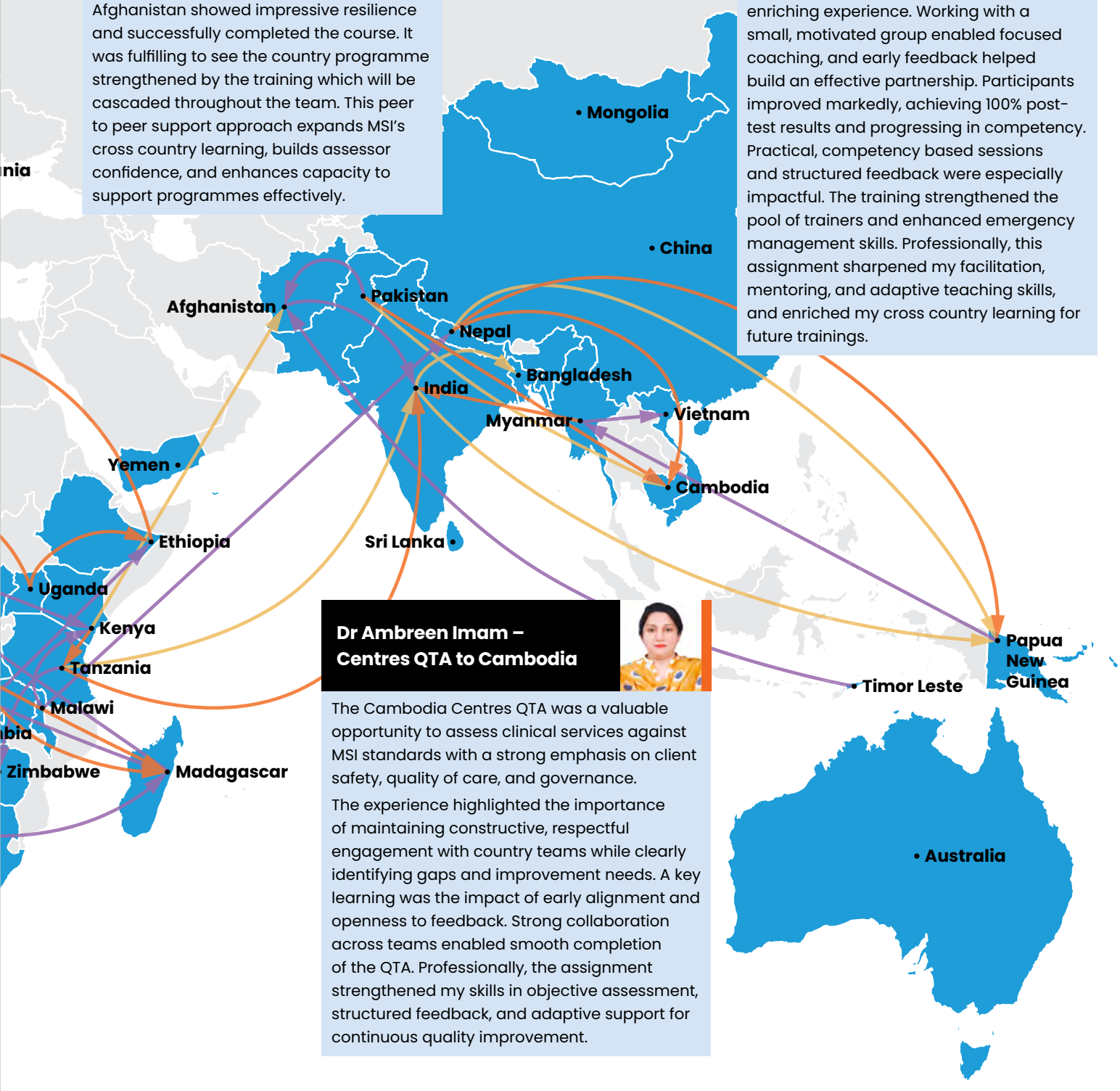
- Peer Quality Technical Assistance (Peer QTA)
- Peer Clinical Audio Video Assessment (Peer CAVA)
- Technical Assistance (TA)

Josiah Mwandaza – Training to Afghanistan

The experience was remarkable, with rich cross learning made possible by the diverse professional backgrounds in the group. Despite the challenges, the participant from Afghanistan showed impressive resilience and successfully completed the course. It was fulfilling to see the country programme strengthened by the training which will be cascaded throughout the team. This peer to peer support approach expands MSI's cross country learning, builds assessor confidence, and enhances capacity to support programmes effectively.

Dr Abbha Dhuriya – Training of Trainers Workshop in Bangladesh

Facilitating the Medical Emergency Mangement Training of Trainers for Bangladesh was a highly engaging and enriching experience. Working with a small, motivated group enabled focused coaching, and early feedback helped build an effective partnership. Participants improved markedly, achieving 100% post-test results and progressing in competency. Practical, competency based sessions and structured feedback were especially impactful. The training strengthened the pool of trainers and enhanced emergency management skills. Professionally, this assignment sharpened my facilitation, mentoring, and adaptive teaching skills, and enriched my cross country learning for future trainings.



Dr Ambreen Imam – Centres QTA to Cambodia

The Cambodia Centres QTA was a valuable opportunity to assess clinical services against MSI standards with a strong emphasis on client safety, quality of care, and governance.

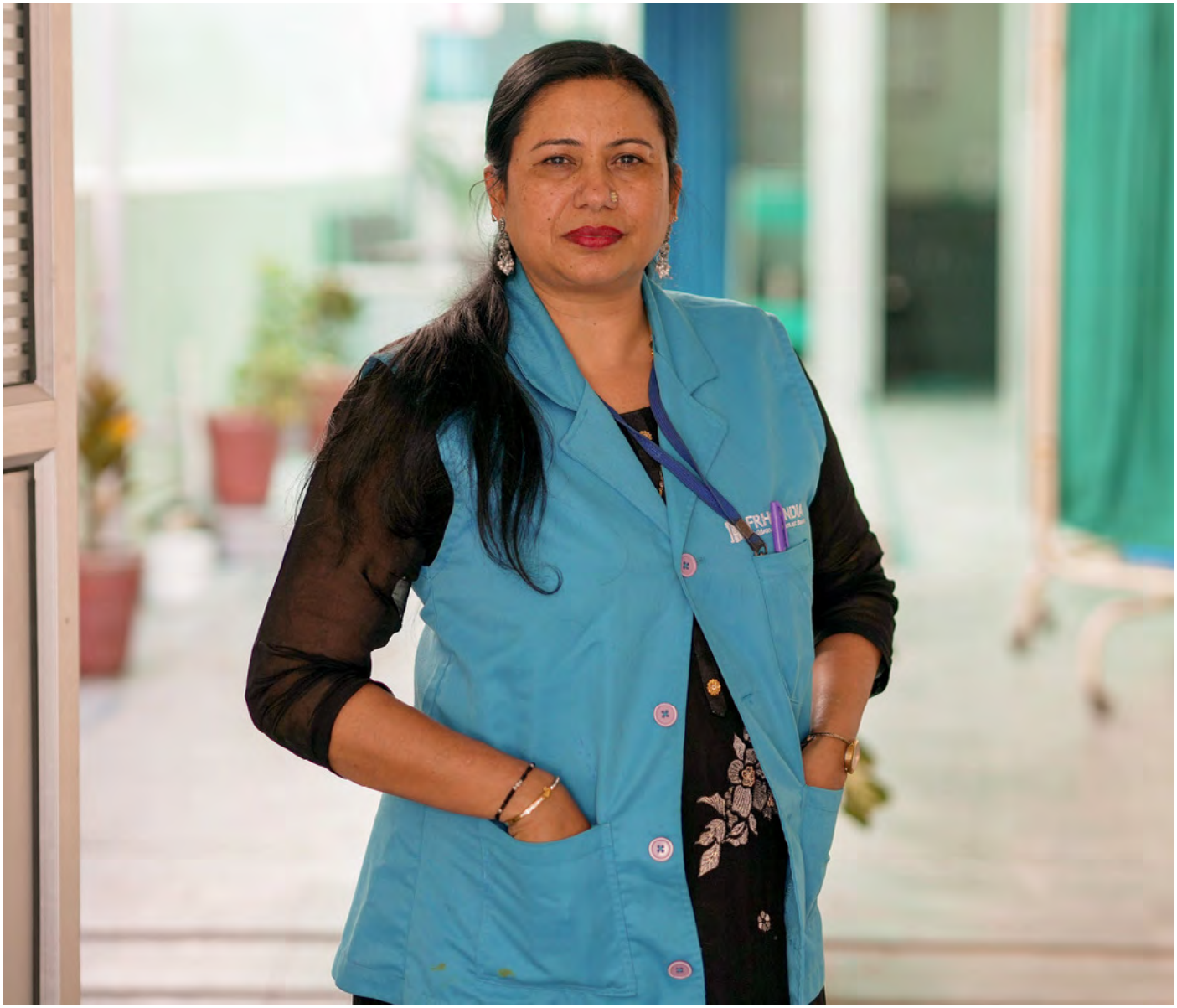
The experience highlighted the importance of maintaining constructive, respectful engagement with country teams while clearly identifying gaps and improvement needs. A key learning was the impact of early alignment and openness to feedback. Strong collaboration across teams enabled smooth completion of the QTA. Professionally, the assignment strengthened my skills in objective assessment, structured feedback, and adaptive support for continuous quality improvement.

INNOVATION IN PRACTICE: ALTERNATIVES TO MIFEPRISTONE

The most common protocol for medical abortion is the combination of mifepristone and misoprostol. However, mifepristone is not registered everywhere which limits medical abortion care to misoprostol-only regimens. While this regimen is safe and widely used, it is associated with higher rates of incomplete abortion and side effects. To address the absence of mifepristone in settings where mifepristone is unavailable MSI teams are taking an innovative approach to offer clients additional choice.

Updated MSI clinical guidelines, in line with WHO guidance, support the use of letrozole as an alternative to mifepristone combined with misoprostol. From 2026, MSI teams in selected settings will introduce letrozole–misoprostol regimens for clients between 6 and 8 weeks gestation. This regimen is expected to enhance both clinical quality and client experience, and reduce failure rates.

Providers and counsellors are being trained and supported with pictorial job aids and client information materials to ensure correct use of medication. Implementation will be accompanied by regular monitoring of effectiveness, safety, and client experience. Findings from the initial letrozole–misoprostol initiative will help us offer this combination to MSI clients where mifepristone is unavailable.



DIGITISING QUALITY: TRANSFORMING CLINICAL AUDITS THROUGH TECHNOLOGY

Safe, reliable health systems depend on continuous, robust clinical governance. Across MSI, clinical quality audits play a vital role in reviewing clinical governance, client care, service delivery, infection prevention, emergency preparedness and clinical documentation. These audits help identify gaps, guide quality improvement and inform investments that strengthen client safety and quality of care.

In 2025, across 31 countries, MSI teams conducted 8,965 clinical quality audits of facilities in their own countries, with a further 674 health facilities assessed by external auditors.

Traditionally, these audits have relied on extensive Excel-based tools, requiring auditors to complete hundreds of indicators manually and compile results before analysis through the Clinical Quality Assessment databases. This process is time-intensive and can delay the insights needed to support improvement.

To improve efficiency and responsiveness, in 2025 we developed a digital version of the clinical quality audit checklist using an open-source data collection and management platform. A mobile assessment option was introduced to improve usability in field settings, enabling assessors to complete audits directly on handheld devices, including offline.

The digitised audit process is already delivering benefits in the four country programmes where it has been introduced. Automated data validation has helped reduce missing sections and incomplete indicators, while improving the accuracy and completeness of data. The time needed to turn assessment findings into actionable insights has been significantly reduced. For example, provider competency triangulation exercises that previously took weeks to compile can now be completed by the end of an assessment.

Users have reported easier data entry and a reduced administrative burden, allowing teams to spend more time on analysis, learning and quality improvement. This positive response has created strong momentum for a phased partnership-wide rollout by 2027.

By modernising assessment processes and accelerating access to insights, MSI aims to make quality improvement more responsive, effective and sustainable – ultimately supporting safer care and better outcomes for clients.

QUALITY, NOT LUCK: THE CLINICAL STANDARDS BEHIND OUR MATERNITY CARE

What should not happen*:

I went into labour at night. The facility was open, but the room was packed and there was only one nurse on duty. She avoided my questions and just assigned me a bed. As the contractions became stronger, time passed without explanations or assurances. I was told to lie still.

When I cried out, I was asked to be quiet. I was alone; my husband could not join me because the room was shared. The room door was open, and staff walked in and out.

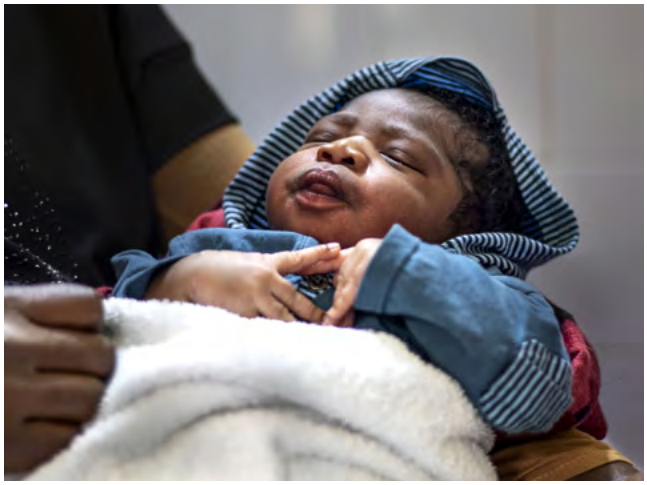
When the pain was unbearable, the staff came to me, but they spoke over me, not to me. Something seemed to not go to plan. I heard them disagree about what to do next.

I finally delivered my baby in pain. I was operated on without an explanation. My baby did not cry and was immediately taken away, out of my sight. No one told me what was happening. I lay there bleeding, exposed, frightened, and in pain. I did not know if my baby was alive. Afterwards, I was told I should be grateful. I did not feel grateful. I felt small, ignored, and ashamed.

What every woman deserves*:

I attended antenatal care, and during my visits, I was told what was normal and what is not, what signs to watch out for and when to return urgently. I was listened to, and I actively shaped my birth plan with the help of my midwife. When labour began and I got to the hospital, they assessed me promptly and explained what they were seeing and what would happen next. My partner and I were in a labour room with privacy and were supported throughout.

When the pain became overwhelming, I was offered several pain relief options, and I chose an epidural.



When it was time to push, the midwife explained that my baby was not coping well in the birth canal and that the delivery needed to be expedited. More staff arrived, calmly and with purpose. They spoke to me, even as decisions had to be made quickly.

I was asked for my consent to use an instrument to help my baby be born and was informed that a small cut to my perineum was needed. When my baby was born, she did not cry immediately and was taken to a nearby examination table to help her breathe. I could see her from my bed, and the midwife and paediatrician explained each step of what they were doing. As soon as my baby was well, she was brought back to me so that I could hold her close. I was monitored closely and supported to breastfeed. Before I left, we talked about recovery, future fertility and contraception, and where to return if me or my baby needed help.

*These fictionalised accounts are based on themes and experiences reported by women around the world and are intended to illustrate variations in women's experiences of maternity care.

Preparedness for the unpredictable

What determines maternity outcomes is whether teams are prepared, supported, and held to clear standards. MSI maternity teams know this well.

MSI's maternity care is built on strong clinical systems: regular audits, active incident review, periodic competency assessments, and frequent obstetric emergency simulations that prepare teams to act quickly and effectively when complications arise.

Safety is a must, but it is not enough

Safety alone, however, is not enough. Quality care must also protect a woman's dignity, autonomy, and experience. Respectful obstetric care training, together with systematic client feedback, ensures that care is not only clinically sound but also compassionate, informed, and responsive. Negative experiences during childbirth can leave lasting physical and psychological harm, shaping how women engage with health services long after delivery.

When strong clinical governance systems are combined with respectful, woman centred care, safe births and positive experiences are not competing priorities – they are the same goal. **Quality is not luck – it is design, preparation, and accountability.**

BUILDING A CULTURE OF CLINICAL EXCELLENCE THROUGH REWARDING QUALITY

At MSI, clinical excellence is a daily commitment, and one that deserves to be celebrated. In 2025, we introduced our Clinical Excellence Awards, recognising and rewarding outstanding clinical performance. Winning MSI teams are given the opportunity to invest the prize funds in advancing quality improvement and to inspire excellence across the partnership. This approach reflects MSI's belief that recognition for clinical safety should not only celebrate achievement but enable sustained improvements in care.

Presented at the Annual Clinical Directors' Conference in Malaysia in February 2026, the selection process for winning country programmes is grounded in MSI's clinical quality assurance processes. To win, country programmes must demonstrate high performance against key clinical quality indicators across all service delivery channels. Winners are typically programmes that show strong leadership, accountability and a sustained commitment to delivering safe, high-quality care.

Pakistan received the Gold Award for 2025 performance, together with a £50,000 grant. Myanmar received the Silver Award and £30,000, while Nigeria received the Bronze Award and £20,000. Each winning team submitted a clear proposal within three weeks of receiving the awards, outlining the investments they would make using the prize funds.

These achievements are a reflection of the dedication, teamwork and discipline required to maintain consistently high clinical standards across diverse operating environments.

The introduction of prize funds has further strengthened the impact of the awards by supporting targeted investments in training, supportive supervision, quality assurance activities and MSI-approved clinical products.

By celebrating strong clinical performance and reinvesting in quality improvement, MSI continues to strengthen a culture where clinical excellence and client safety remain at the heart of everything it does.

"One of our most important lessons has been to focus on learning rather than blame, creating an environment where quality issues can be openly addressed and client care continuously improved."

Dr Tasneem Fatima
Clinical Director, MSS Pakistan

"Regular clinical risk reviews, structured supportive supervision and a culture of shared learning have helped us proactively address challenges, strengthen accountability and continuously improve the quality of care provided to our clients."

Dr Zaw Zaw Win
Clinical Director, MSI Myanmar

"A key lesson has been that quality improvement depends on strong processes, not just individual capability. By strengthening supportive supervision, expanding quality assurance capacity and digitizing incident reporting, we created greater accountability, faster learning and a consistent focus on delivering safe, high-quality care, every time"

Dr Kingsley Odogwu
Clinical Director, MSI Nigeria

PAIN MANAGEMENT: A MUST IN REPRODUCTIVE HEALTHCARE

Making sure our clients never suffer unnecessary pain is an inherent part of delivering safe and high-quality care. Pain management helps clients feel more comfortable during procedures and makes them less likely to avoid getting care because they fear pain. When clients know their pain will be identified, understood and managed, they can choose the care that suits them best. Client-centred pain management also helps prevent complications during procedures, or procedures having to be discontinued. In short, effective pain management leads to a better client experience and safe and successful procedures.

Over several years, MSI clinical guidelines have been revised to put greater emphasis on anticipating, preventing, and actively managing pain. Guidance now sets out clear, procedure specific and client centred pain management options, moving away from one size fits all approaches and outlining counselling and expectation setting, oral and injectable analgesics, local anaesthesia, and para-cervical blocks tailored to client preference and procedure type.

Improving client-centred pain relief in MSI Nepal

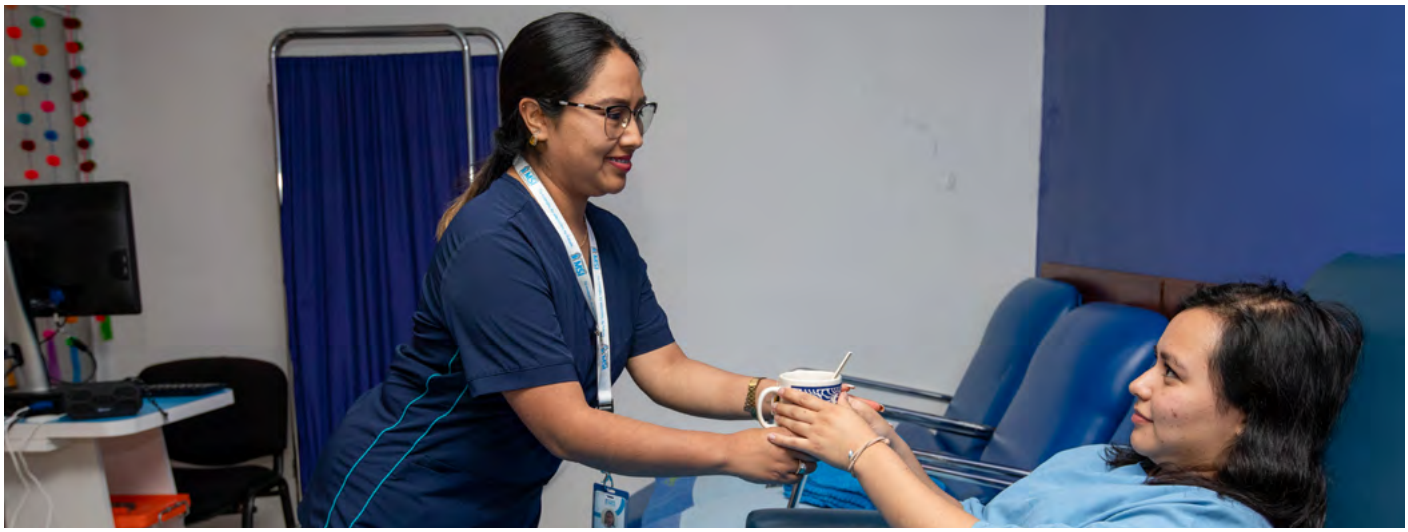
Our Nepal programme showed how attention to pain management rapidly improves service quality and client experience. Across our 22 centres in Nepal that provide surgical abortion and post-abortion care some client feedback showed dissatisfaction, prompting training of surgical abortion care providers to offer paracervical blocks. These trainings were followed by ongoing supervision and support.

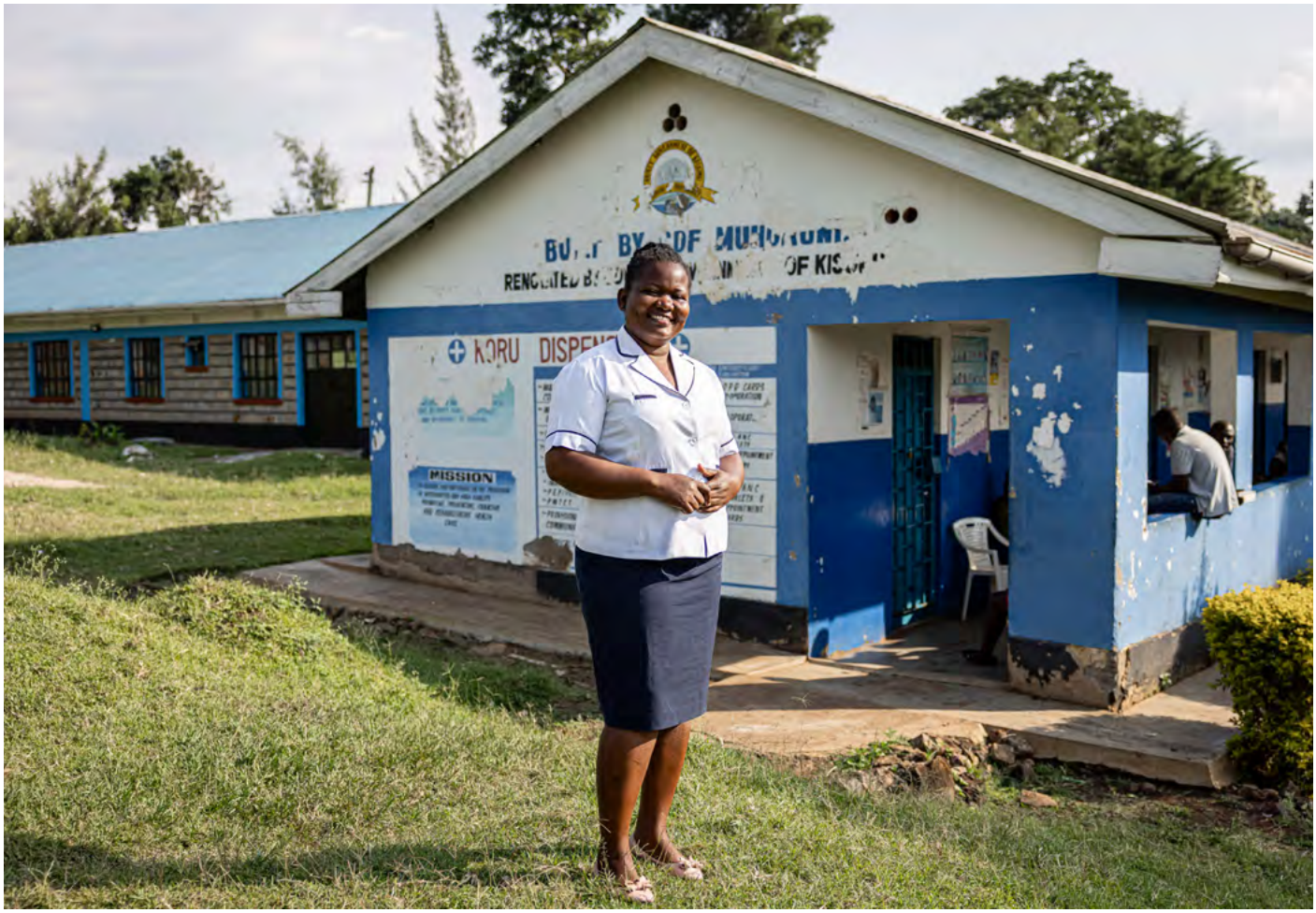
By 2025, all abortion care providers in MSI Nepal were trained, and offering paracervical block to all clients seeking surgical abortion and post-abortion care was made mandatory. This led to a clear reduction in pain during cervical dilation and during the procedure, with near complete pain relief when the para-cervical block was combined with preoperative injectable analgesics. Improved pain control led to higher client satisfaction and greater confidence in surgical abortion care.

Improving client choice through better pain relief in Ethiopia

In MSI Ethiopia, improvements in pain management for surgical abortion and post-abortion care have led to measurable changes in our abortion care method mix. From 2024 paracervical block and improved pre-medication was consistently applied to all surgical abortion cases, 26 abortion care providers including Clinical Training and Quality Assurance officers, received formal training in paracervical block, complemented by on the job coaching. Training focused on correct technique, routine offering of para-cervical block, and improved pain management counselling. Trained providers reported greater confidence in performing the procedures, and there was an increase in surgical abortion clients from 2024 to 2025.

Pain management is inseparable from quality and safety in reproductive healthcare.





BUILDING SAFER PUBLIC HEALTH SYSTEMS THROUGH INCIDENT REPORTING

Clinical services invariably carry a degree of risk. The best clinicians make mistakes. They encounter complications and adverse events. Every health system needs a strong culture of incident reporting to improve client safety and the quality of care. When healthcare providers are supported to report, review and learn from clinical incidents, health systems can move beyond blame and create a culture that identifies gaps, strengthens accountability and fosters continuous improvement in care.

MSI partners with national health systems to share our best practices and experiences. With MSI's support, many national health systems have expanded contraceptive service delivery and started to expand lifesaving abortion and post-abortion care.

As the volume of higher-risk procedures such as tubal ligations expands within the national health systems that we partner with, we have also started to show the value of fostering strong clinical incident reporting systems based in no-blame cultures. As a result we have seen Ministries of Health steadily increase the number of incidents that they report.

In 2025, nearly 20% of the 3,500 critical incidents reported to MSI originated from government health facilities that we support. Alongside this, we are also seeing a notable increase in reporting non-critical incidents, suggesting that a culture of learning from incidents is slowly but surely taking root. The growing incident reporting reflects growing transparency, stronger accountability and an emerging culture of learning within government health systems.

We will continue to encourage and further strengthen reporting practices, especially focusing on those that deliver high volumes of higher-risk services. At MSI, we do not view incident reporting as a compliance exercise but as a critical enabler of safer, patient-centred health systems. Each reported incident represents an opportunity to learn, improve and prevent future harm.

CLOSING THE GAP IN CERVICAL CANCER PREVENTION

Globally, an estimated 350,000 women died of cervical cancer in 2023. Cervical cancer is almost exclusively caused from persistent infection from certain human papillomavirus (HPV) types. While most HPV infections clear spontaneously, those that persist can lead to precancerous lesions and to invasive cancer. Because this progression is well understood and typically takes several years, cervical cancer is among the most preventable and treatable cancers when detected early.

HPV vaccination is the cornerstone of primary cervical cancer prevention, protecting against the HPV types responsible for most cervical cancers. This approach underpins the WHO's Cervical Cancer Elimination Initiative's 90–70–90 target, which combines HPV vaccination, screening with a high performance test, and timely treatment. However, many women and girls remain beyond the reach of prevention efforts or continue to be offered less effective interventions.

From missed opportunities to integrated prevention

Vaccination programmes primarily target young adolescent girls, where vaccines achieve their greatest impact prior to the first HPV exposure. For unvaccinated young and adult women, effective prevention requires screening.

For this secondary prevention to save lives, the quality of the screening is critical. HPV DNA testing is the most sensitive and reliable method and is the recommended screening approach. The decades old Visual Inspection with Acetic acid (VIA) is highly operator dependent, poorly reproducible, and less effective at detecting precancerous lesions. Continued reliance on VIA delays transition to HPV based screening and slows progress toward elimination. Similarly, the older and widely used Pap Smear approach strongly relies on the quality of the pathologists, and Pap results are not available on the same day.

Prevention can be further strengthened by combining HPV vaccination and high-quality screening in the same visit, an approach known as HPV FASTER. By addressing both current risk and future protection, this model reduces missed opportunities and ensures prevention is comprehensive.

MSI is well positioned to deliver the full spectrum of cervical cancer prevention strategies, including combined vaccination and screening. Taking this responsibility seriously, we have moved away from VIA and our cervical cancer prevention approach leads with vaccination as primary prevention and HPV DNA screening combined with cryotherapy of thermal ablation as secondary prevention. MSI centres are a practical and trusted platform to offer HPV vaccination and HPV DNA testing and treatment in the same visit (HPV FASTER). MSI's outreach teams can also be trained in vaccination, HPV DNA screening and treating screened positive women using cryotherapy or thermal ablation.

Delivering protection where women already seek care

In our centres in Nepal, cervical cancer prevention has been integrated into routine care for adult women, with HPV vaccination and screening offered separately or together and increasing the use of HPV DNA testing. Clear client facing information and person-centred counselling support informed decision-making, while strong referral linkages ensure timely treatment when needed. In 2025, Nepal screened 1954 women with HPV DNA test and treat approach and provided 346 HPV vaccines.

Our centres in Kenya have also begun offering high performance cervical cancer screening tests. In 2025, 1,524 women were screened, with 8% opting for HPV DNA tests and 92% for Pap smears. Towards the end of 2025, MSI Kenya also introduced HPV vaccination for the secondary target group of adult women.

Our centres in Cambodia have generated strong demand for HPV vaccination among girls, boys and adult women aged 25–39 (the secondary target group for vaccination). By offering vaccination and screening through trusted services, centres reach women not covered by school based or public prevention programmes, while demonstrating that investment in prevention for adult women can advance both public health goals and service sustainability. Cambodia vaccinated 363 girls aged 9–14 years and 3,798 women aged 15–45 years in 2025.

A lack of government and donor investment makes expanding high impact cervical cancer prevention services difficult and keeps these life saving technologies beyond the reach of millions of women, especially in low- and middle-income countries.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