

# Bridging the gap to FP2020

## Supporting reproductive health programme innovation through action-oriented research

Marie Stopes International is a global organisation providing personalised contraception and safe abortion services to women and girls. Our local teams of professionals are passionate about the work they do in communities across 37 countries. Our operations are data-driven, and we strive to use evidence-based approaches to achieve our organisational goals of scale and impact, quality of care and sustainable service delivery. In addition to the collection and analysis of comprehensive routine data on our clients, our Evidence to Action teams globally undertake a range of formative, clinical, operational and evaluative studies both to gather insights on the needs and behaviours of our clients and potential clients and to test innovative interventions and deliver cost-efficient programming.

### Expanding service delivery beyond the doctor: task-sharing family planning

We have a long history of expanding access to long-acting and permanent methods of family planning services through non-physician providers, such as clinical officers, nurses, midwives and community health extension workers. Since 2012 we have run task-sharing studies on:

- Injectables provided by community health workers in Sierra Leone.
- Tubal ligations performed by clinical officers in Ethiopia, Uganda and Zambia.
- Implant provision and removal by community health extension workers in Nigeria and by midwives in the Philippines.
- Short- and long-acting contraceptive methods to primary care and community health workers in Burkina Faso.
- Medical abortion by secondary midwives in Nepal and Cambodia.

While some studies are ongoing, two studies on female sterilisation have been completed and published. They demonstrate the safety and acceptability of provision by clinical officers. Rates of serious adverse events among the 774 women studied were very low, ranging from 1.5% in Uganda to 3% in Ethiopia. In Ethiopia adherence to clinical protocol (measured by an 18-item clinical checklist and observed during the procedure) was high, at 96.9%.

In response to the recent liberalisation of task-sharing policies for family planning in Nigeria, we have also recently conducted a study comparing the safety and acceptability of implant provision by community health extension workers (CHEWs) with that of nurses. The research is funded by the UK's Department for International Development (DfID), USAID and DANIDA and supported by the Step-Up research consortium. Results will be published in early 2018.

**References:** Gordon-Maclean C et al. Safety and acceptability of tubal ligation procedures performed by trained clinical officers in rural Uganda. *International Journal of Gynaecology and Obstetrics* 124: 34–3, 2014.

Marie Stopes International. *Monitoring and evaluation of task-sharing of Depo-Provera to community health workers in Sierra Leone*. Research Brief. Available on request from [evidence@mariestopes.org](mailto:evidence@mariestopes.org). 2015.

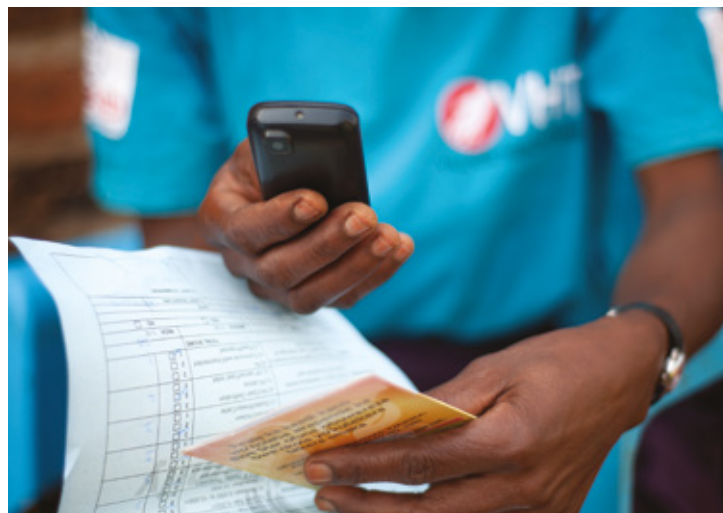
Nuccio O et al. Optimizing tubal ligation service delivery: a prospective cohort study to measure the task-sharing experience of Marie Stopes International Ethiopia. *Health Policy and Planning*, 32(2):163–169. 2017.

Reiss K et al. Study protocol: a quasi-experimental, non-inferiority study of the safety and quality of contraceptive sub-dermal implant provision by community health workers versus nurses and midwives in Nigeria. Under peer review, available on request from [evidence@mariestopes.org](mailto:evidence@mariestopes.org).

# Applying a behavioural economics approach to behaviour change within MSI's sexual and reproductive health programmes

We have been partnering with ideas42, a group of behavioural economists, with support from the Hewlett Foundation. This approach promotes the use of behavioural design with a user-centred process to achieve small 'nudges' in the behaviour of our clients, potential clients or providers. In Uganda we have been testing a redesign of text messages sent to call centre users (toll-free hotline), aiming to increase redemptions of e-coupons for services. In Nepal we designed and tested a peer comparison tool in our clinics to increase long-acting reversible contraceptive (LARC) provision among abortion and post-abortion clients. Managers were sent monthly performance data positioning them against other clinics and asked to discuss with their teams. Each country went through a four-stage design and testing methodology (Fig. 1). Evaluation in both countries used a randomised controlled trial design (with additional step-wedged design in Nepal).

Trials in Uganda and Nepal were completed in mid-2017. Preliminary analysis shows that in Nepal LARC uptake among abortion and post-abortion clients was 8.7% higher in intervention clinics than in controls ( $p=0.02$ ) (controlling for month and clinic). Preliminary results from Uganda show no difference between intervention and control group overall, but sub-group analysis shows increased referral among those who were calling on their own behalf (vs called made on behalf of someone else) and among those who got straight



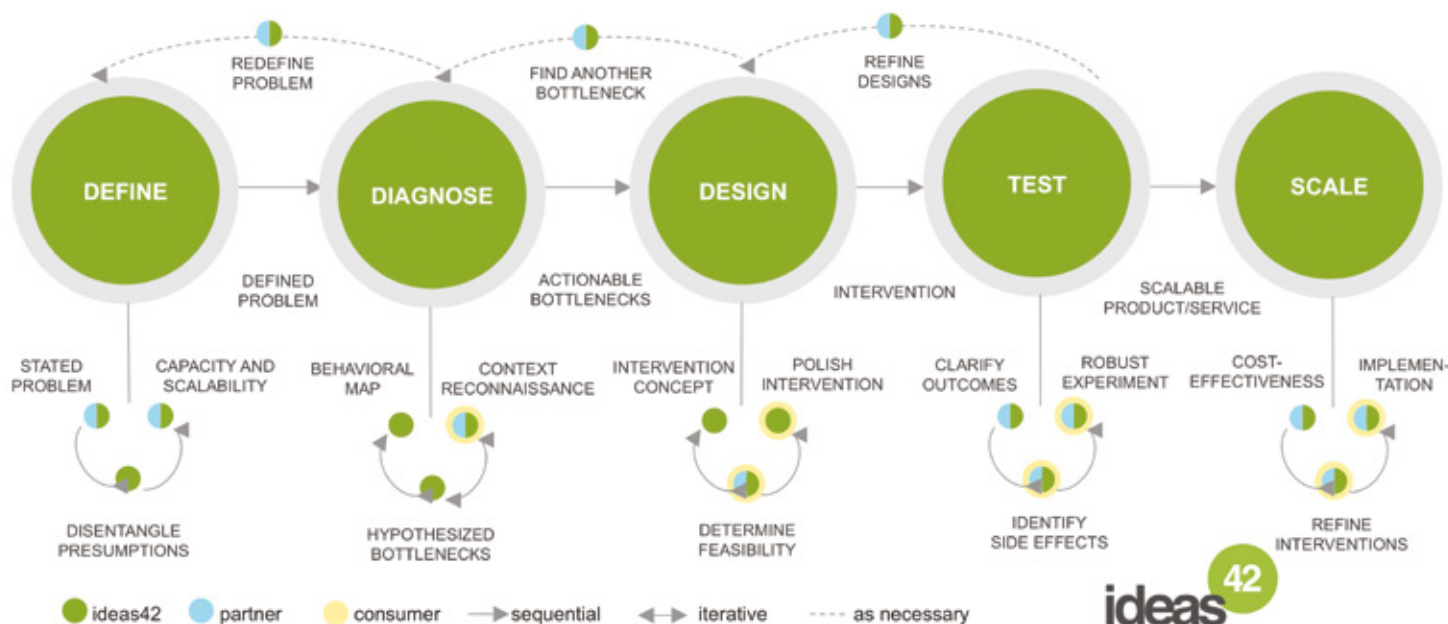
E-coupon wording tested in Uganda to increase referrals from MSI's call centre to clinics

through to a counsellor (vs those who got through to voicemail) ( $p<0.05$ ). Results are currently being written up for publication.

## Harnessing the power of routine data to test programme innovation: the case of the youth-focused 'Future Fab' initiative in Kenya

Since 2013 we have been rolling out an electronic routine data system in our clinics and outreach programmes known as the 'Client Information Centre' (CLIC). CLIC provides real-time data to clinic and programme managers to allow rapid

Figure 1: Behavioural economics approach to programme design, testing and scale-up



programme learning and course correction. CLIC captures clients' socio-demographic characteristics and service history, and their visits over time and across clinics can be identified using unique IDs. We use interrupted time series analysis of CLIC data to test programme innovations where projects are rolled out in a staged way, allowing a controlled test.

Throughout 2016, Marie Stopes Kenya implemented the 'Future Fab' intervention across its 24 clinics, with support from the Children's Investment Fund Foundation (CIFF) and Hewlett Foundation. Future Fab is a community mobilisation



Future Fab intervention, Marie Stopes Kenya

model aiming to increase adolescent service use, designed and tested with urban adolescent girls. Piloting highlighted the value of aspirational messaging around 'bright futures' to promote family planning as well as testimonials from adolescent contraceptive users. The final intervention model included Future Fab events, dialogues with parents and gatekeepers, parent meet-ups, teen meet-ups and support to attend facilities through 'teen connectors' and 'Future Fab ambassadors'. Youth-friendly clinics were a core element and included weekend opening, free contraception to under 20s (widely publicised); separate adolescent waiting space and adolescent counselling training for providers.

Intervention roll-out was staggered and tested using interrupted time series analysis at mid-point, when 14 intervention centres were compared with 10 controls (Fig. 2). Regression analysis showed a 13% (CI: 7–19%,  $p < 0.001$ ) increase in the mean daily proportion of adolescents (15–19) attending for family planning and post-abortion care services at Future Fab clinics in the 150 days post-intervention vs the

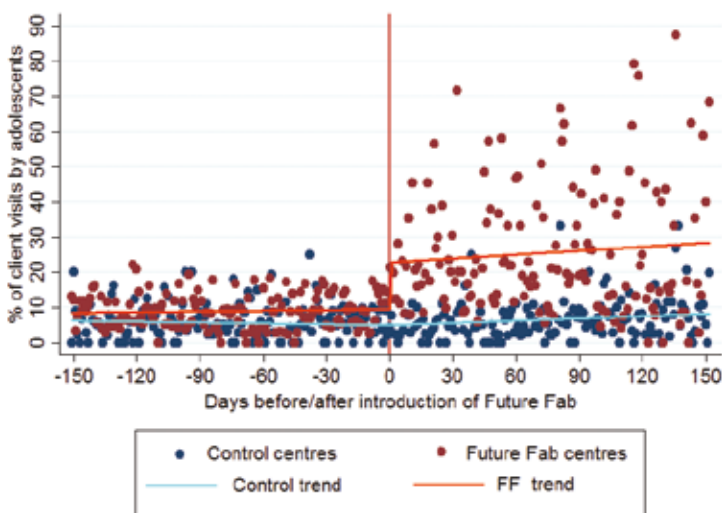


Figure 2: Interrupted time series analysis of effect of Future Fab implementation on FP and post-abortion care visits in Marie Stopes Kenya centres (2016)

Each dot shows mean daily % of adolescent visits (15–19) across intervention ( $n=14$ ) and control ( $n=10$ ) centres (clinics)

pre-intervention trend. There was no step-change in control centres. Further analysis is ongoing to unpack intervention effects by centre and results will be written up for publication.



MSI's Client Information Centre (CLIC) enables real-time programme monitoring and rapid evaluation

## Youth voucher programme in Madagascar increases access to voluntary family Planning and STI services for adolescents

In addition to its static clinics and outreach sites, MSI also delivers services through social franchise networks. In Madagascar, with support from USAID and UNFPA, we piloted a youth voucher programme aiming to improve the quality of Blue Star franchise services as well as generate demand for services among adolescents. Community health educators distributed vouchers for free services to the under 20s, redeemable at a BlueStar social franchisee for a package of voluntary family planning and sexually transmitted infection (STI) information and services. Franchisees – private providers accredited by MSI – were reimbursed for the costs of provision. We analysed service data from the first 18 months of the voucher programme (2013–2014) as well as the demographic profile of clients in 2015.

Over the 18 month programme, of the 58,417 vouchers distributed to adolescents, 74% were redeemed for free family planning and STI services. Most (78.5%) chose a long-acting reversible contraceptive, and just over half (51%) of adolescents benefited from STI counselling as part of their voucher service. Most (78%) services were provided in the Analamanga region (the capital and its surroundings), which was expected, given the population density in this region and the high concentration of BlueStar franchisees. The client profile data snapshot from July 2015 revealed that 69% of voucher clients had never previously used a contraceptive method, and 96% were aged 20 or younger, suggesting that the voucher programme is successfully reaching the intended target group.

**References:** Burke E et al. Youth voucher program in Madagascar Increases access to voluntary family planning and STI services for young people. *Global Health: Science and Practice*, 5(1):33–43, 2017.

Eva G et al. Vouchers for family planning and sexual and reproductive health services: a review of voucher programs involving Marie Stopes International among 11 Asian and African countries. *Int J Gynaecol Obstet*. 130 Suppl 3:E15–20. 2015.



MSI outreach in Burkina Faso

## How can we support sustained use of LARCs? Comparing active and passive client follow-up approaches in Pakistan through a multicentre trial

The use of LARCs is low in Pakistan, with relatively high discontinuation, mainly attributed to method-related side effects. Supportive client follow-up may help sustain use, but evidence on its effectiveness is mixed. We compared active and passive follow-up approaches in rural Punjab:

- Active follow-up, with two sub-groups of a) home-visits or b) telephone call: all contacted for counselling at 1, 3, 6, 9, and 12 months post-insertion.
- Passive follow-up: participants asked to contact health facility if in need of medical assistance related to their LARC.

Study participants were recruited with equal allocation but were not randomised. 1,246 IUD and implant users were successfully followed up to assess the cumulative probability of method continuation at 12 months. We found active follow-up was marginally more effective than passive follow-up (88% vs 84%, adjusted risk difference -4.1 (95% CI -7.8 to -0.28;  $p=0.035$ ). Within active models telephone-based was as effective as home-based follow-up, and more cost-efficient (40% lower costs). Active follow-up through phone or home visits could, therefore, improve LARC continuation, especially in the critical post-insertion period.

**References:** Hameed W et al. Comparing effectiveness of active and passive client follow-up approaches in sustaining the continued use of long acting reversible contraceptives (LARC) in rural Punjab: a multicentre, non-inferiority trial. *Plos One*, 11(9):e0160683, 2016.

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## Understanding youth access to family planning services in the Sahel: a qualitative study in Burkina Faso, Mali and Niger

We undertook a formative study in 2016 to understand community and user perspectives around use of family planning services among rural youth in the Sahel. Funded by USAID and implemented in collaboration with FHI360, we conducted qualitative in-depth interviews and focus group discussions (FGDs) in rural Burkina Faso, Mali and Niger. We interviewed youth contraceptive users and non-users in six rural communities where we deliver outreach family planning services as well as male partners, female relatives, community leaders and key informants (100 interviews and 4 FGDs total). We also observed outreach service provision using a checklist and notes. Thematic analysis of the interviews and observations revealed that:

- Social norms around early marriage and high fertility persist, but there is evidence of recent reductions in desired family size and motivations to delay marriage/first pregnancy.
- Fear of infertility is pervasive and underlies concerns about using methods, especially LARCs. It is important for youth to prove fertility before 'risking' infertility through contraceptive use.

*"As I am not yet married but concentrated on my studies, if I use a contraceptive method, it may not be possible to remove it at the time it is supposed to come out, and in that case I would become sterile."*

**(Never-user (youth), Burkina Faso)**

- Sexual activity and contraceptive use before marriage is highly stigmatised, but the equally powerful stigma of pre-marital pregnancy is used to justify youth contraceptive use.
- Birth spacing is widely accepted for youth and can be justified by health, economic and educational benefits. Family planning is also accepted as a way to allow girls to complete their education, including by older women.

*"[Family planning] is the solution; that's the only thing that has saved us. There is no other way out without problems. If she gives birth to a baby, she'll be responsible for two, but if she gets help, it will just be her.... God willing, she will finish her studies...."*

**(Older female community member, Burkina Faso)**

- MSI outreach services are being successfully integrated into pre-/postpartum care and immunisation services, including for youth, and this model supported demand-generation efforts. Mali also has a particularly successful sensitisation programme in schools, markets and public events.

Findings are being incorporated into demand-generation strategies and will also be presented at the forthcoming IUSSP Population Conference in late 2017. Contact [evidence@mariestopes.org](mailto:evidence@mariestopes.org).