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Support for International Family Planning Organizations Marie Stopes International (SIFPO-MSI)

Final Performance Monitoring Report (September 30, 2010 – September 29, 2015)

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Acronyms

AHME	African Health Markets for Equity
AIDS	Acquired Immunodeficiency Syndrome
AMO	Assistant Medical Officer
AOR	Agreement Officer's Representative
ART	Antiretroviral Treatment
BPG	Best Practice Gateway
CBM	Community-Based Mobilizers
CHEW	Community Health Extension Worker
CHW	Community Health Worker
CLIC	Client Information Center
CPR	Contraceptive Prevalence Rate
CYP	Couple Year of Protection
DFID	UK Department for International Development
DOVVSU	Domestic Violence and Victims Support Unit
EoP	End-of-Project
FHE	Field Health Educators
FP	Family Planning
GBV	Gender-Based Violence
GHS	Ghana Health Service
HIP	High Impact Practice
HIV	Human Immunodeficiency Virus
HLI	Higher Learning Institutions
IBP	International Best Practice
ICFP	International Conference on Family Planning
ICRW	International Center for Research on Women
IFPS	Improving Family Planning Services
IP	Infection Prevention
IUD	Intrauterine Device
LA	Local Anesthesia
LARC	Long-Acting Reversible Contraception
LGA	Local Government Authorities
LHW	Lady Health Worker
M4QI	Mobiles for Quality Improvement
M&E	Monitoring and Evaluation
MARP	Most At-Risk Population
MCH	Maternal and Child Health
MoH	Ministry of Health
MSI	Marie Stopes International
MIS	Management Information System
MSBF	Marie Stopes Burkina Faso
MSC	Marie Stopes Cambodia
MSE	Marie Stopes Ethiopia
MSG	Marie Stopes Ghana
MSS	Marie Stopes Senegal
MSSS	Marie Stopes South Sudan
MSK	Marie Stopes Kenya
MSM	Marie Stopes Madagascar

MSSL	Marie Stopes Sierra Leone
MSS	Marie Stopes Society (Pakistan)
MST	Marie Stopes Tanzania
MSU	Marie Stopes Uganda
MSZ	Marie Stopes Zambia
NGO	Non-Governmental Organization
OA	Opioid Analgesics
OI	Opportunistic Infection
OSC	One Stop Center
PAC	Post-Abortion Care
PLHIV	People Living with HIV
PM	Permanent Method (of contraception)
PPFP	Post-Partum Family Planning
PPI	Progress out of Poverty Index
PPIUD	Post-Partum Intrauterine Device
PSI	Population Services International
PSZ	Population Services Zimbabwe
QA	Quality Assurance
QAF	Quality Assurance Framework
QTA	Quality Technical Assistance
REDI	Rapport Building, Exploration, Decision-making, and Implementing (framework)
SRH	Sexual and Reproductive Health
SBCC	Social and Behavior Change Communication
SHOPS	Strengthening Health Outcomes Through the Private Sector
SIFPO	Strengthening International Family Planning Organizations
SMS	Short Message Service
SOPM	Standard Operating Procedure Manual
STI	Sexually Transmitted Infection
SWAA	Society for Women Against AIDS in Africa
TA	Technical Assistance
TL	Tubal Ligation
TLG	Technical Leadership Group
ToT	Training of Trainer
UCAD	Université Cheikh Anta Diop
USAID	United States Agency for International Development
VL	Vocal Local
VCT	Voluntary Counseling and Testing
VHT	Village Health Team
WHO	World Health Organization
WTP	Willingness to Pay

Executive Summary

The Strengthening International Family Planning Organizations (SIFPO) project was a five-year (2010-2015) Cooperative Agreement with Marie Stopes International (MSI) funded by the United States Agency for International Development (USAID). The project was led by MSI in partnership with four organizations: EngenderHealth, International Center for Research on Women, International HIV/AIDS Alliance, and Population Council. SIFPO's mandate was to increase the use of voluntary family planning (FP) services globally by strengthening selected international FP organizations that have extensive reach through multi-country networks of service delivery points in order to achieve maximum impact and synergy.

SIFPO was designed to meet its objective through four main result areas:

- Result 1: Strengthened organizational capacity to deliver quality FP services to target groups;
- Result 2: Internal quality assurance (QA) standards and results quantified and disseminated to strengthen FP performance at a global level;
- Result 3: Increased organizational sustainability of country-level programs, including internal south-to-south support and technical assistance (TA); and
- Result 4: Gender-sensitive FP services targeting youth strengthened at a global level.

Over the life of the project, SIFPO contributed to global FP technical leadership and best practices that are dramatically increasing the number of FP clients served; providing them with a wide range of voluntary FP choices, effective counseling, and a broad contraceptive method mix, including increased access to long-acting reversible contraception (LARC) and permanent methods (PMs); and leveraging the potential of private sector approaches to reach new users and for maximum health impact.

SIFPO has also been a game-changer for MSI as an organization, transforming our delivery models, approaches, and institutional capacity. As a result of SIFPO, MSI is more effectively reaching youth, and investment in MSI's internal capacity is improving our ability to monitor, document, and share our practices with the wider FP community. Improvements in knowledge management are enhancing MSI's ability to identify caches of expertise across its country programs, increasing south-to-south and global learning and TA, thus advancing the technical quality of transformative FP programming globally.

SIFPO advanced MSI programming and the FP sector in the specific areas described below.

SIFPO underwent an **external mid-term evaluation** in 2013, including interviews with USAID, MSI head office staff and other stakeholders, and visits to Ghana and Madagascar. The evaluation concluded that SIFPO 'has provided an exciting and unique opportunity for USAID':

*SIFPO provided MSI with funds to carry out **trailblazing work** that has strengthened not only their own systems but also those of their local and international partners. For USAID, it has proved to be a **cost-effective, high-impact investment** yielding cutting-edge tools, systems, and technologies. SIFPO funding has also **increased the reach of high-quality service provision in a sustainable manner** through a variety of original and appropriate channels.*

*USAID/Washington appears to be extremely satisfied with MSI's performance via SIFPO [in] four main areas: **cost-effectiveness, metrics and M&E, quality of services, and models of service delivery**. Involving MSI made for a very lean project...[as one Mission noted], "MSI FP programs are sustainable with or without SIFPO because of its prior structure and the long-term vision of MSI for organizational building." USAID recognized that MSI is extremely good at metrics and M&E and could provide evidence of impact as well as the cost of service delivery using different approaches. USAID also articulated that they were impressed with the quality of services delivered and with the overall systems of quality assurance. The new modes of service delivery and sensitization—for example, using tuk tuks for outreach in Tanzania or mobile money in Madagascar—have **substantially improved USAID's reach**. The fact that local MSI staff provides on-the-job training and mentoring, particularly for government counterparts, was seen by the Agency as an effective way of **strengthening local capacity and sustainability**.*

SIFPO MSI Mid-Term Evaluation Report, August 2013

Scaling up, strengthening, and evolving delivery models

Through targeted support for 66 **mobile outreach** teams in Burkina Faso, Cambodia, Ethiopia, Ghana, Madagascar, Niger, Pakistan, Senegal, Tanzania, and Zimbabwe, SIFPO investments directly financed the delivery of over 700,000 voluntary FP services resulting in over 2.5 million couple years of protection (CYPs). These investments catalyzed long-term non-SIFPO USAID and other donor funding in several countries which supported provision of over 600,000 additional voluntary FP services, resulting in over two million CYPs. In Madagascar and Tanzania this funding enabled significant expansion of mobile outreach to achieve national impact, growing the national contraceptive prevalence rate (CPR) by an estimated two percentage points in both countries. Mobile outreach service delivery was supported by wide-reaching SIFPO core investments which saw the standardization of mobile outreach best practice, the development of a range of rigorous assessments – from clinical quality to costing to client profiling – and the piloting and scaling of new delivery models including the nurse-led *bajaji* model which is now operational in over ten countries.

SIFPO and the additional funds it leveraged catalyzed significant expansion in MSI's global mobile outreach operations. MSI's global mobile outreach service delivery almost doubled in impact, from just over two million services provided in 2011 to nearly 3.7 million in 2014, delivered through 533 teams in over 38,000 sites in rural and underserved areas. Between 2011 and 2014, these voluntary FP services averted an estimated 15,000 maternal deaths and prevented an estimated 7.8 million unintended pregnancies. In 2014 an estimated 7.6 million people were using a contraceptive method provided by an MSI mobile outreach team. An estimated 42% of MSI's 2014 mobile outreach clients were FP adopters (defined as not using a contraceptive method in the three months prior to coming for an FP service), 80% were living on less than \$2.50/day, and 32% had previously been using a short-term method and chose to switch to a voluntary LARC or PM. These results demonstrate the value of MSI's mobile outreach model and offering a range of voluntary FP method choices to best meet women's needs and preferences.

SIFPO also contributed significantly to the scale-up of MSI's **social franchising** channel. SIFPO funded the start-up and expansion of social franchising in Ethiopia, Madagascar, Pakistan, Senegal, and Zimbabwe; networks that delivered services to nearly 400,000 clients and generated over 500,000 CYPs during the award period. SIFPO core funds were also invested in: strengthening franchisee clinical quality through improvements in MSI's clinical audit tool; enabling franchisees to better serve young people through integrated supply and demand side interventions such as youth-friendly training and voucher initiatives in Madagascar and Zimbabwe; applying the social franchising model to the public sector in Madagascar; and improved franchisee business skills to support sustainable service provision. These investments facilitated MSI's social franchise networks globally to grow from the delivery of 400,000 voluntary FP services (generating 1.3 million CYPs) to 1.2 million (generating 3.8 million CYPs) between 2011 and 2014. MSI's global social franchise networks now include 4,000 franchisees across 17 countries. In 2014 an estimated 68% of MSI's social franchise clients choose a LARC method, 49% lived on less than \$2.50/day, and 31% were FP adopters. SIFPO enabled MSI to build the evidence base for, and increase understanding of, social franchising through documentation and technical leadership including technical consultations, harmonization of metrics across the sector, and the publication of landmark social franchising papers.

Building evidence to improve programming and influence the sector

SIFPO supported MSI to dramatically improve our **understanding of our clients** – who we are reaching, who we are not reaching, and why. Through the scale-up of client exit interviews, which engaged 19,000 clients across four delivery channels in 29 countries in 2014, MSI now has a deeper understanding of trends and differences between countries and channels – in terms of client age, poverty levels, FP history (for example, new users or switchers from short-term to longer-term methods), FP decision-making, counseling quality, and client experience – and is better equipped to tailor programming accordingly. SIFPO funds enabled a better understanding of who we are not reaching as well through wide-ranging consumer insight studies in six countries that disaggregates non-FP users by preference and behavior. Findings are being utilized to shift to

an FP life-stage approach that is improving market segmentation to engage non-users (including young people and lapsed FP users) and to better address concerns around side effects and impact on fertility in social and behavior change communication (SBCC) and counseling.

Clinical quality is and will continue to be the cornerstone of MSI's work. SIFPO supported MSI to evolve our approach to QA to match exponential growth and ensure our clinical frameworks, tools, and QA approaches are cutting edge in a changing and dynamic service delivery environment. In particular, SIFPO facilitated MSI to learn from other implementers which served to strengthen our FP clinical protocols, clinical QA standards and assessment tools, develop a more holistic approach to QA, and evolve our counseling standards and approaches. SIFPO also supported MSI to test new QA tools, such as the Mobiles for Quality Improvement (M4QI) pilots in India and Nigeria, and to build an evidence and external consensus around core MSI clinical approaches such as "vocal local" and the minilaparotomy tubal ligation (TL) procedure.

Access to **voluntary permanent methods** has not increased at a pace comparable to the growing unmet need for FP. Through SIFPO, MSI and EngenderHealth – two of the leading providers of voluntary female sterilization in low-resource settings – shared experiences, learnings, and approaches to voluntary TL provision. This collaboration led to consensus-setting on appropriate clinical methods in different settings to ensure a common understanding and reduce provider confusion and galvanized the sector to keep voluntary PMs on the FP agenda; this included the production of a consensus statement endorsed by experts across the sector. SIFPO also facilitated MSI to improve our vasectomy programming, including piloting and learning from vasectomy research and SBCC campaigns in Kenya and Uganda.

MSI built a strong **task-sharing** evidence base and advanced the global task-sharing agenda through a series of inter-linked initiatives such as targeted task-sharing research that changed policy and practice resulting in expanded voluntary FP access. This included task-sharing TLs to clinical officers in Uganda (where positive findings spurred policy change and implementation), and injectables to community health workers (CHWs) in Sierra Leone (where one-third of women reached were under 18). Globally, SIFPO facilitated MSI to lead the task-sharing agenda, advocating successfully with the World Health Organization (WHO) and informing their progressive 2012 FP task-sharing guidance and carrying that momentum forward through technical consultations, the development of a task-sharing impact advocacy tool, and the formation of a task-sharing working group to harmonize and prioritize research and programming.

While many women in developing countries seek maternal health services from private providers, private sector ability to deliver voluntary post-partum FP (PPFP) remains limited. SIFPO supported MSI to improve its **FP and maternal and child health (MCH) integration** through training and supporting franchisees in Ghana, Kenya, and Nigeria to insert post-partum intrauterine devices (PPIUDs) as part of a mix of FP methods. SIFPO also enabled MSI to strengthen **FP/HIV integration** and **post-abortion care (PAC) services** across its programs. With SIFPO partner the International HIV/AIDS Alliance, MSI implemented a series of activities to deepen organizational understanding of HIV/FP programming gaps and opportunities, and to strengthen the quality of HIV/FP programming in countries including Cambodia, Kenya, Tanzania, and Zambia. In Cambodia, initial SIFPO core-funded assessment findings informed a field buy-in to strengthen HIV/FP integration and support national-level HIV/FP policy implementation. SIFPO supported the documentation of MSI's voluntary medical male circumcision work in Malawi and Zambia. SIFPO funds were also used to review and improve PAC service delivery protocols and training materials and encouraged MSI to actively participate with collaborating agencies in technical working groups and communities of best practice to strengthen PAC programming through its own channels and more widely in the FP community.

Investments made in research and dissemination capacity stimulated MSI to make a step change in our **technical leadership and collaboration with other agencies**, including our flagship SIFPO partners EngenderHealth, Population Council, and ICRW, in key areas including LARC and PM service delivery modalities, voluntary FP/HIV integration, gender, task-sharing, method choice, and the role of the private sector.

MSI co-led a series of technical consultations where FP service delivery and technical agencies shared programmatic experience, field perspectives, and technical expertise. MSI's contribution at international FP conferences grew considerably since 2011, with over 59 abstracts presented at the Addis International Conference on Family Planning (ICFP) (over 20 were SIFPO-supported) and 78 accepted to the upcoming 2016 ICFP. The number of MSI-authored articles published in peer-reviewed journals grew significantly with over 10 published during the project period. These contributions were a direct result of investments in research capacity, and reflect MSI's increasing prioritization of learning, knowledge sharing, and dissemination encouraged through SIFPO.

MSI's collaboration with SIFPO partners—the Population Council, ICRW, EngenderHealth, and the HIV/AIDS Alliance—not only enabled them to develop innovative new tools for programming but also influenced how these four internationally recognized institutions looked at voluntary FP service delivery. This lasting legacy within four influential and established partners is likely to have a global impact in years to come.

SIFPO Marie Stopes International Mid-Term Evaluation Report, August 2013

Developing sector-leading, cutting-edge tools to improve programming and demonstrate impact

MSI invested in tools to model FP impact, track clients over time, and improve operational effectiveness. MSI evolved its cutting-edge **FP impact modeling tool**, *Impact 2*, which estimates the broader health and economic impacts of voluntary FP service provision. In addition to MSI country program use, *Impact 2* is now being used by governments, donors, and non-governmental organizations (NGOs) to help planning and service delivery forecasting for FP2020 goals, such as those developed by the Government of Zambia. MSI also invested in strengthening its management information systems (MIS) to ensure evidence-based decision-making, including development and roll-out of the **Client Information Centre (CLIC)**, a client-based MIS which enables country platforms to have access to real-time, site-based information on client profiles, FP take-up, switching and discontinuation practices; produce client tracking reports (for example identifying and following up clients due for a method refill); undertake marketing and finance analyses to improve business practices; and report against clinical quality indicators more fully. SIFPO supported the development of MSI's **FP costing tool** which can determine the cost effectiveness and main cost drivers of each FP delivery channel and service, informing budgeting, projections of future impact, efficiency analysis, and a deeper understanding of the effect of varying operational costs and service volumes.

Strengthening our youth and gender programming

SIFPO supported MSI to gain a better understanding of where we are, and are not, reaching **youth**. Through better documentation, sharing of approaches, learning, and expansion of our client exit interview protocol MSI was able to design, implement, and scale up innovative approaches that enabled our service delivery models to reach more young people with SBCC, counseling, and voluntary services. For example, young people often express a preference for seeking FP information and services from the private sector however our exit interview results showed that the proportion of young people reached through our social franchise networks was low. MSI tested different approaches for increasing youth access to franchisees, experimenting with both demand side and supply side interventions. In Madagascar, MSI combined franchisee youth-friendly service training (supply side) with FP youth vouchers (demand side) through initial funding from the Africa Bureau and then scaled up its intervention through a field buy-in. This intervention resulted in over 43,000 youth under age 20 taking up a voluntary FP service from a franchisee using FP vouchers during an 18 month period and the majority of these clients chose a LARC. In Senegal, Africa Bureau and field buy-in funds were used to implement an adapted clinic model on a university campus, while in Tanzania a field buy-in enabled MSI to tailor its mobile outreach (including the nurse-led *bajaji* model) to better reach youth through linkages with community-based groups and higher learning institutions.

SIFPO facilitated MSI to benefit from the technical expertise of the International Center for Research on Women (ICRW) to better integrate **gender** considerations into our programming. ICRW collaborated with MSI to develop a gender and youth self-assessment tool tailored to MSI's

programming and operating ethos which was used to inform our programming in Bangladesh, Malawi, and Nigeria. With ICRW technical support, MSI also developed an organizational gender policy which defines a programmatic commitment to gender integration, offers illustrative examples, and links to tools to assist both support offices and country platforms to integrate a gendered and inclusive approach into business planning and programmatic strategies. MSI strengthened its approach to gender-based violence (GBV) programming through the development of GBV clinical and training guidelines and a policy on GBV for voluntary FP programming which were used in a field buy-in project in Tanzania to support the roll-out of national GBV response strategies including police-led “One Stop Centers”.

Strengthening MSI: people, systems, and standards

With more than 12,000 employees across 37 countries, investment in staff capacity across MSI is a crucial input required for continued success in serving clients and managing operations. With SIFPO funding MSI strengthened its **global leadership** pool and has also invested – with a combination of core and field buy-in funds – in a tailored country-level leadership program in Madagascar which is subsequently being rolled out across the global organization. SIFPO was instrumental in enabling MSI to move from an organization with limited in-country **research capacity** – with few externally shared results and a focus on routine service delivery data – to a leader in the sector on metrics and monitoring. Through a multi-year program of training and capacity investment, SIFPO supported MSI to build strong in-country research teams and robust monitoring and evaluation (M&E) systems that are now integrated into all MSI country and global programming.

MSI also strengthened and evolved its approach to **intra-organizational TA**. Through SIFPO, MSI’s internal TA was largely devolved to regional and country levels, with global teams setting standards, providing oversight, and brokering “business-to-business” TA by talented team members in one country program in response to TA requests by another. This initiative included the identification and training of cadres of Master Trainers embedded within country programs; development of peer-to-peer TA between country programs; an increase in secondments between country platforms; and a shift from one-off trainings to modular approaches combined with remote learning follow-up. At the end of the SIFPO award, MSI had a peer TA staff roster of 125 team members from 34 country programs with a diverse skill set available to provide internal TA in finance, M&E, clinical quality assurance, and clinical training among other areas.

SIFPO also strengthened **MSI systems** and capacity in finance, procurement and logistics, and USAID award management and compliance, ensuring a strong basis for ongoing and future service delivery and funding expansion.

Conclusion

Over the five-year award period, SIFPO catalyzed MSI to provide hundreds of thousands of women and men with access to contraceptive method choice, and helped to build sustainable demand for voluntary FP. SIFPO transformed MSI, strengthening our capacity and systems to position the organization to reach millions more women and men in future years. SIFPO provided MSI with a welcome opportunity to strengthen the evidence base for our own programming and use this evidence, alongside our programmatic expertise, to both learn from and influence the wider sector.

Result 1: Strengthened Organizational Capacity to Deliver Quality Family Planning Services to Target Groups

Sub-Result 1.1: Produce significant impact by testing and replicating innovative FP service delivery activities

Sub-Result 1.1 Objective: *By identifying and implementing successful FP practices, SIFPO will contribute to expanded and more cost-effective FP coverage in areas of high unmet need, particularly in sub-Saharan Africa. For instance, MSI's country programs have undertaken a variety of service delivery models and innovations to effectively provide underserved women and couples with a full range of contraceptive methods in both rural and high-density urban areas. MSI provides a critical bridge to the private sector through social franchising and other quality-driven networks that engage private and NGO health providers by offering training, accreditation, branding, and promotion in order to increase client volume and amplify quality FP service provision. Over the life of the project, MSI will identify promising new approaches to delivering needed FP services through these platforms and, through testing and analysis of the results and lessons learned, position them for broader replication.*

Summary of Key Activities and Outputs for Sub-Result 1.1

1.1.1 Evolving innovative, high-impact delivery models

Through SIFPO MSI made great strides in scaling-up and supporting the evolution of impactful service delivery models, building and sharing an evidence base to demonstrate the impact of these models, and testing innovative approaches to reach the underserved.

Testing and rolling out innovative delivery approaches: the *bajaji* model

In SIFPO project Years 1-2, Marie Stopes Tanzania (MST) tested a new low-cost mobile FP delivery model using *bajajis* (a local term for auto-rickshaws) and a small team comprised of a nurse and a driver to provide counseling and a broad range of voluntary FP methods including implants and IUDs. MST had identified a gap in voluntary FP access and choice for low-income urban and peri-urban women in **Tanzania**. MST's static clinics serve only a limited catchment area, and MST's traditional rural mobile outreach model (that utilizes a larger team) was designed for more dispersed and isolated communities rendering it less cost-effective in urban and peri-urban contexts. MST saw the need to develop a new model to meet FP demand among low-income urban and peri-urban women that would complement wider short-term method availability.

MST piloted its *bajaji* outreach model in 2010 in Zanzibar where over one-third of women of reproductive age had an unmet need for FP (10% higher than the rest of Tanzania) and many women face restrictive mobility due to religious reasons. A range of delivery sites in areas

MSI's expansion of service provision has induced a "culture" of demand for FP in some countries. In Malawi and probably in Tanzania, Madagascar, Zimbabwe, and Uganda, MSI has contributed significantly to the national modern contraceptive prevalence rate (CPR).

Mobile outreach models are adapted for the specific setting in which they are used and the skill set available. For example, in Ethiopia, an emphasis on task shifting has meant that clinical officers can safely and effectively perform TLs. In Tanzania, cervical cancer screening has been integrated into outreach provided by Bajajis, and MSI staff members in Ghana mentor government providers with regard to LAPMs. Observations of this during the evaluators' field visits revealed Ghana Health Service's satisfaction with the collaboration. As one health worker put it, "If Marie Stopes Ghana (MSG) stops coming, the pregnancy rate will go up!" MSG has been providing outreach in her district since 2011 when the CPR was 12.9%. In 2012, it was 33.9% (Source: Gomoa East District, Health Directorate Report). This nearly threefold increase was attributed to MSG mobile outreach by the Regional Director of Health.

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with low contraceptive prevalence were selected in collaboration with the Ministry of Health (MoH), along with the option for home-based service delivery to support access and discretion in response to stakeholder feedback that confirmed that many women access voluntary FP services without their partners' knowledge. The pilot was expanded to Mwanza in 2011.

In the 12-month period beginning March 2011 (once both pilot sites were active) over 6,000 women across 94 sites received FP counseling and voluntary services from the *bajaji* nurses. Women chose a range of FP methods, with implants being the most popular.

Table 1: Voluntary FP Services Provided by MST's Bajaji Pilot (March 2011-February 2012)

Implant services	IUD services	Injectable services	Pill clients (3 cycles per client)	Referrals for permanent methods	Total services
3,554	719	1,908	543	86	6,724

In Years 3-5, MST built on the success of the pilot and scaled-up adaptations of the *bajaji* model through USAID bilateral and other donor funding. MST now operates ten *bajaji* teams, which delivered over 42,000 voluntary FP services in 2014; over half of services were LARCs.

Tools developed through SIFPO enabled MST to assess the relative equity and cost-effectiveness of the *bajaji* model. MST's 2013 exit interviews (see also Result 2.1) revealed that 70% of *bajaji* clients were living on less than \$1.25/day (higher than the national figure of 68%), and over half were not using FP when they presented for the service. This client profile is similar to those reached through MST's traditional mobile outreach, suggesting that the *bajaji* model is able to reach a similarly underserved (although less remote) population. Costing tool results (see also Result 2.2) indicated that the cost-per-service for LARCs and short-term methods was 30-50% lower for *bajajis* than for MSI's typical mobile outreach team, an indication that this model is a cost-effective option for reaching more accessible populations in urban and peri-urban areas.

SIFPO also supported MSI to document and share its experiences with the *bajaji* model, accelerating the pace of take-up in other countries, and disseminate the results to the broader sector through the publication *Innovating mobile service delivery to increase FP choice and access for the peri-urban poor: Marie Stopes Tanzania's bajaji model*^l and a presentation at the SIFPO end of project (EoP) meeting in September 2015. MSI now has *bajaji*-style models operating in over ten country programs, and a dedicated global Channel Lead who guides standard-setting, sharing of best practice, and replication across MSI and beyond.

Generating an evidence base for mobile outreach: Population Council evaluations in India and Zimbabwe

While MSI consistently measures the range and quality of services provided by its mobile outreach programs through monitoring, clinical audits, and client follow-up, external evaluations were lacking. In Years 2-4, SIFPO partner, the Population Council, conducted evaluations of MSI's mobile outreach programs in [India](#) and [Zimbabwe](#) to provide a better understanding of the safety, acceptability, and quality of services provided as well as client profiles.

In India, 875 women receiving voluntary TLs and 402 women receiving IUDs from mobile outreach teams in Rajasthan were enrolled between March and October 2012. Pre-procedure and exit interviews were conducted with all clients on the day of service, with follow-up interviews of 1,172 clients after 15 days. IUD clients (n=393) were also followed up at 90 days. MSI's country platform in Zimbabwe, Population Services Zimbabwe (PSZ), sampled 665 women who received voluntary FP services (TL = 7; IUD = 48; implant = 610) from mobile outreach sites in four provinces in September and October 2013. Exit interviews were undertaken before leaving the outreach site, with follow-up interviews of 610 clients after 15 days. Client-provider observations were carried out with all women to measure quality of care and adherence to protocols. Informed consent was obtained by all clients for every data collection activity. Ethical approval was obtained from the

Population Council's Institutional Review Board, MSI's Ethical Review Committee, and through the ethical review processes in each country.

Findings from India

In India the majority of women surveyed were from poor households (although IUD clients were wealthier), had little or no education, and were not using contraception when they presented for the service. The median age was 26 years and all women were married with at least one child. Overall client satisfaction was high, with 98% of clients saying that the quality of the services they received was as expected or better than expected. Most clients (91% TL and 86% IUD) would recommend the service to other women. No major complications were reported; 15% of TL clients and 21% of IUD clients reported still experiencing some side effects (primarily pain and menstrual bleeding) at 15 days, but fewer than 5% of clients reported a moderate or severe side effect which required medical attention. These were made up of:

- 32 TL clients, of which 31 reported moderate side effects (24 of the 31 reported pain from the wound, and 10 reported abdominal pain) and one woman had a serious side effect - bleeding from the wound and infection – which required hospitalisation for one day; and
- 19 IUD clients, of which 15 reported moderate side effects (nine of the 15 reported moderate pain, 10 moderate issues with menstrual bleeding, and two moderate abdominal swelling/pain) and four reported severe side effects (three reported severe pain, two severe menstrual bleeding, and one severe abdominal swelling/pain).

At 90 days post-procedure, 8% of IUD clients had discontinued use, primarily due to bleeding, feeling weak, discomfort during sex, or objections from the husband. Of those who had discontinued and still wanted to avoid pregnancy, fewer than half had started using another method, leaving who discontinued at risk for unintended pregnancy. As a result of these findings, Marie Stopes India strengthened the quality of information provision and follow-up support around side effects for clients.

Findings from Zimbabwe

The median age of clients surveyed in Zimbabwe was 26. Almost three-quarters of respondents were married, and all but one had at least one child. Most women had primary or secondary education, with rural women typically only attaining primary school level. All women in the study had previously used a contraceptive method at some point, although 62% of women reported that they had become pregnant while using some form of contraception, typically contraceptive pills. All clients received information before service provision on method risks and benefits as well as dual protection, but only 61% of clients received HIV/AIDS counseling and 58% were asked about sexually transmitted infections (STIs). In exit interviews, 95% of clients reported that they had been told how to manage side effects and 100% reported that they were happy and satisfied with the service. Two-thirds of clients reported experiencing a side effect at 15 days, most of whom expected side effects and were aware of how and where to seek treatment. The majority of side effects were categorized as “very mild” or “mild”. No serious complications were reported. Four percent of clients experienced a side effect requiring follow-up treatment, half of which were managed through a call to PSZ’s helpline. Half of callers to PSZ’s helpline returned to the facility to see a provider. PSZ incorporated its findings into its mobile outreach programming, for example, strengthening voluntary FP/HIV integration and dispersal of misconceptions during pre-service counseling.

These studies demonstrated the safety and effectiveness of MSI’s mobile outreach provision in India and Zimbabwe, as well as the model’s ability to increase access for underserved groups. Findings were disseminated in-country to government and other stakeholders, as well as globally at



Figure 1: USAID's HIP brief on mobile outreach services

the SIFPO EoP meeting, and contributed to the establishment of mobile outreach as a USAID FP HIP with the results from India were cited in USAID's 2014 mobile outreach high impact practice (HIP) brief.

Systematizing MSI's mobile outreach approach

Operating mobile outreach across MSI's country programs entails complex systems and human resource management requirements. SIFPO funds were invested in the production of minimum standards and guidance and assessment tools for mobile outreach to ensure the use of common approaches across country platforms which are flexible to context but maintain high standards of quality and effectiveness. MSI developed a Standard Operating Procedure Manual (SOPM) which prescribes minimum standards and codifies best practice for mobile outreach operations, allowing country platforms to better respond to context-specific challenges and opportunities. SIFPO also supported the development of a complementary mobile outreach evaluation tool which enables the systematic assessment of capacity across management functions to support mobile outreach, helping managers identify where programs are strong and where weaknesses persist. For example, sections on logistics and staffing identify whether mobile outreach team schedules are being managed to reduce unnecessary travel time and if staffing configurations are appropriate in relation to the mix of voluntary FP services provided. In [Burkina Faso](#), the mobile outreach evaluation recommended adding additional service delivery days to site visits, strengthening monitoring and support for community-level FP awareness raising activities, and undertaking a more systematic approach to engagement with district level MoH partners.

Demonstrating demand for FP in the Sahel: mobile outreach in Burkina Faso and Niger

The vast majority of women in the Sahel face barriers to FP access and choice, including poor health infrastructure, lack of trained providers and FP commodities, financial barriers, and community opposition to FP. Access to LARCs and PMs in particular is extremely limited outside urban areas. In rural areas of [Burkina Faso](#), modern method CPR is 11%; in [Niger](#), which has the highest total fertility rate in the world at 7.6, CPR is 12%. SIFPO investment in 2014 and 2015 enabled MSI to reach new FP users in this challenging, low-CPR environment, demonstrated that demand for voluntary FP (including LARCs) is high even in remote areas of the Sahel, and that targeted investments can help to catalyze voluntary FP uptake in the region.

In April 2014, SIFPO supported MSI Burkina Faso (MSBF) to start-up mobile outreach services in the Fada region, an extremely isolated region on Burkina Faso's border with Niger (estimated CPR of 8%). A second team in the nearby Kaya region was established in May 2015. Together, these two teams made regular visits to over 200 sites serving numerous rural communities. SIFPO also enabled MSI to commence operations in Niger for the first time, providing catalytic funding for one mobile outreach team which commenced providing services in seven underserved districts outside Niamey in July 2014. Between April 2014 and September 2015, these three teams provided 11,878 women with FP information, counseling, and voluntary services – with 8,213 choosing a LARC – generating 31,867 CYPs. Separately, SIFPO core funds were invested to catalyze voluntary FP access and choice in rural but less remote areas of Burkina Faso, providing important seed funding for additional mobile outreach teams which successfully attracted longer-term donor funding and provided over 45,000 voluntary FP services in a two-year period (generating over 150,000 CYPs). MSI's 2014 exit interview results showed that a third of MSBF's mobile outreach clients were under 25 years of age, 90% did not complete primary education, two-thirds were not using an FP method when they presented for their service, and clients had an average of 3.5 children.

SIFPO supported MSI to tailor its SBCC and community engagement approaches to meet the unique demands of the Sahel environment through targeted village-level strategies that garnered critical support from local religious leaders. MSI also developed partnerships with other organizations working in the Sahel – such as the Resilience and Economic Growth in Sahel - Enhanced Resilience initiative – which allowed MSI to offer a more integrated package of information and services to communities. In Burkina Faso, MSI-trained community based

mobilizers (CBMs) also worked closely with a network of over 50 high schools and colleges to undertake FP information sessions as part of a coordinated effort to reach more youth.

In addition to supporting MSI's initial mobile outreach team in Niger, SIFPO investment enabled MSI to initiate broader voluntary FP programming in the country by demonstrating the effectiveness of mobile outreach in this context, which attracted additional donor funds as well as larger investments (enabling expansion of mobile outreach operations) under SIFPO2 (Marie Stopes Niger provided almost 20,000 women with voluntary FP services in 2015).

1.1.2 Increasing FP access and choice for post-partum women: introducing PPIUD provision in the private sector

While many women in developing countries seek maternal health services from private providers, private sector ability to deliver PPF choice, and specifically capacity to provide post-partum intrauterine devices (PPIUD), remains limited. To address this challenge, SIFPO supported MSI to build social franchisee capacity to provide PPIUD as part of a broad voluntary FP method offering. In Year 3, MSI developed a training package (based on a review of existing curricula) for the introduction of PPIUD provision (as part of a broader PPF package) to social franchisees, trained a small set of clinical providers as Master Trainers, and tested the training with a group of eleven franchisees in **Kenya**. In Year 4, MSI provided follow-up support and mentoring to the Kenyan franchisees, and expanded the training to **Nigeria**, where 18 providers (11 franchisees, two government midwives, and five BlueStar clinical managers) were trained using an adapted version of the curriculum developed in Kenya. Subsequently, a second wave of 35 franchisees in Nigeria and **Ghana** were trained with SIFPO2 support in mid-2015.

MSI found high levels of enthusiasm among staff and private providers for the training, but experienced challenges with low client numbers (despite demand generation efforts in ante-natal clinics and teaching hospitals) thus limiting provider opportunities to practice and gain full competency. In response MSI's Clinical Supervisors subsequently provided ongoing training and support to ensure trainees achieved competency and certification to provide PPIUD insertions independently. Follow-up supervision visits highlighted good retention of clinical and client-centered counseling skills, with franchisees demonstrating good technique and scoring well in clinical audits, but variable take-up across franchisees, with a few franchisees contributing most of the PPIUD clients (in two of the Kenyan franchisee clinics, for example, approximately one-third of women delivering at the clinic received a PPIUD).

A learning exercise was funded under SIFPO2 in early 2015 to understand success factors and challenges behind the Kenya and Nigeria PPIUD initiatives to date. Successful strategies included: training MSI staff and franchisees at the same time; providing essential instruments and equipment to providers, and lending Mama U models for continued practice post-training; and the importance of specific supportive supervision and follow-up to ensure skill retention. Identified gaps included a need for enhanced demand generation for voluntary PPF and PPIUD services prior to conducting trainings to ensure adequate client volumes for practical training sessions. These findings informed the trainings conducted in Ghana and Nigeria and informed new competency checklists, MSI's global obstetric quality technical assistance (QTA) tool, and other customized PPF data collection tools.

SIFPO investment in this area has galvanized MSI to address the "missed opportunity" for PPF by franchisees, with several country programs now implementing franchisee PPIUD training with other donor funds using the global tools and manuals developed under SIFPO. MSI is also stepping up to encourage private sector inclusion in government PPF initiatives. Ten MSI country representatives participated in *The Accelerating Access to Post-Partum Family Planning Global Meeting* in May 2015, and country programs are now engaged in follow-up national PPF initiatives, including integration with other services, competency-based training, emphasis on counseling along the continuum of care, and integration of PPF indicators into routine data collection and supportive supervision.

1.1.3 Testing the effectiveness of Mobiles for Quality Improvement approaches to improve provider knowledge and behavior

Health service providers in many developing countries have only limited access to up-to-date clinical protocols, or face-to-face trainings, particularly in the private sector. Mobile phones offer an innovative channel through which to provide cost-effective approaches for clinical training and support for improving quality of care. M4QI is a technology-supported approach to performance improvement, using short message service (SMS) text message reminders and quizzes for post-training message reinforcement, identification and resolving of knowledge gaps, and enhancing the effectiveness of supportive supervision and follow-up. It has particular relevance for training and monitoring of social franchisees, where geographical and resource barriers can limit regular face to face training and supervision. However, the M4QI evidence base remains limited.

Following an initial M4QI pilot through the Strengthening Health Outcomes through the Private Sector (SHOPS) award with MSI in Uganda, SIFPO supported M4QI trials in **India** and **Nigeria** in Years 4 and 5. Marie Stopes India piloted the activity with its nurses to improve the quality of post-operative counseling and follow-up guidance to clients, in light of findings from clinical audits and the Population Council outreach evaluation (described in Activity 1.1.1 above).

Marie Stopes India selected nine nurses (one per mobile outreach team) who were responsible for providing procedure counseling and guidance to clients (including follow-up calls). The nurses received SMS message reminders for three months. Team leaders and district coordinators monitored progress using observational checklists and follow-up calls to clients were tracked and validated. In-depth interviews were conducted with the nurses after the intervention period to attain provider feedback and perceptions of performance changes. The response rate of the nurses to the SMS messages varied from 40-100%, and between 20% and 100% replied correctly to quizzes. In-depth interviews with the nurses affirmed that regular informative messages and quiz questions helped them remember key instructions such as warning signs, complications, and side effects. The observational checklist indicated that seven of the nine nurses were adhering to all post-operative guidelines at the end of the intervention, and the proportion of clients receiving a follow-up call from the nurses within 24 hours of service increased from 21% to 50%. The nurses provided positive feedback on the content and timing of the messages stating that, “messages were clear and informative and I would refer to a past message if I forget anything,” and “initially I would give general instructions but now because of these messages I have started giving method specific instructions.” Outreach teams also reported that receipt of an SMS message prompted team discussion and learning, “I would look forward to the quiz message and my team members would ask what question did you receive today?” and “it benefitted us in two ways – now we remember important things to be shared, and there is also more consultations within the team.”

In **Nigeria** MSI undertook a study to assess the effectiveness of M4QI as a tool to improve franchisee knowledge and performance, using a randomized control group design and measuring differences in quality of counseling, clinical service delivery, and knowledge retention. A total of 137 social franchisees were randomly assigned to control and intervention groups, and a baseline survey completed in early 2015 covering three assessment areas: a mystery client survey; a clinical assessment; and a customized M4QI survey. The intervention start date was delayed due to technical challenges establishing the SMS platform and limitations around phone reception in some of the regions where franchisees operate. Problems were resolved and the intervention commenced in May 2015 and ran for five months. The endline survey and dissemination of results are part of SIFPO2.

Sub-Result 1.2: Document and share innovations, catalyzing state-of-the-art FP programming globally

Sub-Result 1.2 Objective: *Innovating, demonstrating, and identifying promising innovations in FP programming and models, combined with dissemination, will expand the global FP and sexual and reproductive health (SRH) knowledge base, ultimately improving the quality and reach of FP services in alignment with USAID's global objectives. MSI's approach will provide concrete evidence and examples, for the benefit of the global SRH community, that FP innovations are scalable, cost-effective, and have the potential for national impact.*

Summary of Key Activities and Outputs for Sub-Result 1.2

1.2.1 Advancing the task-sharing agenda through country-level research and global leadership

Task-sharing of FP service delivery to lower-level providers increases the number of qualified providers for a given FP service, thus increasing access and particularly in rural areas. SIFPO enabled MSI to build the task-sharing evidence base and advance the global task-sharing agenda through a series of inter-linked initiatives.

Targeted task-sharing research

Task-sharing research was undertaken both in countries where restrictive policies were hampering voluntary FP access and choice, and where more liberal task-sharing policies were in place but not implemented. In **Uganda**, access to LARCs and PMs is limited, and there is an imbalance of health workers between rural and urban areas. In Year 2, MSI documented its experience of task-sharing TLs to clinical officers in response to a request by the MoH for locally-generated evidence on the safety and acceptability of this approach in Uganda. Four Marie Stopes Uganda (MSU) clinical officers were trained in TL provision and then observed providing the service to 518 TL clients who had consented to take part in the study. Safety and acceptability outcome data was collected at baseline and during three follow-up visits (days three, seven, and 45). Study findings included a low adverse clinical events rate of 1.5% and strong client satisfaction, with the majority of clients rating their clinical officer as “good” or “very good” and reporting that they would recommend the procedure to a friend.

Findings were presented to national WHO and MoH stakeholders as well as members of the Ugandan parliament. As a result the MoH approved implementation of TLs by trained and supervised clinical officers. While public sector implementation of the new policy has moved slowly, the policy enabled MSU to deploy clinical officers instead of doctors on mobile outreach, dramatically improving retention and cost-effectiveness while increasing access to voluntary PMs as part of a broad method mix for rural women (previously doctor staffing gaps had been a regular issue). In 2013 MSU provided over 45,000 voluntary TLs to rural women through mobile outreach, a 28% increase on the number provided in 2012 when clinical officers could not be utilized. Study findings were published in the paper *Safety and acceptability of tubal ligation procedures performed by trained clinical officers in rural Uganda* (see Annex 1 for full publication details).

MSI used lessons from the Uganda task-sharing initiative to inform ongoing task-sharing research in **Zambia**, where TL provision is restricted to doctors and medical licentiates, and TL prevalence among women of reproductive age is 1.4% and substantially lower than elsewhere in the region. Marie Stopes Zambia (MSZ) is partnering with the Zambian MoH and the Lusaka University Teaching Hospital to institutionalize TL task-sharing to clinical officers through task-sharing demonstration research following a design and protocol similar to the one used in Uganda. Training of four clinical officers (two MSZ staff and two government staff) was completed through SIFPO and data collection, analysis and dissemination will take place under SIFPO2.

In **Sierra Leone**, where FP access and choice is particularly limited in rural areas due to a lack of health workers and poor infrastructure, CHWs are the first point of contact for healthcare for many.

However, MoH policy currently permits CHWs to distribute oral contraceptives and condoms only, with referrals to government health facilities for other FP methods. Numerous studies demonstrate that CHWs can safely and effectively provide Depo Provera (a three-month injectable contraception) thereby expanding voluntary FP access and choice to underserved clients. In Year 4, Marie Stopes Sierra Leone (MSSL) and the MoH conducted a pilot to add Depo-Provera provision to the CHW service mix. The pilot design was informed by expertise and guidance from FHI-360, building on their trialing of Depo Provera task-sharing to CHWs in Kenya and Uganda.

Conducted in the rural Koinadugu District, this six month intervention was successfully implemented despite the Ebola outbreak. A total of 150 CHWs were trained on FP counseling and Depo Provera provision, and provided 10,810 Depo Provera services during the intervention period, with fortnightly supervision throughout. Evaluation of the pilot was based on CHW training scores, client demographics, client acceptability, adverse events, and quality of counseling and service provision through direct observation by supervisors. The pilot was successful in reaching first-time users (42% of clients), young women (33% of clients were under 18), and women with little education (52% of clients having primary education or less). The proportion of young clients reached by CHWs was greater than the proportion of young injectable users nationally, suggesting CHWs are better placed than other providers to reach youth. No clinical incidents occurred and supervision observations found CHWs could satisfactorily provide implants and IUDs.

In **Nigeria** continued skepticism of task-sharing feasibility means their policy has not been adopted by Nigerian states. MSI is undertaking a non-inferiority trial comparing the safety, quality, and acceptability of implant insertion and (where caseload permits) removal performed by community health extension workers (CHEWs) to that of nurses in Kaduna and Ondo states, aiming to drive implementation and scale-up of Nigeria's policy by evidencing the ability of CHEWs to provide implant services and the training and monitoring needed to do so safely. The study protocol has completed ethics review, and training of 60 CHEWs and 60 nurses (30 each per state) commenced in September 2015. Provider accreditation, service provision, data collection and dissemination will be completed under SIFPO2.

Operationalizing task-sharing policy: scaling up community-based injectable provision in Uganda

In **Uganda**, FHI-360 and others successfully undertook research to demonstrate the safety and acceptability of task-sharing injectables to Village Health Teams (VHTs) resulting in government policy change, but the policy had not been fully implemented at scale. In Year 3, SIFPO supported MSU to trial a delivery and monitoring model that utilized existing mobile outreach teams to supervise, supply, and support VHTs in the provision of voluntary short-term FP methods, including Depo Provera. MSU then undertook operational research (using separate bilateral USAID funds) to assess the effectiveness of this model with a focus on client care, quality, and access.

Between March and September 2013, MSU trained 109 VHTs in the provision of voluntary short-term FP services including Depo Provera, and mobile outreach teams and MoH staff then provided follow-up monitoring and supervision. Almost 9,000 injectables were delivered by VHTs in the six-month period in addition to almost 24,000 pill cycles. VHTs were also trained to use MSU's mobile phone SMS reporting tool (MarieTXT) as a cost-effective solution to the otherwise cumbersome paper-based reporting system.

Findings from operational research conducted in late 2013 indicated that among MSU's VHT Depo Provera clients: four out of five reported receiving comprehensive information on all available FP methods; four out of five rated the counseling they received from VHTs as "good"; 60% recalled being given information on side effects of Depo Provera; and two-thirds recalled the date of next injection being discussed. When clients were asked their views on VHT provision of Depo Provera, the most common four responses were: "provided with desired service"; "satisfied with services offered"; "treat us with courtesy, respect, and privacy"; and "good interpersonal relationships with clients".

Advancing the global task sharing agenda

MSI played a leading role in **successfully advocating with WHO for inclusion of progressive FP task-sharing approaches** in their 2012 published guidelines, *Optimize4MNH*ⁱⁱ. These contain recommendations for optimizing health worker roles to improve access to key maternal and newborn health interventions through FP task-sharing with a particular focus on LARCs and PMs. MSI was also asked by WHO to lead the drafting of the summary FP recommendations from *Optimize 4MNH*. The guidelines and summary recommendations are proving to be an invaluable policy engagement tool at international and national government level.

MSI built on the momentum created by these new WHO guidelines by facilitating a technical consultation on task-sharing in Washington DC in 2012. The meeting brought together more than 40 representatives from key agencies and leading organizations in the field of SRH including USAID, Pathfinder International, Population Council, CapacityPlus, Jhpiego, Population Services International (PSI), AFP, EngenderHealth, Abt Associates, PAI, FHI360, UNFPA, and IntraHealth. The workshop covered issues on service delivery implementation, research, advocacy, policy, communications, training, and scale-up. Participants mapped existing and planned activities on the ground, brainstormed key messages and audiences that would help support the rollout of the WHO recommendations, and prioritized countries for enhanced work and implementation by all organizations represented. The momentum created by the task-sharing consultation led to the formation of a task-sharing working group which is being taken forward under SIFPO2. MSI also disseminated its task-sharing research findings at numerous conferences and developed a task-sharing impact modelling tool which can be used for advocacy purposes (see also Activity 2.1.2).

1.2.2 Build the evidence base for innovative clinical approaches: assessing the effectiveness of vocal local for tubal ligation procedures in Kenya

MSI recommends that TL procedures only use general anesthesia or opioid analgesics in special circumstances due to the increased risk of side effects and adverse events. MSI utilizes a less-medicalized pain management approach that uses “vocal local” (verbal encouragement and support) combined with local anesthesia as this lowers anxiety, pain, and discomfort; has fewer side effects; offers a shorter recovery time; and is more cost-effective. MSI has successfully used this less-medicalized approach to enable TL services to be more widely available in low-resource settings while achieving high levels of client satisfaction. Though MSI’s vocal local approach was believed to reduce pain and anxiety for clients and to reduce the side effects of opioid drugs it lacked a robust experimental evidence base.

SIFPO supported MSI to implement a study in **Kenya** to compare the acceptability of vocal local plus local anesthesia (VL+LA) versus the more traditional use of opioid analgesics plus local anesthesia (OA+LA) among women obtaining voluntary TLs during outreach services. Quality of care, follow-up, and client satisfaction were examined and documented. The research protocol received MSI and local ethics approval in October 2011. Two mobile outreach teams were involved in this study and received vocal local refresher training as well as training in the administration of the opioid analgesic tramadol hydrochloride. Project sites were selected and randomly allocated to control and intervention groups. Data was then collected over a period of six months between February and August 2012. A total of 884 women (423 in the control arm and 461 in the intervention arm) who had been counseled on their FP options and voluntarily chosen a TL consented to be part of research and were included in the study.

The study concluded that the use of VL+LA was not an inferior pain relief approach as compared to the use OA+LA during a minilaparotomy TL procedure. Furthermore, the use of VL+LA was found to be highly-acceptable to clients. Bivariate analyses of pain, anxiety, and satisfaction outcomes between the two groups found very few significant differences. After adjusting for baseline factors, pain during the procedure was not significantly different between control and intervention groups. This finding suggests that use of VL+LA does not lead to increased pain during a minilaparotomy TL procedure as compared to the use of OA+LA. The evidence supported MSI’s less-medicalized and lower-cost approach to pain management applied in its client care that

begins with the introduction of FP options, provision of safe and effective voluntary FP services, and concludes with a satisfied client.

MSI disseminated these study findings widely within the sector, adding to the body of evidence regarding client comfort and satisfaction as well as the operational aspects of voluntary female sterilization procedures. The academic paper *Vocal local versus pharmacological treatments for pain management in tubal ligation procedures in rural Kenya: a non-inferiority study*ⁱⁱⁱ findings were also shared in the permanent method exchanges and symposium described in Activity 1.2.3 below.

1.2.3 Increasing the knowledge base on permanent methods: technical exchanges and consensus-setting on clinical approaches

Access to voluntary PMs has not increased at a pace comparable to that of the unmet need for FP. SIFPO facilitated MSI and EngenderHealth – two of the leading providers of voluntary female sterilizations in low-resource settings – to share experiences and approaches to TL provision, reach consensus on appropriate clinical methods in different settings to ensure a common understanding and reduce provider confusion, and galvanize the sector to keep PMs on the agenda in order to help close the FP access gap.

MSI and EngenderHealth have slightly different clinical approaches to TL procedures based on experience, settings, and provider populations (EngenderHealth works primarily with generalist public providers managing low TL client volumes, whereas MSI trains specialist FP providers who see high client volumes). MSI and EngenderHealth clinical staff took part in technical exchanges in Years 2 and 3, including reviews of clinical protocols and visits to Malawi to observe the two organizations' clinical approaches in action, followed by meetings to discuss the findings and explore options for how the organizations could use their experience to inform global best practice.

In Year 4 MSI and EngenderHealth hosted a PM symposium in Nairobi with experts from 27 organizations across 13 countries who shared their organizational experiences of voluntary PM programming in low-resource settings; reviewed differences in surgical techniques and service delivery modalities; shared clinical protocols and training approaches; and identified areas for further research to strengthen evidence-based clinical practice. Research priorities included a comparison of the safety of minilaparotomy procedures performed by physicians and mid-level health providers; comparison of pain management regimens; and effective interventions to increase vasectomy uptake. Participating organizations developed and signed a consensus statement on increasing access to high-quality PMs in low-resource settings which is described in more detail under Activity 2.4.1.

Sub-Result 1.3: Strengthen MSI organizational and technical capacity at the global, country, and headquarters level

Sub-Result 1.3 Objective: *Investments in MSI's core operational and technical capacity will ensure the advancement of global voluntary FP programs through leadership, knowledge generation, and the highest level of quality oversight of FP services. In addition, MSI has a Technical Leadership Group (TLG) for the SIFPO project that includes peer organizations with a wide range of expertise and experience in FP and SRH. Through TA and consultation with its TLG, MSI will identify promising approaches to service delivery, share technical resources and research findings, and obtain peer review of technical and programmatic tools and materials.*

Summary of Key Activities and Outputs for Sub-Result 1.3

1.3.1 Strengthening clinical quality to meet the needs of a growing organization

Clinical quality is a cornerstone of MSI's work. SIFPO supported MSI to evolve our approach to QA to match the organizations' exponential service delivery growth and ensure that our clinical frameworks, tools and QA approaches are fit for purpose in a changing and dynamic service delivery environment. In particular, SIFPO has enabled MSI to learn from others – from a technical consultation on clinical quality with clinical leads from ten leading health service delivery organizations, to ongoing peer review and support from EngenderHealth – to strengthen our FP clinical protocols, clinical quality standards and assessment tools and implement change through country-based training-of-trainers and dissemination.

Strengthening of clinical standards, protocols and training approaches

In Years 1 and 2, EngenderHealth peer reviewed MSI's clinical standards and protocols and their feedback was incorporated into an overall strengthening and updating of our clinical standards and protocols in Years 3 and 4, along with a review of the format and training methodology used to disseminate these protocols to field level to ensure maximum cost-effectiveness and sustained good clinical practice. In Year 4, MSI updated, simplified, and restructured organizational FP standards to ensure that they are user-friendly, adaptable for various levels of cadres, simple, and applicable in all MSI FP delivery channels.

Similarly, training curricula were simplified and made more flexible to allow trainers to create context-specific training packages depending on the needs of the country program. MSI worked with EngenderHealth to review training methodologies and develop on-the-job training and mentoring guidance using best practice from both organizations and externally. MSI decentralized its training process, establishing a Master Trainer development program in 2014 which has so far produced a cadre of 18 regionally-based Master Trainers able to co-train and/or lead MSI clinical service trainings. MSI provided Master Trainers with instruction on adult learning and training design, followed by supervision, and mentoring opportunities in order to quality assure training delivery.

Evolving MSI's Quality Technical Assistance clinical audit mechanism

MSI's QTA visits, conducted annually in each country program, audit the quality of care being provided to clients while simultaneously providing TA to address any areas of weakness. Over the course of SIFPO, MSI evolved the tool from being headquarters-led to a peer- and self-assessment process, extended the scope to cover the social franchise delivery channel, and made several updates to technical aspects of the tool. In Years 1 and 2, MSI organized a technical consultation on clinical quality with clinical leads from ten leading health service delivery organizations, and used findings from this consultation along with internal and external peer review feedback to update the QTA tool. Key aspects of the tool were strengthened, including client focus, principles of voluntarism and informed choice, and FP/HIV integration. In Year 4, the tool was

refined to include weighting of scores for clinical governance and infection prevention, and the site selection methodology was revised to be randomized based on a 10% confidence interval. MSI also evolved its approach to conducting QTAs, allowing peer-to-peer QTAs in Year 4 (rather than relying on external consultants or MSI's small team of Regional Medical Advisors) for high-performing country programs. By 2015, 11 country programs had scored sufficiently highly and consistently to graduate to peer-to-peer QTAs, and an additional eight country programs were in the process of being accredited.

Improving MSI's approach to counseling

Ensuring effective counseling is central to MSI's client-centered approach. In Years 4 and 5 MSI reviewed and refreshed its approach to client-centered counseling based on findings from market insight surveys (see also Activity 2.1.2), feedback from the SIFPO mid-term evaluation related to issues with the accuracy of counseling messages by some social franchisees, exit interview findings (see also Activity 2.1.3), and anecdotal evidence from country programs suggesting a need to provide more client-friendly information in more efficient ways. A new counseling policy, set of guidelines, and training curriculum were produced with input from EngenderHealth. Founded on EngenderHealth's rapport building, exploration, decision making, and implementing (REDI) framework for client counseling, new tools and training materials were produced that place a greater focus on client lifestyle preferences to ensure that choices are informed by both medical eligibility and client preference, while avoiding overloading clients with information. The expectation is that this more focused counseling approach will result in uptake of the most appropriate method for the client and less discontinuation. Staff responsible for counseling clients will undertake a new one-day training course on counseling skills, including the use of newly developed materials. The training and materials were tested in Ghana, Niger, and Uganda in Year 5, and ongoing refinement and rollout of the newly developed counseling tools will be undertaken under SIFPO2.

Moving towards a holistic quality assurance approach

To ensure ongoing high levels of clinical quality across country programs as we grow, MSI identified the need to move beyond the QTA "snapshot" approach and develop a more holistic framework for defining and assessing clinical quality on an ongoing basis, enabling identification of risk and decision-making to support continuous quality improvement. MSI's Quality Assurance Framework (QAF) was developed to provide a structure to improve the consolidation, measurement, and analysis of key clinical quality information. The QAF goes beyond MSI's QTA compliance process, requiring deeper analysis of clinical quality at a program level through the domains of clinical effectiveness, client safety, and client experience on an ongoing basis (rather than annually) to more rapidly determine priorities, embed quality into our behaviors, and assist in business planning and decision making.

As part of this process, MSI has developed a QAF dashboard which provides country programs with an integrated clinical quality measurement tool. The dashboard pulls together previously disparate clinical information (including QTA information and other country-level indicators such as clinical complications) and is designed to be managed, used, and easily understood by clinical and non-clinical managers. The dashboard was tested in Tanzania before being rolled out in Ghana, Kenya, and Zambia. A key lesson from the initial roll-out was the need for greater focus on dashboard utilization by senior management teams. In Year 5 MSI Regional Medical Advisors worked closely with initial country programs to increase dashboard literacy, emphasize the added value of the QAF dashboard, and embed dashboard reporting and monitoring into routine quarterly meetings and reviews. QAF-specific reports are now being generated to support quality related decision making in these countries. MSI will roll-out the QAF dashboard globally under SIFPO2.

Sub-Result 1.4: Integrate FP service delivery with related health services

Sub-Result 1.4 Objective: *In order for FP services to be most effective, every opportunity in serving clients and identifying synergistic opportunities should be exploited. MSI will examine its current approaches to integrated programming – including FP/HIV, GBV, maternal, neonatal and MCH – and use those findings to improve its operational policies, service delivery protocols and practice, and referral networks. The SIFPO TLG will provide advice in designing and enhancing health services integration.*

Summary of Key Activities and Outputs for Sub-Result 1.4

1.4.1 Strengthening HIV/FP programming at MSI

MSI recognizes the two-way value of integrated HIV and voluntary FP services for the populations it serves, both in HIV prevention and ensuring HIV-positive women have access to voluntary FP without bias or barriers. With SIFPO partner International HIV/AIDS Alliance, MSI completed a series of activities to deepen organizational understanding of HIV/FP programming gaps and opportunities, and strengthen the quality of HIV/FP programming in selected countries. In project Years 1 and 2, the Alliance developed a self-assessment tool to measure the readiness, level, and quality of integration of HIV prevention and treatment services within MSI's reproductive health programs. This tool was field tested in **Tanzania** and **Zambia** before being refined and finalized, and the Alliance conducted a webinar on the tool for MSI support office and country program team members in Year 3. In Zambia, the Alliance recommended development of integration indicators and increased involvement with national and community HIV organizations, building on “a very enthusiastic approach to integration at country office and clinical level...the team observed consistency in non-judgmental attitudes and approaches, and to assuring confidentiality, all of which is conducive and provides good entry points for integrated services.” In Tanzania, findings from the assessment helped MSI to expand voluntary counseling and testing (VCT) throughout its delivery channels.

Building on findings of the assessments, a voluntary HIV/FP service delivery integration training package was developed on key FP service elements – such as HIV prevention, dual protection, stigma reduction, and working with people living with HIV/AIDS – to support MSI country programs and other key stakeholders to improve integrated implementation. MSI and the Alliance used the materials for a global training-of-trainer (ToT) workshop in Zambia for MSI country program team members implementing integrated services. The workshop also reviewed approaches, successes and challenges to integrating services and enabled a forum for colleagues to share experiences.

Using the self-assessment tool as a basis, MSI and the Alliance subsequently conducted peer assessments on each other's FP/HIV integration activities in **Cambodia** and **Kenya** to determine programming strengths and gaps where FP/HIV services could be strengthened. Both organizations worked collaboratively in reviewing key findings and recommendations, and developed a consensus driven action plan to further integrate service delivery moving forward. In Cambodia, key recommendations from the assessment included: ensuring dedicated clinic space for counseling, testing, and education for clients related to HIV, STIs, and voluntary FP; and holding focus group discussions with most at risk population (MARPs) representatives and women living with HIV to assess their HIV/SRH service needs, and use this to inform provision. The two organizations have since worked together to develop strong HIV/SRH referral pathways, for example, through mapping of services and MoUs signed with relevant organizations. Findings also informed Marie Stopes Cambodia's SIFPO buy-in FP/HIV strategy (see the Cambodia field buy-in description below).

In Kenya, key recommendations included improving Marie Stopes Kenya (MSK) and KANCO (the Alliance's linking organization in Kenya) staff technical integration capacity; strengthening community sensitization on the right to demand integrated services; development of job aides and marketing materials to integrate voluntary FP/HIV services; and linking KANCO with MSK during

outreach service delivery to provide integrated services. MSK and KANCO staff participated in a training facilitated by the Center for African Family Studies on integrating FP/HIV programs. MSK then trained service providers in voluntary FP/HIV integration, and integrated key points into supportive supervision, to improve provider awareness and knowledge around FP/HIV service integration. MSK and KANCO also met with the Department of Reproductive Health to discuss the assessment findings in relation to the national policy on FP/HIV integration services.

1.4.2 Strengthening MSI's PAC programming

MSI is committed to providing high-quality PAC in relevant delivery channels across its country programs as an important component of comprehensive SRH services. MSI seeks to ensure that PAC includes FP counseling and provision of a comprehensive range of voluntary FP methods for women seeking to avoid a future unintended pregnancy. SIFPO supported MSI to review and improve its PAC service delivery protocols, including sharing of materials with USAID experts for their feedback. The full PAC protocol – including PAC FP training materials and tools, and the beginner PAC training module – has been shared with a number of country programs (e.g. [Afghanistan](#) and [Yemen](#)) and is available as part of a range of MSI trainings based on country requests.

SIFPO also enabled MSI to actively participate with collaborating agencies in technical working groups and communities of best practice to strengthen PAC programming through its own channels and more widely in the FP community. MSI programmatic and clinical representatives have regularly attended PAC Connection meetings where we have learned from others' work in the field and shared our own experiences of PAC programming in diverse country contexts.

Result 2: Internal quality assurance standards and results quantified and disseminated to strengthen FP performance at a global level

Sub-Result 2.1: Strengthen organizational capacity to monitor, evaluate, disseminate, and use data and research

Sub-Result 2.1 Objective: *The ability to track performance and results has been a critical feature of MSI's service delivery model. In 2009 MSI expanded its key performance metrics from basic service statistics, such as client numbers and FP services, to include additional indicators that allow for deeper analysis of results and impact. MSI is beginning to consistently collect data on equity, access, and quality. MSI proposes to accelerate this effort by strengthening its research and metrics capacity at all levels of the organization through on-the-job skills building, TA, and trainings.*

Summary of Key Activities and Outputs for Sub-Result 2.1

2.1.1 Building world-class monitoring and evaluation capacity

SIFPO has been instrumental in enabling MSI to move from an organization with limited in-country research capacity, few externally shared results, and a focus on routine service delivery data, to a leader in the sector on metrics and monitoring, with strong research teams across multiple country programs and robust M&E systems integrated into country and global programming.

In Years 1 and 2, MSI standardized a set of global M&E metrics (with inputs from the Population Council on quality indicators) and an accompanying MSI M&E manual and launched these across its global programs. An initial M&E cascade training, which included an M&E manual roll-out, took place in Year 1, with 30 M&E and program manager participants from across country programs trained as M&E Trainers through a mix of real life case studies, interactive question and answer sessions, and hands-on exercises. Post-test results showed higher confidence in logframe development, improved ability to set M&E indicators, and a strengthened understanding of MSI's poverty measurement metrics. This was followed by one-day speed-training sessions for London-based staff. Training materials (updated based on user feedback including videos and interactive sessions) were subsequently published on MSI's Best Practice Gateway (an internal resource library). In Year 2, country staff certified in the Year 1 training, undertook country-level cascade trainings in a range of countries including Afghanistan, Bangladesh, India, and Pakistan. In Year 3, MSI delivered a follow-on M&E workshop for 30 participants from 22 countries, with preference given to team members from country programs not exposed to previous training sessions. In total 262 team members from over 20 MSI countries benefitted from M&E trainings delivered between 2011 and 2013. This was supplemented with additional tailored trainings, including a Population Council-led operations research training for 24 field staff in Year 1 covering the manager's role in operational research, quasi- and non-experimental designs, conducting a study, and research ethics.

This initial phase of trainings and support strengthened country-level M&E and quantitative research capacity greatly, as seen through the increases in numbers of countries undertaking exit interviews, for example (see Activity 2.1.2). However, qualitative research capacity was identified as a gap by both country program and global M&E staff, and also highlighted in the SIFPO mid-term evaluation as an area for strengthening:

Focus on qualitative research has appeared only recently in the MSI portfolio. However, it can help the organization better understand its client base and develop locally and culturally appropriate initiatives, especially for youth.
SIFPO MSI Mid-Term Evaluation Report, August 2013

In Years 4 and 5 MSI focused on building its qualitative research capacity in order to better understand who our clients are, who we are not reaching, and the qualitative factors behind voluntary FP decision-making. MSI conducted a qualitative research capacity building workshop for

22 participants from 14 country programs at the end of Year 3 that focused on designing and implementing focus group discussion research, stakeholder interviews, and other qualitative research approaches. All participating countries committed to undertake qualitative client insight research in the six months following the training putting their new skills into practice, with support and mentoring provided by MSI's Regional Research Advisors.

In the final years of SIFPO, MSI worked to embed and maintain country research capacity through a combination of remote and in-person TA and the development and roll-out of M&E e-learning modules organized for self-learning and with each taking around one hour to complete. Completion of the e-learning modules was made compulsory for M&E staff across MSI in 2015. SIFPO also supported MSI's Ethics Research Committee, which reviews around 30 research protocols annually from a variety of countries and has produced research ethics guidance on key issues such as research involving minors and community engagement.

2.1.2 Understanding the client: investments in client exit interviews and consumer insight research

Starting in 2010, with support from SIFPO and other donors, MSI began to invest in annual client exit interviews to get a more robust and standardized understanding of who we were reaching in different countries and through different delivery channels. Growing from a handful of countries initially in 2010, in 2014 exit interviews were conducted with over 19,000 clients across 29 countries covering four delivery channels. Exit interview information enables country programs, and MSI globally, to understand trends and differences between countries and channels in client age, poverty levels, FP history (for example, new users or switchers from short term methods), and experience. SIFPO supported MSI's exit interview work both in-country (by funding TA for country programs) and at a central level (by supporting collation, analysis and dissemination of country level data through user-friendly exit interview summary documents).

Most importantly, SIFPO enabled MSI to continually strengthen and evolve our client exit interview process, so that we continue to lead the sector in terms of the breadth and depth of our client profile data. For example in Year 4, the exit interview protocol was expanded to increase MSI's focus on client counseling and method choice. The addition of new questions allowed MSI to understand, for example, whether clients had made their method decision prior to arriving for the service (73% had in 2014), whether they felt the level of information provided was "too much", "too little", or "about right" (77% thought it was "about right" in 2014), and how many methods they could recall being counseled on (four on average). SIFPO also supported an increased focus on exit interview data utilization, including a series of dissemination webinars, the creation of an interactive exit interview dashboard enabling users to assess how key indicators have changed over time, and creating automated factsheets for each country platform. MSI's M&E team tracked over 40 country examples of use of exit interview data to improve programming in 2014 alone, demonstrating the high utility of exit interview data to country programs.

Client exit interviews provide MSI with an excellent snapshot of who we are reaching. Prompted by the SIFPO mid-term evaluation findings MSI sought to deepen our understanding of who we are not reaching, and why, through better use of existing data (for example Demographic Health Survey data) and through consumer insights research that disaggregates non-FP users by preference and behavior (rather than by standard demographic segmentation). MSI contracted a market research agency to undertake multi-stage consumer insight research in six countries (including Bangladesh, Nigeria, and Uganda), including a review of secondary data, initial in-depth interviews (30 per country), and an initial phase of country consultation and feedback followed by larger-scale quantitative research in the six countries. Key findings and recommendations shared globally included: the need to shift from age and geographical segmentation to life-stage and FP adoption journey segmentation; better disaggregation and understanding of non-users (including youth), lapsed, and non-users not opposed to FP; high levels of concern around side effects and impact on fertility, with the recommendation to reflect this more in SBCC and counseling; and the need to provide better support to women in navigating FP choices by taking into account their circumstances, past experiences, and preferences. Detailed findings by country have also been shared with the six focus countries through country visits and these countries were supported to

incorporate findings into marketing and SBCC strategies, including new product and service areas (which will not be tested and rolled out until after the end of this work plan period). Informed by the consumer insight research findings, MSI is working with a marketing agency to develop and test marketing packages based on “archetypes” – client typologies differentiated by life-stage and FP attitudes and preferences, rather – than simply by the demographics of age or location. These approaches will be further developed and rolled out under SIFPO2.

2.1.3 Supporting cutting-edge impact modelling tools

In Year 3 SIFPO supported MSI to launch its *Impact 2* tool which facilitates programs to estimate the wider impact of voluntary FP services and is freely available on the MSI website. MSI has continued to update the tool as new data becomes available and participated in a modeling tools harmonization exercise with other organizations in the sector to calibrate different FP modelling tools and ensure common assumptions and data sets are being used across tools. Country programs have made extensive use of the tool: for example, MST has used the tool to advocate for increased government FP budget allocations in Tanzania, and led an *Impact 2* validation exercise to compare Demographic and Health Survey data with retrospective *Impact 2* estimates based on service delivery figures from the major public and private FP providers in Tanzania. *Impact 2* has also been widely shared externally, including trainings for donors and NGOs, and presentations of the tool at the Global Maternal Health Conference in Arusha in January 2013 and at the ICFP in Addis in 2014. Numerous government, donor, and NGO stakeholders are now using *Impact 2*, in particular to help with planning and service delivery forecasting around FP2020 goals. For example, the Zambian government worked with MSZ to use *Impact 2* to develop an eight-year FP plan based on national FP2020 commitments, and the First Lady of Zambia cited *Impact 2* in relation to figures used during her presentation at the Women Deliver conference in May 2013.

As a leading FP provider, MSI acts as a catalytic influence in task-sharing LARC and PM services in order to increase access and choice for women. Even when evidence of the safety and efficacy of FP task-sharing is available, there are often challenges supporting policy change at the national government level. During Years 3 and 4 MSI developed an impact model to estimate the national-level effects (on health care costs and access to services) of FP task-sharing. The tool, which is also available to download on the MSI website, models the potential impact of implementing WHO’s recommendations for optimizing health worker roles in terms of expanding access, improving cost-effectiveness, and reducing negative health outcomes. The tool was presented to key stakeholders at the Progressing Task Sharing Evidence for Family Planning workshop held in London in July 2014 (see Activity 1.1.2), at the High Impact Practices Meeting in October 2014, and with WHO representatives in early 2015. Several MSI country programs have utilized the tool, including Pakistan (for advocacy work on task-sharing injectables to Lady Health Workers), Zambia, and Nigeria (to estimate the impacts of Nigeria’s 2014 task-sharing policy reforms once implemented). The tool has been integrated into the Task-sharing Research Framework developed by the newly formed international Task-Sharing Working Group (supported under SIFPO2) to help prioritize research questions at the country level. A list of tools with links can be found below in Annex 1.

Sub-Result 2.2: Improve data management through enhanced use of technology at the global, country, and headquarters level

Sub-Result 2.2 Objective: *In 2011, MSI served more than seven million clients and provided approximately 20 million CYPs worldwide. The organization's year-on-year FP service delivery expansion is matched by a growing complexity in its systems and information needs in order to efficiently operate and meet clients' needs. In response, MSI has initiated an ambitious upgrade of its MIS, which encompasses all aspects of routinely collecting, sharing, analyzing and using information to support the management of MSI's programs and services. Broadly interpreted, MIS covers the routine flow and use of information from initial contact with each client right through to the management decisions that are made at clinic, country, or global level. The overall goal of the MIS upgrade project is to strengthen MSI's capacity to deliver high-quality FP services by ensuring that decision-making at all levels of MSI is evidence-based, and informed by comprehensive, reliable, and up-to-date information.*

Summary of Key Activities and Outputs for Sub-Result 2.2

With support from SIFPO and other donors, MSI invested significantly in strengthening its MIS capacity at country and global levels to ensure that decision-making is evidence-based and informed by comprehensive, reliable, and up-to-date information. MSI developed and rolled out its **Client Information Center (CLIC)**, a simple and user-friendly, real-time, client-based MIS. With CLIC, MSI country programs: can better understand and have timely site-based information on client profiles, voluntary FP take-up, switching and discontinuation practices; produce client tracking reports (e.g. to identify clients due for a method refill for follow up contact); undertake marketing and finance analyses to improve business practices; and report against clinical quality indicators more fully.

MSI initially tested various off-the-shelf software packages and found that they entailed too steep a learning curve for staff with low-levels of computer literacy, and did not meet all MSI's programmatic needs. In Year 2 MSI therefore developed CLIC, software bespoke to MSI although with the potential to be utilized by other organizations. In-country testing and roll-out began in clinics in **India** and **Uganda** in Year 2 along with the development of training packages. In Year 3, CLIC was rolled out to clinics and mobile outreach teams in six countries, and by the end of Year 4 CLIC was operational in 14 country programs, with tangible improvements seen at the clinic level due to standardization of MSI's business processes.

Managers reported CLIC data has had a positive outcome on the accuracy and timeliness of billing to insurance companies and corporate clients improving MSI's ability to cover costs through domestic financing mechanism. However, the full benefits of the system were not being fully realized in many countries, with inconsistent use of reporting functions and partial roll-out across mobile outreach teams. In Year 5, MSI therefore focused on supporting country programs to embed CLIC and improve use of CLIC data for decision-making, including data quality training and use of performance dashboards and reports. In Ghana, Tanzania, and several other countries, CLIC is now scaled-up across mobile outreach teams, with managers citing benefits from the improved site-level analysis and data checks made possible by the system.

With SIFPO support, MSI also began to explore social franchising MIS gaps and priorities. As social franchisees are not staffed by MSI employees, and usually lack computer infrastructure, it is not feasible to roll out CLIC to the BlueStar franchise network. MSI has gathered experiences from various country programs who have invested in franchisee mobile phone based reporting, as well as assessing data management needs by MSI employees who support franchisees and in-country country senior management teams. This work to develop a more robust MIS for BlueStar is being taken forward under SIFPO2.

Sub-Result 2.3: Increase organizational knowledge management capacity

Sub-Result 2.3 Objectives: *MSI will seek to fill gaps in reaching its clients with high-quality FP services by generating new knowledge, either by testing new approaches, or consolidating existing experience and learning from country programs. Knowledge gaps will also be addressed by tapping into the combined expertise of the MSI's TLG and through collaboration and information sharing with the wider FP/SRH community. The end result of improved knowledge management will be the dramatic growth in the adoption of best practices and innovations, both by MSI country programs and by external partners and implementers.*

Summary of Key Activities and Outputs for Sub-Result 2.3

With SIFPO investment, MSI strengthened its mapping and documentation of innovation and best practices, facilitated greater learning between country programs and enabled MSI knowledge and results to be shared externally within the sector. MSI developed and disseminated a series of **best practice reports**, including documentation of innovative approaches tested under SIFPO such as the Tanzania *bajaji* and Madagascar youth voucher pilots; collation of experiences in key areas where cross-country learning remained limited, and to inform global strategic direction (e.g. MSI's new public sector support models of outreach and youth programming); technical areas where MSI expertise could benefit the FP sector more broadly (e.g. a review of MSI's voluntary male circumcision programming in Kenya, Malawi, and Zambia); and syntheses of MSI's key approaches and results under SIFPO (e.g. mobile outreach impact and learning, and programming in the Sahel). This documentation has been widely shared within and beyond MSI, including at the SIFPO EoP meeting in Washington DC in September 2015 and at events with Missions and MSI internal stakeholders.

MSI also produced a series of user-friendly, digestible **research briefs** summarizing key research findings from SIFPO and beyond on topics including vocal local in Kenya, TL task-sharing in Uganda, MSI's poverty measurement approach, and the importance of moving beyond first-time FP users in FP2020 goals. A full list of reports produced under SIFPO can be found in Annex 1.

SIFPO, along with other donors, supported MSI to invest in its **Best Practice Gateway**. Launched in 2011, the BPG is an internal online organizational library for technical resources that discuss, inform, or evaluate FP/SRH programmatic models, approaches, or tools. The BPG serves as a critical knowledge repository for MSI's 12,000 staff members around the world and includes MSI-produced documents as well as key external journal articles and other organizations' publications. The BPG also includes a data center which allows MSI staff to create custom tables and graphs using the most current impact, market share, and national health data. By the end of 2012 all country programs had registered to participate in the BPG and each country designated a lead person responsible for quality assuring submissions and building country ownership of the platform. As of September 2015, over 10,000 resources were available on the BPG ranging from webinar recordings, to operational tools, to published research studies. Document download rates increased from under 2,500 between July-November 2012 to almost 5,000 between January and June 2013, and totaled 25,000 in 2014 and 2015. The top five most downloaded documents were all SIFPO supported tools: 1) *Impact 2* tool; 2) exit interview protocol package (part 1); 3) M&E manual; 4) exit interview protocol package (part 2); and 5) exit interview factsheets.

SIFPO also supported MSI to pull together results and learning based on its extensive experience of **FP and MCH voucher programming**. A country voucher mapping and information gathering exercise was

The Best Practice Gateway serves as a critical knowledge repository for MSI's staff members. The MSIG country director stated, "The gateway has been instrumental in assisting the program to produce client chart forms that are easy to adapt for their programs specific needs."...the presence of the knowledge gateway assists with the SIFPO end results of improved knowledge, adoption of best practices, and dissemination of resources and innovations by MSI country programs and by external partners and implementers.

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undertaken in Year 2, with findings used in Year 3 to develop an MSI voucher SOPM and accompanying guidance document for MSI programs operating vouchers with USAID funds, *Implementing Marie Stopes International Family Planning Programs with USAID Support*. The SOPM and guidance document were disseminated during Country Director and Social Franchising Manager workshops in Years 4 and 5 and formed the basis of a broader effort to systematize MSI's voucher programming through the development and roll-out of MSI voucher minimum standards under SIFPO2. In addition, MSI undertook external dissemination of voucher program results, including the 2015 publication of a research brief, *Are our voucher Programs working? Evaluating our methods and results in six countries*^{iv} a forthcoming journal article; and *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*^v, and two panel and abstract presentations at the upcoming January 2016 ICFP.

Sub-Result 2.4: Disseminate and increase utilization of results and best practices in a cost-effective manner

Sub-Results 2.4 Objectives: *Best practices, evaluations, and operations research results generated through SIFPO-MSI will be published and disseminated through existing channels of MSI, its TLG and existing fora, ensuring maximum exposure, and ultimately encouraging adoption of best practices and approaches by other implementers. This includes technical working groups, conferences, organization websites, health listservs, peer-reviewed journals, and other online media to ensure cost efficiencies. Internally, investments in improving knowledge management will facilitate communication and information transfers.*

Summary of Key Activities and Outputs for Sub-Result 2.4

SIFPO provided MSI with a welcome opportunity both to strengthen internal capacity to research and disseminate project learning, and to increase organizational technical leadership in the FP sector. These investments in research and dissemination capacity have stimulated a step-change in MSI's technical leadership in key areas including LARC and PM service delivery modalities, task-sharing, method choice, and the role of the private sector.

With SIFPO support, MSI increased the number of MSI-authored FP articles published in **peer-reviewed journals**, with 11 published during the project period. This was a direct result of the investments in research capacity described in Section 2.1 above, both at London and field levels, in addition to SIFPO support for publication costs. This result area also reflects MSI's increasing prioritization of knowledge sharing and dissemination encouraged through SIFPO. MSI can add huge value to the FP knowledge base within the sector, and despite the significant cultural change under SIFPO, much of our most innovative and impactful work remains undocumented; this area will see increasing focus and resource allocation under SIFPO2.

MSI is now better—and more productively—integrated with the international FP community...MSI representation within technical working groups, as one of the largest global clinical service providers, will serve to move the field of FP forward considerably. MSI will provide access to important resources for other partners working toward realization of the agendas of Family Planning 2020 (FP2020) and Millennium Development Goals (MDGs)

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SIFPO enabled MSI to greatly increase its presence, number of accepted abstracts and leadership at **international conferences**, aiding the dissemination of results and innovation from SIFPO programming and beyond. In 2011, SIFPO supported MSI to participate at the ICFP in Dakar, where MSI had 18 abstracts accepted. By Year 4, MSI had a record 59 abstracts accepted for the Ethiopia ICFP in November 2013, of which 20 were SIFPO-supported. MSI events at ICFP conferences included: the presentation of a film profiling MSI Ghana's SIFPO-supported *kayayei* project; MSI leadership participated in high-profile panels and round-tables on subjects including the role of the private sector in voluntary FP provision and use; ensuring FP choice; and task-sharing innovation. A range of SIFPO-supported research and tools were also showcased during presentations (a full list can be found in Annexes 2 and 3). Many key SIFPO-supported initiatives are also being profiled at the upcoming January 2016 ICFP, where MSI has had 74 abstracts accepted and participation is being supported under SIFPO2. MSI global and country program staff also presented abstracts and participated in panels in the annual m-health summits in Washington DC, the International Federation of Gynecology and Obstetrics annual conferences, and others.

SIFPO Supports the Publication of Landmark Social Franchising Papers

SIFPO supported MSI to publish two landmark social franchising papers in the *Global Health Science and Practice Journal* in June 2015 alongside an editorial by Jim Shelton, *Social Franchising: A Blockbuster to Address Unmet Need for Family Planning and Advance Toward the Family Planning 2020 Goal*.

Establishing and Scaling-Up Clinical Social Franchise Networks: Lessons Learned from Marie Stopes International and Population Services International, a joint MSI-PSI paper that describes the social franchising approach and *Increasing access to and expanding choice of high quality family planning services through the private sector: results from MSI's social franchising program* highlighting the rapid scale-up of MSI's social franchising service channel between 2008 and 2014. In that time, MSI's social franchise network expanded from seven to 17 countries cumulatively reaching an estimated 3.75 million clients and significantly increasing clinical quality. In 2013 68% of MSI's social franchise clients choose a LARC method, 57% lived on less than \$2.50/day, and 40% were FP adopters (not using an FP method in the three months prior to receiving the service). Both publications have been widely disseminated through USAID, MSI, and PSI networks and the wider social franchising community, deepening understanding of this high-impact service channel.

MSI has taken on a global leadership role and **shared expertise within the social franchising community**. Despite the rapid growth of social franchising as a key approach to increase voluntary FP access and choice, published evidence and documentation of the approach remains minimal, limiting opportunities for global learning. In 2012, MSI presented at the Health System Research Symposium on metrics for social franchises in a panel on aligning measurement between organizations to assess private sector impact. This symposium led to the formation of a social franchise metrics working group that aims to harmonize and align measurement indicators across social franchisor organizations that includes MSI participation. MSI global and country program staff participated actively in the 2012 and 2014 global social franchising conferences; MSI had 12 abstracts accepted at the 2014 conference (e.g. quality improvement, health financing and technology) and MSI social franchising leadership staff participated in panels on the future of social franchising and harmonization of metrics. MSI has also shared its social franchising expertise through the production of a "social franchising 101" e-learning course in collaboration with PSI that was launched in 2014 and is hosted on USAID's Global Health E-Learning Center.

MSI co-led a series of **technical consultations** under SIFPO, bringing together experts to share experiences, present cutting-edge results, discuss points of difference, and agree future research and learning agendas. This included the task-sharing and PM consultations (described under Activity 1.2), a consultation on youth and LARCs, co-led with PSI and FHI-360, and a programmatic series co-led with the RESPOND project, SHOPS, and SIFPO-PSI focused on increasing access to LARCs and PMs through mobile outreach, the private sector, and social franchising. Participants from over 20 organizations attended the consultations. MSI, PSI, and partner field teams shared experiences and debated the merits and challenges of different approaches. The meetings highlighted the key role of these delivery channels in scaling up LARC and PM delivery to underserved populations. MSI has also participated in numerous other consultations on topics ranging from vasectomy to PPF.

The PM and youth and LARCs consultations resulted in the production of landmark **consensus statements**, which MSI was instrumental in developing and disseminating. The *Increasing Access to High-Quality Voluntary Permanent Methods of Contraception in Low Resource Settings*^{vi} statement commits to ongoing collaboration to achieve the goal of universal access to voluntary FP, which includes the provision of a broad method mix, including PMs, particularly in underserved areas. The addendum on female sterilization technique outlines key consensus points on mini-laparotomy for female sterilization, including the advantages the technique has over the laparoscopic approach for many different contexts, particularly for low-resource countries. Signatories, including MSI, EngenderHealth, IntraHealth International, International Planned

Parenthood Federation, Population Council, PSI, Jhpiego and Pathfinder, committed to advancing high-quality, voluntary PM provision through advocacy, sharing best practice and progressing the PM task-sharing research agenda. The *Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception*^{vii} advocates for programs promoting improved SRH of adolescents and youth, including provision of full and informed choice of contraceptives by ensuring that LARCs are offered and available during contraceptive education, counseling and services.

SIFPO enabled MSI to participate in, and learn from, a series of other **technical working groups**, including representation on all FP2020 working groups, USAID's PAC Connections group, the LARC/PM Community of Practice, the HIP for FP working groups and the International Best Practice (IBP) consortium. Participation in the HIP groups has enabled MSI to advocate for and inform the production of several new HIP briefs during the reporting period, including briefs on mobile outreach, vouchers and CHWs. Through its involvement in IBP, MSI has shared evidence from its experience of implementing HIPs with a wide array of global and regional stakeholders. For example, MSI Ethiopia presented on MSI's mobile outreach approach and implementation differences in Kenya and Ethiopia at the IBP East Africa regional meeting in June 2015; MSSL presented the findings of the Sierra Leone injectable task-sharing study at a West African Health Organization regional meeting in July 2015; and Marie Stopes Society from Pakistan presented experiences of research utilization at the 2014 global IBP meeting.

Finally, MSI and PSI co-led a **SIFPO end of project meeting** in September 2015 in Washington DC. Over 160 attendees participated in the meeting, from USAID and partner organizations attending both in-person and remotely. The end of project meeting was organized around themes that have been key focus areas of SIFPO programming. Plenary panels included speakers from the country programs and headquarters technical staff addressing key topics: expanding voluntary FP method choice and access; the role of the private sector in achieving universal health coverage (UHC); strengthening quality and building institutional capacity; and understanding the client. Concurrent breakout sessions included speakers sharing innovations in service delivery and research and cutting-edge tools and approaches. Subsequent highlight materials and webinars have been shared with USAID Missions who could not attend the September 2015 meeting, including a SIFPO I dissemination meeting in Antananarivo, Madagascar in November 2015, attended by MoH, USAID Mission and MSM staff in addition to media organizations and other partners.

Result 3: Increased organizational sustainability of country-level programs, including internal south-to-south support and technical assistance

Sub-Result 3.1: Improve tracking of costs, revenue, and improving cost efficiency

Sub-Result 3.1 Objectives: *One way to achieve increased organizational financial sustainability is through innovative approaches to reducing costs and monitoring expenses. Reducing the cost of contraceptives, a major cost for a FP organization, is one approach. Better tracking of the costs of delivering services and managing service delivery operations, is another mechanism to make informed decisions about program design and implementation. A robust financial sustainability strategy relies on income diversification and efficient management of resources. MSI will examine how to maximize user fees and revenue to sustain services by identifying those most able to pay and those most in need of subsidies.*

Summary of Key Activities and Outputs for Sub-Result 3.1

During the SIFPO award, MSI strengthened its financial systems and business skills capacity, introduced systems to improve operational efficiency, developed new tools to better understand clients' willingness to pay and service costs, and explored diversification of financing sources to maximize sustainability. These strategies enabled MSI to increase its reach and impact for any given funding, and lay a foundation for sustainable voluntary FP service provision in the future.

SIFPO supported MSI to invest in integrated, robust, organizational-wide **financial management systems**, bringing all country programs with disparate charts of accounts, analysis dimensions, and currencies together to generate a single organizational view. This accelerated reporting, provided greater visibility on global financial and operational performance, and ensured a common finance infrastructure MSI-wide which is more adaptable to changing business requirements.

MSI upgraded its financial management system to SUN version 6 through a phased process which began with consolidation and harmonization of global accounting structures followed by a stepped roll-out to country programs. The roll-out required a combination of discrete work streams including country-level internet connectivity, updating of global policies and procedures, and development of a global ongoing support model including training, hardware and software. By the end of SIFPO, all MSI country programs were using the SUN 6 system.

Due to USAID requirements, the SIFPO award necessitated setting up new systems of accountability and compliance that benefited MSI as a whole, at both an institutional and a country level. The capacity strengthening was evident in all sectors of MSI's work [including] areas such as financial management and technical capacity related to human resources.

SIFPO MSI Mid-Term Evaluation Report, August 2013

To facilitate implementation of the new financial system and associated policies and processes, and to create a **financial community of best practice at MSI**, a series of workshops were facilitated for country program staff between 2011 and 2013, aimed not only at Finance Directors and Managers but also Country Directors and Program Directors, to ensure strong financial literacy and understanding across country level senior management. SIFPO also supported financial training for Country Directors without a finance background, including those from Burkina Faso, Mali, and Madagascar.

MSI also invested in other initiatives to improve operational efficiency, including the introduction and testing of a **fleet management system**. Vehicles are one of the largest cost drivers for any MSI country program, particularly those with large mobile outreach programs. With SIFPO support, MSI evolved its fleet management practices, trialing a global fleet management system

incorporating global positioning system tracking of vehicles to increase accountability, safety, and efficiency in its programs in Madagascar, Tanzania, and Uganda. Initial findings suggested significant improvements in safety (e.g. reduced night driving) and efficiency, and Tanzania also successfully utilized fleet management data in its mobile outreach team performance management. However, technical support glitches resulted in MSI deciding not to roll-out a global system but instead encourage country programs to invest in locally-procured systems where context-specific technical support would be available, utilizing learning from the initial roll-out experience. This work is being supported further under SIFPO2, informed by lessons learned from the SIFPO pilots.

SIFPO supported MSI to adopt a new **poverty grading tool** that provides a standardized poverty measure to ensure that user fees are appropriately set, that we are reaching the poorest women, and that subsidies such as vouchers reach the neediest of clients. MSI adopted the Grameen Foundation's Progress out of Poverty Index (PPI), and has integrated it into the client exit interview process (see activity 2.1.2 above). Using ten country-specific, asset-based questions, the PPI estimates the proportion of respondents who are living below various poverty lines including: \$1.25/day poverty line (extreme poverty); \$2.50/day poverty line (poverty); and national poverty lines. The questions can be included in any survey to estimate the proportion of a population who are poor. The PPI is not available for all MSI countries as this depends upon funding from the Grameen Foundation and the availability of and access to data from a high quality nationally-representative expenditure survey¹. The development and adoption of this standard methodology has allowed MSI country programs to gather more precise data about the poverty levels of clients they are serving through various delivery channels, and compare these levels to the national average, enabling a better understanding of whether subsidies are being appropriately targeted.

Accessibility to voluntary FP services is partially determined by the costs faced by the prospective client. Through SIFPO MSI sought to examine **client willingness to pay** (WTP), pricing and fee-setting strategies in **Burkina Faso**, with lessons informing broader pricing and WTP strategies across MSI. Population Council and MSI implemented a study consisting of 1,772 client exit interviews on willingness to pay and client satisfaction for three voluntary FP methods (TL, implants, and IUDs) from 44 mobile outreach sites and one clinic. Implant users accounted for 46% of interviewees, and IUD users 35%. One-third of clients earned less than \$1.25/ day, and 82% had no formal education. Half of respondents learned about MSI through another client, and the three primary reasons for choosing an MSI service were low cost (59%), good reputation (23%), and proximity (15%).

WTP findings indicated that a significant proportion of women surveyed (80%) would be willing to pay increased fees for voluntary FP services, suggesting that MSBF could increase prices of services to improve the financial sustainability of operations. MSBF incorporated these findings into the price structures in its Patte D'Oie clinic, where the research was undertaken, but decided against increasing costs on mobile outreach in an attempt to attract increased numbers of women living under \$1.25/day, highlighting that WTP findings are just one of a number of factors to be taken into account during price-setting. MSBF presented findings from the WTP study, and programmatic changes made, to Country Directors at MSI's Africa and Latin America retreat in June 2013 as part of a session on pricing. Study findings were presented by Population Council at the ICFP in Addis in 2013. MSI also extrapolated from the study design tools and protocols to develop a generic toolkit that can be used by other countries to determine context-appropriate pricing models and fee-setting strategies.

MSI identified a need to develop a rigorous methodology for evaluating the cost-effectiveness of its service delivery models to inform programmatic decision-making. SIFPO supported the development and roll-out of a **FP costing tool** to compare cost-effectiveness across voluntary FP services, service delivery channels, and countries. The costing tool can be used to determine the cost-effectiveness and the main cost drivers of each FP delivery channel and service, which informs budgeting and planning, projections of future impacts, understanding current efficiency,

¹ For those countries without a PPI, MSI uses the Multi-Dimensional Poverty Index. The tool is not country-specific and does not provide a universal definition of poverty; instead, it estimates the proportion of respondents who are "multidimensionally poor."

and the effect of varying operational costs and service volumes. To accompany the roll-out, MSI produced guidance documents, data collection instruments and a user-friendly visual online guide. The tool was piloted in [Ghana](#), [Madagascar](#), and [Nigeria](#), and was rolled out to an additional ten countries in 2013. In 2015 a total of 16 country programs will utilize the tool. It is expected that country programs utilizing the tool will undertake the costing analysis on an annual basis. In 2014 and 2015, the focus was on supporting country programs to utilize findings to adapt their programming. In Madagascar, for example, findings have informed changes to the mobile outreach model, including more efficient travel planning, reorganization of team staffing structures to create nurse-led teams in areas where demand for PMs was low, and expansion of the cost-effective Marie Stopes Ladies model. The costing tool sparked considerable external interest, and was presented at the 2013 Addis ICFP, as well as presentations to USAID, the Clinton Health Access Initiative, and other NGOs.

Private health facilities are often managed by clinical staff who lack business training and expertise. MSI believes that [building franchisee business capacity and skills](#) can result in more efficient and sustainable private sector FP provision, as well as help keep franchisees engaged and motivated. Under the USAID-funded SHOPS project, a franchisee financial skills training curriculum was developed with Banyan Global, and tested among MSI's BlueStar providers in Malawi. With SIFPO support, MSI rolled out the training in [Ethiopia](#) and [Sierra Leone](#) in Years 2 and 3, beginning with a franchise business needs assessment by Banyan Global in 2011 which informed adaptation of the original curriculum into a two-day Financial Management and Record Keeping course. The course covered assessing one's business; setting goals; record keeping; financial statements and analysis; cash flow plans; and accessing finance to meet one's business goals. A ToT was conducted in Ethiopia in 2012 for 16 MSI team members from [Ethiopia](#), [Ghana](#), [Kenya](#), and [Sierra Leone](#). The newly trained facilitators conducted two pilots of the course with a total of 26 Ethiopian franchisees, supported and evaluated by the ToT trainer.

In 2013, the training was cascaded to 90 franchisees in Ethiopia and 92 in Sierra Leone. MSI's Social Franchising Field Officers also attended the trainings in order to build their capacity to support the franchisees in this area. The high attendance reflects the strong interest across MSI's franchise network in improving business and financial management skills. Over 90% of trainees in both Sierra Leone and Ethiopia felt that the course had improved their ability to manage their business, and between 75% and 80% said that the course had made them more likely to apply for credit to invest in their facility. In Ethiopia, aspects of the course that participants found the most useful were the sessions on cash flow planning and record keeping. Franchisee post-training comments included, "the way we were running business was based on hunch. Now we have got the tool to do business scientifically." The training package has been made available to all franchise programs across MSI. While the training has proved popular, maintaining and strengthening franchisee business skills post-training remains a challenge and MSI is seeking to address this under SIFPO2.

Lastly, MSI focused on strengthening its expertise in health financing, adding a Head of Health Financing to the Health Markets Department in 2013. A [health financing assessment tool](#) was developed to support country programs to better understand the local health financing landscape and identify opportunities and strategies for integration with health financing schemes such as national insurance and government contracting. SIFPO supported the piloting of this tool in [Cambodia](#) in 2013. Principal recommendations from the assessment included: emphasizing contracting as the preferable mechanism to purchase and deliver SRH services; conducting a costing exercise to demonstrate cost effectiveness and prepare for insurance mechanisms and contracting opportunities; and bringing in local expertise to support national level efforts to develop contracting mechanisms, to ensure inclusion of a broad range of voluntary FP services. Based on the Cambodia experience, the tool was refined and assessments have since been carried out in 15 countries. MSI's health financing work continues to be supported under SIFPO2.

Sub-Result 3.2: Improve capacity to deliver cost-effective inter- and intra-organizational south-to-south technical assistance

Sub-Result 3.2 Objectives: *With its global network of clinics and decades of experience, MSI country programs are a repository of innovation and tried-and-true FP practice. Experience has shown that learning is transferred from the headquarters and horizontal communication channels to country program to country program. Throughout the life of the project, the capacity of MSI to deliver cost-effective intra-organizational TA will be increased and, as a result, operational and programmatic best practices will be replicated throughout the organization.*

Summary of Key Activities and Outputs for Sub-Result 3.2

3.2.1 Embedding leadership and management capacity across MSI

With more than 12,000 employees across 37 countries, development of leadership, management and strategic thinking capacities is crucial for MSI's continued success in serving its clients and managing its operations. To build sustainable leadership capacity among MSI's global senior management, MSI used SIFPO investment to evolve an ongoing internal **Leadership Development Program** in 2011-2012 with 34 candidates completing the program (18 from country programs and 16 from the London support office). A series of training events were held during 2011 (focused on leading self, leading others, and leading MSI), delivered by a combination of external trainers and in-house graduates of prior leadership program cohorts. Participant working groups were formed to combine the delivery of a business project with their on-going exploration of leadership between the two learning events. Participants were then given access to one-to-one leadership performance coaching over the following six months to ensure post-training momentum, with progress measured against individual initially set leadership development objectives.

In Years 3-5, based on country program feedback, MSI explored **management training packages** that could be tailored to individual country program contexts and requirements. The country-tailored approach has several advantages: leadership and management approaches relevant to the local environment can be used; and the level of the training can be calibrated to staff capacity, within a global framework to ensure consistency, with MSI globally providing expertise, specialist advice, and QA. SIFPO core funds were used to supplement USAID/Madagascar buy-in funds to support the development and piloting of a management training package for the top two tiers of Marie Stopes Madagascar (MSM) (executive management team and senior management team), delivered in-country over a nine-month period. Participants worked together intensively against a set of structured management and leadership topics, with pre-learning and action-based assignments, use of personal development plans, and coaching. The Madagascar training proved successful, with three participants subsequently undertaking extended secondments in leadership positions in other MSI country programs, one of whom has since been promoted to the Country Director position in Madagascar, and another about to take over as Country Director in Niger. An adapted version of this training is being rolled out and scaled up across MSI's West Africa programs under SIFPO2.

3.2.2 Strengthening country program capacity through tailored support, tools and technical assistance

SIFPO supported MSI to strengthen and evolve its approach to intra-organizational TA delivery. Through the project period, **TA provision in many areas was devolved to regional and country levels**, with global teams setting standards, providing oversight and brokering "business-to-business" training by talented trainers in one program in response to TA requests by another. This included the creation of cadres of Master Trainers embedded within country programs; development of peer-to-peer TA between country programs, which benefits both the recipients and providers of TA; an increase in secondments between country programs; and a shift from one-off trainings to modular approaches combined with remote learning follow-up. At the close of SIFPO, MSI had a diverse country peer TA provider staff roster of 125 team members from 34 country

programs who are available to provide peer TA to other country programs. MSI continues to build the TA capacity of these “peer providers” under SIFPO2.

One key area of TA focus during SIFPO was **clinical quality**. As described under Activity 1.2 above, with SIFPO support, MSI’s Medical Development Team developed a Master Trainer program in 2014 with 18 country-based Master Trainers now able to co-train and/or lead on MSI clinical service training. MSI also adapted its clinical training approaches and materials, moving towards a modular, more accessible and flexible framework, which was launched in Year 5. In tandem with this, and with support from EngenderHealth, MSI is evolving its model of clinical supervision to become more supportive of individual skills development, developing a framework for on-the-job training, mentoring and supervision to support efforts to improve quality at the provider level and complement existing clinical audit procedures. This revised approach was tested in Year 5 and is being taken forward under SIFPO2. Finally, MSI decentralized the QTA process where country standards are sufficiently high through the peer QTA scheme.

In Years 1 and 2, MSI invested in strengthening **procurement and logistics** policies and approaches to improve operational effectiveness and ensure adherence to USAID rules and regulations. Procurement and logistics staff members used knowledge gained through USAID procurement and supply chain professionalization trainings to review and adjust MSI’s procurement and logistics processes, training materials, and toolkits. Revisions included an MSI FP and SRH supplies quality policy which reinforces the organization’s commitment to procure only WHO Pre-Qualified or from a Stringent Regulatory Authority. These updated standards were then rolled out to, and embedded in, country programs through a series of support visits and regional workshops for procurement and logistics managers in Year 2, with a focus on: specification and supplier management; documentation and auditing requirements; competitive procurement; warehousing and inventory management; and USAID procurement rules.

In response to the growing scale and complexity of MSI’s franchise programs, MSI undertook a series of **social franchising TA initiatives** during Years 3-5, moving towards a peer-to-peer model of TA to facilitate scale-up of high-quality, effective FP voucher and social franchising activities that are in line with evolving global best practice. This included: peer learning visits such as a clinical QA visit by social franchise managers from India, Uganda, and Zambia to Ethiopia in 2013 to observe clinical supportive supervision and a clinical quality audit within an established franchise network; TA visits by expert franchise managers from Ethiopia and Madagascar to Malawi and Senegal in 2014; and a four-month secondment by the Madagascar Operations Director to support Senegal’s social franchising program in 2014. SIFPO also supported the MSI Global Social Franchise Workshop 2014, which brought together 70 participants from 20 country programs, primarily local Social Franchise Managers, to share experiences and lessons and input into SOPM updates and franchise insight research design. Lastly, in August 2014 SIFPO and the African health Markets for Equity (AHME) project jointly supported a social franchise quality supervision workshop attended by 24 participants focused on improving social franchise quality through the supervision process. Findings from the meeting informed the subsequent development of updated MSI quality supervision tools, including an electronic (palm pilot) component which has been tested with AHME funds and will be rolled out under SIFPO2. The SIFPO mid-term evaluators found that **“under SIFPO, the number of social franchisees increased significantly and the quality of their services improved”**.

Result 4: Gender-sensitive FP services targeting youth strengthened at a global level

Sub-Result 4.1: Strengthen organizational capacity to reach youth, and monitor, evaluate, and disseminate results

Sub-Result 4.1 Objectives: *Based on client exit interviews and service statistics approximately half of MSI's clients in Africa and one-third in South Asia are young people under the age of 25. MSI therefore aims to continue to make special efforts to improve the FP and behaviors of youth. MSI will strengthen its capacity to reach youth with an emphasis on the special needs of girls, engaging men, including young men, in healthy male norms and FP and SRH services, and incorporating gender considerations across all areas of its programming.*

Summary of Key Activities and Outputs for Sub-Result 4.1

Vouchers and youth friendly service provision

SIFPO facilitated MSI to gain a better understanding of where we are and are not reaching young people through documentation of approaches in different countries, and expansion of our client exit interview process. This information has been used to design, implement and scale up innovative approaches for reaching young people with FP information, counseling and voluntary services.

In Years 1 and 2, MSI undertook a mapping and consultation process to **identify approaches for reaching young people** across MSI country programs. Information from this process was used to develop the report, *Delivering sexual and reproductive health services to young people: Key lessons from Marie Stopes International's programs^{viii}*. The expanding exit interview data set was also used to identify countries and channels where we are succeeding in reaching a greater proportion of young people than the national average, as well as those countries where we have more work to do in order to aid learning across countries. Young people often express a preference for seeking FP information and voluntary services from the private sector. However, exit interview results demonstrated that in social franchise networks the proportion of young clients, and particularly those under 20 years of age, remained low. MSI utilized SIFPO funding to test different models for increasing youth access through franchisees, experimenting with reducing demand and supply side barriers through youth-friendly training and demand-side financing approaches.

MSI began with provider initiatives, producing, testing and disseminating guidance, training materials, and adapted QA and monitoring tools to support franchisee youth-friendly service provision in Years 1 and 2. These materials were informed by a literature review, USAID technical expertise, and a brainstorming meeting with PSI during the 2011 Social Franchising Conference. Based on country experiences and feedback that youth-friendly provider training alone did not seem to significantly shift provider behavior or youth FP uptake, particularly where financial barriers to access existed. MSI **tested an integrated demand and supply side approach in Zimbabwe** in Year 3, combining franchisee youth-friendly training with a youth voucher. A total of 20 franchisees were trained in March 2013, and 200 vouchers redeemable for all FP methods and free for under 25 year olds were distributed between April and June 2013 by two youth organizations, a teachers college clinic, and a community-based distributor supported by youth-friendly SBCC materials and youth "edutainment" sessions.

A total of 95% of vouchers were redeemed, with the majority of youth preferring implants (148). An evaluation of the pilot found a rise in the number of young people (voucher and non-voucher clients) visiting participating franchisees from an average of 280 per month in the three months preceding implementation to 430 per month during the intervention – an increase beyond the number of youth voucher clients – including a rise in implant uptake by young people from 30 per month to 130. By contrast, the franchisees that were not trained in provision of youth-friendly services and did not participate in the voucher program did not record any change in youth client numbers. The evaluation also found high client comfort with the peer voucher distributor approach; positive feedback on the level of courtesy and quality of counseling received from franchisees; and a recommendation from voucher clients, distributors and franchisees that voucher service package be expanded to cover STIs and other reproductive health services. These findings informed the design and implementation of the Africa Bureau and SIFPO buy-in funded youth m-voucher program in Madagascar in Years 4 and 5 (see text box below).

Increasing FP/STI access for youth under age 20: Madagascar's youth voucher program

In response to high rates of pregnancy, early marriage, and low contraceptive use among 15-19 year olds in Madagascar, and based on the positive findings from the Zimbabwe pilot (Years 4-5), SIFPO core funds were used to leverage UNFPA and SIFPO buy-in funds to pilot a youth voucher program to reach youth under 20 in Madagascar. Young people identified by MSM's Community Health Educators received a free voucher redeemable at a BlueStar social franchisee for a package of voluntary FP and STI information and services. BlueStar social franchisees were reimbursed for the cost of providing these services through mobile money payments. Vouchers were initially designed to be SMS-based and sent to young people's mobile phones, but MSM learned that many young people did not own mobile phones, especially in poorer communities. In response to this information MSM adapted their voucher system to enable young people without mobile phones to access the services of their choice using a paper voucher.

Between July 2013 and December 2014, **58,417 vouchers were distributed to young people of which 43,352 (74%) were redeemed for voluntary FP and RH services.** Most clients (78%) choose to take up a LARC, and just over half (51%) benefitted from STI counselling as part of their voucher service. A client profile data snapshot from July 2015 revealed that **69% of voucher clients had never previously used an FP method, and 96% of clients were aged 20 or younger,** indicating that the voucher successfully reached the intended target group. MSM has since expanded and integrated the program into its large-scale SIFPO2 service delivery field buy-in.

These impressive results demonstrate that with a combination of community-based SBCC activities; removal of service fees; availability of a broad range of voluntary FP methods; and a quality provider of their choice with the willingness and capacity to serve under-20 year olds, there is a demand for a broad range of FP services, particularly LARCs, among young people. The program also demonstrates that the private sector can be an appropriate and acceptable delivery channel for a broad range of voluntary FP methods for young people once financial barriers are removed. This combined demand/supply side approach of youth vouchers and supported private providers has the potential to be replicated (with adaptation to context) and taken to scale in other countries where financial barriers are a key factor preventing young people from accessing services, thus increasing FP access and choice for the growing youth cohort in developing countries.

Expanding access to FP and SRH information services for young people in Senegal using a university mini-clinic model

In Year 3, SIFPO mid-term evaluation findings highlighted that, whilst 'important advances have been made in targeting youth in Tanzania, Zimbabwe, Madagascar, and Ghana', MSI needed to better develop their youth services, building on formative research to identify 'the multiple vulnerabilities of the most at-risk youth' to design 'successful interventions that engage young people as both project beneficiaries and stakeholders', using the 'groundbreaking' Kayeyei project, which targeted the most vulnerable and provides integrated services, as a model: "it may be more effective to actively move services to the places that [youth] frequent and recruit peers from among the target group". These findings informed the design of an innovative Africa-Bureau and core funded initiative in Senegal in Years 4 and 5.

While **Senegal** has made great strides to increase modern method CPR in recent years, unmet need among unmarried young people stands at 70%, one of the highest in the world, and 32% of Senegalese girls have begun childbearing by the age of 18. Young people in Senegal lack access to accurate FP information and method choice, due in large part to stigmatization of sex before marriage. In 2013, funded by Africa Bureau through the SIFPO core work plan, Marie Stopes Senegal (MSS) began working with youth-led organizations to conduct “edutainment” and peer education sessions on SRH at locations where young people usually spend their leisure time (e.g. beaches, universities, and schools). To keep in touch with young people after these events, MSS sent SMS messages with SRH quizzes and information to over 3,700 young people who had provided their contact details.

MSS also undertook semi-structured interviews with almost 400 young people to better understand their sexual health behavior and information/service preferences. Findings included: low knowledge about pregnancy risks; incomplete knowledge of the range of FP options; good knowledge of HIV but low awareness of other STIs; reluctance to attend public health facilities for FP due to fear of judgement or risk of running into an adult they know; preference for accessing FP from locations close by that are not labeled as FP/contraception clinics; and preference for a youth-orientated center within the university as the optimal way to meet their SRH needs.

These findings informed the design and establishment of the first two youth-orientated centers of their kind in Senegal: one in Dakar (funded through SIFPO) and a second in the northern city of Saint Louis (funded by UNFPA). Between October 2013 and May 2015, 14,369 people benefitted from services at the youth-orientated clinics (9,031 in Dakar and 5,338 in Saint Louis). Most clients (79%) received screening for STIs, HIV, or cervical cancer, and 21% chose to take up a contraceptive method. An estimated 40% of FP clients in Dakar and 45% in Saint Louis had never used an FP method before. One-third of clients in Saint Louis chose to take up an FP method compared to 13% in Dakar. Due to the location of the Saint Louis clinic on the periphery of the university, it serves a broader catchment population, and the proportion of non-students using the Saint Louis clinic (53%) is significantly higher than that in the Dakar clinic (21%). Anecdotal feedback indicates that the non-students are more likely to be married and already have children, perhaps reducing the stigma around FP use, and leading to higher FP uptake, compared to the student population. Additional information on the clinic model can be found in the Senegal field buy-in section below.

Sub-Result 4.2: Ensure greater involvement of men, particularly young men, in FP programs and address gender norms around contraception, family size, and gender-based violence

Sub-Result 4.2 Objectives: *Male attitudes, behaviors, and gender norms play an important role in influencing FP use. The dynamics of contraceptive decision-making are increasingly recognized as influencing the uptake and consistent use of FP. Sexual and GBV puts women at risk of negative reproductive health outcomes and can interfere with access to and utilization of FP services. MSI will improve its service provision to men and use this as an entry point to increase male SRH knowledge and reinforce positive male norms.*

Summary of Key Activities and Outputs for Sub-Result 4.2

MSI utilized SIFPO funds to focus on improving our understanding, programming and documentation around provision of **vasectomy and voluntary medical male circumcision services**. Vasectomy is one of MSI's commonly performed procedures, with around 100,000 services provided every year. However, services are provided at scale in only a handful of countries, and MSI has experienced challenges increasing vasectomy access in sub-Saharan Africa in particular. In Years 1 and 2, MSI's vasectomy protocols and training materials were updated following a symposium attended by representatives from MSI's largest vasectomy programs (Bangladesh, Kenya, Nepal, Uganda, and the UK). This symposium ensured that the extensive programmatic and service delivery experience were the basis of the revised materials. The materials (consisting of a resource workbook, trainee logbook, and trainers guide) were reviewed by EngenderHealth prior to finalization, and MSI's QTA tools were updated to take the revisions into account.

In Years 3 and 4, drawing on internal and external lessons learned from previous vasectomy projects, MSI undertook pilots to increase vasectomy access in **Kenya** and **Uganda**. In Uganda, MSI tested an integrated demand- and supply-side intervention, launching a vasectomy campaign to address the myths and misconceptions in two districts working in coordination with a marketing agency to design and develop key messaging. The SBCC campaign included radio talk shows, DJ mentions, printing of posters, and engaging satisfied clients in communicating their choice. Male involvement champions were identified and trained to provide counseling and discussions on FP, and refresher training was undertaken for clinical providers in vasectomy services. During the campaign period, "men's special days" were held in centers following community mobilization activities.

A campaign monitoring tool was developed to monitor community knowledge, attitude and practice around the use of vasectomy as a voluntary FP method and 168 interviews and focus group discussions with men of reproductive age were conducted. End line data showed that 92% of surveyed men knew about vasectomies as a FP option compared to 65% at the beginning of the campaign. MSI also found improvements in the level of understanding of the importance of male engagement in FP. Most of the respondents (74%) learned about vasectomies through targeted radio announcements. The study indicated that existing misconceptions about vasectomies are a barrier to seeking further information. These findings informed the development of customized communication tools. In the first six months of 2014, MSU provided 859 vasectomies nationwide, a 40% increase on the same period in 2013.

In Kenya, MSK identified a gap in information on knowledge and attitudes around vasectomy in Kenya, and undertook a Knowledge, Attitudes and Practices survey on vasectomy among the urban population in Nairobi County, to help determine appropriate messaging and aid in designing activities and strategies for improving male involvement in FP. MSK also conducted follow-up interviews with two vasectomy clients to better understand the factors that led them to take up the service. Findings indicated that the main barriers to vasectomy uptake were: a lack of awareness of vasectomy as a contraceptive option among potential clients; common myths and misconceptions about the service, such as misconceived risks; religious and traditional factors; a lack of access to

vasectomy services among potential clients; and indifference and bias on the part of vasectomy providers.

The findings of the survey informed the development of a specialized SBCC strategy by MSK, including responding to common myths and misconceptions on vasectomy through: local radio station campaigns and SBCC materials; refresher training on vasectomy information provision with accompanying materials for 350 CHWs that conduct mobilization within the informal settlements in Nairobi; and mini-caravan road shows using five male champions (included two satisfied vasectomy clients) to disseminate information in the targeted communities and provide referral linkages. Unfortunately, MSK experienced retention issues with doctors in 2014-2015, which impacted on access to PMs including vasectomy, limiting the impact of the SBCC strategy. However, MSK now has a new set of doctors in place and plans to revitalize the SBCC strategy, building on the findings of the survey.

MSI has learned from these pilots that a longer-term, sustained, and multi-year approach is preferable when seeking to increase vasectomy access. MSI will be implementing a four-year program to increase PM (including vasectomy) understanding and access in Ethiopia through a SIFPO2 field buy-in.

Sub-Result 4.3: Increase ability to incorporate gender considerations into programming at the global, country, and headquarters levels through an integrated and comprehensive approach

Sub-Result 4.3 Objectives: *While serving millions of women and men around the world already, MSI seeks to better assess its efforts to understand and address gender-based barriers and facilitators to accessing its FP services. In order to refine its approaches to gender concerns and to reach more potential clients in need of FP, MSI will analyze its gender sensitivity at all levels of management and service delivery as a result of needs assessment, gap analysis, training, and monitoring.*

Summary of Key Activities and Outputs for Sub-Result 4.3

4.3.1 Development of gender and youth self-assessment tool

SIFPO enabled MSI to benefit from the technical expertise of ICRW in the development and roll-out of a gender and youth self-assessment tool tailored to MSI's programming and ethos. Initially, ICRW undertook assessments of two MSI country programs (**Ethiopia** and **Zambia**), and independently assessed MSI's youth-friendly programming, gender integration and community involvement in these two countries through observations of service delivery, meetings with MSI teams and other agencies, and interviews with clients and local community members. The assessments pinpointed opportunities for improvement, including male involvement, better reaching young women, and improving MSI's understanding of the gender dynamics of the environment. This formative research provided the basis for a gender self-assessment tool developed in year three. The tool guides countries through preparatory activities and a three-day workshop designed to help country programs gain a better understanding of gender, explore how gender and youth considerations affect programming (using the various interactions and influences on the client journey to service uptake as a tangible guide), and identify programming implications, gaps and priorities. The tool is organized in alignment with MSI's M&E Framework, and helps country programs think through how gender considerations, and current programming gaps, affect equity, access, quality and efficiency.

The tool was initially piloted in **Bangladesh**, refined based on country program and USAID technical feedback, and finalized for roll-out in Year 4. ICRW also visited MSI's London office to present the tool to program and technical teams at the end of Year 3. Assessments were subsequently undertaken in **Malawi** and **Nigeria** with ICRW co-facilitating the former alongside MSI London and country program facilitators to build in-house capacity, and MSI conducting the latter in-house.

Undertaking the gender and youth self-assessment in Malawi

Banja la Mtsogolo (BLM) – MSI's Malawi country platform - undertook the gender and youth self-assessment in January 2015 with the objective of expanding its reach to, key populations including girls, males. Preparations for the assessment included collection and analysis of relevant program data, service statistics, and background information as well as a site visit to a mobile outreach facility. During the assessment workshop, BLM identified gender and age-related factors that affected service delivery and developed and prioritized potential programming responses to better serve youth and address gender. Priority actions focused on development of gender and age appropriate SBCC materials, addressing provider bias, establishing youth-friendly and male-friendly services, and developing strategic partnerships. The action plan BLM developed has informed the design of an upcoming SIFPO2 field buy-in addressing HIV and FP access gaps for young people, as well as a SIFPO2 core activity seeking to strengthen male involvement. MSI will support BLM in the design, implementation and evaluation of these activities, with technical assistance from EngenderHealth.

4.3.2 Development of organizational gender and GBV policies

In partnership with ICRW, MSI examined its organizational gender practices and policies with the aim of developing standards and guidelines relating to incorporating these considerations into its voluntary FP programming. Areas of attention for examination with a gender-lens included: clinical services; community engagement; client satisfaction; project proposals; monitoring indicators and data collection; and project monitoring. To inform the development of an **organizational gender policy**, MSI reviewed existing donor and NGO gender policies and undertook consultations with key internal stakeholders, including interviews with London support office and country program staff to understand how gender is perceived in voluntary FP programming at MSI, the status of gender mainstreaming efforts, promising practices and current gaps in gender programming, future priorities, and next steps.

The policy provides the context and rationale for gender mainstreaming, defines MSI's organizational and programmatic commitment to gender integration, offers illustrative examples, and links to tools to assist both support offices and country programs to integrate a gendered and inclusive approach into business planning and programmatic strategies. The policy refers to the Gender Program Continuum, which characterizes approaches as harmful, neutral, sensitive, responsive or transformative. Country programs are encouraged to aspire to implement transformative approaches and activities, meaning they, "actively seek to build equitable social norms and structures in addition to individual gender-equitable behavior" (Care and ICRW, 2007). The policy also links to useful tools to support country programs in mainstreaming gender. A programmatic checklist is added to the policy, adapted from WHO's Gender and Health Checklist and USAID's Gender Integration Questionnaire.

SIFPO also facilitated MSI to develop **GBV clinical and training guidelines and a policy on GBV for FP programming**, which frames the clinical guidelines and place them in a programming context. The clinical guidelines were developed based on a review of current best practice and existing literature and guidelines, notably the USAID-funded *Step by step guide to strengthening sexual violence services in public services*^{ix} by the Population Council as well as EngenderHealth materials developed under the RESPOND project. The accompanying policy, which was also developed based on a literature review, outlines expectations and guidance for country programs who are implementing sexual and GBV projects and for programs which are operating in areas with high sexual and GBV prevalence, regarding support for clients who are survivors, specifically guidance around assessment, care and treatment of these clients. Among other key areas, the policy outlines voluntary and informed consent guidance, education and training requirements, monitoring and QA mechanisms. The clinical guidelines and policy were piloted in Tanzania in Year 4, to support Marie Stopes Tanzania's implementation of a GBV-focused SIFPO field buy-in. The guidelines were revised and finalized in light of the review and feedback from the workshop participants, and have since been disseminated to country programs on demand.

Progress on US Government Family Planning Policy & Legislative Compliance

USAID's principles of voluntarism and informed choice align with MSI's commitment to providing high-quality information and services that respect individual decision-making and fully informed choice in regards to choosing voluntary FP and SRH services. MSI undertook a variety of measures to strengthen its understanding of USAID legislative and policy requirements and ensure compliance through its programming. MSI takes the issue of compliance extremely seriously, having also invested its own resources to raise awareness among its staff of all relevant US government regulations. SIFPO has supported the development of tools, resources and TA in the areas described below.

1. Provision of compliance monitoring resources and tools

- MSI developed, update and continues to review and refine a suite of compliance resources for MSI and its country programs. Resources include guidance documents, an organization-wide SoPs for USG FP compliance, a compliance training package, and a Compliance Monitoring Checklist. These have been reviewed by USAID and shared with other agencies to aid them in strengthening their own compliance capacity. Key compliance resources including the training package have been translated into French.
- MSI produced programmatic guidance for country programs on key areas of compliance, including Pay for Performance guidelines and FP voucher programming guidelines for USAID-funded country programs.
- MSI developed, disseminated and updated key policies including a USAID Disclosure Policy, reiterating when and how MSI country platforms should inform USAID of any concerns they may have around any aspect of their programming. The guidelines exceed the contractual requirements of USAID Cooperative Agreements and are focused on ensuring good partnership.

2. Training on USAID FP principles and US policy and legislative requirements

- Regular (annual) trainings on FP Policy and Legislative Compliance were conducted by the MSI SIFPO team and trained consultants in all country programs receiving SIFPO funds. Country programs then undertook regular cascade training for all management and implementation staff working on USAID-funded projects, in addition to non-MSI staff such as partner organizations, MoH staff, franchisees and CHWs. MSI country programs also included refresher compliance training updates as part of review meetings and non-compliance related trainings.
- SIFPO team members and London MSI staff attended trainings by the USAID compliance team, including the USAID FP Compliance Training facilitated by Kimberley Cole, Lindsey Miller and Richael O'Hagan in 2014.

3. Global Health e-Learning course on FP Legislative and Policy Requirements

- MSI ensured that all staff working with USAID-funded projects completed and passed the FP legislative and policy requirements e-course annually. SIFPO key personnel and over 100 staff from London and the US office who charge time to USAID projects have obtained completion certificates. These certificates of completion are kept on file at MSI London, and are renewed annually.
- Relevant MSI country program staff were also required to complete and pass the e-course annually and retain certificates on file in-country. Training certificates are checked during SIFPO staff visits to country programs.

4. Inclusion in SIFPO-MSI sub-agreements

- All applicable provisions were included in partner sub-agreements.
- Compliance refresher training and ongoing monitoring issues were raised at regular partner meetings, such the Technical Leadership Group.

5. Continued Efforts for “Comprehensible Information” and Tiahrt Amendment compliance

- In the first year of the SIFPO project, MSI ordered wall chart posters from JHU-CCP in order to ensure that MSI country programs had the appropriate tools and information to ensure both providers and clients had the tools for understanding comprehensible information regarding FP method choice.
- In addition to the Tiahrt posters, MSI country programs develop materials such as brochures, leaflets, context-specific posters and other materials in local languages to ensure comprehensible information for all clients.

6. Support and TA to MSI country programs for compliance capacity building monitoring

- The SIFPO team conducted regular (at least annual) visits to all countries receiving SIFPO funds to undertake compliance checks and to verify that key policies are in place, implemented and documented. These checks formed part of a broader capacity building approach which included regular remote support, and financial and programmatic strengthening from MSI’s Operations and Finance teams. For example, compliance visits are undertaken jointly with non-SIFPO team members (e.g. country-level FP compliance focal points, senior management team members, and project support staff from London), to ensure sharing of learning as well as a common understanding of how FP compliance needs to be implemented in practice.
- Country programs developed extensive FP compliance monitoring and checking systems based on the global templates and guidance provided by the MSI SIFPO team, and have also integrated FP compliance indicators into routine monitoring and supervision processes.
- MSI also facilitated exchange between country programs receiving USAID funding to share lessons learned and tools.
- MSI successfully integrated USG FP policy and legislative compliance indicators regarding voluntarism and informed choice into MSI’s routine QTA, which are conducted at all MSI country programs by MSI’s Medical Development Team.
- All SIFPO field buy-ins had approved USG FP policy and legislative country compliance and a designated compliance focal point.

7. Continue to ensure pro-active communication with USAID

- MSI kept USAID abreast of compliance-related activities in regular phone calls and meetings. Where potential questions related to compliance come up, MSI staff promptly contacted the SIFPO Agreement Officer’s Representative (AOR) for support and advice. In some cases, direct communication with USAID’s FP Compliance Unit proved extremely helpful.
- MSI Country Directors and senior staff in country programs with SIFPO field support were asked about efforts to monitor FP legislative and policy compliance during regularly scheduled program review calls with MSI headquarters.
- MSI provided updates to the SIFPO AOR regarding compliance activities and actions in annual work plans, technical progress reports, trip reports, as applicable, and as part of the management review.

Environmental Mitigation and Monitoring

Environmental Mitigation Measures and Monitoring Plans

Over the life of the project country programs with SIFPO core funding and field buy-ins (Cambodia, Ethiopia, Ghana, Madagascar, Senegal, South Sudan, Pakistan, Tanzania, and Zimbabwe) maintained Environmental Mitigation Measures and Monitoring Plans based on their annual work plans.

MSI submitted the final annual Environmental Monitoring and Mitigation report for SIFPO core and buy-in countries on October 30, 2015.

Current Status of Environmental Mitigation Measures

MSI country programs implement policies and guidelines that comply with mitigation measures outlined in SIFPO documents, host country laws and policies, and MSI's internal partnership policies.

Infection prevention (IP) and clinical waste management guidelines are standard modules in MSI's clinical curriculum:

- MSI's IP curriculum focuses on preventing the spread of infection at service sites by teaching participants the importance of IP, to identify risks, learn the standard IP techniques and procedures, and to develop IP service site plan; and
- The purpose and aim of the clinical waste management curriculum and guidelines is to describe in detail the arrangement for the correct segregation, storage, collection, and disposal of all types of waste generated in order to assist managers to establish and maintain safe and effective waste management systems as well as to inform and assist team members to apply correct and safe procedures at all times.

IP and waste management are key components of MSI's QTA audits that MSI conducts annually on all country program service delivery channels. The QTA tool is also used more frequently by in-country staff.

A section on environmental monitoring and waste management is part of MSI's USG FP legislative and policy compliance checklist used during monitoring visits by both international and local staff.

Over the course of the project, minor refurbishment was conducted in Ethiopia, Madagascar, Pakistan, and Tanzania. Principles for environmentally-sound rehabilitation, as provided in the *USAID Environmental Guidelines for Small-Scale Activities in Africa and Asia*, were provided to vendors completing the work.

MSI's country program in Pakistan hired a consultant to provide recommendations to improve and optimize the program's waste management across all service delivery channels. The consultancy resulted in an environmentally friendly waste management plan and policy, with specific plans for management, monitoring and training, each service delivery channel, guidance on budget requirements and training materials. The package has been shared with the MSI partnership as a resource.

SIFPO-MSI Financial Performance

Total core obligations over the course of the award totaled \$13,375,000.

Total field support obligations totaled \$30,329,916, broken down as follows:

1. Cambodia:	\$1,845,870
2. Ethiopia:	\$3,350,000
3. Ghana:	\$1,190,814
4. Madagascar:	\$8,634,099
5. Pakistan:	\$7,408,018
6. Senegal:	\$850,000
7. South Sudan:	\$600,000
8. Tanzania:	\$4,514,980
9. Zimbabwe:	\$1,736,135

In addition, the Africa Bureau obligated \$200,000 for additional voluntary FP program activities.

MSI demonstrated a 100 percent burn rate at the end of the project (September 29, 2015).

SIFPO Field Support Activities Summary by Country

Cambodia

August 1, 2011 – September 30, 2014

\$1,845,870

Project Background

This field buy-in had two components:

- Increasing access to the full range of voluntary FP methods through improved availability of LARCs and PMs by building public and private sector capacity and reducing financial barriers to access; and
- Piloting effective means of integrating voluntary FP into services for prevention and treatment of HIV.

Key Achievements

- Over the course of the 36 month intervention **342,000 voluntary FP services were provided by mobile outreach teams and via vouchers generating 240,000 CYPs.**

Increasing access to LARCs and PMs:

- Marie Stopes Cambodia (MSC) provided FP counselling and service training to almost 100 public and private facilities ranging from referral hospitals to STI clinics, providing them with post-training and on-the-job coaching to ensure availability of a broad range of high quality voluntary FP methods. All facilities demonstrated higher levels of capacity on voluntary

[Marie Stopes Cambodia]'s work with most at-risk populations provides an example of how mission support and engagement of local technical partners and government can combine to provide effective programming among hard-to-reach groups as well as more mainstream clients.

SIFPO MSI Mid-Term Evaluation Report, August 2013

- FP counselling and service delivery, including implants and IUDs, as a result of the support. For example, during the final year of the buy-in the scores in six project-supported health facilities showed an average improvement in QTA scores of 15% for implant insertions and 29% for IUDs.
- MSC developed an innovative method to increase effective use of resources and improve coaching methods – 25 health centers were selected as core health facilities in which to provide QA on-the-job coaching, and five midwives from surrounding health centers were invited to participate in the QA activities. This method proved successful in streamlining resources, encouraging provider dialogue between health centers, and increasing QA capacity for providers who require it.
- In addition to clinical training and capacity building, MSC conducted FP sensitization efforts reaching thousands of community members using targeted and innovative methodologies such as informal group discussions with at-risk populations, *tuk tuk* banners, and holding special events.
- MSC mobile outreach teams provided voluntary FP services and distributed FP vouchers to clients which were redeemed for free LARC and PM services at both private and public health facilities. MSC also designed and printed new FP vouchers with updated information specific to people living with HIV (PLHIV) and entertainment workers in the community.

FP/HIV Integration:

- MSC led an assessment which brought together key stakeholders to discuss priorities and the scale-up FP/HIV integration. This assessment identified TA priorities for development partners to support FP/HIV integration and research priorities on FP/HIV linkages. Priority outcomes from the assessment included developing and operationalizing FP/HIV guidelines, ensuring commodity provision and service training, strengthening counselling on FP for PLHIV and MARPS, and implementing research for cost-effectiveness of different models.

- In Kandal and Takeo health facilities, FP/HIV integration was piloted in both opportunistic infection and antiretroviral treatment (OI/ART) and STI clinics. Clients were provided vouchers that facilitated their access to free and voluntary FP services thus reducing financial barriers to integrated care. These experiences positioned MSC to input into national-level dialogue and standard setting about integrated service delivery approaches.
- By identifying, piloting, and documenting innovations in FP/HIV integration programming, MSC also expanded the FP/HIV integration knowledge base and resources in the country. MSC contributed to the development of the national FP/HIV integration curriculum, job aids for providers, and client educational materials for most at-risk populations. MSC also collaborated with the National Maternal and Child Health Center to jointly conduct a training of trainers on the national FP/HIV integration curriculum.
- MSC held a close-out workshop in Kandal province with 39 representatives of the provincial health department, operational districts, health centers, NGO partners, and MARPs, including PLHIV and entertainment workers. At the workshop an action plan was developed with the provincial health department to continue FP/HIV integration efforts post-project, including critical activity areas such as: supporting budget requests from referral hospitals for FP counselors working at OI/ART sites; attendance at monthly community meetings with village chiefs to raise awareness about voluntary FP; and supporting commodity security within the public health system through submission of quarterly projections for central medical store allocation.

Lessons Learned

- Project data showed that only 6% of PLHIV clients chose to take up a voluntary FP method - lower than anticipated. MSC believes that this was due to: the high percentage of clients who were over 40 years in age (54%) and/or reported to be sexually inactive (49%); persistent experiences of stigmatization within the health system deterring PLHIV from accessing services; and a lack of suitable FP/HIV integration SBCC materials. Despite OI/ART managers agreeing to improve their integration of FP counseling, referrals, and SBCC materials into their standard practices and working with public sector staff and peer educators to more effectively meet the needs of PLHIV and entertainment workers in the community, additional approaches are necessary to enhance the effectiveness of future FP/HIV integration efforts.
- The availability of FP commodities continues to be a challenge in Cambodia. In Takeo and Kandal a large number of FP awareness raising activities were conducted to increase knowledge related to voluntary FP. However, service sites were often restricted by commodity shortages, particularly implants. MSC worked closely with public sector staff at monthly meetings to discuss stock control in order to minimize shortages. The MSC Senior Management Team worked at the national level about the impact of commodity stock-outs at the community level.

Future Plans

MSC received SIFPO core funding from October 2014 to September 2015 to start preparatory activities for a follow-on project under SIFPO2 field support to increase access to health services including FP information, counselling and voluntary services to garment factory workers.

Ethiopia

October 1, 2011 – September 29, 2015

\$3,350,000

Project Background

Marie Stopes Ethiopia (MSE) operated between six and ten mobile clinical outreach teams in the regions of Addis Ababa, Amhara, Dire Dawa, Oromia, Southern Nations, Nationalities and Peoples, and Tigray. Outreach teams provided comprehensive and voluntary FP services in hard-to-reach communities at public health facilities where government workers did not have the capacity to provide the full range of FP methods (e.g. adding PM access in facilities where only LARC and short-term methods were available). Starting in October 2013 MSE began shifting to a public sector support model and began training public sector workers on LARC and PM provision and further supported them through follow-up supervision and mentoring.

From project inception until August 2014 SIFPO also supported the BlueStar social franchise network in Oromia, Addis Ababa, Tigray, and Dire Dawa. Over 100 BlueStar franchisees located in urban and peri-urban areas were supported to deliver FP information, counseling, and voluntary services. In addition to increasing provider capacity, SIFPO contributed to an FP voucher scheme to reduce financial barriers to voluntary FP access in the private sector. Vouchers focused on reducing financial barriers to IUD access, but voucher holders could access any FP service of their choice.

Key Achievements

- Between October 2011 and October 2014, **22,224 clients accessed voluntary LARC and PM services from MSE mobile outreach teams, generating 94,930 CYPs.**
- Between October 2013 and September 2015, **14,267 clients accessed voluntary LARCs through MSE trained public sector service providers generating 44,803 CYPs.**
- Between October 2011 and August 2014, **144,728 clients (including 244 voucher clients) were provided with voluntary FP services by BlueStar social franchisees, generating 57,999 CYPs.**
- Complementing direct service delivery, MSE implemented awareness raising activities using mass media, SBCC leaflets and posters, coffee ceremonies, satisfied clients, and through community events with support from health extension workers. Referral linkages were created and maintained between government health facilities, private clinics, and MSE's mobile outreach teams.
- In order to strengthen government health facilities, 157 public sector health providers were trained in comprehensive FP counseling and voluntary service provision, and MSE provided ongoing coaching and support for dozens of public facilities.

Lessons Learned

- The turnover of enrolled and trained BlueStar staff was a constant challenge, requiring additional resources to map, enroll, and train new staff.
- MSE worked with CHWs, youth associations, women associations, *kebeles* (neighborhood) and Health Bureaus to increase community awareness of voluntary FP. This collaboration increased client flows to BlueStar clinics and MSE tried to create a referral tracking system by organizing a consultative meeting with stakeholders including public and private sector providers. Though an improvement was observed in linking potential clients with FP service delivery points, tracking referred clients still remains a challenge.
- In some areas, commitment from *woreda* health leaders to the project's activities and FP in general was not as strong as expected. In order to address this, MSE conducted experience sharing sessions and reviewed project activities together, bringing in other *woreda* leaders who were willing to share their positive experiences and lessons learned.
- When MSE conducted clinical trainings on PMs for public sector providers, finding clients desiring a PM to participate in the practicum portion of training was difficult. Some strategies to address this included holding the training in an area where more clients indicated interest in a PM.

Future Plans

- Activities will continue in Ethiopia under SIFPO2 field support. The intervention's goal is to reduce maternal deaths from unintended pregnancy. MSE will build on SIFPO activities to contribute to measurable increases in awareness of and access to high-quality voluntary PMs within comprehensive voluntary FP method choice. The project will focus on urban, rural, and pastoralist communities with high unmet need for voluntary FP, with an emphasis on creating access to the poor and new voluntary FP adopters in more than 123 *woredas* (districts).

Ghana

November 1, 2011 – March 30, 2014
\$1,050,000 (multiple buy-ins)

Kayayei Project
November 1, 2011 – March 30, 2014
\$550,000

Project Background

This project focused on the *kayayei* (head porters), a highly-marginalized group of predominantly young women and girls working and living in poverty and at great health and safety risk in Accra's markets. The intervention delivered FP counseling and voluntary LARC services, VCT and referrals for treatment in government health facilities, and addressed GBV by raising awareness and developing linkages between *kayayei* communities and the local police for reporting cases.

The SIFPO-MSI mid-term evaluation included a visit to Ghana and found that, **“the *Kayayei* project in Accra is ground-breaking and can be used as a model for other youth-orientated services MSI may want to deliver in the future. Its programmatic strengths are the targeting of very vulnerable, poor migrant, market workers and providing them with FP and integrated GBV services along with HIV/AIDS prevention and testing.”**

Key Achievements

- Marie Stopes Ghana (MSG) provided **9,680 FP services, generating over 28,000 CYPs** through an urban outreach team working in public and private sector host sites. The most popular voluntary FP method was the implant with over 7,000 *kayayei* clients opting for this method. Over 2,200 VCT services were also provided.
- MSG developed strong partnerships with key stakeholders including: Society for Women Against AIDS in Africa (SWAA) Ghana, Ghana Health Service (GHS) facilities in the project areas, Ghana Police Service's Domestic Violence and Victims Support Unit (DOVVSU), the *Kayayei* Association, and Assemblies of God Relief and Development's Elim Center.
- MSG adapted its outreach model (moving to shorter sessions) to allow its team to reach multiple sites in a day which enabled the intervention to expand to additional market areas and increased the number of *kayayei* reached in the final year.
- A total of 75 peer educators provided information to over 25,000 *kayayei*; in the last year of the project the majority of *kayayei* seeking services had been referred by peer educators. Referrals were the result of one-on-one counseling by peer educators using highly-pictorial SBCC materials specifically produced to support their activities. Due to the multiplicity of languages spoken by the *kayayei*, MSG engaged peer educators to facilitate the group counseling sessions that preceded service delivery in their own language.
- MSG created a GBV referral system and identified 18 Anti-GBV Champions (all *kayayei* community members) who served as the critical link between the *kayayei*, DOVVSU, and other referral services such as the Elim Center for sheltering. Six formal referrals were made to GBV survivors during the intervention, though many additional survivors were supported and there a wider sensitization effect among the *kayayei* leadership and local religious leaders.
- MSG built the financial and project management capacity of SWAA Ghana (a local NGO that received a subaward) which included all relevant areas of USAID compliance.

Lessons Learned

- Access to both condoms and HIV test kits were a challenge due to delays in receiving stock promised through the Global Fund. MSG was able to secure a small number of HIV test kits through GHS as well as condoms which it provided to peer educators for distribution during their counseling sessions.
- The frequent migration of the *kayayei* was a critical challenge throughout the project. The seasonal nature of farming in the northern part of the country meant that many *kayayei* traveled back and forth making it difficult to provide follow-up care.

- Frequent displacement and evictions of the *kayayei* from the *Agbogbloshie* market (largest slum in Ghana) created unrest and many *kayayei* moved to other locations in Accra. This disrupted field work and scattered the peer educators into other market areas.

Future Plans

- MSG's urban outreach team transitioned to funding provided by the Embassy of the Kingdom of the Netherlands and the UK Department for International Development (DFID). Under this new funding MSG was able to add an additional team and replicate its approach for the *kayayei* in Kumasi (Ghana's second largest city).
- The GBV structures and referral systems built within *kayayei* community are strong and are being sustained by the *kayayei* themselves. MSG built the capacity of 75 peer educators and 18 anti-GBV Champions who continue to refer their peers for voluntary FP and VCT services and to victim support from DOVVSU.

Successful media and government engagement gives the *kayayei* a voice

“When a girl child is born in my village, as soon as she can walk, she learns to carry something on her head. Then she must earn money” – Amina (16 year old *kayayei*)

This SIFPO intervention provided an integrated package of services for the *kayayei* in selected markets in Accra that included counseling and voluntary FP services, VCT and referrals, and SBCC to combat GBV. MSG quickly learned that much more was needed to help the *kayayei*. MSG raised the plight of the *kayayei* in the media and in 2013 was asked to work with the popular Maternal Health Channel television program to produce three episodes focused on the *kayayei*. Each episode comprised a short documentary followed by an in-studio discussion with radio talk shows in the days following the episode's premiere. The Maternal Health Channel profiled the poverty, discrimination, and lack of resources faced by the *kayayei* and the public reaction was overwhelming and outraged.

In response to public pressure, the Ghana Health Service Director General asked the producers of the Maternal Health Channel to help organize a meeting of stakeholders and for MSG to join and organize *kayayei* community members to attend. MSG mobilized over 20 *kayayei* to attend the meeting where they were given a platform to share their frustrations with public health services, sanitation, extortion by local tax collectors, and other lapses in social services.

The Director General formed a city-wide Health and Welfare Committee to work on the issues raised by the *kayayei*. As a result MSG and the National Health Insurance Authority collaborated to provide free insurance enrollment for over 3,000 *kayayei*. Other outcomes included mosquito spraying in the markets by the Accra Metropolitan Assembly to help combat malaria.

Mobile Outreach Project **October 1, 2012 – December 31, 2013** **\$500,000**

Project Background

This outreach project improved access to voluntary FP services by providing high-quality LARC and PM contraception to women and men living in rural and peri-urban communities and training public sector health workers. Two (and later four) mobile outreach teams operated in the Central and Western Regions visiting approximately 10 GHS host facilities per month to offer counseling and voluntary LARC and PM services. MSG trained GHS sessional doctors in PM and staff at GHS host facilities in LARC provision, as well as community-based volunteers in basic FP knowledge and referrals.

Key Achievements

- Mobile outreach teams provided **10,049 voluntary FP services, resulting in 42,462 CYPs**. As with the *kayayei* project, implants were the most popular method with around 80% of clients choosing this method.
- MSG trained and supported 360 community-based volunteers attached to GHS host facilities in FP information and making referrals.
- A total of 39 GHS staff were also trained and mentored in LARC and PM provision, helping to ensure that high-quality service provision will continue beyond the end of the project. This included training five GHS sessional doctors in voluntary female sterilization provision thus equipping the doctors with the requisite skills to provide the procedure during outreach sessions as well as in their respective regional government hospitals. MSG undertook follow-up mentoring of the doctors, including review meetings to share best practices on complications management, to ensure continued high-quality PM provision.
- Client exit interviews showed that 57% of mobile outreach clients were new adopters of PM, 42% were between the ages of 15-24, and 100% said they would recommend the outreach services to a friend.

Lessons Learned

MSG struggled to recruit clinical staff who would agree to be based outside of Accra, resulting in a six-month delay in starting up one of the two initial mobile outreach teams, reducing expenditure and the impact of the program in the initial nine months. As a result, a project extension was agreed from September 2013 to December 2013.

Future Plans

MSG successfully secured follow-on funding from the Embassy of the Kingdom of the Netherlands and DFID to continue the outreach work of all SIFPO supported teams into 2016.

Madagascar

October 2011 – September 29, 2015

\$8,634,099

Project Background

Marie Stopes Madagascar expanded and strengthened mobile outreach, social franchising, and voucher programming in order to improve FP access and choice for underserved populations.

Project activities (with cost share from UNFPA and other donors) focused on:

1. Providing comprehensive FP counseling and voluntary services through a network of 20 mobile outreach teams active across rural areas of Madagascar;
2. Expanding FP information, counseling and voluntary services in rural and peri-urban areas through 150 private sector BlueStar franchisees;
3. Improving FP choice and quality in the public health system through the establishment of public sector franchisees (CSBStars);
4. Providing free comprehensive voluntary FP and integrated SRH services to poor and young clients through the distribution of vouchers;
5. Increasing the ability of CHWs and MSM team members to provide quality counseling on comprehensive voluntary FP and referral support; and
6. Implementation of SBCC activities coupled with new tools for tracking impact and enhanced data management.

This project greatly expanded MSM's organizational capacity, improved service delivery management structures, strengthened cost-effectiveness, and supported innovation that has benefitted MSI globally, evidence gathering, and documentation that ultimately improved the equity of MSM's services and MSM's ability to respond to unmet need.

Key Achievements

- MSM delivered **856,433 voluntary FP services through mobile outreach, BlueStar, and CSBStar channels combined, generating 1,748,389 CYPs** (1,335,621 via mobile outreach, 404,838 via BlueStar, and 7,930 through the initial seven months of CSBStar operations). MSI estimates that these services will prevent an estimated 1,680 maternal deaths and averted an estimated 722,250 unintended pregnancies, contributing directly to reducing maternal mortality and morbidity.
- Since project inception MSM:
 - Increased the annual number of mobile outreach sites by 89% to 2,119;
 - Increased the number of BlueStar providers by 35% and number of clients served by 62%;
 - Improved equity through vouchers, with over 70,000 services redeemed by clients classified as “poor” and over 40,000 services redeemed by young people;
 - Created and supported new 26 CSBStar public franchises increasing the range of contraception available to include LARCs; and
 - Expanded the range of voluntary contraceptive options available at the community level by supporting over 440 CHWs.
- MSM's sustained and improved clinical quality during a time of rapid expansion: QTA scores of 98% for mobile outreach and 93% for social franchising in 2014 demonstrated increases from the 2011 scores of 94% and 86% respectively.
- Investment in M&E allowed MSM to measure the socioeconomic and health impacts of contraceptive use among outreach and BlueStar clients, improve data collection processes,

[The USAID Mission reported that] MSM provided “world-class clinical services” and “had the local infrastructure in place”, making it cost-effective for USAID, which did not have to set up a service delivery infrastructure from scratch. MSM was the “ideal partner” with regard to responsiveness, technical competence, roots on the ground and quality documentation.” Despite restrictions on working with the Malagasy MOH, “Marie Stopes has adopted an innovative mixed methodology to use other donor funds to work with health centers which compliment USAID investments.”

SIFPO MSI Mid-Term Evaluation Report, August 2013

add SMS and smartphone reporting through collaboration with DataWinners, and to apply systematic assessments to validate its voucher programs.

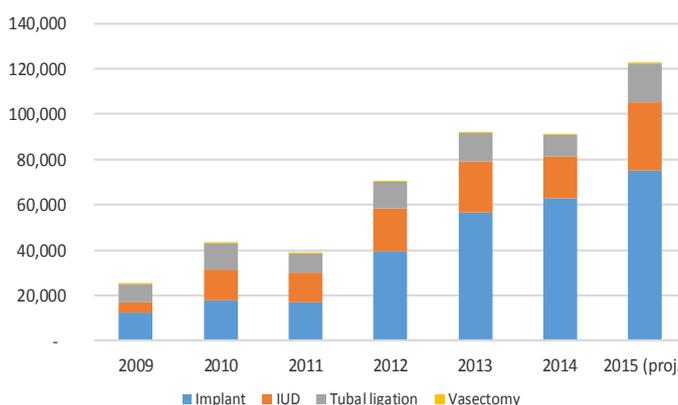
- MSM improved its youth programming through trainings on youth-friendly approaches for BlueStar franchisees. An increased proportion of young clients over the course of the project was recorded; in 2015, 35% of mobile outreach clients, 40% of BlueStar clients, and 47% of CSBStar clients were under the age of 25.

Catalyzing service delivery scale-up and national impact 2011-2015

SIFPO funding had a catalytic effect on MSM's service delivery reach, enabling us to dramatically scale up access to LARCs and PMs and increase method choice nationally.

Through this expanded service provision, and MSM's ability to reach underserved women and FP adopters, we estimate that **MSM increased MCPR by 2.7% points between 2011-2015**, with a total MCPR contribution of 11% points in 2015. This means that by 2015, **more than 1 in 10 of all women of reproductive age in Madagascar, or almost a third of all women using a modern method, were using contraception from MSM.**

Figure 2: growth in MSM delivery of LARCs and PMs 2009-2015 (SIFPO started end 2011)



We estimated that services provided

which were funded through SIFPO, prevented an estimated 1,700 **maternal deaths** and averted an estimated **500,000 unintended pregnancies**, contributing directly to the goal of reducing maternal mortality and morbidity.

Lessons Learned

MSM piloted different approaches to reach young people including free access to voluntary FP and STI information and services through its youth voucher (see activity 4.1 above and Africa Bureau report below for additional information). The voucher was initially designed to be sent exclusively via SMS however many young people declined to use SMS due to lack of phone access or confidentiality concerns. As a result, MSM developed a paper voucher system linked to a toll-free call center in addition to the e-voucher.

Future Plans

Building on the successes and lessons learned during SIFPO, MSM secured field buy-in funding under SIFPO2. SIFPO2 will continue to support MSM's social franchising and voucher interventions. MSM will also strengthen the public sector by accrediting and supporting an additional 100 CSBStars, and through a reframing of its mobile outreach model to include more training and quality assurance of voluntary FP services in the public sector. Some mobile outreach teams will operate as they did under SIFPO, but they will focus on new sites in the most underserved parts of the country. MSM will continue its efforts to reach more adolescents through its youth voucher and 114 new MS Youth Agents. MSM will also continue to strengthen its M&E capacity to effectively track project performance as well as document and share best practice and research findings with local partners and stakeholders.

Pakistan

July 1, 2012 – September 29, 2015

\$7,408,018

Project Background

Marie Stopes Society (MSS) began its SIFPO-funded intervention by laying the groundwork for successful voluntary FP service delivery (e.g. established a competent and qualified team and successfully engaged stakeholders to create a supportive operating environment and bolster public sector involvement). Service delivery commenced in December 2012 in underserved areas of Punjab and Sindh Provinces through six mobile outreach teams working through 120 public sector facilities, 50 Suraj social franchisees, and a voucher to reduce financial barriers to access. The mobile outreach teams provided ante- and post-natal care in addition to a full range of voluntary FP methods. With the signing of a five-year bilateral award with USAID in October 2013, service delivery activities moved to that mechanism while SIFPO continued to support primarily institutional strengthening and capacity-building activities.

Key Achievements

- Between December 2012 and September 2013, a total of **41,851 women were provided with voluntary FP services, generating 88,439 CYPs**, at 121 intervention sites in Punjab and Sindh Provinces. Of these clients 40% were served through mobile outreach and 60% used vouchers to receive a free and voluntary FP service through social franchisees.
- A total of 93 Trained Field Health Educators (FHEs) were identified, trained, and assigned to mobile teams and franchisees. **FHEs reached nearly 100,000 women** with FP information, referrals, and follow up care through door-to-door visits. An informal referral mechanism was established with local Lady Health Workers. FHEs and project field teams also conducted more than 400 meetings with key stakeholders such as teachers, religious leaders, and public representatives on issues related to reproductive health and healthy timing and spacing of pregnancies.
- MSS managed a telephone helpline that provided FP information, referrals, and support to callers on issues such as side effects management.
- MSS human resource capacity was scaled up in preparation for expanded service delivery under the USAID bilateral, including hiring of key staff and establishment of project support offices in Karachi and the two focal regions. Trainings in key organizational development areas – such as leadership, management, and cross-functional team collaboration – were also conducted.
- Key institutional strengthening activities included the alignment of MSS standard operating procedures with USG compliance guidelines and investment in an Enterprise Resource Planning system that improved business processes across MSS' operations (e.g. supply chain, human resources, payroll, and travel) and strengthened internal controls.

Lessons Learned

- Some FHEs faced challenges in gaining access to men in their community and in response MSS engaged men (in addition to women) as FHEs to interact with male family members.
- A few FHEs shared their experience of being met with hostility when they first started talking about SRH and FP. However, they also shared how hostility turned into receptiveness and how women increasingly sought voluntary FP services which FHEs believed was due to their improved counseling skills and support from supervisors.
- The paucity of candidates with required qualifications, positive FP values, and women willing to work outside the home made recruitment and retention of qualified staff difficult, especially in the field. The project utilized existing MSS local networks in remote areas and found suitable candidates via word-of-mouth. In some cases, MSS team members met with community influencers and household members to convince them to give permission for women in their household to work.
- MSS faced security challenges delivering services in frequently unstable geographic areas. MSS established strong security systems and Standard Operating Procedures to mitigate these risks.

Future Plans

In October 2013, MSS signed a five-year bilateral award with USAID to continue and expand the work initiated under SIFPO. Under this award MSS is playing a lead role in increasing voluntary FP and SRH access, choice and equity in the entire Sindh Province and parts of Punjab Province. MSS is also integrating FP/SRH services with other maternal and child health interventions in the public sector, focusing on skills transfer to public sector health workers to ensure maximum sustainability. The expected results of the bilateral project include: an estimated 2.5 million CYPs (projection for planning purposes); 350 private sector providers delivering quality voluntary FP services; increased access to voluntary FP services to women/families earning less than \$1.25/day; and an estimated 1,350 maternal deaths to be averted through increased contraceptive use.

Senegal

March 1, 2014 – September 29, 2015

\$850,000

Project Background

Marie Stopes Senegal received a SIFPO buy-in to increase access to voluntary FP information and services by establishing two mobile outreach teams to operate in the underserved areas of Diourbel and Kaffrine (June 2014 to September 2015); continuing to fund the Université Cheikh Anta Diop (UCAD) clinic established with SIFPO core funds (October 2014 to September 2015 – previous phases described under Activity 4.1, above); and expanding its social franchise network to two additional regions of Senegal (service delivery commenced September 2014).

Key Achievements

- MSS provided **12,812 FP services which generated 52,855 CYPs**. Of the 9,522 women who chose a LARC service, almost half (47%) chose IUDs, a much higher IUD uptake than seen in other countries in the region.
- Mobile outreach teams were established in Diourbel and Kaffrine, where CPR is low at 5% (2011 Demographic Health Survey) and socio-cultural barriers to voluntary FP are high. A tailored service package (including cervical cancer screening, to reduce the stigma associated with attending a voluntary FP service day), a multi-faceted SBCC approach focused on child spacing messages, and ongoing team collaboration with local authorities, community and religious leaders contributed to the following results: voluntary FP uptake by 4,600 women in Kaffrine (where 69% of women were completely new to FP); and 5,100 women in Diourbel (45% completely new to FP).
- MSS strengthened SRH information and service access for young people through the UCAD mini-clinic. A total of 5,224 SRH services were provided by the clinic, of which 524 were voluntary FP services (57% to FP adopters). Mystery client survey findings indicated that young people were happy with the confidentiality, respect for privacy, and non-judgmental counseling at the clinic. MSS also reached 18,906 young people with SBCC initiatives, including one-to-one discussions through peer educators, collaboration with student associations and other student medical centers (who referred clients to the MSS clinic) and “summer beach campaigns” in beach areas where young people congregate. SBCC teams also worked with 14 local high schools and colleges to provide SRH information, VCT and referrals for voluntary FP services (many of whom were then seen at the UCAD clinic) to over 2,000 young people.
- MSS expanded its BlueStar franchise to two new districts (Thies and Mbour) selecting, training, and accrediting 12 private sector providers to join the network which launched in August 2015.

Collaboration with religious leaders on outreach

MSS mobile outreach teams worked closely with all authorities – regional and local health authorities, village chiefs, and religious leaders – in order to be accepted and allowed to provide voluntary FP services and garner community support for their work. Given the highly-stigmatized nature of FP, engagement of religious leaders proved extremely important for both the implementation of activities and to enable these key stakeholders to act as positive sources of information on the importance of voluntary FP for women in their areas. In Diourbel mobile outreach teams had an audience with the Khalife General des Mourides, the supreme leader of the Mourid community. The Khalife heard about MSS’ work in the region and wanted to discuss the impact of their activities for women and couples. During this meeting the Khalife blessed the teams and wished them great success in their work. This meeting was critical for the team in Diourbel to move ahead, and enabled events such as the provision of voluntary FP services during the Magal de Touba, a religious event drawing thousands of pilgrims from West Africa.

Lessons Learned

- Despite being popular with young people, voluntary FP uptake at the UCAD mini-clinic was lower than projected. MSS believe this is due to the continuing stigma around voluntary FP use among unmarried young people. MSS saw an increase in voluntary FP uptake over the project period, and anecdotal evidence suggested that young people were taking up voluntary FP on their third or fourth visit to the clinic. In the next project phase MSS will explore alternative SBCC and service delivery approaches with the aim of accelerating voluntary FP access for young people in the university catchment area.
- Social franchising services were not started until the last month of the project as approval to add this component was not received until early 2015 and selection, training and accreditation then took longer than expected.

Future Plans

MSS secured a field buy-in under SIFPO2 to continue mobile outreach operations in Diourbel and Kafrine, service provision in the UCAD mini-clinic, and expand the university mini-clinic model to other towns using UNFPA and other donor funding. The newly recruited franchisees will be supported through separate donor funding after September 2015.

South Sudan
April 1 2012 – September 30 2013
\$600,000

Project Background

South Sudan has some of the worst health status indicators in the world. This field buy-in aimed to support Marie Stopes South Sudan to start up operations in the remote Yambio county, Western Equatoria State, and establish two new mobile outreach teams to provide voluntary FP information and services to women across 32 locations.

Key Achievements:

- Implementation of an FP KAP survey and subsequent development of a BCC strategy informed by the survey. Perspectives and experiences related to SRH and FP were captured from the proposed mobile outreach sites in WES through focus group discussions (FGDs) and in-depth interviews (IDIs).

Key findings from the South Sudan Yambio KAP survey:

- The most frequently cited health problems were lack of maternity services or lack of transport to reach services, and early pregnancies.
- It was widely recognized that a family with fewer children has the capacity to provide them with proper care in terms of housing, food, health care, and schooling.
- The most commonly known FP methods were condoms, pills, and injectables. Some had heard of the implant, but not the IUD. Pills and injectables were associated with side effects, and participants had major concerns about the potential side effects of the longer-term methods. *“If we are aware of their side effects and how to treat them, we will be more interested.”* (Women’s focus group, Ringazi)
- Birth spacing and child spacing was seen by all as a traditional practice and beneficial for the health of both mothers and children. Traditional pregnancy prevention/birth spacing techniques include the lactational amenorrhea method (LAM), the calendar method, and abstinence.
- Pregnancy among girls under 18 years old was perceived as common but undesirable. Respondents – men, women, and girls - believed that young girls should not be giving birth because they are not mature enough physically. Pregnancy prevention, including modern contraception, was seen as appropriate for school-age girls to enable them to start a family at a healthy age and complete their education.
- Current FP users had access to FP (close to facilities providing it), desired to space births and understood that voluntary FP could do this, and had supportive partners.

- Start-up activities in Yambio county, including recruitment and training of project staff, selection of mobile outreach delivery sites in Yambio, in collaboration with the County Health Team, and initial community meetings at all sites.
- Marie Stopes South Sudan (MSSS) developed partnerships with multi-sectoral NGO and government partners in Yambio to enable integration of mobile outreach activities with existing projects in Yambio.

Lessons learned

The project experienced challenges including funding delays and difficulties in securing agreement from the different levels of the MoH to operate a voluntary FP program in Western Equatoria State, due partially to difficulties at the State level and also to high MoH turnover and lack of clarity regarding the different levels of MoH sign-off required. MSSS was therefore not able to provide voluntary FP services as was originally planned. The FP survey findings were shared with the Mission and other partners, and MSSS used them to inform ongoing BCC work in other States. Assets were transferred to partner organizations, and MSSS utilized trained service providers under other projects.

Tanzania
August 1, 2011 – September 29, 2015
\$4,514,980 (multiple buy-ins)

Family Planning Outreach Program
August 1, 2011 – January 15, 2013
\$3,714,980 (DFID funds)

Project Background

This field buy-in was made possible by funding from DFID administered through USAID as part of a DFID-USAID partnership. Marie Stopes Tanzania significantly expanded FP access and choice in rural areas through **17 mobile outreach teams and six bajaji auto-rickshaws**. The mobile outreach teams were deployed in regions with high levels of unmet need to provide comprehensive FP information, counseling, and voluntary services including LARC and PMS. MST also worked closely with district health teams and government service providers to strengthen their capacity to deliver voluntary FP services. Voluntary FP services were coordinated with awareness-raising activities carried out by community-based mobilizers. *Bajaji* auto rickshaws provided voluntary FP services in peri-urban sites in Zanzibar, Pemba, and Mwanza.

Key Achievements

- A total of **144,734 clients took up voluntary FP services, generating 600,472 CYPs**.
- A total of **60,143 clients received VCT services**.
- Almost three-quarters of MST's clients were living on less than \$1.25/day and one-third were below the age of 25.
- The activity mid-term evaluation conducted by DFID rated the project highly ("A" for progress against all project outputs). The evaluation highlighted MST's flexibility and initiative to demonstrate the progress made despite challenges of a slow start up and removal of cost-share funding from another donor.

Measuring impact at a national level: Raising CPR and catalyzing long-term USAID investment in Tanzania

During the 15 months of the SIFPO buy-in, MST significantly expanded access to voluntary FP in rural areas of Tanzania through mobile outreach teams that provided services to over 150,000 rural women. Thanks to the SIFPO supported *Impact 2* model, MST can estimate the impact that these voluntary FP services will have on maternal health indicators and the Tanzanian health system, **averting over 250 maternal deaths and over 1,300 child deaths, and saving over \$5 million in health system costs**. SIFPO support also laid the foundations for a two-year DFID/USAID bilateral award to MST, where service delivery was further expanded to include 21 mobile outreach teams and eight *bajajis*. During the two-year intervention, **600,000 clients received voluntary FP services, resulting in 2.4 million CYPs, and over 159,000 clients received VCT**. SIFPO funding enabled MST to grow its service delivery infrastructure and scale up its contribution to the Tanzanian government's ambitious CPR goals. Again using the *Impact 2* model, MST estimates that the services it provided between 2011-2014 **increased MCPR by almost two percentage points**, and by the end of 2014, **over one in four Tanzanian FP users received their method from MST**.

Lessons Learned

- MST operated in partnership with the Tanzanian MOH and utilized Assistant Medical Officers (AMOs) seconded by local government authorities (LGAs) in its mobile outreach teams. These AMOs sometimes had additional administrative responsibilities to accomplish before going on mobile outreach, causing delays for the whole team. As a solution, MST revised the procedures for selecting and approving the allocation of LGA surgeons to MST teams.
- Outreach teams faced several shortages of contraceptives (especially implants) and supplies due supply chain issues at the district level. To address this, MST successfully advocated for a buffer stock of FP supplies to be obtained directly from central medical stores.

Future Plans

MST continued with the work started through this SIFPO buy-in and has expanded voluntary FP and VCT services via 21 mobile outreach teams and eight auto rickshaws through a two-year bilateral award with USAID, funded by DFID.

Testing approaches to reach young people in Tanzania

September 1, 2011 – August 30, 2012 (Phase 1)

January 1 – September 29, 2015 (Phase 2)

\$200,000

Project Background

More than half of all Tanzanian women aged 15-24 and 5% of under-fifteens have already married. More than one quarter (28%) of girls aged 15-19 have been or are pregnant, and modern method CPR for married 15-19-year-old women is only 12%. Unmet need for FP among 15-24-year-olds ranges from 22% (married) to 40% (unmarried). To address this unmet need, MST implemented a youth-focused SIFPO buy-in to test the effectiveness of different adaptations of existing delivery models in reaching young people. This was undertaken in two phases:

Phase 1: between September 2011 and August 2012, MST linked mobile outreach service delivery in Lindi and Mtwara with established community-based organizations or “youth network groups” (13 in Mtwara and eight in Lindi). After training on adolescent SRH and FP, the groups worked to raise FP awareness with young people in their local areas and coordinated with MST to refer interested young people to mobile outreach service days (this activity was leveraged by an Australian Department of Foreign Affairs and Trade funded project).

Phase 2: between January and September 2015, MST tested the ability of the *bajaji* model (described under Activity 1.1. above) to reach young people. MST worked with one *bajaji* team in Mwanza to integrate youth-friendly delivery sites into their routine scheduling. Higher learning institutions (HLIs) were identified and agreed to work with MST on this initiative. MST recruited community-based mobilizers and peer educators who supported the *bajaji* team in conducting voluntary FP and SRH services and awareness raising activities in communities and HLIs. During the project period the *bajaji* outreach team in Mwanza made 135 visits, delivering SRH and FP information, counseling and voluntary services in 18 health facilities including two facilities located in HLIs.

Key Achievements

- In the initial phase (nine months of service delivery), **3,878 clients under the age of 25 accessed voluntary FP methods and VCT services from MST’s mobile outreach teams in Lindi and Mtwara and more than 4,450 clients accessed SRH information through awareness raising events.** Service statistics showed that the proportion of mobile outreach clients under 25 increased from 43% in April 2012 to 74% in August 2012.
- In the second phase (six months of service delivery), 2,070 clients under the age of 25 accessed voluntary FP services from the *bajaji* provider, generating 8,693 CYPs. In total, 55% of the Mwanza *bajaji* clients during the project period were under 25, and 7% were under 20.
- Implants were the most popular FP method, followed by injectables, then pills (for the mobile outreach youth clients) or IUDs (for the *bajaji* youth clients).
- An evaluation of the initial phase, which undertook in-depth qualitative interviews and focus group discussions, noted the increase in services provided to young people as the project

“During BCC events MST provided FP and VCT services for free and I have been waiting for nine month because it very far to go to Ligula Hospital for implants, transport is expensive and also asking permission from parent to go to town is a challenge so when the services came in our village I was really happy...”

--Participant aged 24 years, unmarried with two children, living with her parents

progressed, along with positive feedback from young people and local government representatives, who felt that it had raised awareness and improved attitudes towards SRH and voluntary FP among their peers in addition to increasing access to services.

Lessons Learned

- Desire for FP and SRH services among students at HLIs is high; however access is limited due to a lack of available service providers and facilities. During implementation, HLIs' schedule and availability regularly changed making it difficult for MST to plan. For the partnership between MST and HLIs to be successful, it was vital to mainstream SRH and FP activities into HLIs' annual calendar and establish infrastructure that will not compromise quality of services provided. MST will incorporate these lessons into its work under a SIFPO2 field buy-in.
- MST was not permitted to provide voluntary FP services in two colleges which were owned by the Catholic Church. Although the management in these universities recognized the need for FP education and services for the students, the universities' regulations did not permit such activities to take place on university premises. To overcome this, the teams worked with the universities to inform the students where they could access MST services offsite.

Future Plans

Through SIFPO2, MST will build on these learnings to scale up effective innovations and establish new partnerships to contribute to measurable increases in awareness of and access to voluntary, high quality FP and SRH services among adolescents and young people under the age of 25. MST will focus on both urban and rural youth communities with unmet need for FP, with an emphasis on the poorest communities and increasing uptake amongst new voluntary adopters of voluntary FP. The main strategic approaches will be to:

- Increase FP and SRH awareness-raising activities among youth and adolescents in both rural and urban areas with high unmet need by expanding access to information and referrals via peer educators, reducing cost barriers, and engaging key gate keepers.
- Increase access to high quality, comprehensive, and integrated FP and SRH information, counselling and voluntary services through mobile outreach and *bajaji* teams in order to increase client choice among rural and peri-urban youth and adolescents
- Document and share successful approaches with the government and other stakeholders.

Supporting the Tanzanian Police GBV response February 1, 2012 – September 29, 2015 \$600,000

Project Background

This project strengthened the national response to GBV by increasing the availability, quality, and utilization of GBV services by developing and piloting a one-stop package of counseling, services, and referrals at police health facilities in Iringa and Mbeya regions.

Key Achievements

- A total of 345 GBV survivors accessed post-GBV care at One Stop Centers (OSC) in Iringa and Mbeya regions between October 2014 and September 2015. Most of the survivors were women 25 years and older who had experienced emotional or physical violence, followed by women who had experienced sexual violence.
- MST contributed to the development of national GBV guidelines, policies, and training materials (February 2012 to November 2013) and organized two clinical GBV trainings in 2013 and 2014 for 40 government providers in Iringa and Mbeya regions using the new curriculum.
- MST organized the following trainings and meetings to familiarize stakeholders with the new guidelines and how to operationalize them:
 - Orientations on how to complete and use the new Police Form Three (related to GBV reporting) for 91 police officers, state attorneys, health care providers and magistrates from Iringa and Mbeya regions;

- Meetings with all stakeholders in both regions to development of a GBV and Violence Against Children directory to strengthen the referral process. Mapping was conducted to identify GBV stakeholders in the two focal regions, services offered, and contact persons. This information was compiled into a referral directory and shared with service providers, communities through community and religious leaders and community-based organizations; and
- Orientation on how to implement the national guidelines for operationalization of hospital-based OSC for 26 service providers.
- MST refurbished the OSC facilities in Iringa and Mbeya according to the recommended minimum standards for OSC services and provided medical equipment and supplies (such as rape kits) in order for OSCs to provide quality services to GBV survivors. The Iringa and Mbeya OSCs now serve as two of six OSCs now open in Tanzania.
- MST conducted a range of community awareness activities including funding radio interviews for police, health care providers, and social welfare officers during the “16 days of activism against GBV” each year during the project period. MST, in collaboration with the police, made public announcements to promote available services.

Lessons Learned

The process for refurbishing the OSC facilities required more time than originally planned as MST wanted to ensure full compliance with USAID regulations. MST and the SIFPO team worked closely with USAID locally and in Washington to review refurbishment plans and agree the scope and process for completing this part of the activity.

Future Plans

GBV activities implemented by MST ended with the project. MST has urged the government and other partners to undertake the following activities to further strengthen availability of GBV response services in Tanzania:

- Establish additional OSCs to provide comprehensive GBV services in other regions as the six currently in operation do not adequately cover the country.
- Extend GBV training to service providers from all sectors using the established national curriculums and guidelines.
- Support the establishment of more forensic labs for quick investigation of cases.
- Develop SBCC materials and conduct awareness raising events to address socio-cultural barriers regarding GBV in local communities.

Zimbabwe

October 1 2011 - September 30 2012

\$1,736,135

Project Background

Population Service Zimbabwe, a local NGO affiliated with MSI, began receiving USAID support in October 2010 to expand its provision of voluntary FP services. PSZ's initial funding (October 2010 to September 2011) was received through the SHOPS project. PSZ transitioned their intervention to SIFPO between October 2011 and October 2012. From October 2012 to September 2017, PSZ is continuing its voluntary FP intervention through a USAID/Zimbabwe bilateral award. This SIFPO supported intervention has allowed PSZ to increase awareness, coverage, and access to comprehensive voluntary FP services in underserved communities through nine mobile outreach teams and the launch of a social franchise network (27 strong).

Key Achievements

- **Voluntary FP services were provided to 84,387 clients, generating 214,600 CYPs.**
- Expansion of service delivery into nine out of Zimbabwe's ten provinces, with PSZ providing services in 75% of rural government health facilities nationally.
- PSZ's mobile outreach teams experienced improvements in quality through SIFPO; teams attained initial QTA scores of 88% in 2011, improving to 95% in 2012.
- In April 2012, PSZ established a toll-free call center open from 8:00am to 7:30pm and staffed by well-trained and multi-lingual nurses. Callers received information on FP services and referral points, and the call center received an average of 70 calls per day in its first six months of operation.
- PSZ also invested in a Geographical Information System enabled database that allows for detailed filtering of service data for each service delivery site (including BlueStar franchisees). PSZ uses the information as a planning tool to monitor service channel linkages, overlaps, and referral systems.

Lessons Learned

PSZ found low levels of LARC provision, high LARC prices and acute LARC commodity shortages during an assessment of potential franchisees conducted towards the end of the SIFPO project. PSZ worked to standardize and reduce the prices charged for IUD and implants for all BlueStar providers and ensured that adequate supplies were made available to BlueStar network partners.

Future Plans

As PSZ's SIFPO buy-in came to a close, USAID awarded the organization a five-year bilateral award for the Improving Family Planning Services (IFPS) project. The IFPS project builds on PSZ's existing infrastructure, extensive experience of implementing successful, efficient, and high-quality outreach programs and close working relationship with key governmental and non-governmental stakeholders. Building on PSZ's success under SHOPS and SIFPO, PSZ will continue to expand access to high-quality, voluntary FP services through mobile outreach and its BlueStar network. PSZ estimates that over the course of the IFPS project, it will avert almost 1,900 maternal deaths, 5,900 child deaths, and 421,000 unintended pregnancies.

SIFPO-MSI Africa Regional Bureau Activities Summary by Country

As part of Activity 4.1 (also reported on above), the USAID Africa Regional Bureau provided \$200,000 through the SIFPO award to explore the use of mobile technology to increase young people's access to FP information and voluntary services in MSI country programs in two African countries, Madagascar and Senegal. In both countries young people represent a large proportion of the population and are relatively underserved by existing FP providers. In these projects, mobile technologies were used by MSI healthcare providers and peer educators to refer for voluntary FP services via mobile vouchers, and to provide linkages to awareness-raising events and targeted SBCC. This effort advanced the USAID Youth in Development policy, which notes that "promoting SRH of young people, reducing unplanned pregnancies and improved levels of education and earnings of young women are essential to establishing conditions for broad societal change." Activities were integrated into ongoing field buy-ins in both countries once the Africa Bureau project was completed.

Madagascar

Young people often express preferences for seeking FP and other SRH services from private providers where they are offered greater privacy and confidentiality. However, in many of MSI's social franchise networks, the proportion of clients who are young people is low, and particularly for those under the age of 20. MSI learned from programming experience that supply-side interventions such (e.g. youth-friendly training for franchisees) have stronger and more lasting results when matched with a corresponding demand-side component (e.g. vouchers) to allow franchisees to put their new skills and approaches into practice through regular interactions with young clients.

Marie Stopes Madagascar was working with a network of 150 franchised private healthcare providers trained to provide high-quality FP counseling and a range of voluntary FP methods, funded through a SIFPO-MSI field buy-in project. MSM has run a paper-based voucher program for several years, which enabled underserved populations to receive the voluntary FP service of their choice at a subsidized rate. Building on promising results from a SIFPO-funded youth-friendly franchisee training and youth voucher pilot in Zimbabwe in 2013, MSM designed a youth voucher intervention aimed at increasing access to SRH information and services for adolescents (aged under 20) with Africa Bureau funds (via SIFPO).

MSM trained a total of 52 BlueStar franchisees in youth-friendly service provision and briefed them on the new youth voucher. Community-based agents in urban and rural areas which were covered by mobile phone networks were trained to raise awareness of FP, promote the voucher to adolescents, and provide the vouchers to those interested in taking up a voluntary service. The adolescent could then redeem the voucher (which was free) for a range of services of their choice – including FP counseling, a range of voluntary FP methods, and STI services – at one of the participating 52 BlueStar franchisees. MSM then reimbursed the provider via a mobile money payment. Vouchers were initially designed to be SMS-based and sent to young people's mobile phones, but MSM learned that many young people did not own mobile phones, especially in poorer communities, and others were reluctant to have SMSs sent to them for confidentiality reasons. In response to this information MSM adapted their voucher system to enable young people without mobile phones to access the services of their choice using a paper voucher, although use of the SMS voucher continues (linked to MSM's call center).

Take-up of voluntary FP services through the youth voucher program outstripped expectations, with **over 10,000 adolescent voucher-holders received voluntary FP services in the first six months** of the program, and over half choose a LARC method during this period. This was a significant increase in uptake of FP services at franchised private providers by adolescents, who had previously not been seeking services in such large numbers. The youth voucher has now been integrated into MSM's routine programming, funded by USAID through a SIFPO field buy-in and UNFPA. Africa Bureau funds were used to document and disseminate findings from the pilot, including the presentation of an abstract on the vouchers by Lalaina Razafinirinasoa (MSM

Country Director) at the Global M-Health Forum in Washington D.C. in December 2014, and the production of a documentation paper which was disseminated at the SIFPO EoP meeting.

Senegal

As reported above, while Senegal has made great strides to increase modern method CPR in recent years, unmet need among unmarried young people stands at 70%, one of the highest in the world, and 32% of Senegalese girls have begun childbearing by the age of 18. Young people in Senegal lack access to accurate FP information and method choice, due in large part to stigmatization of sex before marriage.

In 2013 Marie Stopes Senegal began working with youth-led organizations to arrange SRH information events and conduct “edutainment” and peer education sessions at locations where young people often spend their leisure time (e.g. beaches, universities, and schools). MSS also established a “last Saturday of the month” for young people at the MSS clinic (including reduced prices), franchisee facilities, and mobile outreach sites, and saw a 28% increase in clients aged under 25 during the project period.

To keep in touch with the young people after initial contact, MSS sent SMS messages with SRH quizzes and information to over 3,700 young people who had provided their contact details. MSS also undertook semi-structured interviews with almost 400 young people to better understand their sexual health behavior and information/service preferences. Findings included low knowledge about pregnancy risks; incomplete knowledge of the range of FP options; good knowledge of HIV but low awareness of other STIs; reluctance to attend public health facilities for voluntary FP due to fear of judgement or risk of running into an adult they know; preference for accessing FP from locations close by that are not labelled as FP/contraception clinics; and preference for a youth-orientated center within the university as the optimal way to meet their SRH needs. As a result of these findings, MSS opened two university-based clinics with SIFPO field buy-in and UNFPA funds (see also the Senegal field buy-in description above).

Annex 1: SIFPO I-supported publications and tools – Reports, briefs, consensus statements, tools and peer-reviewed journal articles

A. Reports

- **Scaling up FP access and choice through mobile outreach: results and insights from SIFPO 2011-2015** has seen the most rapid growth of mobile outreach service delivery in MSI's history, bringing high quality FP services to women and couples with unmet need
- **Supporting the public sector to deliver full contraceptive choice: A review of Marie Stopes International programming models and experiences.** Shares operational experiences and lessons learned by MSI through public sector support initiatives in four case study countries: Ethiopia, Nigeria, Cambodia, and Madagascar.
- **Introducing and scaling up voluntary medical male circumcision** shares programmatic experiences from Marie Stopes International's voluntary medical male circumcision (VMMC) service delivery in Southern and East Africa.
- **Integrated HIV and SRH services: improving service integration in Kenya.** Presents programmatic lessons regarding Marie Stopes Kenya's integration of HIV and SRH services.
- **Innovating mobile service delivery to increase FP choice and access for the peri-urban poor: Marie Stopes Tanzania's bajaji model** Marie Stopes Tanzania's Bajaji mobile outreach, which uses motorized auto-rickshaws, is an adapted mobile outreach model aimed at reducing client barriers to family planning access in peri-urban and urban areas.
- **Increasing access to voluntary family planning and STI services for young people: the youth voucher program in Madagascar** MSM's youth voucher program revealed high demand for voluntary family planning services among 15-19 year olds - could be replicated in other contexts where financial barriers to access prevent young people from accessing services.
- **Increasing family planning choice and access in the Sahel.** Outlines how mobile outreach in remote areas and youth university clinics are reaching new FP users in the Sahel region
- **Delivering Sexual Reproductive Health Services to Young People: key lessons from Marie Stopes International's programs.** Outlines experiences and lessons from youth SRH service provision from MSI country programs.
- **Using Mobile Finance to Reimburse Sexual & Reproductive Health.** Describes and analyses Marie Stopes Madagascar's approach to utilizing m-health in its voucher program.

B. Consensus statements

- **Increasing Access To Female Sterilisation** – endorsed by 11 organizations, committing to ongoing collaboration to achieve the goal of universal access to voluntary family planning, which includes the provision of a broad method mix including permanent methods
- **Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception**– endorsed by over 20 organizations, committing to expanding access to LARC information and services for young people

C. Briefs

- Dietiker, C, Gordon-Maclean, C, Nantayi, L, Quinn, H, Ngo, T. Task sharing: Safety and acceptability of tubal ligation provision by trained clinical officers in rural Uganda. London: Marie Stopes International, 2013
- Bates F, Keogh S, Ngo T. Vocal local is as effective as pharmacological treatments for pain management of tubal ligation procedures in rural Kenya. London: Marie Stopes International, 2013
- Ngo, T.D., Nuccio, O., Reiss, K., Pereira, S.K. Expanding long-acting and permanent contraceptive use in sub-Saharan Africa to meet FP2020 goals. MSI Research Brief Series 2013/006. London: Marie Stopes International, 2013
- Reichwein, B., Weinberger, M., Fry, K., & Nuccio, O. Meeting FP2020 commitments: the importance of moving beyond the first-time user. MSI Research Brief Series 2013/004. London: Marie Stopes International 2013
- James Wumenu, Barbara Reichwein, Thoai D. Ngo, Katy Footman, Measuring poverty for optimal FP2020 programming Research Brief Series, 2015/002
- Eva G, Shah, S, Quinn, A and Ngo, T., Are our voucher programmes working? Evaluating our methods and results in six countries. Marie Stopes International. Research Brief Series 001/2015.

D. Peer reviewed journal articles

Mohamed, M.A., Park, M.H., Ngo, T.D. Levels and determinants of switching following intrauterine device discontinuation in 14 developing countries. *Contraception* 90 (1) 47-53, 2014

Azmat, SK, Shaikh, BT, Hameed, W, Mustafa, G, Hussain, W, Jamshaid, A., Ishaque, M, Ahmed, A., Bilgrami, M. Impact of social franchising on contraceptive use when complemented by vouchers: a quasi-experimental study in rural Pakistan. *PLoS ONE* Volume 8, Issue 9. September 2013

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Thurston, S., Chakraborty, N.M., Hayes, B., Mackay, A., Moon P., Establishing and Scaling-Up Clinical Social Franchise Networks: Lessons Learned From Marie Stopes International and Population Services International *Global Health Science and Practice* June 1, 2015 vol. 3 no. 2 p. 180-194

Munroe, E., Hayes, B., Taft, J., Private-Sector Social Franchising to Accelerate Family Planning Access, Choice, and Quality: Results From Marie Stopes International *Global Health Science and Practice* June 1, 2015 vol. 3 no. 2 p. 195-208

Azmat, SK., Ali, M., Ishaque, M., Mustafa, G., Hameed, W., Khan, OF., Abbas, G., Temmerman, M., Munroe, E., Assessing predictors of contraceptive use and demand for family planning services in underserved areas of Punjab province in Pakistan: results of a cross-sectional baseline survey. *Reprod Health*. 2015 Mar 28;12:25. doi: 10.1186/s12978-015-0016-9.

Reichwein, B., Wolmarans, L., Nantayi, L., Nassali, F., Kakinda, A., Musumba, D., Nguyen, T. H., Baatsen, P., SegWeigh: A mixed-method approach to segmenting potential contraceptive user groups and meeting Family Planning 2020 goals. *International Journal of Gynecology and Obstetrics*

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E. Tools

A number of tools have been developed with SIFPO support to better measure and improve impact of FP services. These include:

- **Impact2** used to estimate past, current and future contributions to national contraceptive use, contraceptive prevalence, and post-abortion care services nationally. The model can be used to estimate the wider health, demographic and economic impacts of these services (<http://mariestopes.org/impact-2>);
- **Task Sharing Impact tool** to help quantify the potential benefits of task sharing of FP services (<http://mariestopes.org/impact-task-sharing>); and
- **The Cost Calculator** which enables country platforms to better understand the costs involved in delivering FP services. By breaking costs down by services, service delivery channels, individual outreach units within a delivery channel and types of costs, the tool allows improved value for money whilst ensuring access and equity are maximized.

Annex 2: SIFPO Performance Monitoring Plan Indicator Framework: Global Indicators

Table 1A. SIFPO-MSI Performance Monitoring Plan Indicator Framework: Global Indicators

	Indicator	Data Source	Frequency of data collection	Project Results (October 2010-September 2015)	Notes
Estimated number of maternal deaths that will be averted through use of family planning provided by MSI	<p>The number of maternal mortalities averted per CYP is derived using the maternal mortality ratio (MMR) as follows: Number of maternal mortalities averted per CYP = $MMR/100,000 \times \text{births averted}$.²</p> <p>The MMR is defined as the number of maternal deaths per 100,000 live births. It includes all women who die whilst pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes.</p>	MSI Impact Estimator ³	Annually	48,000 (MSI globally) 3,500 (SIFPO-MSI)	All results align with the new USAID CYP conversion factors. Madagascar regional demographic data used as proxy for SIFPO estimates,
Estimated number of pregnancies that will be averted through use of voluntary family planning provided by MSI	Total number of pregnancies averted through use of voluntary family planning is derived by analysis of DHS data on the number of unintended pregnancies per year to women with unmet need for family planning, compared with the number of unintended pregnancies which would be expected if they had all used a modern method. One full CYP is the equivalent of one year of protection from unintended pregnancy for one couple. Regional estimates derived from <i>Estimating unintended pregnancies averted by CYPs</i> (Guttmacher Institute, 2011)	MSI Impact Estimator	Annually	27,000,000 (MSI globally) 1,100,000 (SIFPO-MSI)	All results align with the new USAID CYP conversion factors. Madagascar regional demographic data used as proxy for SIFPO estimates,
Total number of couple years of protection provided through voluntary family planning provided by MSI Disaggregated further	CYPs ⁴ are calculated by multiplying the number of each contraceptive method given to clients by a corresponding conversion factor. This yields an estimate of the duration of contraceptive protection per unit of that method. One full CYP is the equivalent of one year of protection from unintended pregnancy for one couple.	MIS	Monthly	66,569,229 (MSI globally) <i>Disaggregated by LARC/PM:</i> TL: 16,368,039 Vasectomy: 3,887,364	SIFPO specific field activities includes service figures from field buy-ins and core service delivery activities who have

² Country-specific coefficients for births averted were derived using estimates from the WHO, UNICEF, UNFPA, and World Bank report *Maternal mortality in 2005*.

³ Methodology of the MSI Impact Estimator 1.2 is in Appendix A.

⁴ Using USAID CYP conversion factors

<p>by the single category comprised of CYPs generated by all long-acting and permanent methods (LAPMs)</p>	<p>Disaggregated further by the single category of CYPs generated by all long-acting and permanent methods (IUDs, implants, tubal ligations, and vasectomies as relevant)⁵</p>			<p>IUD: 26,394,138 Implant: 15,582,731 3,449,721 (SIFPO) <i>Disaggregated by LARC/PM:</i> TL: 827,669 Vasectomy: 16,550 IUD: 812,488 Implant: 1,668,894</p>	<p>undertaken service delivery during the project.</p>
<p>Total number of family planning client visits at all MSI service delivery points⁶</p> <ul style="list-style-type: none"> Percentage under/over the age of 25 years Percentage female/male 	<p>The total number of visits made by clients to all MSI FP service delivery points in one month, collected every month. Client visits are verifiable by the daily register and therefore this indicator does not include a person seen by a community-based distributor, community health worker, or health volunteer or where contraceptives are distributed at talks or events. Those who make general enquiries do not count as clients.</p> <ul style="list-style-type: none"> Disaggregated by age: <=24 years of age/>=25 years of age or older <ul style="list-style-type: none"> Disaggregated by sex: female/male 	<p>MIS</p>	<p>Monthly</p>	<p>28,015,229 (MSI globally)⁷</p> <p>1,467,636 (SIFPO), 99% of which are female. Average client demographic breakdown for SIFPO-supported countries (based on exit interview results): 27% under 25 (23% of mobile outreach clients, 35% of social franchise clients)</p>	

⁶ The age and sex breakdown of client visits will become available over the life of the project as the Management Information Systems upgrades take place. Current data collection does not completely capture this information for all client visits and therefore baselines are not available.

⁷ Includes the following MSI country programs, which receive funding from a variety of funding sources and donors: Burkina Faso, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Nigeria, Sierra Leone, South Africa, South Sudan, Swaziland, Tanzania, Uganda, Zambia, Zimbabwe, Bolivia, Mexico, Cambodia, Timor Leste, Mongolia, Papua New Guinea, Philippines, Afghanistan, Bangladesh, India, Nepal, Pakistan, Sri Lanka, Yemen.

Table 1b. SIFPO-MSI Performance Monitoring Plan Indicator Framework: Core Work Plan Indicators

Sub-Result	Definition	Data Source	Frequency of data collection	Project Results	Notes
Result 1: Strengthened organizational capacity to deliver quality FP services to target groups					
1.1 Produce significant impact by testing and replicating innovative FP service delivery activities	Number of innovations tested and results documented.	Project records	Semi-annually	9	<i>Bajajis</i> , M4QI, PPIUCD, VMMC, Sahel outreach, youth vouchers, university mini-clinic, costing tool, task-sharing impact tool
	Evidence of replication in part or whole of identified innovations, either by MSI or other stakeholders	Project records Correspondence	Annually	7	<i>Bajaji</i> outreach model, M4QI, youth vouchers, costing tool roll-out, task-sharing impact tool, Sahel outreach
1.2 Document and share innovations, catalyzing state-of-the-art FP programming globally	Number of relevant research studies initiated (with protocol review and ethical approval, as appropriate)	Project records	Semi-annually	8	Vocal local study, Uganda TL task-sharing, Sierra Leone task-sharing, Zambia TL task-sharing, Kenya vasectomy KAP, Nigeria M4QI study, India and Zimbabwe outreach evaluations
	Number of research study findings, analyses, or publications produced and disseminated	Project records	Semi-annually	1	All of above except Nigeria M4QI and Zambia TL task-sharing (dissemination under SIFPO 2)
1.3 Strengthen technical and management capacity at the global, country, and headquarters level	Number of new and revised service delivery guidelines and practice protocols produced and disseminated	Project records	Semi-annually	10	Results include voucher SOPM, voucher USAID programming guidance, USAID P4P guidance, mobile outreach SOPM, GBV guidelines and protocols, gender policy, counselling policy and guidelines, and clinical guidelines
	Number of MSI staff at headquarters having received certificate of completion for US family planning policy & legislative e-course	Project records	Annually	165 certificates over 5 years	This covers London-based staff only

	Number of technical fora, including meetings, conferences, workshops, and technical working groups, in which MSI staff participate	Project records	Semi-annually	14	See narrative report above for details
	Number of internal knowledge-sharing activities resulting from participation in technical fora in which MSI staff participate	Project records	Semi-annually	Over 50	All technical fora attendees share information with relevant colleagues
1.4 Integrate FP service delivery with related health services	Number of integrated programming models and approaches identified and documented	Project records	Semi-annually	2	VMMC and HIV/FP integration

Result 2: Internal quality assurance standards and results quantified and disseminated to strengthen FP performance at a global level

2.1 Strengthen organizational capacity to monitor, evaluate, disseminate and use data and research	Number of MSI staff trained in monitoring and evaluation (M&E) and research skills	Project records	Semi-annually	308	Results do not include completion of e-learning courses
2.2 Improve data management through enhanced use of technology at the global, country, and headquarters level	Number of MSI country programs (of USAID BEST ⁸ countries) in which the roll out of the MIS upgrade has been initiated	Project records	Annually	18	Most of these countries have begun using the CLIC system; some country programs (for example Pakistan) are using their own bespoke MIS systems
2.3 Increase organizational knowledge management capacity	Number and type of knowledge-sharing activities, events, and/or publications carried out	Project records	Semi-annually	15	Includes technical consultations, presentations at conferences, and SIFPO EOP meeting
2.4 Disseminate and increase utilization of results and best practices in a cost-effective manner	Number of documents uploaded on the Best Practice Gateway	Project records	Semi-annually	Over 10,000	
	Number of abstracts submitted to conferences and professional meetings	Project records	Semi-annually	Over 250	Abstracts submitted to over 15 different conferences
	Number of articles submitted for publication to peer-reviewed or other technical journals	Project records	Semi-annually	15 (11 published)	

⁸ USAID BEST countries are: Angola, Benin, DR Congo, Ethiopia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mozambique, Nigeria, Rwanda, Senegal, South Sudan, Tanzania, Uganda, Zambia; Afghanistan, Bangladesh, India (UP), Indonesia, Nepal, Pakistan, Philippines, Yemen; Guatemala, Haiti.

Result 3: Increased organizational sustainability of country-level programs, including internal south-to-south support and technical assistance

3.1 Improve tracking of costs, revenue, and improving cost efficiency	Number of MSI country programs (of USAID BEST countries) using poverty grading tool for clients	Project records	Annually	18	Results include all countries doing exit interviews
	Number of MSI staff trained in financial management skills and procedures	Project records	Semi-annually	147	
3.2 Improve capacity to deliver cost-effective inter- and intra-organizational south-to-south technical assistance	Number of MSI staff trained in management and leadership skills	Project records	Semi-annually	34	Does not include Marie Stopes Madagascar staff (training supported through SIFPO buy-in)
	Number and type of technical assistance initiatives delivered intra-organizationally	Project records	Semi-annually	Over 150	

Result 4: Gender-sensitive FP services targeting youth strengthened at a global level

4.1 Strengthen organizational capacity to reach youth, and monitor, evaluate, and disseminate results	Number of MSI country programs (of USAID BEST countries with MIS upgrade rolled out) reporting clients by five-year age bands	Project records	Annually	N/A	MSI has moved towards actual age reporting through CLIC and exit interview results, instead of reporting by 5-year age bands.
	Number and type of knowledge-sharing activities and events and relevant protocols, tools, reports, and/or programmatic guidance on reaching youth undertaken	Project records	Semi-annually	13	Results include production of MSI youth paper; co-leadership of LARCs and youth consultation and subsequent consensus statement; presentation on youth and mobile outreach at a SRH event; presentation on youth results from exit interviews; youth-friendly programming guidance for franchising; documentation of pilots in Senegal, Zimbabwe and Madagascar; gender and youth assessment carried out in Malawi, Nigeria and Bangladesh

4.2 Ensure greater involvement of men, particularly young men, in FP programs and address gender norms around contraception, family size, and gender-based violence	Number of male involvement and gender-sensitive programmatic and knowledge-sharing activities initiated or expanded	Project records	Semi-annually	6	Gender and youth assessments carried out in Malawi, Nigeria and Bangladesh; vasectomy pilots documented in Uganda and Kenya; participation in vasectomy working group meetings including sharing MSI vasectomy experiences
4.3 Increase ability to incorporate gender considerations into programming at the global, country, and headquarters levels through an integrated and comprehensive approach	Number of gender-focused assessments, policies, and trainings implemented	Project records	Semi-annually	10	Gender and youth assessments in Malawi, Nigeria, Bangladesh; formative gender assessments in Ethiopia and Zambia; ICRW stakeholder consultation and presentations in London; formation of gender policy, GBV in programming guidance, and GBV protocols; training in Tanzania on GBV package

ⁱ *Innovating mobile service delivery to increase FP choice and access for the peri-urban poor: Marie Stopes Tanzania's bajaji model*

ⁱⁱ *Optimize4MNH*

ⁱⁱⁱ *Vocal local versus pharmacological treatments for pain management in tubal ligation procedures in rural Kenya: a non-inferiority study* (Thoai D. Ngo, Sarah C. Keogh, Kenzo Fry, Edwin Mbugua, Mark Ayallo, Heidi Quinn, George Otieno) BMC Women's Health, 2014.

^{iv} *Are our voucher Programs working? Evaluating our methods and results in six countries* a forthcoming journal article, Eva, G., Quinn, A., Ngo T. D

^v *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* International Journal of Gynecology and Obstetrics.

^{vi} *Increasing Access to High-Quality Voluntary Permanent Methods of Contraception in Low Resource Settings*

^{vii} *Global Consensus Statement for Expanding Contraceptive Choice for Adolescents and Youth to Include Long-Acting Reversible Contraception*

^{viii} *Delivering sexual and reproductive health services to young people: Key lessons from Marie Stopes International's programs*

^{ix} *Step by step guide to strengthening sexual violence services in public services*