Insight to Action
MSI’s Research, Monitoring and Evaluation Strategy to support Scaling up Excellence 2016-2020

Publication for external dissemination
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<tr>
<td>AAR</td>
<td>Action after review</td>
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<tr>
<td>CLIC</td>
<td>Client Information Centre (Marie Stopes routine data system)</td>
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<td>CRCT</td>
<td>Cluster randomised control trial</td>
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<td>CP</td>
<td>Country programme</td>
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<td>CYP</td>
<td>Couple years of protection</td>
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<tr>
<td>DHS</td>
<td>Demographic and Health Survey</td>
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<tr>
<td>DMPA</td>
<td>Depot medroxyprogesterone acetate (injectable)</td>
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<td>D&amp;E</td>
<td>Dilation and evaluation</td>
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<td>FP</td>
<td>Family planning</td>
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<td>HIC</td>
<td>High-impact client</td>
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<td>IEC</td>
<td>Information, education, communication</td>
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<td>IUD</td>
<td>Intra uterine device</td>
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<td>LAPM</td>
<td>Long-acting or permanent method</td>
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<td>LARC</td>
<td>Long-acting reversible contraception</td>
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<td>LMICs</td>
<td>Lower and middle income countries</td>
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<td>MVA</td>
<td>Manual vacuum aspiration</td>
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<td>MIS</td>
<td>Management information system</td>
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<td>MCH</td>
<td>Maternal and child health</td>
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<td>MSI</td>
<td>Marie Stopes International</td>
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<td>MA</td>
<td>Medical abortion</td>
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<td>NHI</td>
<td>National health insurance</td>
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<td>OOP</td>
<td>Out of pocket (expenditure)</td>
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<td>PEER</td>
<td>Participatory Ethnographic Evaluation and Research</td>
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<td>PAC</td>
<td>Post-abortion care</td>
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<td>PAFP</td>
<td>Post-abortion family planning</td>
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<td>PSS</td>
<td>Public sector support</td>
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<td>QTA</td>
<td>Quality technical assistance</td>
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<td>RCT</td>
<td>Randomised control trial</td>
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<td>RME</td>
<td>Research, Monitoring and Evaluation (team at Marie Stopes International)</td>
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<td>SA</td>
<td>Safe abortion</td>
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<td>SP</td>
<td>Service provider</td>
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<td>Social franchising</td>
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<td>Social marketing</td>
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In order to achieve its ambitious Scaling Up Excellence strategy goals, MSI needs to learn how to improve the effectiveness and cost-effectiveness of its programming. In essence, it needs to do more with less. High quality research is integral to this agenda. While the organisation has rapidly increased the scale of its programming over the past decade, multiple unanswered questions remain on effective models and mechanisms to reach the strategy goals.

The Research, Monitoring and Evaluation Team in MSI’s Central Support Office will work with operations departments and country programmes to ensure they are asking the right questions and answering them in the right way. It will support both operational research to evidence our daily service provision activities, as well as strategic research, to answer the big-picture questions of global relevance, whose results are applicable across and beyond the partnership.

A cross-organisation research prioritisation exercise was undertaken in 2016 to identify evidence gaps for strategic research. Following an online survey with country programmes and the London Support Office, and a prioritisation meeting, MSI has identified 12 key evidence gaps that need to be answered through rigorous research. These 12 questions all contribute to the three pillars of the 2020 Scaling Up Excellence strategy, and include research into high impact groups, demand generation, understanding our markets (in particular the abortion care-seeking pathway), measuring our service offering and client experiences better, and the impact of product and service diversification on our core business. The 12 priorities are as follows:

### Scale & Impact
- Deliver increased scale and impact at lower cost per client served

### Quality
- Set the standard for clinical quality and client-centred care

### Sustainability
- Build long sustainable service delivery models that go beyond donor support

#### Scale & Impact
1. How can MSI increase FP uptake (especially LARCs) by high-impact clients?
2. How can country programmes effectively decrease FP discontinuation and/or increase switching to LARCs?
3. How do women seek abortion and how can MSI support their decision-making?
4. How can MSI ensure that its abortion clients receive and continue to use contraception (PAFP)?
5. How can task-sharing for FP and abortion improve MSI’s programme impact?

#### Quality
6. How can MSI improve measurement of client satisfaction and experience?
7. How can MSI improve the client experience and outcomes of self-managed MA?
8. How can MSI improve its clinical abortion care, including pain management, cervical priming for D&E, and promoting adherence to the regimen?
9. How can MSI reduce provider bias and increase client engagement in decision-making for FP & abortion?

#### Sustainability
10. How can service diversification and cross-selling contribute to sustainability of operations and core service maximisation (FP/SA)?
11. How can community-based providers, including MS Ladies, contribute to programme sustainability?
12. How can public sector purchasing of MSI services within a ‘Universal Health Coverage’ framework impact programme sustainability and health outcomes?
1. Introduction

The Research, Monitoring and Evaluation Strategy 2016-2020 of Marie Stopes International (MSI) sets out a vision for research support and evidence generation across the partnership of 37 country programmes. The strategy is fundamental to support achievement of MSI’s Scaling Up Excellence operational strategy.

MSI is a fast-moving service-delivery organisation, with a constant drive to innovate and deliver more, with higher quality, but with greater cost-effectiveness. Conducting high-quality research to understand our markets and test programme innovations is fundamental. Evidence and lessons learned must feed into programme design, and support the transfer of experience and innovation from one country context to another.

At the heart of this strategy are 12 strategic research priorities which have been defined during a cross-MSI research scoping and prioritisation exercise in early 2016. Generating reliable evidence on these priority questions will help cement MSI’s positioning as a global leader in service innovation within the reproductive health sphere. The strategy also outlines a vision of how operational questions can be tackled on a routine basis through quality operational research, and feedback into our operational guidance. This includes clinical guidance for service-delivery, and programmatic guidance delivered through MSI’s Success Models.

Why now and what is different?
There is a culture shift sweeping through MSI – we are moving insights into programming to guide our actions. We are validating our service numbers through MSI – we are moving insights into programming to guide our actions. We are validating our service numbers into programming to guide our actions.

Box 1: Criteria to determine strategic research priorities

1) Actionable: Will the research help MSI do something with greater scale and impact, with higher quality, or in a more sustainable way?
2) Generates new and reliable knowledge: Will the research generate new knowledge on an unanswered question?
3) Answerable: Can the question be answered in a reliable and timely way with sufficient rigour to guide programme/policy action?
4) Applicable: Will the results be useful across the partnership?
5) Innovative: Will the research cement MSI’s leadership as a service innovator in the global SRH community?
6) Strategic: Will the evidence influence strategic decision-making?

Strategic research at MSI

In addition to the day-to-day operational research conducted by research teams across our country programmes, the London-based research team supports strategic research projects in priority countries. The strategic research agenda detailed in this document is still highly programmatic in nature.

Strategic research tackles questions of global relevance whose results have implications for multiple country programmes and the wider reproductive health research community. It ensures that MSI will deliver services with greater scale and impact, with higher quality and greater sustainability. It aims to generate new knowledge on unanswered questions using well-designed and rigorous research methodologies to ensure that the answers being obtained are reliable and trustworthy, with findings scalable to other country programmes.

Six criteria were used to determine MSI’s strategic research agenda. These criteria were agreed at a Research Strategy Prioritisation meeting held in March 2016 at the London Support Office. The criteria are shown in Box 1. These criteria will also be used to screen research study proposals, both at global level from partner organisations, and for country programmes through the regional research advisors or in-country research leads.

The strategic research questions prioritised in this document (see next Section 2) rely on strong research designs to ensure results are reliable, valid and meaningful across the partnership. Obtaining reliable and valid answers for these strategic priorities will take time, and MSI is committed to ensuring the research is well-designed, well-implemented, well analysed, well disseminated and well used. Different types of research design are considered below in Section 3.
In order to determine the 2016-2020 Research Strategy, a research priority scoping exercise was undertaken to identify the research needs of country programmes and different teams working within the organisation. The methodology of the scoping exercise is detailed in Annex 1. In brief, it involved an online survey with MSI staff in country programmes and the London Support Office, and collation of research priorities arising from operational planning workshops held in 2016.

The research scoping process resulted in an initial set of 125 consolidated research questions, categorised as those likely to result in scale and impact, quality of care or sustainability. A research strategy meeting was held in March 2016, bringing together MSI technical and regional staff, and external reproductive health research experts. Professors John Cleland and Dan Grossman advised the group on the current state of knowledge in the field (see Annex 2). The group undertook a participatory exercise to prioritise 12 strategic research questions, guided by the criteria in Box 1 above. Priorities were then agreed with members of the Executive Team and further refined to ensure clarity and avoid duplication. More detail on priority countries can be obtained from MSI.

**Questions are NOT listed in any order of priority.**

### 2.1 Research priorities to achieve SCALE & IMPACT

There are five strategic research priorities aiming to provide evidence to support the achievement of scale and impact. The focus of family planning questions is on the testing of interventions to increase uptake and continued use of contraception, and specific interventions to be tested are suggested as priorities for evidence generation. The abortion research agenda focuses more on formative research to gather community and client insights on demand and care-seeking behaviours, reflecting the relatively recent availability and rapidly growing use of medical abortion across all country programmes.
How can MSI increase FP uptake (especially LARCs) by high-impact clients?

Rationale: Attracting new users is critical to achievement of MSI’s 2020 strategy, and the organisation has made a clear commitment to double the number of contraceptive users, reach an additional 12 million users, and ensure 80% of its clients are from high-impact groups, including youth 15-19 years. MSI is developing a new youth strategy, and has brought together a youth working group to recommend strategy in this area. Discussions and scoping work indicate that MSI lacks a strong evidence-base on successful strategies in attracting youth contraceptive users, in particular unmarried and nulliparous women. Diverse strategies to reach rural and urban youth will also be needed, with a focus on those that could be applied in multiple contexts. Research conducted within the broader reproductive health community has failed to identify service delivery strategies that consistently work to attract young users. Reaching the poor has also been prioritised within MSI’s 2020 strategy, but appropriate interventions to achieve more equitable service delivery remain untested, and measurement of poverty remains challenging. The range of potential interventions suggested for evaluation below is wide, but some are key operational strategies which still require a much stronger evidence base (*), including for their cost-effectiveness. Marketing campaigns are evaluated as a matter of course within all country programmes using routine data.

Interventions to be tested: A range of interventions were identified as requiring robust evaluation:

- Use of community-based mobilisers in outreach to target high-impact groups, including strategies for incentivisation and remuneration of mobilisers, and relative effectiveness of different types of mobilisation (group vs individual, MSI vs governmental, district vs community, house visits vs community fora)*
- Exemption management and subsidy targeting (exemptions, vouchers, coupons, pro-poor insurance and/or loan schemes (free vs OOP))*; including evaluation of the impact of fees for FP for high impact client profiles
- Comparison of the effectiveness of interpersonal communication (IPC) with vouchers/coupons/referral notes vs IPC alone in reaching high impact clients
- Referral notes from call centres and IPC agents to clinics
- Approaches to youth counselling
- Male partner involvement
- Communication and messaging redesign (for counselling and/or IEC materials)
- Interventions delivered in the post-partum period, including for youth*
- Educational interventions (schools, peer education, curriculum) with explicit linkage to MSI services

Channel settings: Intervention testing is required in all three core channels (centres, outreach, social franchising), and strategies may need to vary by channel.

Research design: Testing of these interventions may necessitate separate evaluation research (see Section 3), but in some instances could be achieved through routine data analysis (e.g. through trend/time-series analysis of routine CLIC or other programme data alongside a staged roll-out approach, where new interventions are tested in certain clinics or outreach teams before others). Research to evaluate impact on FP uptake should be centred around MSI’s behaviour change framework, and should track behavioural change across the continuum from intention to advocacy. Formative research will be particularly critical in the design of interventions to attract young clients. Randomised trials may be needed to test large-scale programme interventions which seek to impact on population-level changes in behaviour, such as voucher schemes.

Methodological challenges: Measurement of success in reaching high-impact groups, in particular ‘poor’ clients and youth, requires attention to detail on how poverty is measured, and the methodological challenges of conducting research on youth SRH behaviours (higher tendency for response bias, ethical challenges).

Priority countries: Countries with large outreach programmes, those strategising to scale-up reach of HIC; those with low CPR or disparate CPR at sub-national level; acceleration countries; those with strong client segmentation.
How can country programmes effectively decrease FP discontinuation and/or increase switching to LARCs?

**Rationale:** Discontinuation of contraceptives remains a critical challenge across all MSI country programmes, in particular those with a high proportion of short-acting method users. Global analyses using household survey data in low- and middle-income countries suggest that up to 38% of women discontinue their contraceptive within one year of starting. Continuation rates of MSI service users remain unknown. Reliable measurement of continuation is a challenge, despite the roll-out of CLIC, due to challenges in monitoring users, and the large biases in estimates from ‘loss to follow up’, i.e. clients lost from the MSI system. Research in this area therefore also offers the opportunity to validate and strengthen routine data collection and data linkage with repeat users. Furthermore, while MSI has been successful in promoting LARC uptake in its outreach programme, we still lack evidence on what works to encourage timely and effective switching from short- to long-acting methods.

**Interventions to be tested:** A range of interventions were highlighted requiring more evidence to support their widespread recommendation. Some are operational priorities (*). Strategies to be evaluated that were prioritised are:

- Client follow-up mechanisms (including facility-led follow-up, call centres, m-health activities including voicemail, SMS, and use of community health workers or mobilisers)*.
- Counselling and communication approaches, including side effect management.
- Revised prescribing practices for short-term methods (i.e. number of pill cycles and condoms given).
- Changes to the number and types of methods offered (e.g. addition of low-dose pill varieties); and promotion of new methods (self-injecting DMPA – Sayana Press)

**Channel settings:** Intervention testing is required in all three core channels (centres, outreach, social franchising), and strategies may need to vary by channel.

**Research design:** Testing of such interventions will necessitate use of robust evaluation methodologies (highlighted below in Section 3), in addition to routine programme monitoring. Strategic research is critical in this area due to the challenges in accurately capturing method continuation rates through routine data. Studies also require in-depth process evaluation to understand why interventions work or fail, as well as costing and cost-effectiveness analysis to support programme decision-making on sustainable strategy development. Health communication interventions should counter misconceptions, and research should involve robust mixed quantitative and qualitative methodologies, including techniques like cognitive response testing.

**Priority countries:** Countries with high rates of short-term method use (>50% of method mix); those with ability to follow up (call centres, m-health, voicemail, SMS) and focus on improving client care.

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Research priority 3

**How do women seek abortion and how can MSI support their decision-making?**

**Rationale:** The rapid scale-up of medical abortion availability across all MSI country programmes over the past decade, in both legally restricted and unrestricted settings, has led to changes in abortion-seeking behaviour. These changes may be influencing the use of MSI surgical abortion services in some of the country programmes where they are provided. There is also huge potential to scale-up availability of MSI’s socially-marketed MA (SM/MA), but little is known about who is seeking SM/MA, and how we can expand our SM/MA and clinic client base to reduce the proportion of women seeking alternative unsafe options. While MSI has conducted some initial research on this topic, this has been limited in scope and conducted in only a few country programmes, e.g. Tanzania, Pakistan, India.² Formative research in this area will be critical to help determine the interventions that need to be designed to increase use of MSI’s safe abortion services. This includes research with our clients but also the wider community of those in need of abortion.

**Specific sub-themes:** Research is needed to gather insights to understand:

- the evolving decision-making pathway for abortion, including timing and circumstances of pregnancy detection, choice of abortion method and reasons for it, choice of provider, timing of abortion-seeking, to inform strategies to reduce late-stage abortions or abortions sought through unqualified back-street providers;
- the changing abortion market place across different contexts;
- post-abortion behaviours, including decision to see post-abortion care, choice of after-care, post-abortion FP, and repeat abortion;
- MSI client insights and experiences, including: understanding of self-managed MA; perceptions of MSI clinics and services, including potential stigma
- external influences on (or drivers of) abortion decision-making including partner, familial and community influences, information and media influence, and programmatic influences;
- assessing affordability of MSI price structures amongst defined client segments, including for clinical services and SM/MA.
- social and programmatic barriers to use of MSI safe abortion services

**Channel setting:** Community-based research is needed with users and potential users of MSI abortion services. Research can also be conducted within MA/SA delivery channels (centres, social franchising, and pharmacies/drug shops for socially-marketed MA).

**Research design:** Qualitative methods will be essential to gather insights on abortion-seeking behaviours, but care is needed to select appropriate sampling approaches to identify abortion users or potential users, for example using community-based snowball sampling, or other forms of respondent-driven sampling. Quantitative methods could also be used to gather community insights, such as exit surveys with pharmacy/drug store clients, or household surveys. The latter face the challenge of substantial reporting bias when investigating abortion, however. Community mapping can be used to understand which providers are delivering services.

**Priority countries:** Abortion research is easiest to conduct in countries where abortion access is less legally restricted. However, research on abortion-seeking including use of non-MSI MA drugs may also be feasible in countries aiming to reduce mortality from unsafe abortion.

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How can MSI ensure that its abortion clients receive and continue to use contraception (PAFP)?

**Rationale:** Increasing PAFP rates to 90% among in-centre abortion and PAC clients is a goal within the 2020 strategy. MSI has begun a programme of research to evaluate interventions to improve PAFP rates, including trials of m-health using voicemail reminders in Cambodia and Bangladesh, a provider orientation and supervision evaluation in franchisees in Kenya, and a data monitoring approach with providers in Nepal. Further research is needed to evaluate the range of interventions that can be effective in increasing not only immediate PAFP uptake (at point of abortion delivery) but also improving uptake of long-acting methods, as well as continued PAFP use in the months following the procedure. In order to effectively measure uptake and continued use, it is also necessary to develop and validate data monitoring methods.

**Specific sub-themes and interventions:** Interventions on PAFP to be tested, including those highlighted as operational priorities (*) include:

- Incentives for providers
- Provision of vouchers within SM/MA packs
- Enhanced PAFP counselling
- Bundling of PAFP with abortion services
- Client follow-up (though clinic or call centre)*
- Pre-abortion contact with the client
- Evaluation of long-term outcomes of immediate vs delayed IUD insertion post-second-trimester abortion

In addition, and as part of these evaluations, attention is needed on the improved measurement of PAFP rates within different channels (including social franchises and pharmacy provision of SM/MA), including immediate PAFP uptake/provision, uptake within two weeks, and continued use at 6 and 12 months. Qualitative research will also be necessary to understand drivers of PAFP uptake or rejection, including factors influencing method choice in the post-abortion period. Triangulation with secondary analysis of clinic level data could also help understand why some centres achieve notably high rates of PAFP uptake, what method mix drives this, or why others underachieve.

**Channel setting:** Research among centre and social franchise abortion clients, but research around SM/MA may also be required.

**Research design:** Testing of such interventions will necessitate use of robust evaluation methodologies (see Section 3). Separate research is critical in this area due to the challenges in accurately capturing method continuation rates through routine data. Studies also require in-depth process evaluation to understand why interventions work or fail, as well as costing and cost-effectiveness analysis to support programme decision-making on sustainable strategy development. Methodological innovation will be critical to ascertain how best to track PAFP rates, in particular following SM/MA, both with MSI- and non-MSI-provided contraception.

**Priority countries:** Same as Priority 3.
How can task-sharing for FP and abortion improve MSI’s programme impact?

Rationale: Task-sharing research remains a focus at MSI, given the potential for expanded access to services and cost-savings through service delivery by lower cadre health workers. Local context-specific research in this area also remains critical since national ministries of health often require local evidence to support service provision by lower cadres in their countries. To-date, MSI has conducted seven task-sharing studies across seven countries, including task-sharing for family planning (implant insertion and removal; injectable provision; tubal ligations) and abortion (MVA procedure). Future national policy windows may be identified where countries see the potential benefit of regulatory change, but require further evidence to promote it. Task-sharing research can also evaluate the provision of clinical services in lower level facilities, for example where MSI works in partnership with public sector facilities; or original research on the provision of services by cadres not currently recommended by WHO (e.g. IUD insertion by community health workers).

Specific sub-themes: Specific types of task-sharing research that may be required include investigating the provision of:

- Implant provision and removal, by low level providers (nurses/midwives/paramedics/lay health workers)
- Self-injection of Sayana Press injectable, by clients.
- IUD insertion and removal, by community health workers
- Tubal ligation, by mid-level providers
- MVA, by nurses
- Second trimester medical abortion, by midwives/nurses
- Provision of D&E, by clinical officers
- Provision of clinical FP/abortion in low-level facilities (to evaluate the clinical safety of the environment for service provision, not only the cadre)

Research to investigate the policy and practice factors influencing successful implementation and scale-up of task-sharing may also be important in some contexts.

Channel setting: Research may be required within a range of different channels depending on the local context.

Research design: Clinical research will be required to adequately demonstrate the safety and efficacy of task-sharing approaches, including experimental approaches comparing provision by new cadres with current practice (either RCTs, cluster RCTs or non-inferiority trials); or observational studies which monitor the quality of service provision and incidence of adverse events in study participants. Research on clinical impacts will need to determine acceptable levels of serious adverse events for any cadre, and method. Client experiences of provision should also be measured to ensure acceptability. Costing research of task-sharing, as well as modelling the cost-effectiveness when task-sharing is delivered at scale (for example using the task-sharing calculator), will be particularly important as an advocacy tool in the wider sector, as well as for MSI internal planning. Measuring the wider service-level impact of task-sharing has also been recognised as an evidence-gap, including the impact on increasing access to LAPM in outreach.

Priority countries: Countries with opportunity to advance policy/ staff competency in LARC provision recommended by WHO task sharing guidelines ‘with M&E’, ‘in specific circumstances’ or ‘in the context of rigorous research’.
2.2 Research priorities to achieve QUALITY OF CARE

Research priority 6

Four priorities were identified contributing to the quality pillar.

**How can MSI improve its measurement of client satisfaction and experience?**

**Rationale:** MSI achieves very high client satisfaction rates across its service delivery channels, as evidenced by high scores (93% overall satisfied on average) in client exit interviews. However, client exit interviews (or the more regular ‘client snapshots’ employed in two CPs) are subject to high levels of ‘courtesy’ bias, a problem particularly common in low- and middle-income contexts where clients may be less empowered than their high-income counterparts, and a bias exacerbated when the interviewers work on behalf of MSI. Other techniques commonly employed by programmes to capture the ‘client experience’, including client suggestion boxes, mood metres and feedback forms, are likely to be unrepresentative of the client experience since inputs are self-generated, although they have the power to detect certain problems. Client follow-up surveys through call centres or SMS systems offer more hope, but may also suffer from non-response bias, and face ethical challenges which have to-date been unexplored. Methodological research is therefore needed to develop metrics that are better able to ‘discriminate’ (i.e. differentiate) satisfaction levels between different clinics and channels, and capture more ‘truthful’ (valid) reporting on the MSI experience, while maintaining confidentiality of service provision. Validation work may also be required to assess internal quality assessments, and investigate correlation with satisfaction measures.

**Specific approaches and designs:** A programme of research is planned in this area including some or all of the following components:

- Review of approaches to capturing the client experience in client-facing companies and other health services in selected LMICs where MSI operates.
- Formative research to identify constructs of satisfaction and dissatisfaction with MSI services, including cognitive testing to identify valued indicators of importance to clients.
- Development of separate measures of satisfaction with abortion services, giving priority to measures of emotional or physical discomfort.
- Modelling of the effects of selection (non-response) bias from follow-up phone/SMS surveys, and developing strategies to reduce non-response and/or adjust for it.
- Qualitative or mixed methods research around the acceptability of phone and SMS follow-up surveys among both FP and abortion clients (including clinic and SM/MA clients).
- Qualitative or mixed methods research around both the acceptability and validity or random pop-up surveys using CLIC data entry systems, including investigation of provider data entry error, and comparative research between provider-entered measures and client-reported measures (ideally using computer-assisted self-entry).
- Validation of QTA and internal clinical audit metrics, testing association with outcomes including satisfaction scores.
- Investigation of the acceptability, usability and impact of computer-assisted client experience surveys (e.g. through tablets/ smart phones) in centres or social franchises, including impact on provider behaviour and quality of care measures in the clinic.
- The development of case-load adjusted quality and satisfaction measures, allowing programmes to directly compare performance across sites or centres.

**Channel setting:** Research in all service delivery channels is needed in this area, and effective strategies may vary by channel and country context.

**Priority countries:** Multiple programmes, where donor interest in quality. Needs diverse range of economic and cultural country profiles.
How can MSI improve the client experience and outcomes of self-managed MA?

Rationale: The use of medical abortion is now widespread across most of the countries where MSI operates, in both legally-restrictive and liberal settings. Self-managed MA is particularly dominant in settings of legal restriction, but even in countries where abortion is legal (partially or fully) it forms an important share of abortion user experience, although the extent of its use remains unknown. The great majority of MSI’s MA provision is through socially marketed products (78% in 2014). The growing scale of this channel implies the need for new insights and programmatic strategies that will ensure access to quality medication, appropriate counselling and advice, linkage to clinical services and improved long-term client outcomes (including completion rates, side effects and emotional support).

Specific sub-themes: There several key themes of research in this area:
- Interventions to improve the experience and outcomes of self-managed socially marketed MA, including:
  - Referral mechanisms from pharmacies/drug stores to MSI call centres or clinics (package inserts, communication strategies, incentives to pharmacy workers)
  - Information provision and communication strategies to pharmacy/drug store workers (detailing/ training/ SMS or call centre interventions).
  - Self-completion health education tools, including checklists of health questions to rule out contraindications, gestational dating wheel, urine pregnancy tests, self-assessment checklists to determine completeness & assess side effects
  - M-health interventions to assist in complication detection, and completion confirmation
  - SMS or call centre interventions for supportive client follow-up
  - Strategies to reduce counterfeiting e.g. scratch off codes
  - Use of telemedicine initiatives to extend reach of trained clinician to provide care
- Development and validation of research tools to measure abortion completeness, including indicators needed and timing of investigation.

Channel setting: SM/MA is the focus of research in this area.

Research design: The range of evaluation methodologies highlighted in Section 3 below will be important to consider, although particular attention to sampling and recruitment will be needed for evaluation of pharmacy-provided MA. Oversampling of pharmacy/drug store clients may be required in order to identify a sufficient sample of MA clients, or techniques such as snowball or respondent-driven sampling, or greater participant incentivisation could be considered. We may also work with our distributors’ data to understand impacts of social marketing vs direct MSI engagement.

Priority countries: Countries with large SM/MA businesses.
How can MSI improve its clinical abortion care, including pain management and cervical priming for D&E?

Rationale: MSI is one of the few health providers in many LMICs where it is possible to conduct clinical research on abortion delivery, in particular second-trimester services. Second trimester abortions, while accounting for a small proportion of MSI service delivery, nevertheless contribute a disproportionately high proportion of abortion-related morbidity and mortality, and research in this area represents a critical opportunity for clinical impact. Aside from routine quality assurance, relatively little rigorous research has been conducted on the quality of MSI abortion service provision and interventions to improve the user experience. Studies conducted within the public sector in South Africa (including provider participants who also work in MSI clinics) found structural barriers resulting in delayed referrals and late receipt of abortion following initial ultrasound screening, which is of particular concern when each additional week of gestation confers a significant increase in the risk of mortality with abortion.\(^1\) MSI is also implementing certain clinical management strategies that could be evidenced with well-designed research to support more effective scale-up, both within MSI and externally to other providers.

Specific sub-themes: Research questions under this priority include:

- Formative research on client experience in reaching and attending MSI centres and impacts on abortion decision-making and preferences for follow-up care.
- Evaluation of the safety, effectiveness and acceptability of MSI’s new pain management protocol (use of Ketafol) for use in surgical abortion services.
- Evaluation of MSI’s cervical priming technique for second trimester abortion.
- Evaluation of the MSI syringe
- Evaluation of improved referral mechanisms to MSI clinics, and/or interventions to reduce time-lags between ultrasound screening and abortion receipt.

Channel setting: Centres delivering second-trimester abortion services

Research design: Clinical research will require either observational cohorts or randomised controlled trials to determine the safety and effectiveness of tested interventions.

Priority countries: Countries offering second-trimester abortion services.

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How can MSI reduce provider bias and increase client engagement in decision-making for FP & abortion?

Rationale: Providers play an integral role in supporting women’s reproductive decision-making, whether for contraceptive selection; decisions to continue, switch or stop methods; and decision-making for abortion, in particular the type of abortion method chosen. Neither clients nor providers can or should make these choices on their own, and achieving a balance of shared decision-making is critical to achievement of informed choice within MSI programming. But achievement of these goals is challenging in practice: providers are empowered with knowledge and authority, while clients, in particular those in low-income settings, are often disempowered and lack knowledge and skills to assert their desires and choices. Certain groups may be particularly disempowered, e.g. youth or the poor. Studies across both high and low income settings demonstrate high levels of provider dominance and so-called ‘bias’ in counselling interactions, at times accompanied by incorrect counselling communication. Given MSI’s stated focus and targets on long-acting and permanent method provision, demonstrating provision of informed choice and shared decision-making is critical for the organisation. Considerable effort is now being put into supporting informed choice within family planning service delivery, including the introduction of various counselling materials (including flip charts, counselling cards, and tablets/apps), some of which have started to be evaluated.

Specific sub-themes:

1) In some country programmes, formative research is required in both abortion and family planning service provision to ascertain the extent and causes of provider bias in MSI clinical practice, including research across channels and communication delivered by community mobilisers or community health workers. This also includes formative research to understand the role of performance-related incentives, and income-generation potential, as well as research on abortion-related stigma and its role in provider behaviour and quality of care.

2) Specific interventions to be tested to improve shared decision-making include:

• Counselling tools and job aids, including evaluation of their costs and cost-effectiveness
• Testing of different counselling approaches and algorithms that balance information provision on LAPMs with adherence to informed choice principles.
• Youth-friendly counselling interventions, in particular impact on youth eligibility denial
• Evaluation of the impact of targets and provider incentives on provider bias
• Evaluation of abortion stigma reduction initiatives on provider counselling behaviour
• Role of differential case-based payments in overcoming provider bias against LAPMs

Channel setting: Research is needed across all channels, including community mobilisers and educators who work on behalf of MSI.

Research design: Formative research should involve qualitative methodologies, including observations through either mystery clients, trained observers or audio recordings. Evaluations should involve the methods described below in Section 3, but also include elements of observation of care.

Priority countries: Multiple programmes, where donor interest in quality.
Three priorities were identified to support this pillar.

**How can service diversification and cross-selling contribute to sustainability of operations and core service maximisation (FP/SA)?**

**Rationale:** The expansion of MSI’s service scope from a narrow focus on family planning and abortion provision offers potential benefits as well as risks. Integrating other health service components into MSI centres, outreach and social franchises, including sexual health services, cervical cancer screening and treatment, infertility management or general health service provision, offers the potential to increase provider productivity, generate programme revenue, and deliver a broader package of care that meets clients’ diverse health needs. Adding additional service components through diversification, however, may impact negatively on quality of care, consume managerial and/or provider resources, or distract programme attention from achievement of core MSI service objectives. Multiple country programmes have embarked on strategies to widen their service scope, but many have not been adequately evaluated, in particular most lack robust cost-effectiveness analyses. Specific sub-themes: Evaluating the diversification and cross-selling of different service components is required, as well as examining impacts on productivity, quality of care, user satisfaction, core service (FP/abortion) uptake, costs and cost-effectiveness. In settings where programmes have had extensive diversification for many years, testing the removal of additional non-core services could also be tested.

**Channel setting:** Any channels diversifying service delivery.

**Research design:** Strong evaluation designs are required, but research could also include analysis of routine data with staggered roll-outs, in particular in centres with CLIC or other strong MIS systems. Priority countries: Countries offering diversified service portfolio.

**Research priority 10**

**Research priority 11**

**How can community-based providers, including MS Ladies, contribute to programme sustainability?**

**Rationale:** MSI works with a range of community health workers across its country programmes, including MS Ladies, community health extension workers and field health educators. They are considered an important service delivery mechanism in contexts where users lack access to centres, or where standard outreach delivery mechanisms are not feasible. MS Ladies are trained nurses and midwives employed by MSI and have to comply with MSI quality standards. In some countries it is possible to demonstrate costs and productivity ratios of community-based providers (e.g. monitoring of costs and outputs of MS Ladies using routine data), but well-designed strategic research would provide stronger evidence on the impact community-based providers on wider programme outcomes, as well as their cost-effectiveness vis a vis other channels. It is particularly critical to demonstrate their capacity to attract HIC clients, and to deliver additional programme income. Evaluations in this area could also support generation of evidence on the most cost-effective ways to incentivise performance, including evaluation of incentives and training systems.

**Channel setting:** MS Ladies, other community health workers (vs other channels)

**Research design:** Supporting the evaluation of community health workers could take a three-pronged approach:

(i) Evidence from routine programme monitoring could be used to provide an in-depth analysis of service provision. This should be conducted in at least three different country contexts to understand the generalisability of the findings across the partnership. Routine programme monitoring could produce evidence on costs, cost-effectiveness, productivity, income generation and success in reaching youth and the poor (relative to other channels).

(ii) A separate evaluation study could demonstrate programme impacts of community-based providers following introduction into a country. This would provide critical evidence to know whether this channel is reaching additional clients who would not otherwise have been reached by other service delivery channels. This could be a controlled prospective study comparing the introduction of community-based providers in certain areas of a country vs other areas,
evaluating impact on regional CYP generation, and accompanied by routine programme monitoring and qualitative research at the community level.

(iii) Interventions supporting community-based provider introduction or scale-up could be evaluated, for example testing different approaches to incentivisation and remuneration.

**Priority countries:** Countries with MS Ladies, including strategy to expand; or countries engaging other community health workers.

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**Research priority 12**

**How can public sector purchasing of MSI services within a ‘Universal Health Coverage’ framework impact on programme sustainability and health outcomes?**

**Rationale:** Diversified sources of financing will be essential for reaching additional family planning users at national scale. International agencies and donors are now actively promoting Universal Health Coverage (UHC) in LMICs, including the provision of essential SRH services. National governments are increasingly seeking to purchase family planning services from third party providers and MSI is beginning to work with governments to establish effective mechanisms for purchasing and delivering contraceptive services. The transition to health markets in which governments use pooled funds for ‘strategic purchasing’ of health services can also remove financial barriers to contraception for the poorest, drive efficiency and potentially improve service quality. A programme of research on government contracting through UHC can support the demonstration of impact these outcomes, including attainment of national FP targets and enhanced programme sustainability.

**Specific sub-themes:** A range of forms of public financing are important to investigate, including:

- MSI pricing management and effectiveness of success model sustainability approaches
- Effectiveness of MSI’s strategies to develop stewardship, strategic purchasing transitioning behaviours, and impacts on our service delivery speed and efficiency. Research comparing trade-offs and sustainability of different outreach models will be important (for example, outreach/PSS vs outreach/PSS + contracting).
- Domestic public financing in MSI channels – effects on client profile and on sustainability
- Effectiveness of linking SF providers to NHI/public financing, including impact on their attitudes/perceptions/value of the franchise network, and on LARC/SA provision
- The impact of case-based LA/PM reimbursements as part of national UHC schemes
- The impact of SRH investment in the garment sector/formal employment sector
- Formative research on financial barriers to service use (especially in the Sahel)
- The impact of the inclusion of FP within a maternal health financing basket, in particular in restrictive settings

**Channel setting:** All

**Research design:** Robust evaluations of government schemes and partnerships will be critical, including demonstration of population-level impacts on reaching HICs (additional users, the poor, youth). Cluster randomised trials could be considered if scale of implementation is large enough, or otherwise complex evaluation designs using multiple sources of evidence to triangulate findings. Policy analysis to investigate effective contracting mechanisms, including qualitative research on the trade-offs of contracting approaches. Costing analysis and modelling to estimate the value of SRH services to employers.

**Priority countries:** Those considering or involved in public sector financing schemes or employer schemes and others in emerging/transitioning market contexts. Countries with low CPR for formative research on financial barriers as well as potential linkages with MCH and UHC agenda. Restrictive FP settings for basket analysis.
3. Supporting the design of high quality studies

This section discusses the research methodologies that the MSI research team will support across country programmes, in order to achieve the 12 priority research objectives.

3.1 Evaluation studies

Evaluations of MSI interventions must first ensure they can answer whether the intervention worked, but also should address how it works, whether it can be improved, whether it is cost-effective, whether it is scalable and sustainable, and whether it is acceptable to the MSI’s clients and potential clients. Evaluation designs should also capitalise on existing MSI data sources where possible, rather than necessitating the collection of original (new) data. In some instances, original data collection will be required, in particular where routine data are limited or unavailable (e.g. outreach, socially marketed MA in pharmacies) or where long-term outcomes must be measured that cannot be recorded with routine data (e.g. discontinuation rates). Some research may also need to demonstrate impact on broader social norms and prove wider behavioural impact, which may require either large-scale studies or data linkage with pre-existing cohort studies (e.g. within demographic surveillance sites).

The research team will support country programmes to consider the following evaluation designs:

**Evaluation using routine programme data**

Several sources of routine MSI programme data can be used to monitor the implementation and impact of programmes. These include:

- **Programme monitoring using CLIC or other MIS data**: May be evaluated through staggered roll-outs (see below); CLIC or other routine MIS data can also be used to triangulate findings from other evaluation methods.
- **Client exit interviews**: Annual client exit interviews can be used to track changes over time, particularly if interventions aim to effect broad-scale and long-lasting changes on programmes. Sampling strategies could also be adapted for certain years to target certain types of client.
- **Mystery client surveys**: Can provide additional information on the quality of interpersonal care being offered. Can be supplemented with observations (see below).
- **Quality Technical Assessments (QTAs)**: Data from routine QTA surveys can be used to provide quality of care information on channels or service delivery points involved in any intervention.

**Staggered roll-outs evaluated with routine data analysis**

Time-series analysis of routine CLIC or other programme data can help programmes determine whether specific interventions have made a difference on key programme outcomes, including client numbers/flow, productivity and costs. This approach needs well-considered design and planned phased implementation of activities across service delivery points, as well as rigorous statistical analysis to measure trends before and after the introduction of an intervention. Coordination of programme implementation activities, along with clear documentation of what was implemented and how, are critical, since a key limitation of this approach is being able to attribute significant changes in service statistics to the intervention being tested.

The approach may not be appropriate if impacts on intermediate outcomes are to be tested, e.g. client acceptability or satisfaction, provider stigma; and may need careful consideration if analysis includes measurement of long-term outcomes (such as discontinuation). The method may need to be combined with other follow-up methods. It also should not be used to test interventions that may bear some risk to the client, for which careful procedural monitoring should be put in place.
Experimental or quasi-experimental programmatic research

To test whether an intervention works on a specific sample of the population. This may include:

- **Controlled pre-/post-tests**: where control groups (individuals, clinics, outreach teams, or even districts) are purposively sampled based on certain criteria (and not randomly selected). Such studies are relatively easy to implement but have key limitations: comparison or control groups may not be sufficiently to the intervention groups, and there may be other non-intervention activities being conducted in parallel. While the approach is relatively inexpensive, caution is required in interpretation, particularly where contextual change is rapid. Uncontrolled pre-/post-tests, which have commonly been used in the past to demonstrate effectiveness of MSI programming, are even more problematic, since isolation of the intervention effect is almost impossible. Such designs can be strengthened with triangulation of data sources (e.g. complimenting survey research with routine data) and with process evaluation that tracks intervention activities and external influences (see below).

- **Randomised controlled trials (RCTs) or cluster randomised controlled trials (CRCTs)**: these studies are considered the gold standard of evaluation research since the strict experimental conditions make it possible to isolate the impact of the intervention and allow researchers to have confidence that any changes observed were due to the programme activities, and not due to another reason. Since participants (or clinics/teams) are randomly allocated, it makes it possible to eliminate bias from self-selection of certain types of respondents who received the intervention. Cluster RCTs are necessary where it is not possible to randomly allocate individual participants (e.g. where activities require changes throughout a whole clinic) but require larger sample sizes. Stepped-wedged RCTs can also be considered, which have similarities to the staggered roll-out discussed above, but the intervention and control groups are still randomly allocated.

Process evaluation

All evaluation studies should also include accompanying process evaluation to understand why interventions work or fail. Process evaluation requires development of a theory of change, or logic model, and monitoring of intermediate programme outcomes in addition to evaluation of ultimate programme impact. For example, if investigating the impact of an m-health intervention on contraceptive uptake, the study would also need to measure interaction with the m-health technology/call centre. Process evaluation may also involve accompanying qualitative research with research participants to understand acceptability and their use of the intervention.
Economic analyses
Costing and cost-effectiveness analyses are a critical component of any evaluation, since MSI needs to know i) how much the intervention cost to implement, ii) how cost-effective it was (e.g. what was the cost per CYP generated or per birth averted?), and iii) how cost-effective it was compared to an alternative intervention. MSI’s financial and accounting systems make it possible to more accurately measure programme costs. Implementation of the Cost Calculator will enable the identification of key cost drivers of our operations, and shed light on the key areas for efficiency improvement and potential cost savings. Through combining results from Cost Calculator with Impact 2, we can gain insights on the different costs per impact by channel. This kind of analysis will be the basis of demonstrating the value for money of our intervention not only internally but equally importantly to our donors. The research team will work closely with Informatics Team for these types of evaluation.

Experimental or observational studies of clinical interventions
Rigorous testing of MSI’s clinical innovations is required to help ensure innovations are accepted and successfully taken up by clinicians across the partnership, and also to demonstrate safety, acceptability and effectiveness to the wider reproductive health community who can benefit from novel technologies or clinical practice. Testing clinical interventions requires either randomised controlled trials, as above, which eliminate any bias in demonstration of effectiveness; or observational studies, in which client outcomes (e.g. adverse events) are measured carefully following the intervention, but ideally outcomes should be compared with a control group of previous or standard practice.

After Action Review (AAR)
An AAR is a structured group de-brief that takes place after a project or an event. It allows you to capture successes, failures and lessons learned – and is a type of process evaluation. An AAR may also help to strengthen team bonding and morale. During an AAR, the group reviews what was intended, what actually happened, and why it happened.
Formative research: gathering insights to feed programme design

3.2

Understanding MSI clients, potential clients and providers is critical to expanding service coverage and reaching high-impact clients. Undertaking high quality formative research is challenging, and requires qualitative analysis skills which goes beyond the ‘descriptive’, or taking reports at ‘face-value’ to understand the underlying drivers of reproductive behaviour and decision-making. Formative abortion research is particularly challenging given the stigmatised nature of abortion use, and research design in this area must focus on the development of effective and unbiased sampling strategies. Some formative research may also be conducted using quantitative methods, either using pre-existing data sets measuring reproductive intentions, or new consumer insight surveys. The following types of formative research will be supported:

Secondary analysis of household survey data
Many countries where MSI operates have the great advantage of having large household surveys on reproductive behaviour. These include primarily the DHS surveys, but also in some countries surveys the PMA2020 household surveys. Some countries also have DHS Service Provision Assessments which may include data on MSI service use. DHS/PMA datasets include information not only on reproductive behaviour and fertility intentions (including detailed tracking of contraceptive use patterns), but also use of media and knowledge of family planning. Some household surveys also include questions on abortion, either through direct questioning, or reproductive history calendars (the former shown to have higher rates of abortion reporting than calendars).

Consumer insight surveys
MSI is developing a generic consumer insight and market segmentation (CIMS) survey (see Annex 1), which provides quantitative data on beliefs and attitudes towards contraception, perceptions of MSI and other service providers, as well as supporting data analysis for market segmentation. They can, and usually should be conducted together with qualitative interviews or observations. There is also a chapter in MSI’s Marketing Handbook that provides explicit guidance on how to conduct effective market research.

Qualitative interviews
Gathering insights through well-designed qualitative approaches will be critical to all MSI country programmes. These may be studies to understand or ‘landscape’ reproductive behaviour and its influences (the ‘drivers’) in the target communities, or formative research to support the design of behaviour change interventions. Specific methods include in-depth or semi-structured interviews, focus groups, and participatory research (for example using the PEER methodology, see Annex 1). MSI will support high-quality qualitative research design and analysis to ensure insights gathered go beyond basic descriptions of responses, but rather provide interpretations based on social and behavioural theory, including the underlying socio-economic, cultural, and structural influences on reproductive and health-seeking behaviour.

Structured and unstructured observations
Structured observations are useful to investigate the quality of care, both technical and interpersonal, being delivered – either at the clinic level, or within provider-client consultations. They can be done using structured checklists, generating quantitative data, or using a more qualitative ethnographic method, in which the observer spends longer periods of time in the service delivery setting making detailed notes.
Annex 1: Methodology to set research priorities

This annex details the methodology used to determine the research priorities. First a research scoping exercise was undertaken involving an internal MSI survey, and collection of priorities through Success Model workshops. This was followed by a Research Strategy Meeting to determine priorities, held with internal stakeholders. Each of these steps are now described:

Research Scoping Exercise

1. **An online survey** was sent to MSI country programmes (directors, technical or operations directors, research managers), regional directors, channel leads, donor teams, and key technical teams (advocacy, health markets, marketing, financing, medical development, impact; management information systems; research, monitoring and evaluation). The survey asked respondents to list up to three priority research questions to generate knowledge under each Strategic 2020 Pillar (Scale & Impact, Quality, Sustainability), along with a rationale for why they felt this question was important.

38 people responded to the survey, among whom 43% were working within the following country programmes: Bangladesh, Burkina Faso, Ethiopia, Kenya, Madagascar, Malawi, Mali, Nigeria, Senegal, Tanzania, Timor Leste, Uganda, Viet Nam, Zambia and Zimbabwe.

2. **Success Model feedback:** The research team members participated in the two regional Success Model (operational strategy) workshops held in Addis Ababa and Bangkok in February and March 2016, and gathered strategic operational questions arising from those discussions. Workshop participants identified the evidence gaps related to each rule or recommendation contained within the draft Success Models, and then rated the questions based on their utility. For each MSI channel (centres, outreach, social franchising), country programmes picked the top three research priorities.

3. **Individual meetings:** Face to face meetings were held with a further seven managers who could not complete survey to gather their inputs on research priorities.

This scoping process generated a total of 303 individual research questions, which were then further consolidated to remove duplication, group similar sub-questions under strategic outcomes, and ensure questions were clearly defined and articulated. Some questions proposed were unanswerable and were removed. This consolidation process resulted in 125 consolidated questions.

Questions were categorised into ‘Scale and impact’, ‘Quality of Care’ and ‘Sustainability’. The grouping of questions suggested is shown in Figure 1. Scale and impact questions were split into those on family planning (21 questions) and abortion (18 questions). Cross-cutting questions were those that impacted upon two or three of the strategic pillars (e.g. health financing, m-health, task-shifting research, and research metrics).

A summary of the programme objectives addressed by the proposed research questions is included below in Table 1.
Figure 2
Results of the research priority scoping exercise – number of consolidated research questions under each pillar

Table 1
Programme objectives addressed by the research questions

<table>
<thead>
<tr>
<th>Scale &amp; Impact</th>
<th>Quality</th>
<th>Sustainability</th>
<th>Cross-cutting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reaching new FP clients (including HICs)</td>
<td>Improving programme management and performance</td>
<td>Delivering effective and cost-effective models of service delivery</td>
<td>Improving access, quality and sustainability through financing interventions</td>
</tr>
<tr>
<td>Reaching youth with services</td>
<td>Improving the quality and safety of abortion</td>
<td>Enhancing centre sustainability</td>
<td>Improving access and quality through m-health and call centres</td>
</tr>
<tr>
<td>Reducing discontinuation &amp; increasing switching</td>
<td>Improving the clinical quality of FP provision</td>
<td>Enhancing outreach sustainability</td>
<td>Overcoming HR policy barriers to provision (task-sharing)</td>
</tr>
<tr>
<td>Increasing safe abortion numbers (all types)</td>
<td>Improving MSI quality standards</td>
<td>Enhancing SF sustainability</td>
<td>Overcoming other policy barriers to provision</td>
</tr>
<tr>
<td>Increasing MA numbers</td>
<td>Improving method mix</td>
<td>Demonstrating impact</td>
<td>Improving metrics and measurement</td>
</tr>
<tr>
<td>Increasing PAFP and PPFP uptake</td>
<td>Supporting providers</td>
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<td></td>
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</table>

The consolidated research questions were discussed and reviewed at a two-day Research Strategy Meeting held in London in March 2016. The meeting brought together research team members, technical and operational teams, regional research advisors to prioritise the questions. The meeting was also attended by two expert researchers (one on abortion, one on family planning) who brought extensive experience and knowledge of research within their respective sectors (see Annex 2). The objectives of the meeting were to:

- Understand and discuss the role of research within MSI
- Review examples of strategic research projects
- Review evidence gaps identified through the success model workshops
- Agree on criteria to determine research priorities
- Review the results of the research priority scoping exercise
- Agree on 2016-2020 evidence gaps and research priorities
Annex 2: Landscaping the sexual and reproductive health research field

During the research strategy meeting, two experts in the fields of family planning and abortion research presented a summary of research gaps in the broader reproductive health community, and their perspectives on the role of MSI in supporting evidence generation. Professor John Cleland, Emeritus Professor of Population Health at the London School of Hygiene & Tropical Medicine, presented family planning evidence gaps. Dr. Daniel Grossman, Director of the ‘Advancing New Standards in Reproductive Health’ (ANSIRH) group at the University of California San Francisco, presented abortion evidence gaps.

**Family planning global research agenda**

Professor Cleland highlighted the large research agenda required to demonstrate effective mechanisms to reach high impact groups, in particular young people. He noted several key themes, including the importance of recognising the diversity of the ‘youth’ group, and encouraged disaggregation into more useful categories, in particular highlighting the need to focus more on unmarried and nulliparous youth, as well as recognising the wide cultural and social gaps between urban and rural youth in LMICs. He also suggested that more research is needed to understand the acceptability of LARCs among young people, given infrequent sexual behaviour in this group. He highlighted the unknown impact of LARC promotion and use on condom use substitution and thus potential impact on sexual behaviour indicators and incidence of sexually transmitted infections. He urged MSI to not give up on condom promotion. He felt that there was still programmatic scope to promote condoms for pregnancy prevention, vs STI prevention, and proposed better evaluation of the promotion of product packages (e.g. condoms, emergency contraception and pregnancy test kits). He also suggested that higher-quality research was needed to understand the impact of sexuality education on contraceptive behaviours.

More formative research is also necessary to understand the needs of couples who are separated for long periods, due to labour migrancy, as well as evaluating the impact of promoting appropriate methods for their unique circumstances. For post-partum women in settings where lactational amenorrhoea is prolonged, he felt that evidence of demand for FP in this period is weak, and evidence on LARC promotion among those in the immediate post-partum period is lacking. An ongoing trial of post-partum IUD insertion is not showing promising results. There is a particular need to support the transition through the cessation of breastfeeding and return of menses, and uptake of contraceptive use at that time. A ‘post amenorrhoeic’ strategy may be needed.

In terms of demand generation, the relatively weaker emphasis on ‘behaviour change communication’ in the wider reproductive health community over the past few years was noted, but larger studies are now under way, including a randomised controlled trial in West Africa to measure the impact of radio messaging on contraceptive uptake. More research is needed in this area. MSI colleagues also noted that the impact of high quality service provision by MSI itself may be a mechanism to promote uptake, but this has not be evaluated.
In terms of MSI-specific activities, he indicated that the effectiveness and cost-effectiveness of voucher programmes, both in terms of demand generation, targeting of the poor, and quality improvement, is still not proven. Demonstration of the impact of social franchising is also still needed, in particular understanding why it works well in some contexts and not in others. And while community-based family planning is now well proven, further research is still needed in this area to demonstrate impact on reaching high-impact groups. Strategies to reduce discontinuation rates also require better evaluation, given the increasing impact of discontinuation on levels of unmet need. This may include more research into understanding women’s experiences of menstrual changes induced by contraceptive use, as well as evaluation of enhanced counselling strategies. Targeted research and programming in countries with high rates of injectable use may be useful.

The problem of skewed method mix was presented and also widely discussed. The challenges faced in skewed programmes were highlighted. The underlying problem is that the dominant method becomes the favoured method; familiarity translates into desirability. Strategies that aim to persuade clients to deviate from the method of choice are not well evaluated, in particular impact on satisfaction and discontinuation. The group discussed the challenges in delivering quality of inter-personal care, and ensuring rights-based approaches to service provision, while balancing the push to deliver CYPs. Method-specific voucher schemes may be an effective way to change method mix, but are controversial. Prof Cleland also hypothesised that providers’ own experience of method use was likely to bias the way they counsel, though evidence is lacking. The ability to provide a ‘perfect choice’ was also questioned, and Dr Grossman noted the growing body of work around ‘shared decision-making’, and its impact on satisfaction and continued use.

Strategic decisions may also be required on the national scale-up of LARCs, and it was considered unrealistic to aim for scale-up of both IUDs and implants in contexts where use of both remains low. Given the natural tendency for service providers to take the easiest course of action, this may mean promotion of IUDs will always be limited, although the IUS holds greater promise given declining costs and a potentially favourable side-effect profile. Globally, IUD use rates are coming down across most countries, and the fact that population-based studies are now measuring lower discontinuation rates with implants than IUDs may be another driving force for prioritisation of implant promotion. He also reminded the group that approximately 10% prevalence of a method may be considered a tipping point for the social diffusion of methods, and strategies are now required to accelerate this process from satisfied users.

Task-sharing research was considered to still be critical, also for abortion (see below), but MSI colleagues stressed the need to ensure research links to potential policy windows and avenues for direct policy change in this area. MSI’s approach to engaging governmental stakeholders in research projects in this area is particularly helpful in this regard.

Lastly, he highlighted two metrics that deserve research attention. He underlined the inadequacies of current approaches to measurement of client satisfaction, and suggested that multi-dimensional measures are required which more sensitively gather information on client experiences with services. He also felt that research was needed to be able to reconcile the differences between MSI CYP estimates with national survey estimates, a point also reiterated by MSI’s Impact team during the research prioritisation exercise.
Abortion global research agenda

Dr Grossman emphasised the large international research agenda on MA, in particular self-induced abortion. Fundamental understanding of why women are choosing to abort alone, even in settings where abortion services are available, is lacking. This includes information on the methods used, experience of side-effects and adverse events, and acceptability of different MA regimens. Intervention research is also needed to promote the use of evidence-based regimens, in particular through pharmacies. Quantification of outcomes with self-induced and ‘unsafe’ abortion can be compared.

He also emphasised the global health imperative for studies of later abortion, given the disproportionate contribution to morbidity and mortality of second-trimester abortions. He underlined how MSI is uniquely placed to study abortion clients in this group. Understanding the causes of later abortion are critical, including women’s decision-making pathways, as well as potential service related delays on abortion provision.

Clinical research on abortion methods is also needed, including experimental studies comparing methods and their outcomes in low-income settings (e.g. D&E vs MA in second trimester). MSI colleagues highlighted the different abortion methods used in country programmes, and discussed the need to understand whether this is driven by the client or the provider/facility, and also whether policy barriers play a role. Programmatic research is also needed to support women to recognise pregnancy earlier.

Technological strategies to support abortion provision also require robust testing, including m-health interventions across the continuum of abortion care (pre-abortion, for pregnancy recognition, finding facility care/obtain MA, eligibility screening; during abortion, for complication recognition, and post-abortion, to confirm completion, and support complication management). Research on telemedicine to extend the reach of trained clinicians for abortion remains very limited and more is needed across different contexts to measure impact and assess safety. Research on other forms of task-sharing for abortion is also still needed.

Dr Grossman also emphasised the challenge of abortion-related stigma. While levels of stigma are now relatively well-documented, research is now needed to understand how to reduce stigma, among providers, clients and at the community level. The ultimate impacts of stigma reduction initiatives also need to be measured, including on care-seeking, job satisfaction and policy change.

In terms of PAFP promotion, one of the greatest evidence gaps is how to increase FP uptake following self-managed MA. Understanding levels and outcomes of experiences of PAFP would also be important, including measuring levels of persuasion and coercion, and potential later dissatisfaction and discontinuation. A rigorous trial comparing immediate vs delayed IUD insertion among second-trimester clients is also warranted, since the clinical outcomes of immediate insertion are not proven.