EXPANDING & PROTECTING CHOICE: THE BALANCING ACT

AN IMPLEMENTOR'S GUIDE FOR SAFEGUARDING CHOICE IN THE CONTEXT OF NEW OR UNDER-ACCESSIBLE REPRODUCTIVE HEALTH INTERVENTIONS

Practitioners of reproductive health know that one of the key tenets of programming is **safeguarding informed choice.** We also know that product **innovation leads to an increase in contraceptive prevalence**[1] by offering additional choices that may better align with women's preferences. These two tenets can be both mutually reinforcing **and** can create tensions in programming when new product innovations are positioned at the expense of individual choice.

SAFEGUARDING INFORMED CHOICE

Informed choice means that the potential family planning client has effective access to information on family planning choices and to the counseling, services, and supplies needed for individuals to choose to obtain or decline services; to seek, obtain, and follow up on a referral; or simply to consider the matter further.

In recent years, there has been an increased focus on **single-method programming.** Evidence demonstrates that women in LMICs often wait years, even decades, after a product is developed to gain access in their communities. There is a recognition that dedicated investment in market entry and market shaping activities for new and under-utilized products is critical to bring those products up to a level of awareness and systems capability that matches products that are already mainstreamed. In order to ensure that new contraceptive products are accessible, investment is also required to establish the enabling (policy & regulatory) environment, as well as to strengthen capacity of the health system to deliver the new product and to support awareness and knowledge so that consumers can make an informed choice.

SINGLE-METHOD PROGRAMMING

A program with dedicated funding towards increasing access to one particular methods with activities solely focused on this method. This is in contrast to a broader Family planning program where cross-cutting access barriers may be the focus.

This dedicated investment in a new contraception or under-utilized method can lead to tensions during the planning and implementation of a program. On the one hand, a singular focus on the innovation may be required to ensure that information on the new/under-utilized contraceptive is available to all women. A singular focus might be required given the depth and width of activities required to fully support an innovation's integration into the health system. Yet, a singular focus may also lead to an explicit (and in some cases, implicit) bias for the innovation such that it constrains choice. For example, providers may steer users to the innovation over other equally relevant choices.

THIS TOOLKIT AIMS TO TACKLE THIS CHALLENGE:
HOW TO BALANCE DEDICATED INTRODUCTION AND SCALE-UP INVESTMENTS IN NEW & UNDER-UTILIZED CONTRACEPTIVES WITHOUT UPHOLDING FULL, FREE, AND INFORMED CHOICE PRINCIPLES?

It is possible to put checks and balances in place across the intervention or program to safeguard free, full and informed choice. However, this needs to be planned proactively and thoughtfully for any single-method program or activity. This implementation toolkit aims to provide a guide for teams in safeguarding choice in the context of single-method or product innovation programs. Furthermore, this guide aims to demonstrate ways to leverage single-method programs to improve overall contraceptive access. It is feasible for investments in new & under-utilized products to have positive halo effects on the quality and accessibility of broader contraceptive programming in areas supported by the intervention or program.

1 Ross J, Stover J. Use of modern contraception increases when more methods become available: analysis of evidence from 1982–2009. Glob Health Sci Pract. 2013;1(2):203-212. http://dx.doi.org/10.9745/GHSP-D-13-00010.

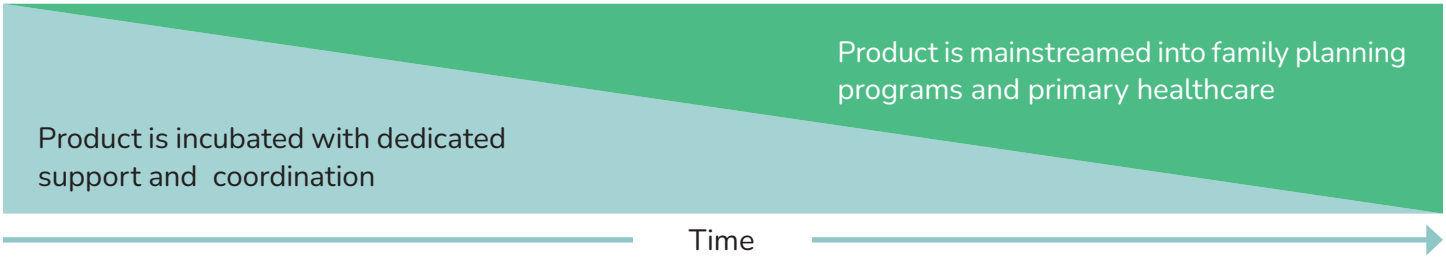
UNDER-UTILIZED METHOD

Contraceptive methods that are already available but are not used as frequently as they could be, often due to lack of awareness, accessibility, price, cultural beliefs or misinformation.

In this toolkit, we define new or under-utilized contraceptive products in the following categories:

- A new product innovation or new usage of an existing product
- The product is missing from prevailing RH policies and guidelines
- Community and/or provider awareness/ acceptance is low compared to other products
- Access is lower to priority segments of women than comparable products.

This guide should be followed from the first launch of the product, through to the point where the product is deemed to be 'mainstreamed' into the health system.



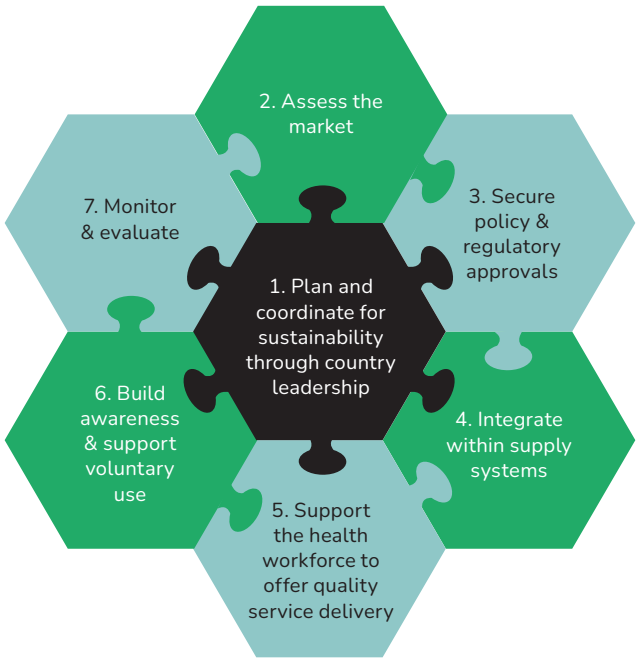
This toolkit is designed for the following audiences:

Implementors of reproductive health programs to guide day-to-day program planning, implementation and measurement. The types of programs include:

- Dedicated 'single-method' programs focused on new product innovation (e.g. DMPA-SC Self-injection) or 'incremental innovation' (e.g. task-sharing and task-shifting to expand access to a specific product through a new cadre).
- Broader FP programs with dedicated activities for new or under-utilized products.

Donors of these programs to provide guidance and recommendations for how to monitor and check for safeguarding of informed choice throughout the program lifecycle.

The structure of this implementation toolkit has been aligned to the Contraceptive Method Introduction to Expand Choice | HIPs (fphighimpactpractices.org), and will cover the seven key elements for a successful program:



This was a deliberate choice, to align the content of this toolkit with an existing resource – and steps have been taken to ensure the content is complementary. Another complementary tool for launching contraceptive innovation is: 20 Essential Resources: Contraceptive Product Introduction • Knowledge SUCCESS

Each section will cover:

CHALLENGES

Tensions or challenges that might surface in the effort to balance method-specific effort, with attention to the full range of contraceptive choices.

RECOMMENDATIONS

Strategies that can be used to mitigate potential bias, coercion, or other constraints on full choice that appear in method-specific efforts.

CASE STUDIES

Tools and case studies to support implementers to adopt for your own program or activities.

The imperative of safeguarding informed choice is intrinsic to contraceptive or family planning programs, whether or not activities focus on a specific method or on the full range of contraceptive method options. However, in the case studies, we have included other product categories within the sexual & reproductive health sector, to provide further inspiration.

We hope you find this implementation toolkit useful in the planning and implementation of single-method contraceptive programs – both to safeguard choice for women and leverage investment in innovation to increase relevance and improve the health system for the full contraceptive basket. If you have questions or other tips for the community of practice, please reach out to Abi Winskell (awinskell@psi.org) or Megan Christofield (megan.christofield@jhpiego.org).

RH provider Julie councilling women on family planning methods at the under-five clinic at George Health Centre, Lusaka. Zambia, 2010. ©Population Services International

1: PLAN & COORDINATE FOR SUSTAINABILITY THROUGH COUNTRY LEADERSHIP.

WHY IS THIS IMPORTANT?

Any reproductive health program requires alignment and engagement from global and country stakeholders. In the case of new & under-utilized contraceptive product programs, commitment from the top is critical to pave the way for substantive behaviour & systems change. Having all stakeholders aligned helps to coordinate the diverse set of activities required to successfully create change (trainings, product quantification & procurement, resource allocation, policy change, data management etc.).

Furthermore, it is helpful to align on a common understanding of the potential health impact from this single-method intervention – and how this ladders up to broader FP/RH national and global goals. It is recommended to agree on what success looks like in increasing access and integrating this product into the method mix – specifically flagging up front any potential unintended consequences on choice and reassuring on the commitment to minimize this tension. This can also help to determine for how long dedicated investment in the single-method is required before it is mainstreamed. A final note – our recommendation would be that single-method programs should not be implemented in areas where access to other methods is very low. In this case, investment is required across a range of methods to ensure choice.

CHALLENGES

It can be difficult securing buy-in for launching and establishing contraceptive innovation when resources and the bandwidth of country leadership are constrained. Some stakeholders may be reluctant to support one method, at the expense of focusing on broader interventions that strengthen the health system across the contraceptive basket. There will likely be questions as to whether this 'new' method should be treated separately or brought into existing mechanisms and processes. The latter may help to avoid some risks to safeguarding choice by avoiding siloed investments, however the former may detract from supporting rapid scale up of a new method to match levels of access already achieved by established products. If there is a recognition of the need for dedicated investment in a single method, it can be a challenge to agree on level of resource to put behind this product. Often a step is missed in modelling the level of resources required to establish widespread access to this method.

Sometimes the potential shifts in behavior and the method mix are not communicated clearly up front – so there is not alignment on what 'success' looks like for the innovation scale-up, especially where success may primarily be achieved through method mix shifts (as women choose methods more aligned to their needs). Similarly, it may be difficult to determine when dedicated investment in the product should stop – namely, when access to the new product is comparable to that of other, established contraceptive methods. For example, self-injectable contraception is an innovation that provides an injectable product with an in-built value proposition of convenience and agency. However, it is not expected that all women will choose self-inject for DMPA-SC.

RECOMMENDATIONS

DEVELOP COMMON EVIDENCE AGENDA & PACKAGE.

Leverage evidence to inform and share insights on what we know about the target segments for this product and what the unique value proposition would be. Outline how the specific benefits of the product will increase choice. It may be useful to position the product as a means of increasing contraceptive choice, rather than as a strategy for increasing overall contraceptive prevalence – this helps demonstrate that method switching can be a positive outcome if women's preferences are better met. Pinpoint specific concerns that stakeholder groups may have related to the innovation and choice. For example, if the introduction of a new short-term method might cause significant shifts away from long-term methods or where a method may lead to reduced use of condoms for dual protection.

Align on a learning/evidence agenda with the MoH, donors and key stakeholders. This will outline the key questions for assessing the impact of the product

program on the contraceptive market within the country and provide insights into acceptance levels by users, providers and stakeholders. This should also aim to capture any 'unintended consequences' on choice as a result of this innovation or single-method program.

It will be important to communicate how increasing access and choice through this new or under-utilized product will ladder up to national priorities for reproductive health. This could include the potential contribution to increases in mCPR or expand a key health area priority (e.g. self-care). Gather inputs from a diverse group of stakeholders to identify the potential health impact of this product within the country. This could include:

- Modelling estimates of potential demand within the country.
- Identifying priority target populations or geographies for increasing access.
- Mapping levels of investment across public and private sectors.

Note: be careful when assigning quantitative targets – see later sections for how to manage targets to avoid unintended biases towards the method at the expense of choice.

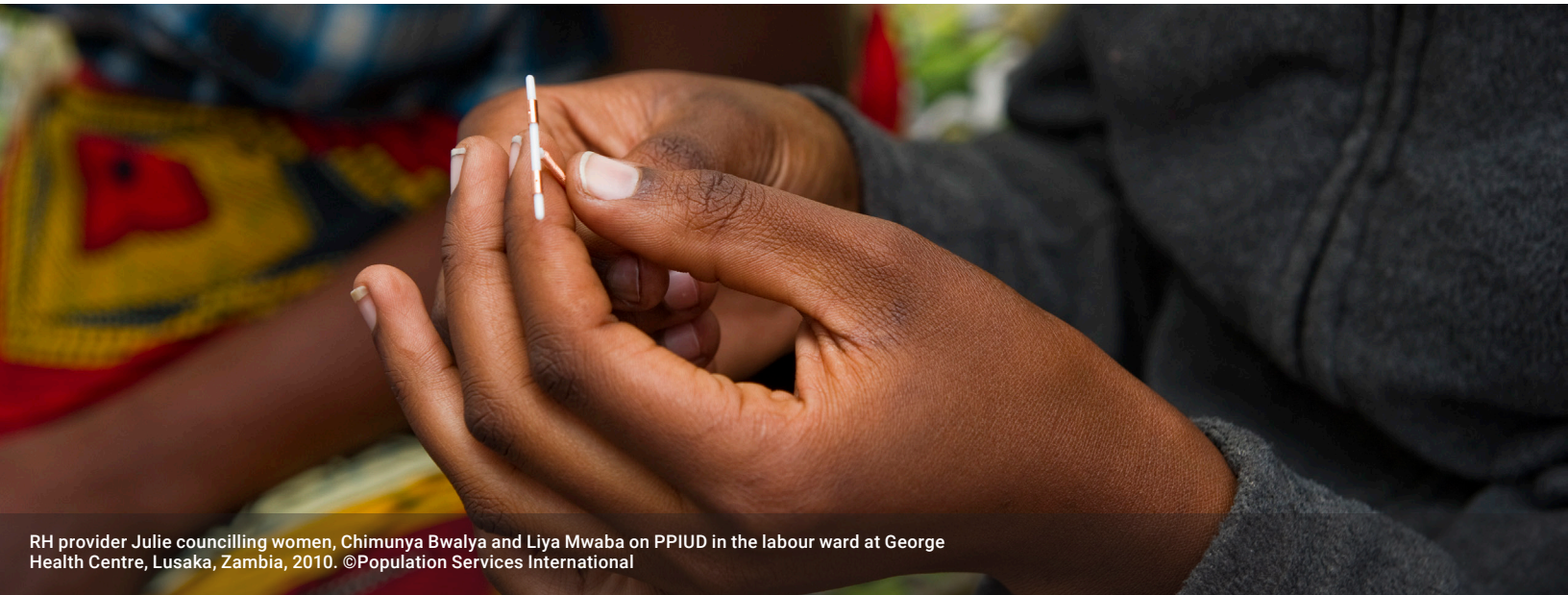
INCLUDE A WIDE RANGE OF PEOPLE IN DECISION-MAKING.

Plan to engage stakeholders from all levels of the health system – from the MoH through to frontline healthcare workers to supply chain actors. Furthermore, consider other groups that influence users, providers and health system stakeholders – for example, professional networks or civil society groups, or women themselves. For example, when focusing on expanding access to innovation or under-utilized products within new cadres (e.g. CHWs) or sectors (e.g. pharmacies), these professional groups may raise additional barriers, or indeed be advocates.

Work with MoH stakeholders and partners to consider whether these engagements should be through dedicated coordination mechanisms or integrated into existing processes. This guidance document developed by the Access Collaborative for DMPA-SC, provides some useful tips for making this determination. https://fpoptions.org/wp-content/uploads/DMPA-SC-SI-program-design-guide-PATH-2022.pdf.

BUILD SHARED ROADMAP FOR IMPLEMENTATION AND BUILD IN FEEDBACK LOOPS.

Provide regular updates on program performance and progress against the 'success criteria' for expansion of the single method. This should include learnings and insights into the lived experience of users and providers as the innovation is established and the program evolves. Include updates on the measured impacts of the program on other methods (aligned to the initial learning agenda questions and concerns). This can also facilitate discussions about how dedicated investment in a single-method will likely taper off over time (as the method is more integrated into the contraceptive basket) or is concentrated into areas where access or uptake is lower.



RH provider Julie councilling women, Chimunya Bwalya and Liya Mwaba on PPIUD in the labour ward at George Health Centre, Lusaka, Zambia, 2010. ©Population Services International

CASE STUDIES

MARKET FACILITATION OF DMPA-SC AND INJECTABLES.

The Injectables Access Collaborative (AC) provides technical assistance, coordination and resources to ensure that women and girls have increased access to DMPA-SC and self-injection as part of an expanded range of contraceptive methods. A frontrunner market for DMPA-SC and SI is Uganda. Before scale-up, the MOH and PATH conducted research to assess self-injection's feasibility, acceptability, and continuation rates, interviewing clients to understand their perspectives. The team then gathered feedback from both clinic providers and community health workers to inform whether and how DMPA-SC and self-injection would enter the Ugandan market as part of a broad method mix. Building on these insights, Uganda became the first country in sub-Saharan Africa to offer self-injection outside of a research setting through the Self-Injection Best Practices project. This PATH-led project implemented and evaluated self-injection program models across sectors in five districts. Evidence from both research and pilot activities has informed policy and practice not only in Uganda, but many other countries who look to Uganda as a model.

With assistance from the **Injectables Access Collaborative**, the MOH has led coordination with implementing partners through regular DMPA-SC partners and task force meetings. At these quarterly meetings and annual national scale-up action planning workshops supported by the project, partners discuss opportunities for leveraging funding to advance self-injection scale-up, share updates, review real-time reporting from community health workers and health facilities, discuss and address supply challenges, and plan how to foster an enabling environment for sustainable public- and private-sector access to DMPA-SC (along side other methods).

Injectables Access Collaborative | PATH PATH, JSI, CHAI, Jhpiego

#2: ASSESS THE MARKET

WHY IS THIS IMPORTANT?

Assessing the market should be a starting point for any reproductive health program to understand the landscape at the outset – highlighting the biggest gaps in access, the major constraints in market performance and the primary opportunities to strengthen product markets and support adoption. Market assessments are usually funded by donors and led by implementing organizations in partnership with MoH.

In the specific case of new and under-utilized product programs, market assessments can:

- Highlight the specific role that the new or under-utilized product will play in the contraceptive market.
  - » For example: which key target population segments could benefit from the intervention and how does this compare to how they are currently being served by the market?
  - » Will the product attract new users of contraception and grow the contraceptive market? Or might there be a shift in women moving to a new method that better suits their needs? How might the product enhance equity?
- Clarify the potential and benefit of offering the product across sectors (public, private and community outreach) – compared to other methods.
  - » For example: expanding access to injectables and implants in pharmacies and drug shops may increase choice if currently they are only offering a limited selection of short-term methods.

- The pricing of a contraceptive method will impact uptake and will influence relative preferences across methods. Consideration upfront to the relative pricing across methods may be able to flag potential shifts across products. It is also helpful to think about the interaction across the public and private sector – where free commodities in the public sector may influence profitability in the private sector.

Finally, assessing the market is useful for different stakeholders to inform their decision-making and informing investment (if, where and how much to invest). Ideally, the progress of market development of the new or under-utilized product is tracked over time in order to understand when dedicated investment for this method can be reduced as the product becomes mainstreamed.

CHALLENGES

LIMITATIONS ON ESTIMATING MARKET SIZE FOR INNOVATION.

Estimating market size and market segments is difficult to do for new product categories as there may be limited prior information or insights to go by. Usually, there is some evidence generated for new products, but it can be limited to few markets and (if the research is from early-stage product development) may demonstrate hypothetical preferences by users rather than revealed, real-world uptake. Studies that ask about potential acceptability of a new method may overestimate interest in the new method unless they also present information on existing methods, due to social desirability bias and low knowledge of contraceptive methods in general. Finally, consumption data from the private sector is notoriously difficult to capture.

Sometimes the impact of an innovation on other methods is not modelled up front. A new product will never be entirely incremental and some volume will come from women switching from other methods. Substitution can occur within the same product category such as one brand of contraceptive pills displacing another, or across product categories—for example, women switching to Injectables from contraceptive pills. Again, it may be difficult to gather concrete evidence to accurately understand these dynamics.

DIFFICULTY IN UNDERSTANDING PRICING DYNAMICS.

Pricing data (especially private sector) is notoriously difficult to source and track over time. Furthermore, for new or underutilized products, it may be difficult to measure the willingness to pay for a product that women are not familiar with. This makes it tricky to understand the impact of pricing on women's choice between methods. Ideally the price of a new method (where not free through the public sector) represents the benefit that women can receive, while not being distortive to the full basket of contraceptive products. Of course, real-world pricing is dependent on several factors including commodity cost, distribution costs and level of competition in the market.

LIMITED RESOURCES FOR TRACKING MARKET DEVELOPMENT OVER TIME.

Ideally the growth of a new or under-utilized product is tracked over time to understand the progress of market development, and to inform investment decisions (particularly when dedicated investment behind a single method might be reduced as the product is more integrated as a standard option in the basket of products across sectors). However, this requires resources to track key indicators of market development (e.g. tracking studies for awareness, intent and uptake), which sometimes is not available.

RECOMMENDATIONS

CONSIDER CATEGORY GROWTH AND SUBSTITUTION

When developing market size estimations, try to model the impact on other methods. This can be done through leveraging data from other markets where the product has already launched. For example, gathering data from other countries on where adopters of self-injection came from – how many were new users compared to switchers from DMPA-IM or other short-term methods. Even if these estimates are imperfect, they can highlight the anticipated trends or shifts in the method mix. Having this information up front can help to manage expectations

of stakeholders, highlight possible risks for the program team to consider during implementation and contribute towards forecasting and procurement plans.

This toolkit may be useful in discerning estimates for demand.

DESIGN SPECIFIC STRATEGIES ACROSS PUBLIC AND PRIVATE SECTOR CHANNELS

The single-method program may have different access goals across cadres (large health facilities vs. a pharmacy vs. community outreach). Consider the specific health or access goal for each channel and identify potential barriers to overcome. For example, do drug store owners have the time or space to train women to inject themselves? Can CHWs place and remove implants? Work with members of different cadres to refine the value proposition for the product – you will get feedback that helps to make these more resonant and distinct from other methods.

There may also be an opportunity to leverage one product to enhance contraceptive access more broadly through advocacy around task-sharing. For example, in Uganda, PATH successfully advocated for policy change to enable pharmacies to offer self-injection of DMPA-SC as well as provider administration of DMPA-SC and DMPA-IM injectables for the first time.

DIVE INTO PRICING STRATEGIES ACROSS SECTORS.

Consider the pricing strategy within the private sector, how this enables access for the priority target segments and how the pricing may impact choice. For example, if the price of the new product is too high compared to other methods it may restrict access (e.g. driving lower income women to choose earlier generation oral contraceptives). In pharmacies, drug stores or private clinics, pricing needs to be considered from a user and provider perspective. Pricing needs to be sufficient to provide appropriate profitability to ensure a private sector provider is motivated to stock the product, and not recommend the product more than others due to profitability. For example, if an innovation has higher margins that another method, it may lead to the retailer promoting the innovation more aggressively (and vice versa). Willingness to pay studies can be beneficial, however, they should also be designed carefully. For example, it is harder for women to determine a price they are willing to pay for an innovation that is less well understood. It is also important to consider the price in the private sector compared to free supply in the public sector.

When developing a pricing strategy, review pricing and margins of other contraceptive products. Ideally pricing could be tracked in a sample of outlets over time – considering the relative prices and volumes across a range of contraceptive methods to assess any major shifts in purchasing behavior. This could be done through a sample retail audit or purchasing data from a data partner (e.g. Maisha Meds or IQVIA).

TRACK MARKET DEVELOPMENT OVER TIME

Review the later section on M&E. At this stage, you can advocate for resources to conduct market tracking of awareness, acceptability, intent to use and uptake to measure progress against the stages of market development over time – and make decisions on where to focus resources to increase access or embed the method into the contraceptive mix.

CASE STUDIES

MAPPING THE OPPORTUNITY FOR HORMONAL IUD IN LMICS.

Until recently, the hormonal IUD was too expensive to be utilized to most LMIC populations and stakeholders in these contexts were too unsure of the value proposition for this method to invest significantly in its introduction. It was important to understand where hormonal IUDs fit within the broader method mix and what value they would add if introduced at scale.

Contributions from a global community of practice working toward a shared learning agenda significantly expanded the evidence for hormonal IUDs in LMICs and showed that the method had the potential to expand method use in these settings. For example, many users of this method would have chosen no method at all if they could not receive the hormonal IUD on the day of their service, indicating that the method was meeting a need not currently being satisfied by other available methods. Subsequent expanded hormonal IUD use in LMICs led to similarly high rates of satisfaction and continuation to what we see in the US and Europe. These insights were gathered through a mix of studies aimed at piloting the introduction of the method and understanding both the client experience and the impact on the FP market through efforts to forecast the demand for this method in multiple countries.

With the gathering of new evidence, alongside advocacy at a country and global level (including to include the method in the UNFPA and USAID procurement catalogs at an affordable price) new funding has been unlocked for the scale up of the hormonal IUD and many countries have committed to national strategic plans to scale access to the method nationwide.

Expanding Effective Contraceptive Options (EECO) - Catalyst Global (Catalyst Global and PSI)

#3: SECURE REGULATORY AND POLICY APPROVALS

WHY IS THIS IMPORTANT?

Regulatory and policy approvals cover a wide range of issues including whether the product can be used at all and/or for what indications, which cadres of healthcare providers can offer or prescribe it, its status as essential (or not) and any subsequent rules on its cost to clients, how it is packaged and/or labelled, whether any off-label uses are allowed, any requirements around the product's manufacturing quality standards and/or from where and whom the product can be imported, the settings from which such a product can be accessed, bought, and/or sold, and more.

In this area, there is a lot of opportunity to leverage advocacy efforts under a single-method program to improve the policy and regulatory environment for a broader range of methods.

CHALLENGES

To aid decision makers (i.e. regulators) in assessing whether a given product is suitable for their population, most regulatory processes are necessarily specific to the product in question. For example, registering a product or having it listed on a country's EML will typically require detailed documentation to characterise the safety and efficacy profile of that particular product and its projected public health impact. Method specificity is warranted (and necessary!) in these cases.

Broader product-related policies such as those that cover task-shifting and task-sharing, those that indicate how the product can be offered (e.g. through national FP guidelines or service delivery guidelines), and/or those that set parameters for product import, distribution and service settings, may be more amenable to an approach

that considers a larger range of products at once. Likewise, securing policy approvals for systems-level improvements and updates like those made to HMIS, LMIS, and in guidelines might only occur on a multi-year cyclical basis, making new product's integration less likely to happen in isolation.

RECOMMENDATIONS

CONSIDER THE BROADER OPPORTUNITY FROM THE START.

- Determine what regulatory processes and approvals will be required for the product to be made accessible. Conduct a landscaping (if possible) of both policy and funding gaps, as well as potential opportunities. This analysis can identify areas where support is lacking and where new resources or adjustments to existing policies might improve outcomes. While doing so, inquire about the extent to which these steps are product-specific or where opportunities to make updates to other products might exist.
- Consult with stakeholders who are mindful of what's going on with other FP products - are any due for regulatory or policy updates? Might a joint effort be timely, warranted, and well received?
- If introducing your product requires any updates to task-sharing guidelines, national FP guidelines, service delivery guidelines, national health insurance plans or other client-side financing strategies, or to supply chain guidelines, inquire with those policies' decision makers about opportunities to address other products. It would be beneficial to highlight the importance of targeted advocacy efforts. Develop a focused advocacy plan which prioritizes decision-makers and clearly defines goals/objectives.

DISSEMINATE WITH A REMINDER OF CHOICE.

Ensure that any communications about regulatory or policy updates to healthcare providers and/or clients reinforce the importance of and accessibility of choice. See the section on Service Delivery for more details on this.

LINKS TO TOOLS & RESOURCES

- https://catalystglobal.org/2022/06/14/eeco-product-registration-toolkit/
- https://www.who.int/publications/i/item/WHO-RHR-17.20

CASE STUDIES

EXPANDED POLICY CHANGE ACROSS A RANGE OF METHODS.

When the WHO released the 5th edition of the Medical Eligibility Criteria (MEC) for Contraceptive Use in 2015, it came with an exciting update: women who were postpartum and breastfeeding could safely use contraceptive implants right from the time of delivery (as opposed to waiting weeks postpartum to initiate). The MEC update spurred action around the world, as LMICs sought to update policies and service delivery guidelines to reflect the new WHO guidance. Fortunately, many countries used this pivotal moment to update policies and guidelines not only for the index product (implants), but to refresh their postpartum family planning guidance more broadly, making updates to PPFP counseling sections, ensuring LAM was accurately represented, and more. Many countries also used this "moment" to conduct provider refreshers on PPFP delivery. Altogether these moves ensured that expanded FP access went beyond the updates to implants alone.

WHY IS THIS IMPORTANT?

For any program to be successful, it is critical to have a consistent supply of commodities at the facility or outlet to match demand. For new product introduction, commodity forecasts are more difficult to estimate when demand is unknown and funding is inconsistent.

Similarly, data is key to understand uptake of a new product or innovation. Ensuring that national monitoring structures for the new product are in place prior to product launch is key to governments having visibility of uptake and supply trends and having the data necessary for future program planning and supply forecasting. Increasingly there is a focus on leveraging MoH systems (HMIS, DHIS2) and improving quality data reporting into these systems. This is a more sustainable approach that helps to assess program performance and enables the health system to assess trends over time and feed into supply planning.

For single-method or product innovation programs, there is a tendency to focus on supply and reporting of this method only. While dedicated modelling and efforts may be required for a new method, there is a great opportunity to improve these processes across the family planning portfolio. Examining the new product within the scope of the broader method mix can bring out lessons for improving service delivery and uptake across the board. To the extent possible, single method programs should invest in strengthening wider contraceptive programs so that benefits (in terms of data, supply, etc.) carry over to the full method mix.

CHALLENGES

- Emphasis on data reporting or supply management solely for one method can trickle down and influence behavior by providers at the facility level (for example, creating an intended consequence of over-emphasis on one method).
- Single method-focused projects are often only resourced to support supply and data collection for that method and aren't equipped to tackle broader health system gaps. Without acknowledging that single method projects are inherently limited, we tend to point fingers with the resulting influence on uptake of that method.
- Creating parallel data or supply mechanisms for a single product may support short-term needs but are not always set up in a way that can contribute towards strengthening the health system. Sometimes the opportunity is missed to leverage a single-method program to strengthen the system for all FP methods.

RECOMMENDATIONS AND BEST PRACTICES

SET EXPECTATIONS FOR INTEGRATION INTO DATA AND SUPPLY SYSTEMS AT THE OUTSET.

Engage with governments that are considering the launch of a new product at the time of scoping to advocate for the inclusion of service statistics data in national health systems (including facility-based service and supply data collection tools). Map out HMIS update country cycles so that any new product updates can be integrated in a timely and non-disruptive manner in broader update. Updating paper-based HMIS systems is a massive undertaking in terms of money and time – efficiencies can be found by coordinating with those working in other health areas on updates to multiple fields of the tools at once.

CREATE A ROBUST SUPPLY FORECAST FOR THE PRODUCT THAT TAKES ACCOUNT OF IMPACT ON OTHER METHODS.

Forecasting supply needs is tough for new product innovation, less so for an incremental product improvement. In fact, ensuring informed choice inherently means enabling wide access to the innovation. Otherwise, the new product might be restricted to only a small proportion of women who might choose and benefit from it. Therefore, conducting a robust supply forecast for the new product - with a focus on ensuring coverage in priority geographies or for priority segments - is important. Within these forecasts, consider impact on other similar methods. It is also important to ensure that accurate forecasting is done across methods so there is availability of a range of methods during the period of the single-method program.

There are a few different approaches to take for forecasting a new product or innovation – this toolkit may be helpful RH-supplies-_-A-Forecasting-Guide-for-New-and-Underused-Methods-1st-Edition.pdf (marketbookshelf.com). Encourage consumption-based supply projections for future need and revisit assumptions frequently. This is especially important for a new product since demand trends will change as frequently as monthly in the first few years.

CONSIDER HOW SUPPLY AT FACILITY-LEVEL MIGHT IMPACT PROVIDER BEHAVIOR.

Programs often include an element of supporting supply & facility level distribution efforts for the product of focus. These activities should apply across all methods to ensure that there is a range of methods available at facilities.

Gather market intel and historical knowledge from partners and stakeholders to understand how interactions between products may impact access at the facility level. For example – in launching DMPA-SC, several trends related to facility supply and interactivity with DMPA-IM have been observed:

- When DMPA-IM stocks are low, DMPA-SC may be substituted for provider administered injections.
- When DMPA-SC stocks are low, some providers (or even governments) may prioritize the product for self-injection. This means those opting for provider-administered would be required to use DMPA-IM.
- Alternatively, where DMPA-SC stocks are low, other providers decline self-injection or decline to supply take home units because they want to reserve DMPA-SC units for more women and use it for provider-administered only.

While these impacts may be outside of direct control for the project in question, teams can encourage providers to ensure women have full choice within the options available in stock.

IDENTIFY HOW THE PROGRAM CAN BALANCE THE FOCUS ON A SINGLE-METHOD WITH STRENGTHENING DATA REPORTING OR SUPPLY MANAGEMENT FOR ALL FP METHODS.

Always review method-specific data within the context of all methods provided. For example:

- Paper and digital data dashboards should include all methods provided at the facility
- Data reviews should review all methods. For example, regular data-driven feedback to district/facility managers and providers with assessment of trends of different products within method mix.
- Skills and tools for forecasting commodities or for improved data reporting for one method can be applied onto the wider methods in the mix.

A Women's Health Practioner shows a client an IUD insertion model, Zambia, 2010.
©Gareth Bentley

CASE STUDIES

STRENGTHENING THE SYSTEM BEYOND SELF-INJECTION.

Despite being a single-method project, DISC applies a holistic health system strengthening lens to address commodity supply issues at multiple levels of the supply chain. At the upstream level, DISC is addressing one of the major 'root causes' of stockouts and shortages –inaccurate forecasting and supply planning. DISC's empathy-based curriculum used to train healthcare providers on DMPA-SC self-inject also encompasses capacity building modules that dive deep into data entry for all FP products, enabling providers to gain confidence in how to accurately record contraceptive consumption rates. As a provider-facing behavior change intervention, DISC's empathy-based trainings and follow-up support help to normalize and reinforce a culture of meticulous data reporting at the facility level—which translates into more accurate forecasting and supply planning at higher levels of the health system.

DISC has also rolled out supply-chain management trainings for multiple cadres of health workers. For example, in Malawi, DISC trained 240 FP providers, health surveillance assistants (HSAs), pharmacy staff, and data / HMIS officers on enhanced commodity management. DISC trainings also educated staff on how to use new stock management systems like FHIN and GFPVAN.

Another area of supply chain management strengthening is stakeholder engagement and coordination. In Malawi for example, DISC worked closely with the Reproductive Health Department (RHD) to establish and facilitate commodity tracking committees that are tasked with improving logistics management, tracking commodity availability, and devising solutions to proactively address supply constraints.

This capacity strengthening is expected to benefit forecasting/ supply chain management across the full method mix.

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SERVICE DELIVERY

WHY IS THIS IMPORTANT?

Quality of care and person-centered care positively influence health seeking behaviour and decision making, leading to positive experience of care and improved health outcomes. Family Planning service delivery should adhere to accepted ethical standards of health care service delivery with respect to client autonomy. Programs with single method programming face inherent risks to informed choice and must deliberately plan to address pitfalls. Careful consideration is required to assess how to introduce a new product across sectors, cadres and models of care.

Some single-method programs may focus on expanding access to an innovation or under-utilized product within a cadre that currently has more constrained choice. For example, pharmacies are usually not able to offer LARCs. In this case, there is a potential positive impact on choice within that sector or cadre.

CHALLENGES

While providers can be trained within all the best practices for balanced counselling, simply the act of delivering single-method training and resources can create unintended bias towards this method. Sometimes there are limited days for training, meaning information on other methods and counselling is minimal. Furthermore, training providers on a single method may increase their confidence and knowledge related to, and their comfort with providing, that method, which in turn may lead them to provide directive counseling.

Women should be provided counseling that facilitates full, free, and informed choice from a wide range of contraceptive methods. Counseling within the range of methods should be guided by women's stated preferences, rather than by the preferences of the provider. Women should be provided with clear information about

the advantages and considerations associated with the chosen FP method, including information on known side effects and conditions that may make the chosen method inadvisable. Sometimes, the side effects for new methods are not always represented appropriately or there is risk that a provider/IPC agent paints a more favourable picture of the method compared to another existing method. This study demonstrated that in PPIUD programs, providers were more likely to discuss only the PPIUD.

Project targets for single methods may be given (intentionally or not) to providers, CHWs or IPCs, which may skew their behavior, leading to less informed choice.

RECOMMENDATIONS AND BEST PRACTICES

AVOID INCENTIVIZATION THAT COULD VIOLATE CHOICE.

Providers should not be subject to quotas or targets for FP method acceptors or FP acceptors of a specific method. Some programs use projections in their measurement plans, particularly for accountability to their donors. However, project teams should take care to communicate these only within the project leadership and not with providers or those working directly with providers (e.g. supportive supervisors), due to the risk that method projections get misinterpreted as targets. Due to the risk that targets for method use may be communicated to providers in spite of best efforts to avoid this, informed choice is even better protected when programs have no method-use targets at all. Project leadership should also be aware of their broader communications around service delivery. When speaking to team members, they should balance an emphasis on choice as well as delivery on the program objectives.

Provider incentive programmes and participation criteria shouldn't create bias towards the promotion of a specific contraceptive method that may put undue pressure on women to take a particular FP method even when they don't want it. Consider instead incentivizing other areas (if appropriate) – for example quality of care.

Make sure all staff are regularly trained on Safeguarding Choice best practices (for example this course from USAID).

BE SELECTIVE ABOUT SINGLE-METHOD TRAINING APPROACHES

Consider upfront if single-method training is required or if training could be integrated into the broader FP training curriculum and roll-out.

Criteria could include:

- Level of complexity of the new method for the provider or user to administer.
- Current level of capacity of the providers to offer FP (ensure providers have sufficient capacity for FP more broadly before focusing in on one method).

Even if single-method training is required to launch an innovation, explore ways to integrate this into wider FP training over time through:

- Getting approvals for integration of the new method training in the national FP curriculum.
- Including into pre-service training programs.
- Incorporating the new method into standard supportive supervision checklists and mentorship processes by sub-national health systems.

ACTIVELY REINFORCE CHOICE PRINCIPLES THROUGH PROVIDER CAPACITY BUILDING

It may be necessary to conduct refresher training on counselling for choice at the same time as the single-method program, or later on if you see a method skew in a particular facility.

There is an opportunity to leverage single-method training to improve the quality of care and counselling for all contraceptive methods. Similarly, in many LMIC countries, providers often do not adequately counsel on potential side effects. Reinforcing the need to provide comprehensive information about side effects during training for one method has potential to improve this for contraceptive service delivery. Another example could be using the project as an opportunity to ensure there are IEC materials available that include a range of methods.

Some programs won't have funding, resources, or donor support for the gold standard (full refresher training, including on the new method), and so instead can reduce the risk of a single method-focused training by adding in some components that relate to all methods or that could improve overall counseling.

CASE STUDIES

EXPERIENCE FROM INTRODUCTION OF IMPLANTS.

The contraceptive implant introduction and scale-up that swelled in the mid-2010s presented a dilemma to funders and program planners: Should provider training be solely focused on implants (which was faster and less expensive), or should other methods be included in the training? On this, Ministries of Health were unanimous: implant training could not occur in isolation – such training was an opportunity to refresh and expand greatly needed provider skills in FP counseling across the range of full contraceptive methods, infection prevention and control, medical eligibility screening, use of short-acting methods, and where resources and time allowed, clinical skills for other long acting and permanent methods. As a result, implant scale-up activities around the world used implants as an opportunity to update provider skills and confidence on a wider range of topics rather than on implants alone. Modular capacity building tools like this one were used to facilitate this: **https://mcsprogram.org/resource/providing-long-acting-reversible-contraception-larc-learning-resource-package/**

INTEGRATING CHOICE COUNSELLING DURING TRAINING.

The EECO project supported some small-scale rollouts of the hormonal-IUD. The team was focused on protecting clients' right to informed choice by ensuring that providers were capable of offering comprehensive, high-quality counseling on all methods and had tools to support clients to choose a method choice that suits their individual needs. The team leveraged the opportunity for capacity building to layer training in other tools which can more broadly strengthen service delivery and technical knowledge of other methods. For example, alongside training on the hormonal IUD, providers were trained on the NORMAL tool. NORMAL is a job aid to support providers to counsel on all contraceptive induced bleeding changes that can be experienced with contraception across the method mix. Community educators were trained to provide information about all methods and their messaging, as well as that of media campaigns and materials developed by these programs, are always upfront about the potential for side effects and bleeding changes (which may be positively or negatively perceived).

Expanding Effective Contraceptive Options (EECO) - Catalyst Global Catalyst and PSI

EMPATHY-BASED COUNSELLING FOR FP CLIENTS.

In Project DISC, an empathy training module was developed to increase the capacity and confidence of providers to coach women to self-inject. Qualitative insights demonstrated that providers appreciated these empathy skills and applied them to their FP clients in general, regardless of method.

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WHY IS THIS IMPORTANT?

Awareness is the first step to product uptake - clients have to know a new product exists and understand how it works and the role it could play in their contraception journey as a first step towards informed choice. To achieve population-wide awareness of a new product, or a new way of using an existing product, a significant investment may need to be made upfront until these products enjoy the same level of awareness as the existing methods within the contraceptive mix (creating a level playing field). However, there is the risk that awareness generating activities focused on a single method could in fact increase awareness, knowledge, and salience of a single method above others. It is therefore important that communities are exposed to information about multiple methods: awareness and accurate knowledge cannot be assumed, even with regard to contraceptive technologies already in widespread use.

CHALLENGES

- Often, when building a brand or a product category, there is minimal mention of other choices available which could mislead consumers and undermine choice. This can either reduce or entrench inequities regarding awareness and subsequent uptake.
- There is tension regarding highlighting the unique value proposition of a new product or new way of using a product that could be perceived as pitting contraceptive methods against each other.
- Top-of-mind awareness generated as a result may undermine choice by skewing provider or community health worker behaviour to spotlight one method over others. With community mobilizers, providers or other parties delivering communications messages, there is a risk that messages are distorted – e.g. over-exaggeration or lower focus on side effects.
- Demand generation for the private sector is often geared towards private sector paying clients and this could affect equity in awareness building and subsequent uptake. In the same vein, promotional materials are skewed towards making a sale and could increase the risk of neglecting to mention the choice available to the end user/client. Sometimes pharmacies or drug stores are proliferated by communications materials for a limited number of brands/products.

RECOMMENDATIONS AND BEST PRACTICES

ALIGN WITH MOH AND REGULATORY BODIES FOR SINGLE-METHOD COMMUNICATIONS.

Regulatory approval should be prioritised as demand generation campaigns are being designed - from manufacturer guidance to the respective national drug authority and health promotion bodies.

DESIGN DEMAND GENERATION CAMPAIGNS WITH A PROACTIVE EYE TOWARDS CHOICE.

Ideally, it is best practice to communicate across a range of methods. However, it is also necessary to drive awareness of the new method, in line with more established methods, and it may not be feasible to provide information on all methods – particularly in some modes of communication. Demand generation should consider sharing the unique value proposition in relation to the clients' preferences and experiences as opposed to making comparisons with specific existing contraceptive options.

There is a huge opportunity to leverage a campaign for a single method to raise awareness and relevance of contraceptives more generally ("a rising tide lifts all boats"). For example, the DISC campaign for self-injectable contraceptive included messaging around 'discover your power' to take control of your future through the use of contraceptives, and encourages couples communication (addressing a key barrier to contraceptive uptake that affects all methods).

Throughout each channel, consider how you can ensure users are exposed to a range of methods throughout their journey. For example:

- For community or facility events, it is critical ensure that there are a range of methods available and that providers are trained to deliver a comprehensive range of methods.

- A radio advert focused on one method could refer people to a website or chatbot to learn more – where the user has the option to learn about a range of methods.

The inclusion of an informed choice module in refresher training and support supervision protocols for health workers is critical, given the role health workers play in sharing information on contraceptive methods. The same must be applied to community health workers or Interpersonal Communication (IPC) agents as they share information about contraception within the community.

PLAN FOR THE DROP-OFF OF INVESTMENT IN TARGETED DEMAND CREATION FOR ONE METHOD.

The goal should be for the new method to enjoy the same level of awareness as existing methods and achieve full integration into the method mix on both the demand and supply side. Shifts in population-wide awareness can be measured through studies like the DHS. At the community level, an indicative measure could be increased peer-to-peer or word-of-mouth recommendations and walk-ins to the health facility.

Once a sustainable level of awareness and adoption for the new methods has been achieved, dedicated investment by MoHs or donors can reduce – instead integrating ongoing communications about the method into broader FP programs. For commercial or private sector actors, they may continue to drive dedicated demand generation to support their business or perhaps a brand.

DESIGN STRATEGIES ACROSS PUBLIC AND PRIVATE SECTORS TO MAXIMIZE ACCESS.

Remember, part of safeguarding choice means that women have access to a range of methods. If an innovation is limited in access to certain segments of users, this also violates choice. Some innovations will be more tailored to one sector or the other (e.g. LARCs vs short term methods) or the enabling environment may limit availability through certain cadres. Design demand generation and pricing strategies across channels (CHWs, public facilities, private facilities, pharmacies) based on the user segments that these usually reach.

To improve equity, you can work with MoHs and donors to design distribution and financing strategies (with or without government mechanisms) to ensure their access to products for the widest group of women possible (which may require a roadmap over time).

Centre De Sante Bomoi, Family planning, IPC, PSI-trained health worker M.J., Mary Jane, also called "Mama Confianz". Democratic Republic of Congo, 2016. ©Benjamin Schilling

CASE STUDY

DEMAND GENERATION CASE STUDY

Even when raising community awareness of DMPA-SC self-inject as a new contraceptive option, DISC's demand generation messaging was carefully designed to encourage positive behavior change and promote women's and couples' consideration of the full spectrum of SRHR services available. Some key best practices that the PSI project has learned experience include:

- Use a broad 'call-to-action' (CTA) that includes consideration of all methods. Common CTAs are 'ask a health worker about family planning options'; 'learn more about contraceptive options via [website, clinic, call center, etc.]', or 'attend X event and learn more about sexual & reproductive health'. Make sure these resources / events are well equipped and prepared to provide unbiased information or counseling.
- Apply a user-centered design approach to find the themes that resonate the most with your target audience. DISC found that Power and Control were motivating themes that women associated with self-care, which provided the inspiration for our #DiscoverYourPower campaign to raise community awareness of self-inject. Featured throughout campaign content, these themes produced a positive ripple effect by encouraging women to assume greater power and control over her sexual and reproductive health.
- One of DISC's highest-reach demand generation 'channels' is Viamo IVR, which enables users to text or call using a basic phone in order to access a series of pre-designed messages that provide information about the full spectrum of short-term and long-term methods.
- To facilitate male partners' learning about SRH, DISC's and Maverick Next Uganda's SBC content featured couples' communication – encouraging couples to collaboratively decide on a method to prevent or delay pregnancy in an informed choice context.
- High-quality counseling can double as demand generation. DISC has learned that empathy-based approaches to counseling clients on FP options has the potential to spur greater uptake of FP services beyond a single method. Satisfied users can play an invaluable role in encouraging peers to seek SRHR services and raise community awareness of new methods like SI via peer-to-peer channels.

Informing clients about a single method doesn't need to detract from messaging on other methods. In fact, the most impactful messages from a health standpoint are those which encourage learning, address gender norms, and promote health-seeking behavior beyond any single product.

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WHY IS THIS IMPORTANT?

As the program is executed, it is critical to monitor implementation to ensure that the guardrails put in place to ensure informed choice are working.

Tracking can be important at two levels:

1. Output level – for example:
   - » Checking that women are being counselled on a range of methods according to the national guidelines for balanced counselling/informed choice) and providers are not pushing women to choose this particular method.
   - » Ensuring women feel comfortable selecting whichever method they choose at the clinic or an event.
   - » Checking messaging about the product is correct and holistic (ie. reporting side effects appropriately).
2. Outcome level – identifying if the program is having distortive impacts on the method mix.

It can also be worth exploring other indicators that track integration of the single method into the contraceptive basket and health system. For example, the use of HMIS data for decision-making by stakeholders, inclusion in national quantification exercises, policy changes.

CHALLENGES

- Any new method or product innovation is likely to see switchers from other methods as well as new users – this can also be a positive outcome if women's preferences are better met. , Significant and rapid distortive shifts in the method mix could be a red flag that informed choice may be undermined to some extent.
- Single-method programs often focus performance metrics on the single method, and do not consider up tracking metrics for informed choice and impact on the method mix. This can lead to an insular focus on the single method.

RECOMMENDATIONS AND BEST PRACTICES

AVOID TRACKING A SINGLE-METHOD IN ISOLATION.

Even if the program utilizes projections related to method uptake, ensure that the project team tracks all methods within the program facilities (where possible) over the course of the program.

LEVERAGE QUALITATIVE & QUANTITATIVE EVIDENCE FOR CONTINUOUS OPTIMIZATION.

It is recommended to take an 'adaptive implementation' approach to optimize throughout the program lifecycle. By conducting regular checks across a range of measures, the program team can identify challenges and course-correct as necessary.

Mr. Stanford Munsaka, a New Start councelor in a session with a client. Zambia, 2010. ©Population Services International

1. Monitoring activities and outputs.

Here is a list of some approaches that can be used:

METHODOLOGY	WHAT CAN IT MEASURE?	WHAT ARE THE LIMITATIONS?	SUGGESTED FREQUENCY
SUPPORTIVE SUPERVISION CHECKLISTS AND ASSESSMENTS	Observation of providers' counselling and training. If issues are observed, on-the-job mentoring and reminders of informed choice tools (e.g. counselling for choice) can be used to adjust provider behaviors.	Provide an 'objective' clinical perspective on the service, but not the client experience.	SSVs often happen on a semi-regular basis (e.g. quarterly). Ideally more frequent at the outset, reducing over time.
MYSTERY CLIENT SURVEYS	Insights into the client experience of the training and counselling.	May be ethical limits on what a mystery client can be asked to do (e.g. they cannot be given a LARC).	Conduct early on during implementation to enable time for course correction.
CLIENT EXIT INTERVIEWS	Insights into the client experience of the training and counselling. Provides qualitative insight to pinpoint if there are any issues with clients not receiving appropriate counselling, correct information or feeling pressured into a particular method. Quantitative analysis can demonstrate how widespread the issue is, or if specific to set of facilities.	Providers are often aware that CEIs are happening – risk that they ask clients to report positive sentiments. Clients often may report favorably due to "social desirability" bias.	If there are issues, conduct follow ups to monitor performance post course corrective actions. If few issues, future rounds may not be necessary or conducted infrequently.
OUTREACH EVENT MONITORING	Availability and provision of a wide range of methods. Insights into uptake trends including skews to method mix.	Mobilisation of clients for outreaches as a demand generation approach is often targeted towards clients more likely to take up the method of focus. Likely to see a higher number of clients taking up the method for which demand is being created. Implicit provider bias due to a funded outreach activity to create awareness for a specific method.	Highly likely for each outreach event. Continuous emphasis on informed choice for the providers to centre client needs while counselling. Mobilisation messages should include messaging on the availability of a wide range of methods for all interested clients, and not just one methods.
QUALITY AUDITS	Provide a robust assessment of the quality of service delivery across a number of dimensions. Any issues can be highlighted to the program team and the facility. Program teams can revert with SSV or other mechanisms to address the specific issues raised.	Providers are often aware that CEIs are happening – risk that they ask clients to report positive sentiments.	Annual or as-needed.
QUALITY AUDITS	Provider knowledge and attitudes, including biases for and against specific methods. For example, questionnaires with providers can ask providers if they would restrict administration of specific methods to certain groups (e.g., unmarried or young women). Clinical vignettes can also be used to assess provider biases.	Results may be subject to self-reporting bias. If providers are aware of the "correct" answer, they may provide it even if it does not represent their actual practice.	Annual or as-needed.

As a program team, identify at the start of the project which combination of these would be most appropriate for the context and can be feasibly supported using available funding. Explore the appropriate cadence for monitoring, and how the results will be used to take corrective actions if necessary.

2. Tracking trends in method mix (outcome level)

The main distortions to watch out for are:

- Sharp skews in the focus method.
- Declines in another method that suggests significant levels of substitution or switching.

There are also potentially positive trends to be uncovered – in particular if the new product or innovation is attracting new users and increasing overall FP use. Remember, if there is switching because women are able to select a new method that better suits their needs, this is beneficial.

Ideally, the method mix is assessed using HMIS data at the facility level or a more aggregate level depending on the project scope of focus across the method mix over a standardised period (monthly, over 3 months, over 6 months, over 12 months). Another comparator to better understand method mix vs method uptake would be to look at the total number of FP clients to identify the new users and where the shifts could be registered (we tend to exclude condoms from the method mix).

When HMIS data are not readily available or not fully reliable, projects can utilize a sampling-based approach to monitoring the method mix at a subset of project-supported facilities. Depending on resources available for research, this activity can include a small-scale service point assessment (SPA) style survey with integrated provider and client exit interviews (described above) or stand-alone client exit interviews. When data isn't flowing into national health systems, an audit of facility data collection tools (family planning registers, client cards, and relevant stock cards) can provide valuable insights into method provision, client demographics and use history, and stock at facility. Provider interview components can help a project to understand any underlying provider biases, misinterpretations of policies related to newer technologies and products, as well as provider perceptions of a new product. While the SPA and provider interviews target quality of care from the health system perspective, the CEIs provide valuable insights around client experience and perceived quality, including informed choice.

ONE MORE CONSIDERATION!

When naming the project, consider how the name gets interpreted and trickles down as an implicit (or explicit!) focus of the work once used project documents, official communications, and in project promotional materials like banners and t-shirts. For example, "Expanding Access to Vaginal Rings" may be precise, but could also signal to health workers that they should focus on rings over other methods.

CASE STUDIES

The DISC project focuses on interventions to support access to adoption of Self-inject (SI). SI requires significant user and provider behavior change – so dedicated investment is required in creating awareness, building confidence and integrating the method into the health system and basket of contraceptive methods. DISC expects to see significant, measurable increase in uptake and continuation of DMPA-SC SI – within the context of informed choice. DISC continually monitors and analyzes key metrics related to DMPA-SC and the other contraceptive methods at the level of both the facilities the project supports, as well as the national level (using NHIMS data).

DISC uses quality audits, Client exit Interviews (CEIs) and Service Point Assessments (SPAs) to evaluate the client experience of care. If there is evidence in a particular facility that balanced counselling is not being applied, DISC addresses these challenges within SSV and other provider mentoring activities. DISC also monitors trends in method mix (where possible) to track the proportion of new users that are selecting SI and track the impact of this method introduction on other methods. Between 10-30% of SI visits under the program are coming from new contraceptive users, with others switching from short term methods (esp. condoms) and other provider-administered injectables.

DISC also uses this data at a sub-national level to assess whether demand and adoption of SI is reaching a tipping point (for example, where walk-ins to facilities are sustaining without demand generation activity). In this case, dedicated investment in SI demand generation can be scaled back, instead focusing on integrating SI into broader FP programs.

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Husbands learning about contraception in Ethiopia, AYSRH Project 2021. Ethiopia, 2021.