MSI 2030 RESEARCH & LEARNING STRATEGY

Research and learning to inform the delivery of high-quality, client-centred sexual and reproductive health and rights information and services.

MSI REPRODUCTIVE CHOICES

Charity details

Registered name and charity number
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MSI REPRODUCTIVE CHOICES (MSI) PROVIDES CONTRACEPTION AND ABORTION CARE ACROSS SIX CONTINENTS, SUPPORTING MORE THAN 93,000 PEOPLE WITH SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) INFORMATION, SERVICES, AND PRODUCTS EVERY DAY

Every year, we collect
300 million
client data points from across 50,000 communities.

With this unparalleled robust and real-time data, we ensure our programming is evidence-based and that our teams are continually adapting to address the evolving needs of our clients. This helps us deliver the greatest impact for women and girls.

MSI's 2030 organisational strategy aims to rapidly and sustainably scale up access to sexual and reproductive health services and products, with a commitment to making reproductive choice possible for all. Since 2020, when our global strategy was developed, MSI has supported over 70 million people across 36 low, middle, and high-income countries. If we are to reach our ambitious goals—including to support 120 million women and girls by 2030 with SRHR information and services—we need evidence-driven decision-making to be at the core of everything we do. This research and learning strategy outlines how we generate evidence that can help us to achieve the goals and commitments under our organisational strategy "MSI2030: Your Body, Your Choice".

This strategy will steer MSI's research activities and shape partnerships and collaborations. Internally, it will function as a roadmap for MSI teams to foster a culture of learning across the organisation. And it will support the entire SRHR sector at large, as we continue to build an evidence base that can help enhance SRHR information and services.

The research and learning agenda outlined in this document aims to address key evidence gaps in the SRHR sector, with a focus on MSI's core services: contraception and abortion. We will do this by:

- **generating evidence and learnings on approaches and strategies** to strengthen health systems and equip governments to deliver SRHR information and services
- **testing new innovations and approaches** that expand SRHR access, especially among people living in poverty, adolescents, people with disabilities, and those affected by displacement
- **supporting advocacy efforts** to create an enabling environment to provide SRHR
- **centring client choice, and change behaviours and social norms** to facilitate access to services
- **leveraging digital technologies and artificial intelligence (AI)**

We're in good stead to achieve these objectives with the robust service data we generate from our management information systems (MIS), programmatic monitoring, evaluation, and learning (MEL), and research initiatives.

MSI remains committed to working in partnership within the SRHR and wider development sector to implement this strategy. When we learn and innovate together, there will be quicker and bigger transformations in the lives of women and girls everywhere.

PART 1

MSI'S 2030 RESEARCH AND LEARNING PRIORITIES

Part 1 presents MSI's research and learning priorities for evidence generation working towards 2030 as a critical juncture.

The 12 research and learning priorities outlined in this strategy seek to test and evaluate strategies and document effective approaches to expand access to quality SRHR information and services across all service delivery channels and pathways at MSI (Box 1). Each priority outlines specific research and learning objectives that will help frame specific research questions for research protocols.

Box 1. MSI service delivery channels and pathways

Through **mobile outreach**, health teams and sole providers deliver SRHR information and services directly in hard-to-reach areas and among communities who have limited access to SRHR information and services. Depending on need, outreach teams may be situated at health facilities that lack capacity to deliver a full range of reproductive health services.

MSI provides support on a range of activities designed to strengthen the health system and quality of service delivery within public sector health facilities through our **Public Sector Strengthening (PSS)** model.

The **MSI Ladies** model supports qualified nurses or midwives, working at home or who travel across communities, to offer SRH care either as fee-paying, subsidised, or free services.

MSI Centres (outpatient clinics) offer contraception, comprehensive abortion care (CAC), and other SRH or general health services such as STI/HIV testing, primary and secondary cervical cancer prevention, gynaecological conditions, and postnatal outpatient care.

MSI Maternities are mostly CEmONCs and offer the full range of MNCH services: vaginal and assisted births, C-Sections, blood transfusion capacity, CAC (including second trimester), antenatal and postnatal care as well as gynaecological surgeries and admissions.

Varied research methods will be used to answer the research and learning objectives. Objectives that aim to demonstrate effectiveness or impact will be answered by either controlled experimental or quasi-experimental evaluation(s). Research that seeks to document implementation learnings of different approaches will be addressed through case studies, insight gathering, and a combination of routine data and qualitative methods.

In addition to the 12 outlined key priorities, MSI will use routine service and programme data to assess the effectiveness of programme strategies and interventions to improve affordable access to contraceptive and abortion services and to generate awareness around MSI services.

MSI will collaborate with a broad range of partners to implement this strategy. These partnerships will facilitate opportunities for MSI staff to strengthen their research capacity and for external partners to leverage MSI's position as a leading SRH service provider.

Our breadth and depth of service delivery across multiple countries and contexts provides an unparalleled opportunity to work with partners on clinical and implementation research on innovations in reproductive health technologies in SRHR and inform roadmaps to effectively scale innovation across the sector.

The prioritisation process identified several evidence gaps that are research priorities for the SRHR sector and critical to drive the work MSI does but better suited to be to be led by partner organisations. This includes research on effective strategies to increase domestic financing for contraception and abortion services. As well, the evaluation of the long-term socio-economic and environmental outcomes of reproductive health programming. The long-term health impacts of SRHR programming are well documented, but there is a requirement for evidence on broader socio-economic and environmental impacts. This evidence gap is best filled by research focused organisations with longitudinal data at the community level, including health and demographic surveillance sites, or countries with long-term panel surveys initiated in childhood or adolescence.

STRATEGY DEVELOPMENT AND PRIORITISATION PROCESS

The priorities and approaches presented in this strategy emerged from a consultative process conducted across the MSI partnership from October 2023 – March 2024

01

Scoping exercise

A literature review[1] identified research gaps and emergent priorities across the SRHR sector. These were compiled into a list of 'emergent topics' and categorised into four broad categories on abortion, contraception, adolescent SRHR and cross-cutting themes to inform subsequent prioritisation activities.

02

Focus groups with key stakeholders

Eight focus groups were conducted with staff working across global, regional, and country teams at MSI. Feedback was gathered on research and learning priorities, perceptions on internal capacity, opportunities and challenges around generating and sharing research and learnings.

03

Prioritisation survey with country programmes

Findings from the scoping exercise and focus groups were consolidated into 32 priority topics and shared through an online survey with MSI country programmes, who worked in cross-functional teams to rank and prioritise topics.

04

Validation workshop

The highest-ranked priority topics were reviewed against the pre-determined criteria (Box 2) in an online validation workshop and prioritisation exercise attended by 16 MSI global support staff working across technical services, clinical operations, programme operations, advocacy, and donor engagement.

05

Finalised strategy

Inputs from all activities yielded a final list of 12 priorities and included in draft document outlining the research strategy. This was reviewed by key stakeholders across MSI prior to finalisation.

Box 2: Criteria guiding prioritisation of topics

Actionable: guide decision-making for programme operations and clinical service delivery

Impactful: demonstrate the value in investing in SRHR programming

Enabling: create an enabling environment for SRHR programming

Relevant: generate new knowledge for the organisation, the sector, or specific countries

Research and learning priorities	To document	SRHR focus area
1. What are effective strategies to support public sector health systems to scale up innovations and approaches for the sustainable delivery of high-quality, rights-based, and equitable sexual and reproductive health services?	PI IE CP CE	Abortion, Contraception
2. What is the impact of delivering SRHR information and services through a mobile outreach service model on sexual and reproductive health outcomes at a population level?	PI IE CE	Abortion, Contraception
3. What approaches and mechanisms ensure that clients have access to their choice of high-quality abortion care, both in the first and second trimester?	PI CP A	Abortion
4. What are effective strategies to safely expand and sustain quality of abortion care using new technological innovations, medical advancements, and task-shifting, including pharmacy provision and self-managed care?	PI CP A	Abortion
5. What approaches effectively support the scale-up of contraceptive access post-pregnancy, and within Maternal Newborn Child and Adolescents Health (MNCAH) services, infant immunisation and nutrition programmes?	PI	Abortion, Contraception, Other SRHR services
6. What are the impacts of delivering client-centred reproductive healthcare on client and provider behaviours, experiences, engagement, and outcomes?	PI CP IE CE M	Abortion, Contraception
7. How can social and behaviour change communication (SBCC) successfully address social norms and increase reproductive autonomy?	PI M	Abortion, Contraception
8. What service delivery models and approaches work to achieve equitable and inclusive reproductive healthcare that meets the needs of adolescents, youth, and persons living with disabilities?	PI A M	Abortion, Contraception
9. How can digital health initiatives improve access to and quality of reproductive healthcare?	PI IE	Abortion, Contraception
10. How effective are school-based SRHR education programmes in improving adolescents' knowledge and utilisation of SRHR information and services?	PI IE A	Contraception
11. What approaches work to counter the threat of the anti-rights, anti-gender and anti-choice movements on SRH programming?	PI A	Abortion
12. What works to expand delivery of SRHR information and services from development contexts to settings that are affected by conflict and climate-change?	PI M	Abortion, Contraception, Other SRHR services

PI Programmatic Improvement · IE Impact Evaluation · CP Client Perspectives (and quality) · A Advocacy · CE Cost-effectiveness · M Measurement

*All priorities are expected to contribute to evidence and best practices in the SRHR sector


MSI

MSI offers a range of reproductive healthcare services globally that include contraception, abortion care, and safe motherhood services in rural, peri-urban, and urban settings. We do this through direct service delivery provided at a variety of service delivery points and by supporting national and district health systems to provide services. Through this process, MSI works to strengthen health systems, with a focus on fostering sustainability through national ownership. This support may range from supporting an enabling environment, to changing social norms, clinical service provision, and working to improve access to a range of person-centred reproductive healthcare services. The research and priorities outlined in this document address key learnings across these areas of work.

Table 1 maps the priorities against each of these areas of work

Area of work	Research and learning priorities
Facilitating an enabling environment	
Supporting favourable law and policies	1, 10, 11
Community engagement and support	
Driving sustainable demand	1, 2, 7, 10, 12
Strengthening health systems	
Integrating SRHR into other PHC and health services, including MCH, HIV, Nutrition, SGBV	5, 7,12
Supporting governments to scale	1, 5
Ensuring cost-effectiveness	2
Expanding access to contraceptive and abortion products	1, 3, 4
Provider training and maintaining competency	1,9
Ensuring access to counselling and information	1, 2,3, 9, 10
Client health care journey and experience	
Innovating service models to enable choice and increase access (incl. self-managed care)	3, 6, 7, 11
Building provider capacity and positive engagement	1,9
Providing post-service care	9
Ensuring and maintaining the quality of care	1, 2, 3, 4, 5, 8, 9, 12
Achieving a positive service experience and soliciting client feedback	1, 3,5,6

01: What are effective strategies to support public sector health systems to scale up innovations and approaches for the sustainable delivery of high-quality, rights-based, and equitable sexual and reproductive health services?

Purpose

- Programmatic Improvement
- Impact Evaluation
- Cost-effectiveness

SRHR focus area(s)

- Abortion
- Contraception

What we know

Health systems strengthening is critical to scale-up access and coverage of SRHR information and services within a Universal Health Coverage (UHC) framework.

While the aims of health system strengthening approaches, including the strengthening of health worker capacities and skills are well documented, other components necessary to achieve these goals are less well researched. These include the implementation of effective management and supervision systems, enhanced quality control and assurance, the strengthening of logistics and health-management information systems (LMIS/HMIS) for commodity supply, and what the most effective and cost-effective mechanisms are.

In general, there is limited evidence on the sustainability of systems-strengthening interventions at different levels of the health system, as well as improved health outcomes[2].

Why it matters

MSI works with governments around the world to support the public sector to deliver SRH services, with intent to expand access for all persons and especially underserved communities in rural or peri-urban settings.

In 2023, MSI supported 12,000 government health workers across various countries, reaching over 7.5 million women and girls with SRH services.

MSI's approach involves working with Ministries of Health (MoH) at a national and regional level to support the delivery of SRHR information and services through improved supply management, building provider competence and skills, and by fostering community-level momentum around SRHR use.

At the initial stages of collaboration with governments, our approach is to work intensively with facility staff and providers to build provider confidence and competency and working in parallel with government supervisors to strengthen their supportive supervision capacity.

Once government provider confidence and competence are built, MSI teams transition to lighter-touch support models, whilst continuing to monitor delivery and quality. MSI is keen to evaluate the long-term impact of systems strengthening initiatives on the capacity of the health system to deliver SRHR information and services under its current approach.

Research and learning objectives

1 What is the lasting impact of MSI's approach to health systems strengthening?

- How does this approach impact increased choice, access, use, and quality of contraception and abortion services?
- To what extent does MSI's health systems strengthening approach contribute to an increase in modern contraceptive prevalence rate (mCPR)?
- Which strategies under this approach empower communities and healthcare providers, alongside strengthening health systems?
- What strategies are effective at providing adolescent friendly SRH services that are confidential, non-judgemental, and accessible?
- How cost-effective is this approach?

2 Is MSI's health system strengthening approach successful in ensuring the sustained provision and quality of services under national ownership in the public sector systems?

- What strategies work to build sustained capacity for values-driven and rights-based reproductive health service provision that encapsulates adolescent-friendly services, reduced abortion stigma, and client-centred care, within the public sector?
- What are effective strategies to support public sector community health workers in the long-term to deliver effective health promotion and social and behaviour change communication (SBCC) activities for social norms change and expand access to rights-based contraceptive use and access to abortion and post-abortion care?

02: What is the impact of delivering SRHR information and services through a mobile outreach service model on sexual and reproductive health outcomes at a population level?

Purpose

- Programmatic Improvement
- Impact Evaluation
- Cost-effectiveness

SRHR focus area(s)

- Abortion
- Contraception

What we know

Mobile outreach, a service delivery model, dispatches trained clinical providers equipped with supplies to provide services in communities. For decades, mobile outreach teams have supported family planning services for underserved populations who have limited access to health services due to geographic, social and economic barriers, or conflict.

The scale and effectiveness of using a mobile outreach model to deliver contraceptive services and reach vulnerable and marginalised groups has been documented by NGOs, including MSI[3]. The model is enhanced when services are delivered in conjunction with SBCC interventions to address negative social norms around reproduction and contraception[4,5].

There remains a need to gather empirical evidence on the impact of mobile outreach over and above standard approaches to service delivery, including its cost-effectiveness as a health intervention.

Why it matters

In 2023, 360 MSI outreach teams conducted 4.5 million client visits (with 34% of people living in poverty) across 23 countries. In the past decade mobile outreach models have evolved and diversified. Evidence from MSI suggests that mobile outreach plays an important role in health systems strengthening, where local providers are involved in aspects of outreach service delivery[6]. But this has not yet been studied systematically.

MSI is keen to study the effectiveness of these models and document the impact and any value-add of outreach models to scale up contraception programmes in settings where public sector service delivery is unfeasible and to help expand access for populations that are underserved.

Research and learning objectives

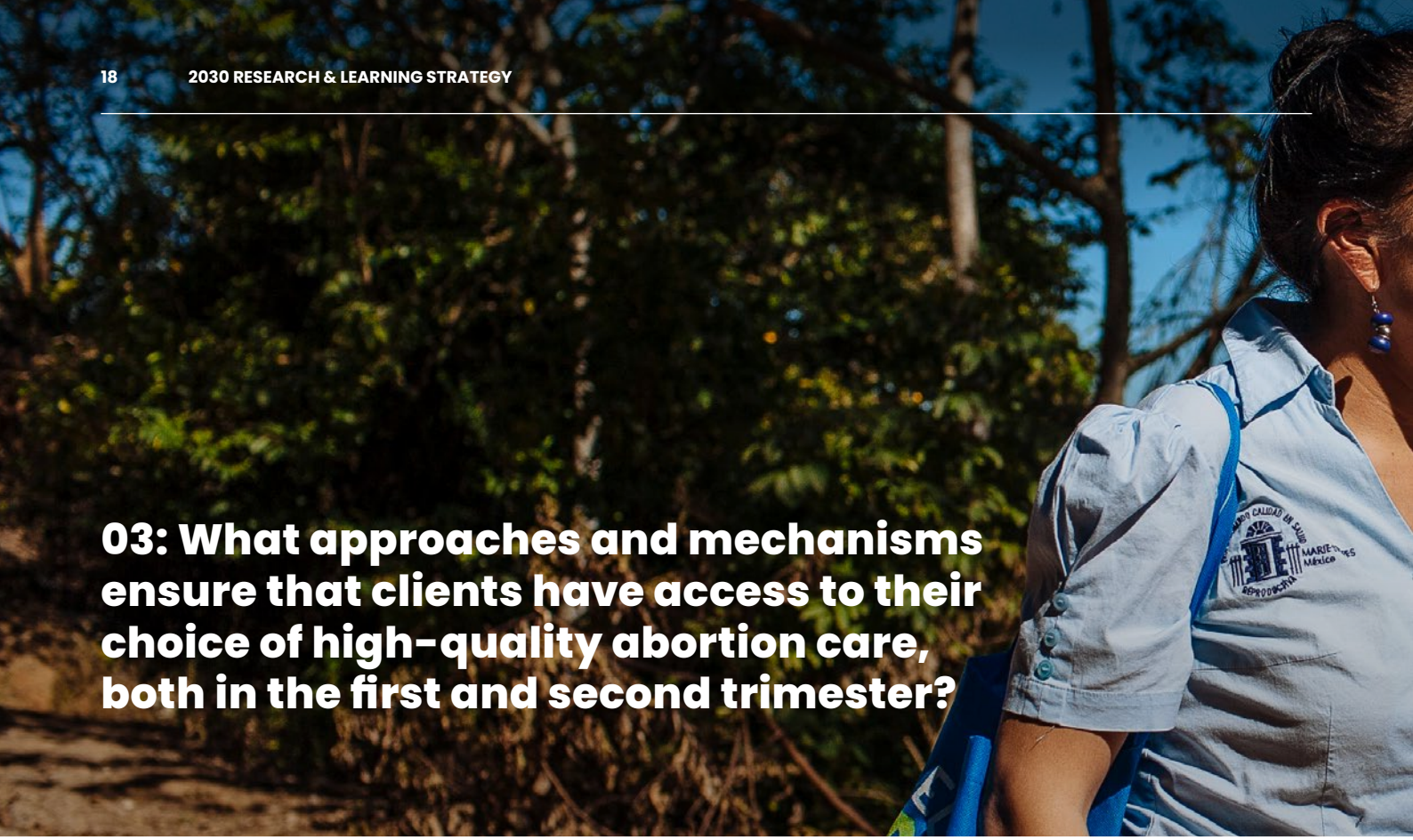
1. How does the implementation of mobile outreach services contribute to meeting the demand for contraception, particularly for underserved populations such as those living in poverty, adolescents, and individuals affected by displacement?

2. What is the comparative effectiveness and cost-effectiveness of various mobile outreach service models providing access to high-quality SRH services?

3. What factors enable the successful implementation and scale up of sustainable service models that replicate outreach in expanding access to SRH services to remote and underserved communities and can be led by government?

4. What programmatic strategies are most effective in delivering medical abortion services and guaranteeing continuity of care through outreach models?

5. How effective are community SBCC models conducted through a mobile outreach model in enhancing awareness and fostering positive social norms on reproductive autonomy and choice?



03: What approaches and mechanisms ensure that clients have access to their choice of high-quality abortion care, both in the first and second trimester?

Purpose

Programmatic Improvement

Client Perspectives

Advocacy

SRHR focus area(s)

Abortion

What we know

Abortion is a common and lifesaving health intervention and yet it remains stigmatised, inaccessible, and legally restricted in many countries. Over the past decade as the distribution of quality-assured medical abortion (MA) products has gradually increased within most health markets, access to safe abortion has increased in many countries. Medication for medical abortion can be directly purchased from pharmacies and drug-shops, enabling more women to safely self-manage their own abortion outside formal health services.

The provision of abortion via medication is a cost-effective option for resource-constrained health systems making abortion both affordable and accessible to more women.

While the use and access to medical abortion has expanded, surgical abortion remains a critical service within health systems and its continued provision helps to ensure that clients can choose their abortion method. Evidence demonstrates that people place high value on being able to choose their preferred method[7], and satisfaction increases too.

Why it matters

Ensuring access to all options for abortion (medical, surgical, self-management or facility based) is essential to advance women's health and rights. Comprehensive access enhances individual autonomy and dignity by ensuring that individuals can choose the method that best suits their individual health needs, circumstances, and preferences. MSI is committed to offering a full spectrum of abortion services to help address the diverse and complex situations women face, reduce the risk of unsafe abortion, and promote better health outcomes. To inform and improve service delivery, MSI strives to better understand and document women's decision pathways on seeking abortion, their preferences on method choice, including medical regimen and facility based or self-managed models of care. Furthermore, while the growth in medical abortion has resulted in opportunities to expand choice around abortion care, this has come with an increased number of counterfeit and unsafe medical abortion products in many markets. MSI is keen to ensure that options available through pharmacies are trustworthy brands and products so that women have access to the best quality of care and to fill current knowledge gaps around effective strategies that support increased, equitable access to quality-assured products.

Research and learning objectives

1 How do different medical abortion regimes (i.e. misoprostol alone, mifepristone + misoprostol, letrozole + misoprostol) compare in terms of client experience?

2 Are trends in selection of service delivery model and abortion method (surgical vs. medical / medical regimens / administration / surgical process) driven by client choice or structural and supply factors, such as potential provider bias?

- How might this vary by gestational age?
- How do clients experience these different service delivery models and options and what influences their preference in their choice of these?

3 How is the total market for abortion and post-abortion care evolving, and which market shaping activities are most effective in enhancing access to information and safe services?

- How can women know what is a "fair price" for an abortion or post-abortion care service in their market, including in restricted contexts?

4 What distribution strategies can be employed to broaden access to quality-assured medical abortion (MA) products and displace sub-standard alternatives in an equitable manner?

5 What strategies are effective in providing support to staff engaged in abortion care, with the aim of improving resilience and staff well-being, alongside diminishing stigma, and how might these enhance the quality and sustained provision of abortion and post-abortion care provision within private and public sector facilities?

04: What are effective strategies to safely expand and sustain quality of abortion care using new technological innovations, medical advancements, and task-shifting, including pharmacy provision and self-managed care?

Purposes

- Programmatic Improvement
- Client Perspectives
- Advocacy

SRHR focus area(s)

- Abortion

What we know

Over the past two decades, the massive scale-up of medical abortion access, alongside surgical abortion—in Africa and Asia in particular—has undoubtedly been instrumental in scaling up safe access. But this is mainly concentrated in urban areas, with rural communities being left behind. New technologies, medical advancements, and task shifting to lower-level providers and self-managed care have the potential to further expand access and decrease the current inequities in access to safe options for abortion and post-abortion care.

The **World Health Organisation's self-care** and **abortion care guidelines** mark a shift in approaches to self-managed abortion and provide guidance to approaches and service models around self-care. Self-managed abortion and the 'demedicalisation' of abortion has revolutionised perceptions, access, and the future of abortion care. Evidence has shown that abortion clients increasingly use digital platforms, peer referral networks, youth centres, community health workers, and grassroots organisations. People increasingly value quick and accurate information and advice over the phone and social media. As advances in technology have transformed abortion access, trends towards self-managed care and digital support will continue, with an increased demand for private sector services and the use of telemedicine.

Why it matters

By 2030, MSI's aim is for every woman and girl to be only one contact away from a safe provider or service. To achieve this, MSI has developed, implemented, and advocated for new models and approaches on information sharing, self-management, telemedicine, task-shifting, revised gestational assessments, digital access, and removing unnecessary clinical requirements. MSI is keen to build on this work to continually adapt and design new models that will expand access to abortion care, especially among populations that face the greatest barriers and restrictions.

Research and learning objectives

1 What are effective strategies and approaches to support and train pharmacists, pharmacy workers and lay health providers in providing and supporting self-managed abortion care for pregnancies less than 12 weeks gestational age?

2 What are effective and acceptable methods for disseminating information on the self-management of medical abortion through informational materials, pharmacies, hotlines, and telemedicine in different legal contexts?

3 How can models of supported self-managed medical abortion, including accompaniment networks, be successfully scaled to enhance support for self-managed medical abortion?

- In what ways might these models require adaptation to cater to diverse demographic groups and different legal contexts?
- How can referral networks be effectively established and maintained to ensure onward care as needed or desired, or for those who may be ineligible for medical abortion?

4 What specifically works to enable men to support women in seeking support and purchasing abortion products?

05: What approaches effectively support the scale-up of contraceptive access post-pregnancy, and within Maternal Newborn Child and Adolescent Health (MNCAH) services, infant immunisation and nutrition programmes?

Purpose

Programmatic Improvement

SRHR focus area(s)

Abortion

Contraception

Reproductive Health Services

What we know

Provision of post-pregnancy contraception, including postpartum family planning (PPFP) and post-abortion family planning (PAFP) is an essential element of SRHR programming, due to its impact on healthy birth spacing and the consequent positive effects on maternal and child health outcomes[8].

WHO has clear recommendations on programming strategies across a continuum of maternal and newborn health (MNH) care, including on the need to offer and provide PAFP[9].

These recommendations are based on a solid body of evidence demonstrating the effectiveness of approaches such as contraceptive counselling and method provision throughout maternal care (including during antenatal, immediate postpartum, post-natal care) and integration with infant health care, including immunisation services and infant feeding support. Despite this guidance, use of post-pregnancy contraception remains low in many low- and middle-income countries: one recent analysis estimated that 43% of postpartum women have an unmet need for family planning, and these needs are higher among rural women and those who do not give birth with skilled attendants[10].

Levels of post abortion family planning are not well monitored, but studies suggest it continues to be low in the public sector[11]. Uptake is inhibited by health systems weaknesses and inadequate PPFP and PAFP service scale-up[12], as well as by a range of social and normative barriers, including knowledge of postpartum fertility, and fears of side-effects which may be particularly pronounced during infant feeding.

Why it matters

MSI routinely and effectively addresses post pregnancy contraception across its own private centres network and supports the delivery of contraceptive services in the extended postpartum period through its work in the public sector. We are keen to continue to support government partners to scale up access for these services within broader MCH programmes. This includes understanding how to develop effective partnerships with child health and nutrition programmes to support the effective use of lactational amenorrhoea as well as a secure transition to other effective methods of contraception.

Research and learning objectives

1. Can partnerships between reproductive health and nutrition organisations effectively scale post pregnancy contraception access for underserved individuals?

2. What are the patterns in use and factors influencing client attitudes and behaviours around use of post pregnancy contraception, with particular focus on clients presenting at public sector sites?

06: What are the impacts of delivering client-centred reproductive healthcare on client and provider behaviours, experiences, engagement, and outcomes?

Purposes

- Programmatic Improvement
- Impact Evaluation
- Client Perspectives
- Cost-effectiveness
- Metric Development

SRHR focus area(s)

- Abortion
- Contraception

What we know

Client-centred care is fundamental to the delivery of rights-based high-quality contraception and abortion services.

It underpins client involvement in reproductive health decision-making, respectful and non-judgemental service interactions, and client and community involvement in quality improvement. Existing evidence has demonstrated that improved counselling and client engagement in healthcare can lead to improved health outcomes (including successful use and continuation of contraception) and client satisfaction[13,14].

Within abortion care, client-centred approaches have scope to improve emotional support and decrease abortion stigma, thus reducing recourse to unsafe services[15]. Client-centred approaches may also enhance health worker engagement and motivation and consequently may reduce burn-out and staff turnover[16].

The evidence on client-centred approaches and outcomes overall remains weak, however. In tandem, a growing body of evidence has documented persistent factors in the reproductive health sector that undermine client-centred care. These include provider bias towards certain contraceptive methods, inadequate offer of contraceptive choice, and disrespectful, abusive, judgemental, or stigmatising attitudes of staff towards clients[17].

Why it matters

Over recent years MSI has developed a suite of tools to support client-centred approaches. In 2020, MSI developed a client-centred care strategy and measurement framework to support full operationalisation of client-centred approaches across all service delivery.

MSI is keen to further validate its client-centred care measurement framework, which aims to assess client-centred care across the whole system, to ensure collection and processing of the most relevant and useful indicators.

MSI's operational framework recognises that provider behaviour is heavily influenced by the organisational culture within which health workers deliver care and clients receive it. While MSI's initial programmatic assessments within its own service points indicate that a client-centred approach leads to improved client satisfaction and client-reported quality, the impact on client and provider outcomes has not been demonstrated.

There is a need to document research and learning on the design and implementation of client-centred approaches and their impact on health and provider outcomes. As well, we are keen to build on the work that MSI has done in this area to develop and test approaches to efficiently scale-up client-centred approaches within the public sector, as well as demonstrate the relative costs and benefits of client-centred care.

Research and learning objectives

1. How does delivery of client-centred care (centred on provider engagement and client satisfaction) impact reproductive health outcomes, such as increased contraceptive continuation, reduced unintended pregnancy, avoidance of reproductive and obstetric violence?

2. How can we effectively measure client-centred care within reproductive health programmes and ensure these efforts lead to sustained improvements in quality, client satisfaction and staff engagement?

3. How can social accountability mechanisms drive improvements in quality and the delivery of client-centred care, including through client involvement in quality assurance, community scorecards and client feedback mechanisms?

4. What approaches and interventions work to scale delivery of client-centred reproductive health services across the health sector including public, private and NGO-run facilities?

5. What is the cost-effectiveness of a client-centred care intervention within reproductive health care in relation to the impact on quality of care, client and staff satisfaction?

07: How can social and behaviour change communication (SBCC) successfully address social norms and increase reproductive autonomy?

Purposes

- Programmatic Improvement
- Impact Evaluation
- Metric Development

SRHR focus area(s)

- Abortion
- Contraception

What we know

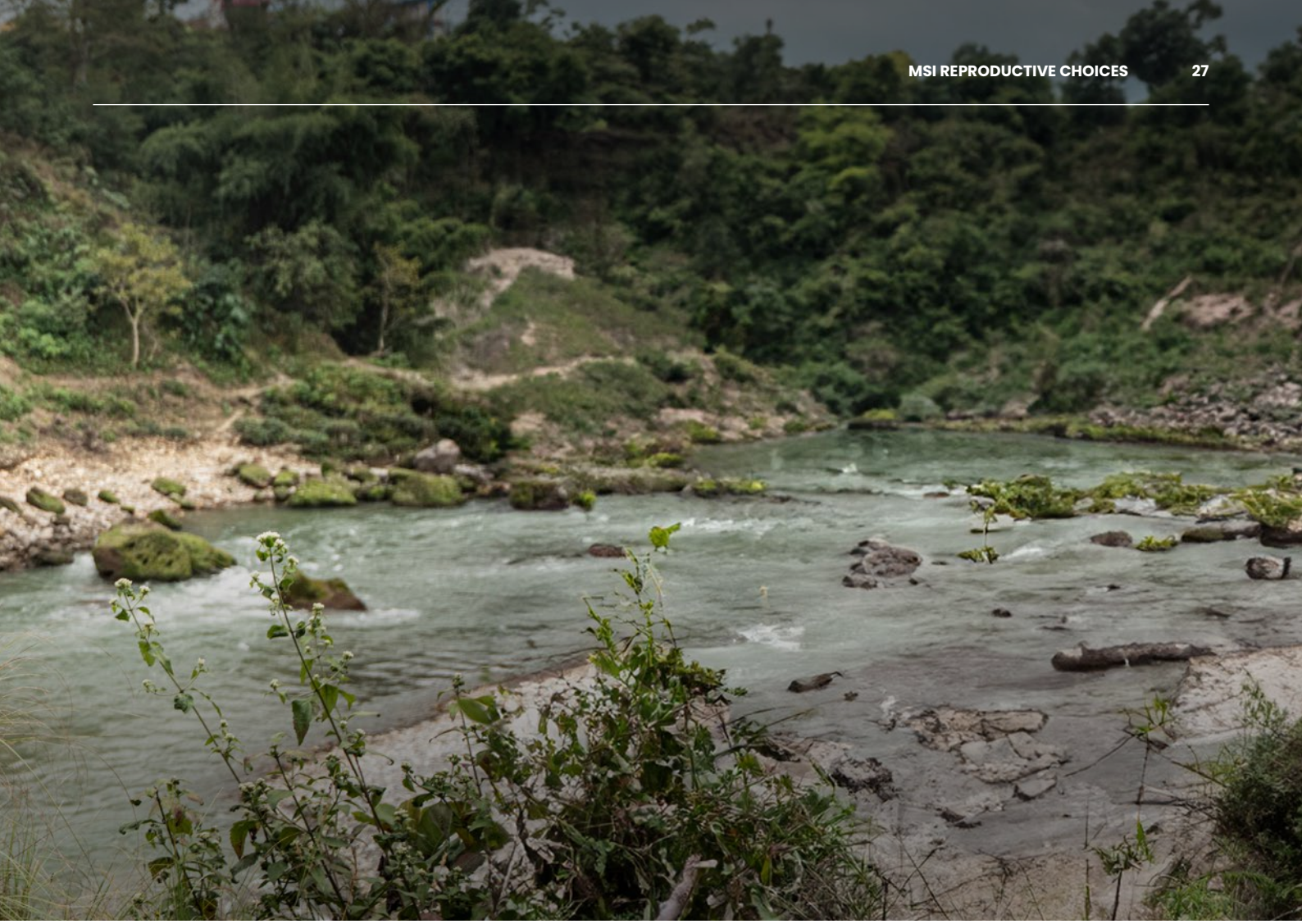
A large body of evidence demonstrates the utility of social and behaviour change communication (SBCC) as a 'high impact' practice for its positive impact on family planning outcomes[18].

These include activities to promote the health, social and economic benefits of family planning and healthy birth spacing, activities to influence gender norms and empower women, their partners and communities to value reproductive choice (including work to address abortion-related stigma), and educational activities to increase awareness of service availability and options available to women and girls. Modelling suggests SBCC has a potential role in increasing national contraceptive prevalence[19].

Demonstrated strategies include the use of mass media (including social media) for education and social norms change; the use of community group engagement for empowerment and education; and the use of digital health technologies for education, service engagement and referral[20].

Despite the positive evidence, activities remain small-scale, usually donor-funded, and inadequately integrated into national family planning or health promotion programmes. There are growing calls within the wider health sector to address verticalised programming approaches and ensure that SBCC for family planning is adequately integrated with other health promotion activities, both to reduce duplication of effort and to ensure efficient use of resources. The effectiveness of this integrated and inter-sectoral approach to SBCC, for example family planning combined with nutrition or water and sanitation programmes, remains unknown[21].

Testing these integrated approaches is imperative to ensure the effectiveness of SBCC for family planning is not reduced. Meanwhile, approaches to address social norms around abortion, including abortion stigma, remain understudied in many countries.



While values clarification and attitude transformation (VCAT) interventions have been shown to be effective at addressing stigma among health providers, there is now an increasing need to assess how to influence social norms on abortion in communities, in particular in contexts where access to abortion products and services are being liberalised, yet where stigma presents a persistent barrier to uptake of safe services.

Why it matters

MSI is implementing a wide range of SBCC interventions to promote positive social and gender norms around reproduction, and create awareness on the health and social benefits of family planning, and on addressing abortion-related stigma and increase awareness to care. We are keen to build an evidence base that identifies and documents effective approaches to doing this work with a particular focus on understanding which strategies are transformative from a gender equity and social inclusion lens. Moreover, funding for SBCC activities remains inadequate, in particular in the context of rapidly growing young populations.

MSI is keen to understand the relative cost-effectiveness of different approaches and their impacts on social norms change to ensure the most cost-effective use of donor resources.

Research and learning objectives

1. How do we effectively monitor and measure social norms programming around SRHR, both in terms of short-term impact on service use outcomes as well as long-term changes in social norms, with a focus on different population groups (e.g. urban, rural, adolescents, men)?

2. What are the opportunities for intersectoral SBCC (including the integration of reproductive health with nutrition and WASH) and what impact do these approaches have on contraceptive access and broader development outcomes? What are effective approaches to influence community social norms around abortion and to reduce abortion-related stigma in communities?

3. What are effective approaches and strategies to strengthen the capacity of the public sector to deliver effective SBCC around contraception and abortion?

08: What service delivery models and approaches work to achieve equitable and inclusive reproductive healthcare that meets the needs of adolescents, youth, and persons living with disabilities?

Purposes

- Programmatic Improvement
- Advocacy
- Metric Development

SRHR focus area(s)

- Abortion
- Contraception

What we know

Achieving equitable access to reproductive healthcare is at the core of Universal Health Coverage. While there has been some progress in reducing inequity in accessing and using services there remain severe challenges[22]. Groups suffering from inequity or discrimination include adolescents, those living in rural areas or severe poverty and those with particular vulnerabilities, including people living with disabilities who experience some of the greatest health inequities[23,24]. They are often particularly underserved and neglected by sexual and reproductive services. They have diverse needs, which are often invisible, and many of the barriers they face are rooted in inequalities and power dynamics related to social identity. A growing body of evidence has documented approaches that can tackle some of these inequities. Approaches to reach adolescents include adolescent-friendly health services, social and behaviour change interventions, and social marketing combined with pharmacy distribution to allow access outside of maternal and child health clinics.

There are still many areas of an equitable programming approach that require further programmatic attention and evidence. Evidence on effective strategies to reach adolescents often considers this group as homogeneous. Further evidence is needed to consider how to adapt strategies that effectively reach adolescents in different contexts and considers their marital, education and employment status, as well as geographic location (rural vs urban) and age.

Why it matters

MSI's **ten-year organisational strategy** articulates an ambition to "leave no-one behind" as one of its three core pillars of action. Given constraints on health systems, programming is not always able to adapt to address the needs of different groups such as adolescents or persons living with disabilities, groups that often get left behind and suffer the negative outcomes of coverage inequities, including unintended pregnancies, recourse to unsafe abortions and maternal morbidity and mortality.

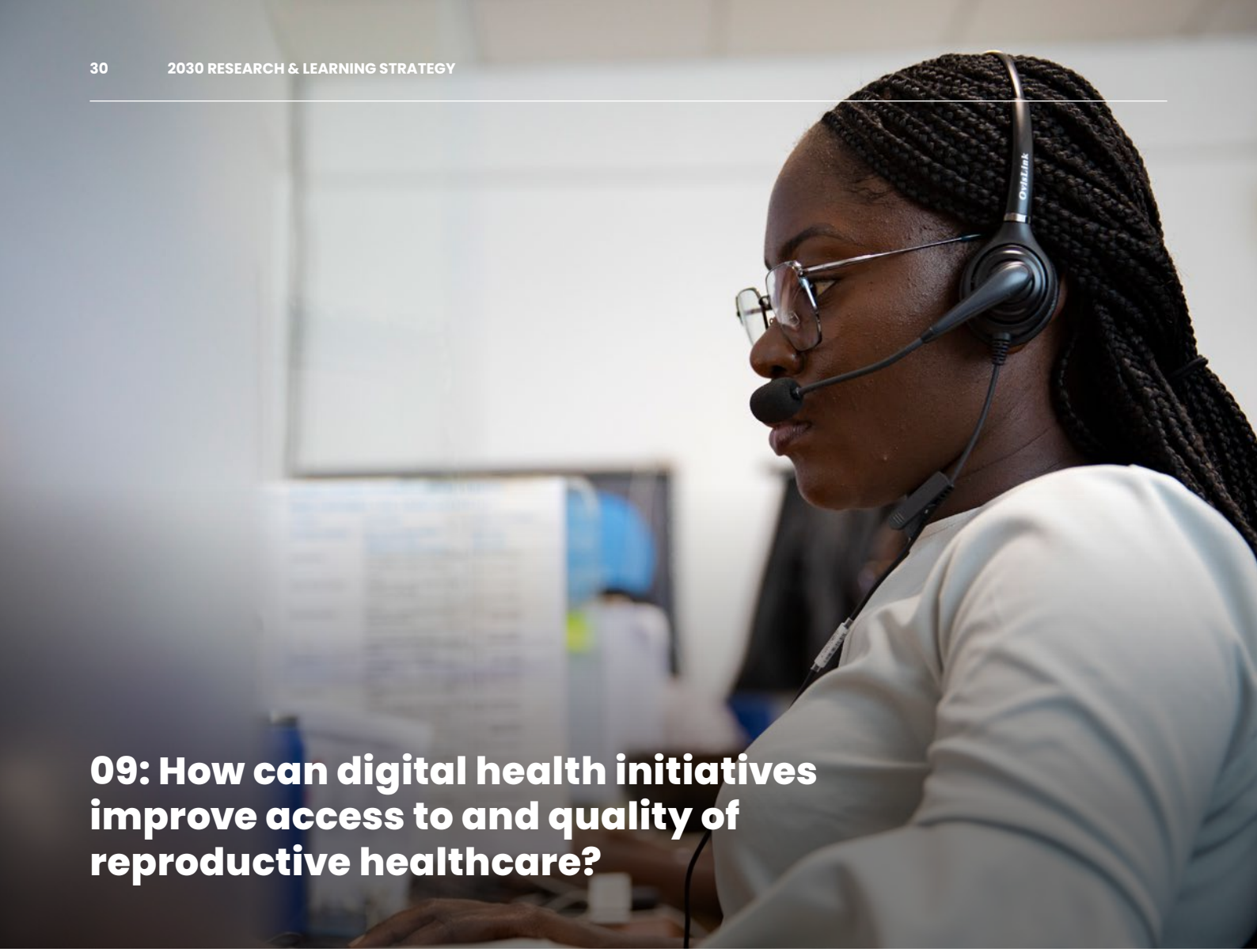
MSI's adolescent strategy recognises that serving adolescents is a core part of the organisation's mission and serves as a guide to help MSI teams, services, and programming be more responsive to the individual needs of adolescent clients. Since the inception of the strategy, MSI has had success in reaching adolescents, driven by engagement with both rural and urban youth, outreach and partnership with schools, and development of adolescent-friendly service approaches.

Over the last six years MSI has nearly tripled the proportion of adolescents accessing its services from 6% to nearly 17% in 2023 (which is about double the national benchmark in most countries).

MSI is keen to build on its successes in delivering services to adolescents to continue to ensure access to this group, while also ensuring that services provided are tailored to be inclusive and responsive to their needs. People living with a disability are also a priority population in much of MSI's gender equality and social inclusion (GESI) programming and we are keen to generate reliable evidence to inform effective strategies in reaching people living with disabilities with inclusive, accessible, and high-quality care.

Research and learning objectives

1. What strategies work to deliver SRHR information and services that are responsive to adolescent needs and how might they be adapted to effectively consider the needs and preferences of adolescents in different contexts?
2. What are the impacts of interventions with community influencers and gatekeepers for adolescent SRH decisions on improving adolescents' access to SRH services?
3. Are there feasible, acceptable, and effective methods of collecting routine data on the disability status of clients accessing SRH services?
4. What strategies are effective in reducing stigma related to people with disabilities' SRHR?



09: How can digital health initiatives improve access to and quality of reproductive healthcare?

Purposes

Programmatic Improvement

Impact Evaluation

SRHR focus area(s)

Abortion

Contraception

What we know

Digital health has grown exponentially over the past decade alongside advances in technology, including rapid growth in mobile phone ownership and internet access as well as advances in health data systems. It is estimated that by 2025, 73% of the world's population will have mobile phone access and 64% will have a mobile internet connection[25].

Future advances will be most dramatic in sub-Saharan Africa, where mobile internet connectivity is currently 28%, and the coverage gap 19%[26].

Digital health is recommended as a 'high impact practice' in family planning, including for use within health and logistics management information systems (HMIS/LMIS), for use in service delivery to support information provision, counselling and effective referral, for remote supportive supervision, and for supporting social and behaviour change communication (SBCC) interventions[27]. There is evidence that using digital tools and applications in delivering maternal and child health services (including for reproductive health) increases efficiency of data collection, improves quality of care, and increases communication between health workers and their managers and supervisors[28].

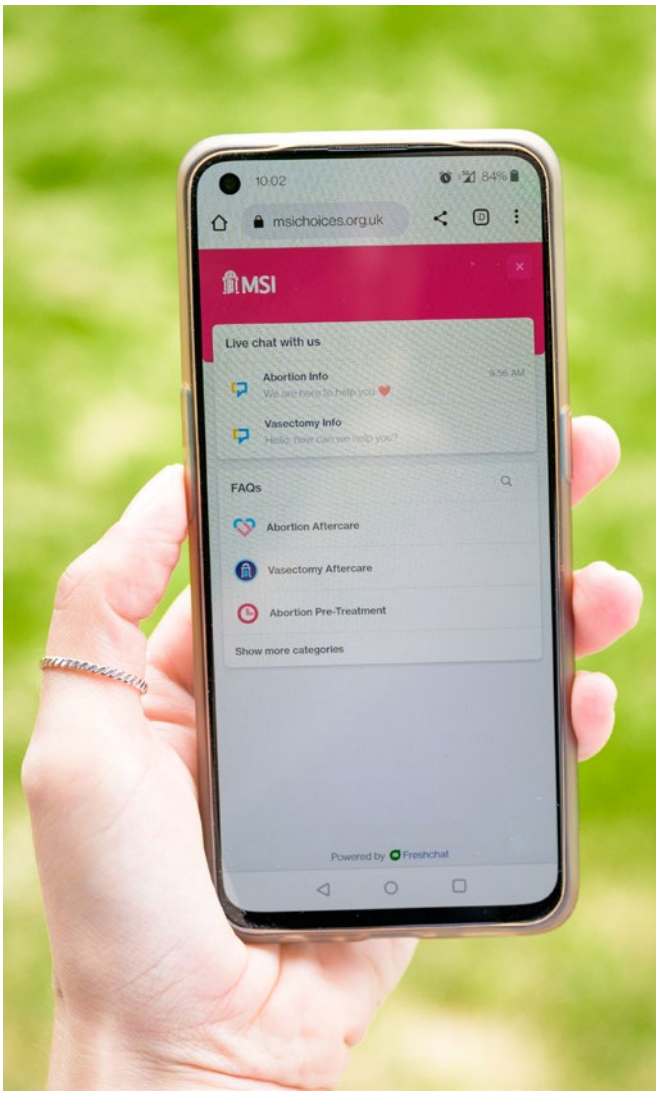
There is some evidence that suggests very modest impacts of digital interventions on increasing contraceptive uptake, or no effects[29,30]. However, the evidence on its impacts on client behaviours and outcomes and consequent benefits of investment in digital are not so clear. There is a call for high quality trials and cost-effectiveness analyses to reliably ascertain the effects and relative benefits of targeted client communication delivered by mobile devices, and the integration of bespoke solutions into a whole-systems strengthening approach[31].

Why it matters

MSI's internal assessments of digital tools and systems demonstrate the potential impact on efficiency, quality and accessibility of services and information. Given the potential scale of digital interventions, and in particular for education and engagement of clients and providers, they are likely to be cost-effective. MSI's **digital strategy** aims to optimise client experience using digital tools and applications to enhance knowledge transfer and increase access to services and products. The strategy seeks to ensure that MSI's teams are equipped with technology to help deliver reproductive choice and health systems where MSI operates and are strengthened through support to digital data systems. MSI's strategy acknowledges that challenges remain, including the ongoing digital divide in many low-income settings where MSI works, the investments needed to build digital infrastructure (including for interoperability of systems), the high set-up costs of digital systems, and the digital capacity required in teams to support them. Regulatory and health financing barriers also impact the feasibility of digital solutions, for example tele-health.

MSI is keen to leverage MSI's digital data systems and HMIS and the contact centre to support the generation of evidence and learnings, including assessment of the impact of digital health interventions on behaviours and health outcomes.

We will work in partnership with others to support the implementation of digital health platforms and innovations in the SRHR field.



Research and learning objectives

1. Can telemedicine increase access to safe abortion services in semi-urban and rural settings in low- and middle-income countries (LMICs)?

2. How can digital tools and approaches for clinical decision support improve the quality of counselling for abortion care and contraception and enhance client involvement in reproductive health decision-making?

3. What are effective digital approaches to increase
   - access to contraception and abortion services?
   - the effectiveness of training and supervision for reproductive health?

4. Do digital channels improve awareness and knowledge of safe self-managed abortion, including available medications, regimens, access points, side-effects and follow-up care options?

5. How can the use of hotlines, contact centres and chatbots impact the client experience and journey in accessing contraception and abortion services?

10: How effective are school-based SRHR education programmes in improving adolescents' knowledge and utilisation of SRHR information and services?

Purposes

- Programmatic Improvement
- Client Perspectives
- Impact Evaluation
- Advocacy

Note: interventions to address the needs of out-of-school adolescents are covered under Priority 8

SRHR focus area(s)

- Contraception

What we know

There is a solid body of evidence demonstrating the effectiveness of well-designed comprehensive sexuality education (CSE) curricula, in particular those that address negative social and gender norms[32]. There is no evidence that CSE increases sexual activity, sexual risk-taking behaviour, or rates of HIV or other STIs. However, there are still challenges around maintaining the quality of CSE when implemented at scale[33], as well as the translation of sexual health knowledge or self-efficacy into physical protection against unintended pregnancy[34]. Bringing outreach workers into schools to deliver SRH SBCC and services has been considered a potentially beneficial strategy in contexts where teachers struggle to deliver CSE themselves[35]. However, there is a dearth of evidence demonstrating how this approach can be implemented effectively, as well as on how effective strategies have been to gain teacher and parent support and buy-in.

There is also a lack of evidence demonstrating the impact of school-based services and SBCC outreach on unintended pregnancy or other health, educational, and social outcomes.

Why it matters

MSI's approach to working with schools in Senegal, in partnership with the Ministry of Education, has demonstrated improvements in condom use (at last sex), HIV prevention knowledge, and increased knowledge and use of contraceptive methods[36].

MSI is keen to do further evaluation to test the scaling of school-based outreach and health-education partnerships in other contexts.

Research and learning objectives

1. Does delivering SRH services via outreach models within or near schools reduce adolescent unintended pregnancies and school drop-out rates? How cost-effective is this model?
2. How does support for comprehensive sexuality education (CSE) and health services in schools enhance quality and outcomes and what is the impact on gender norms and reproductive autonomy?
3. What are effective linkages between SRH outreach services and comprehensive sexuality education (CSE) and health services in schools that will improve SRHR outcomes and gain teacher and parent support buy-in?
4. What strategies are effective in building strong partnerships between SRH service providers and stakeholders in the education sector (e.g., Ministry of Education, school leaders, teachers, and parents)?

11: What approaches work to counter the threat of the anti-rights, anti-gender and anti-choice movements on SRHR programming?

Purposes

Programmatic Improvement

Advocacy

SRHR focus area(s)

Abortion

What we know

Across the world, the anti-rights, anti-gender and anti-choice movements have been increasing their efforts to restrict access to SRHR services, spread misinformation, dismantle agreed international norms and to block or regress progressive legislation, particularly in relation to abortion access. This "opposition" is increasingly more professional, well-coordinated, transnational, and well-funded. Most recently anti-SRHR groups and individuals have been emboldened with the overturning of Roe vs Wade in the USA, demonstrating the effectiveness of long-term anti-choice advocacy on political and health outcomes. The SRHR sector is well-aware of these movements and their motivations but is not yet fully equipped to deal with escalating activity at local and national levels. Anti-choice groups have been increasingly emboldened and vocal, pushing for governments to roll back existing abortion rights and there is increasing political mobilisation across many low- and middle-income countries. Anti-SRHR is enveloped within broader anti-rights lobbying, including against LGBTQI rights, sexuality education rights and gender rights. Communication is increasingly embedded within anti-feminist movements promoting forms of toxic masculinity. A growing body of research has produced insights on mechanisms to tackle disinformation on vaccines and climate change, but there is to-date very limited understanding of either the extent of misinformation and anti-rights lobbying and advocacy activities on SRHR in low- and middle-income countries, or on effective ways to tackle them.

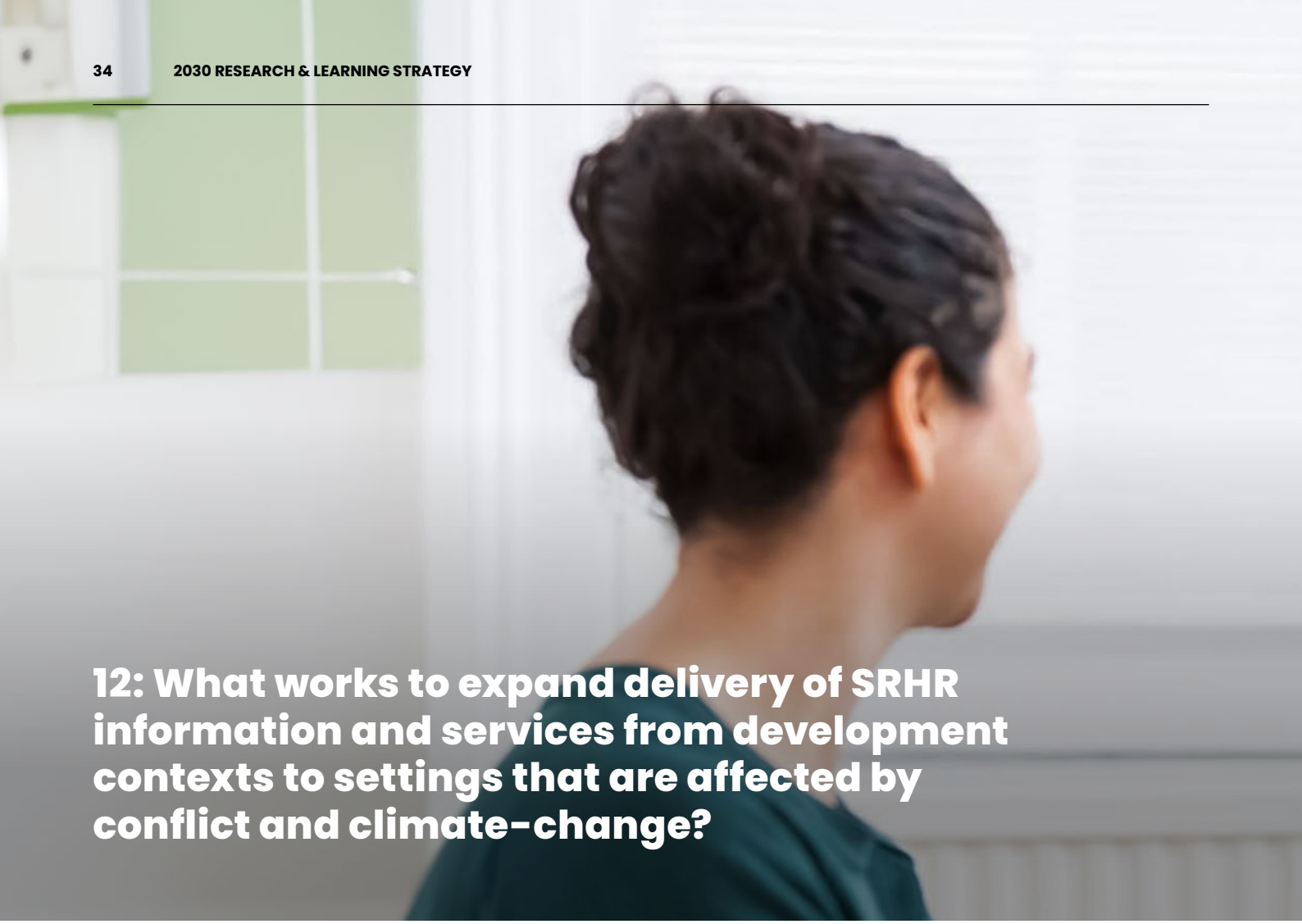
Why it matters

As a leading provider of services and information, MSI's operations are directly impacted by anti-rights and anti-choice groups, individuals, and misinformation. Many MSI country programmes, including Ghana, Mexico, Nepal, Vietnam, Uganda, Kenya, are regularly impacted by both real world and virtual attacks. MSI is keen to understand the extent of, and how anti-choice activity is impacting service delivery to be better equipped to adapt strategies and plans to counter this, along with countering misinformation and knowledge about abortion services.

Research and learning objectives

1 What is the extent to which anti-choice activity, including misinformation and threats to service operators and providers, threatens service delivery in the countries where MSI operates?

2 Are MSI's political engagement strategies (including VCAT) effective at bolstering support for SRHR in the countries where MSI operates?



12: What works to expand delivery of SRHR information and services from development contexts to settings that are affected by conflict and climate-change?

Purposes

- Programmatic Improvement
- Impact Evaluation
- Metric Development

SRHR focus area(s)

- Abortion
- Contraception
- SGBV

What we know

The number of people requiring humanitarian assistance continues to grow every year. In 2023 a record 339 million people needed humanitarian assistance, a substantive increase from the 274 million recorded in early 2022.[37]

There is a growing body of evidence on aspects of SRH provision within fragile and conflict-affected settings (FCAS). This includes evidence on the feasibility of distributing medical abortion and providing contraception, including LARCs[38,39].

Systematic reviews, however, point to important gaps. These include weak evidence on the sustainability and scalability of service delivery strategies, the transferability of SRH interventions from development contexts into humanitarian settings, economic outcomes and cost-effectiveness analysis, and health service delivery mechanisms, including task sharing.

Research priorities include contraceptive service delivery strategies (including for LARCs), adolescent SRH, the integration of sexual and gender-based violence (SGBV) response into SRH, health worker capacity and support mechanisms, the promotion of self-care, and broader abortion provision mechanisms[40,41]. There are also broader questions on how SRH implementers can work more effectively with humanitarian protection actors.

Why it matters

MSI works in several fragile and conflict affected settings, including those contexts of protracted crisis, acute crisis, and districts supporting large numbers of displacement-affected people. MSI's current service delivery approaches centre around the provision of SRHR information and services via mobile outreach teams or through community midwives (MS Ladies). MSI is expanding its service offering in some humanitarian contexts to address SGBV and the provision of psycho-social support in these contexts.

It is also expanding provision of safe abortion services in selected contexts without legal restrictions. MSI is keen to demonstrate effective strategies and models of service delivery among these populations and in particular how organisations can adapt structures set up to deliver services in development contexts to rapidly respond to SRH needs in fragile and conflict and climate-affected settings. We intend to do this through discrete research, as well as operational learning.

We are working to standardise and streamline indicators to capture data on the reach to displacement-affected populations in existing service catchment areas to allow for comparisons across locations and to contribute toward building an evidence base on effective SRH programming.

Research and learning objectives

1. What are effective strategies and programming approaches to deliver contraceptive and abortion services in settings impacted by conflict and climate crisis?
   - What approaches work to integrate SGBV and social support services into SRHR programming into these models?
2. How can SRHR social and behaviour change communication, and service provision be effectively integrated with broader Maternal Newborn Child and Adolescent Health and humanitarian developmental assistance?
3. How do concerns on climate change and climate related displacement affect fertility intentions?
4. In what ways can integrating family planning services into climate adaptation and mitigation strategies enhance community resilience?
5. What are feasible, acceptable, and effective indicators to capture data on the reach to displacement-affected populations?

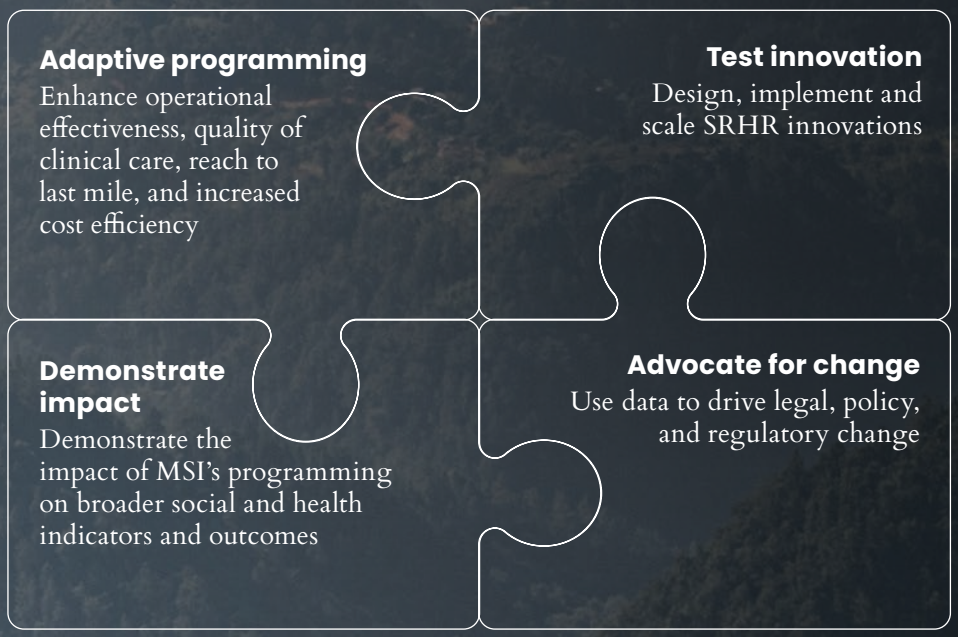
PART 2

BUILDING FOR THE FUTURE: ENHANCING THE FOUNDATIONS OF RESEARCH AND LEARNING

Part 2 articulates the principles that guide MSI's research and learning agenda and defines the building blocks and enablers that will guide how we operationalise the strategy and foster a learning culture across MSI.

Value of research and learning at MSI

Evidence-based programming is at the core of all MSI's work. We are committed to generating evidence to drive programmatic improvements and policy change. Our approach is grounded through the implementation of research and evaluation, routine collection of health services data, and ongoing monitoring and evaluation across all MSI programming. By continual measurement of our work, we can contextualise our impact across a wider ecosystem.



Principles of evidence generation and use at MSI are:

Routine first and nimble

MSI utilises robust management information systems (MIS) that interconnect with financial data systems, yearly client exit interview surveys, and provider engagement data. These standardised data sources enable teams to swiftly monitor and evaluate programme activities, generating immediate insights and knowledge that enable timely responses to implementation challenges.

Research with a purpose

MSI conducts research with a clear policy or health service improvement goal in mind and with a commitment to operationalise research findings. We remain committed to generating and disseminating evidence that will fill evidence gaps and scale best-practices across the SRHR sector, guide operational priorities, and inform decisions around high-impact investment opportunities.

Committed to equity

Committed to leave no one behind and to facilitate access to SRH services for underserved populations, MSI data systems disaggregate all data by age and sex, and social and health indicators, where possible. We continually work to develop or update indicators and measurement methodologies that help disaggregate data to capture the needs, experiences, and perspectives of marginalised and vulnerable groups.

Accountable to clients and providers

MSI's routine data systems include multiple mechanisms to capture client feedback, which helps inform programming and service delivery. We also remain committed to hearing from our staff and providers, especially those offering abortion care, to enable the development of strategies to facilitate provider wellbeing.

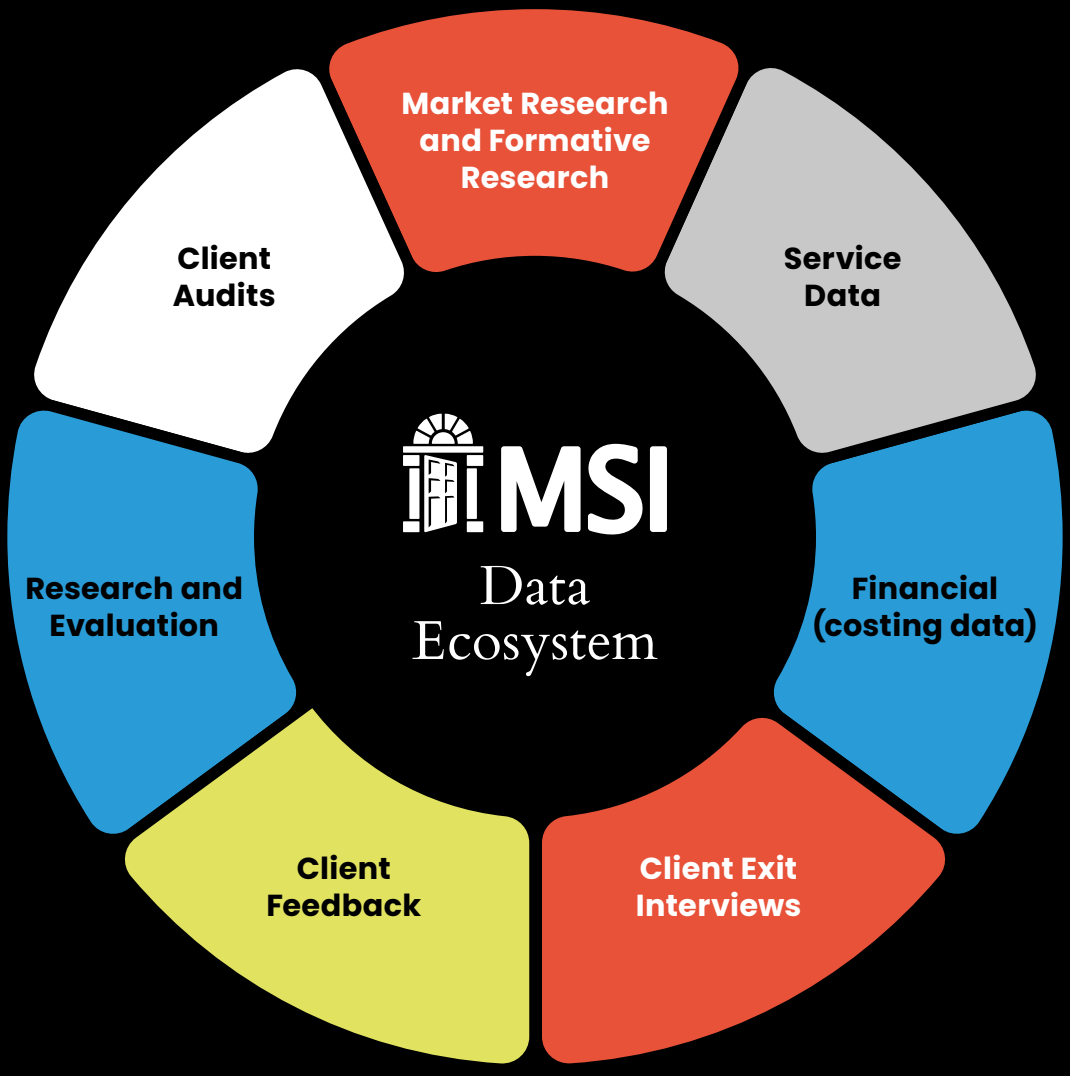
Value for money

Our robust data systems are positioned to collect a wealth of routine data and programme insights that allow us to minimise research costs and offer cost-effective solutions for operational SRHR research.

Grounded in ethics

MSI established an independent Ethics Review Committee (ERC), comprising external SRHR research experts and ethicists, in 2013. The ERC provides oversight on all research conducted at MSI, ensuring our teams adhere to the highest ethical and technical standards.

All research and learning efforts will be generated through strategic research efforts, supported by validated, rigorous research instruments and tools, operations/ implementation learning, supported by standardised metrics and robust performance management systems, and data analytics to inform adaptive programming. MSI will invest in strategic enablers to further develop the infrastructure to support these processes.



Box 3

Our robust data infrastructure (Box 3), composed of multiple data platforms, facilitates data collection across all service points and allows programme teams to aggregate and analyse information in a routine systematic way. In the next decade a key area of focus will be strengthening data collection tools and client feedback mechanisms to collect more routine client feedback data that enables quick programme adaptation. Within our work with the public sector, our goal is to align with existing government HMIS systems and to support the public sector to strengthen the broader 'ecosystem' of SRH data available at the national level. We will also seek to strengthen clinical records to enable high-quality clinical evaluation within MSI services.

As Artificial Intelligence (AI) rapidly evolves, offering solutions that can strengthen multiple functions and processes related to research and learning, MSI will invest in its data and systems infrastructure throughout its global operations to leverage this opportunity to support evidence generation. We will look to integrate AI algorithms to help process client feedback data to enable adaptive programming responses and/or for clinical incident or fraud management. We will also explore enhanced feedback systems at the community level with the intent to increase social accountability mechanisms.

We will use AI to support implementation of rapid surveys and additional qualitative research by the use of speech-to-text processing and translation; and natural language processing models that can support rapid textual analysis of qualitative data.

MSI is focused on using relevant and validated metrics that are essential to ensure that performance is being measured correctly. We will engage with the wider sector to ensure alignment with sector validated metrics and share insights around the development or adaptation of metrics that are specific to MSI programming. This includes measures on health system strengthening, including how effective approaches to public sector support are, ways to identify marginalised and vulnerable groups and measuring reach, and on client-centred care to ensure the relevant aspects of client-centred are being measured and reported.

MSI has invested in the development of Power Bi data dashboards to facilitate with data analysis, data reporting, visualisation, interpretation, forecasting, and reporting. Our efforts to put these data at the fingertips of all our teams and enable access to analytics and data in real time that lends itself to adaptive programme management.

Our teams have developed Impact 2, as part of our commitment to quantifying the impact of our work. Our Impact models allow our teams to estimate increases in mCPR, users reached, contributions to national contraceptive use, and abortion or post-abortion care services nationally. In addition, Impact 2 can be used to estimate the wider health, demographic and economic impacts of these services, including, country level pregnancy and abortion estimates. MSI's Impact investment calculator has been designed to estimate the impact of specified investments made in MSI.

An ongoing priority for MSI is to build research capacity and analytics skills both within, and beyond, its monitoring, evaluation, and research teams.

MSI will work across the partnership to build capacity to communicate data effectively and shape the role of data to inform new proposals, programme design, and ongoing implementation. MSI intends to develop a network of regional 'hubs' bringing together in-country and regional partners, research organisations, academic institutes, design firms, and service organisations working in adjacent sectors (e.g., nutrition, livelihoods, primary health care, or SGBV) to support research and learning and to facilitate cross-country learning. The hubs will be affiliated with advisory groups or partnerships with entrepreneurial groups based in the country or the wider region with expertise in health innovation.

We will focus on sharing research and learning outputs with external and internal audiences to guide programming. Internally, MSI's evidence is regularly disseminated across the 36 country programmes to support the sharing of best practices and to promote evidence-based programming strategies.

This will be achieved through development of technical guidance and resources that communicate evidence-based best practices on SRHR information and programming. MSI has a large community of practice that brings together colleagues around specific workstreams, including thematic areas and research, monitoring and evaluation to create an interactive space that fosters cross-county learning and innovation. Externally, MSI makes efforts to share its evidence through webinars, conferences, evidence briefs (such as the Evidence and Insights Compendium), or scientific reporting in peer-reviewed journals. But more needs to be done. MSI will focus on future external communication of evidence to share insights among national partners working in the SRH sector, through for example presentation at SRH Technical Working Groups, or at national SRH or public health conferences, or through face-to-face technical meetings with the Ministry of Health.

ACRONYMS

AI	Artificial Intelligence
ANC	Antenatal Care
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CLIC	Clinical Level Information Centre
CSE	Comprehensive sexuality education
ERC	Ethics Review Committee
FCAS	Fragile and conflict-affected settings
GESI	Gender Equality and Social Inclusion
HIPs	High Impact Practices
LARCs	Long-acting Reversible Contraception
LMICs	Low- and Middle-income Countries
LMIS/ HMIS	Logistics and Health Management Information Systems
MA	Medical Abortion
MCH	Maternal and Child Health
mCPR	Modern Contraceptive Prevalence Rate
MEL	Monitoring, Evaluation, and Learning
MIS	Management Information Systems
MNCAH	Maternal Newborn Child and Adolescents Health
MNH	Maternal and Newborn Health
MoH	Ministry of Health
NGOs	Non-government Organisations
PAFP	Post-abortion Family Planning
PHC	Primary Health Care
PNC	Post-natal Care
PPFP	Postpartum Family Planning
PSS	Public Sector Strengthening
SBCC	Social and Behaviour Change Communication
SGBV	Sexual and Gender-Based Violence
SRHR	Sexual Reproductive Health and Rights
STI	Sexually Transmitted Infections
UHC	Universal Health Coverage
VCAT	Values Clarification Attitudes Transformation
WASH	Water, Sanitation and Hygiene

CITATIONS

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