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INTERNATIONAL**



## MSI Mobile Outreach Services

Retrospective evaluations from Ethiopia,  
Myanmar, Pakistan, Sierra Leone and Viet Nam.

by Gillian Eva and Thoai D. Ngo

October 2010

# Acronyms

MSI	Marie Stopes International
MSI Myanmar	Marie Stopes International Myanmar
MSI Ethiopia	Marie Stopes International Ethiopia
MSI Viet Nam	Marie Stopes International Viet Nam
MSSL	Marie Stopes Sierra Leone
MSS	Marie Stopes Society (Pakistan)
IUD	Intrauterine device / intrauterine contraceptive device
LAPM	Long-acting and permanent contraceptive methods
DHS	Demographic Health Survey
CPR	Contraceptive Prevalence Rate
TFR	Total Fertility Rate

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# Executive Summary

Over the last two decades, MSI has pioneered innovative approaches to reaching men and women with high quality contraceptive services. A promising model which reaches areas where traditional health services cannot reach is the use of mobile outreach health teams. The MSI outreach model generally consists of a team of nurses, healthcare assistants, counselors and a driver visiting rural, hard-to-reach areas and providing a range of high quality contraceptive services. In 2009, MSI provided services to over 1,200,000 men and women through its outreach services.

To ensure that MSI mobile outreach services are consistently providing high quality services for poor women living in rural settings, we conducted a retrospective cohort study to measure:

- the demographic characteristics of women attending outreach
- their satisfaction levels
- their level of knowledge of removal options
- reasons for discontinuation
- the availability of follow-up services.

This outreach evaluation took place in April 2010 across five MSI mobile outreach programmes (Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam) focusing on women who had IUDs and implants fitted between March 2008 and September 2009.

The ultimate aim of this report is to provide information to programmes on the type of women served through outreach and whether or not they are providing a quality service, in particular with regards to the counselling provided and availability of follow-up mechanisms in case of complications or adverse side effects or for removal.

A total of 4,273 women were successfully re-contacted across the five countries (n=995 implants; n=3,278 IUDs). The distribution for IUD and implant adoption among the five countries was as follows: Ethiopia 562 implants; Sierra Leone 433 implants and 307 IUDs; Myanmar 1,332 IUDs; Pakistan 639 IUDs; and Viet Nam 1,000 IUDs.

The **demographic information** of the women receiving services at outreach demonstrated that MSI mobile outreach programmes are reaching poor women and the underserved, who have the highest unmet need for family planning services. Most women were young and un-educated and had previously been using no method of contraception.

A high percentage of women were **satisfied** with the whole experience and reported that they would reuse the services. At least 80% of all women in all five programmes would recommend the service to a friend (and in some cases nearing 100%).

**Discontinuation** rates were generally low compared with estimates from other programmes (2.3-20.9% for IUDs, 5.7-6.2% for implants). The top three **reasons for discontinuation** were: experience of side effects; expulsion; and the desire to become pregnant. The vast majority of women who had their IUD/implant removed **switched** to either no method, a short-term family planning method or a traditional method (85.6-100%).

Most women knew when and where the IUD/implant should be removed, although this evaluation does highlight some countries in which programmatic improvements need to be made to increase the **levels of knowledge**.

A high proportion of respondents reported experiencing **side effects** (an average of 32% across all countries), of whom between a quarter and a half sought **medical assistance**. The

majority of these women had no problem finding medical assistance when needed (range: 73.2-99.6%). However, there is a need for action in several countries to address the high proportion of women who found it difficult to find medical assistance (26.8% in Ethiopia and an average of 20.1% for IUDs and implants combined in Sierra Leone).

The vast majority (>94%) of women who had had their IUD/implant removed had no problem **accessing the removal service** in Myanmar, Pakistan and Viet Nam. However, in Ethiopia and Sierra Leone a high proportion of women found it difficult and/or had to travel long distances for their removal.

**In conclusion**, this evaluation has been useful in demonstrating the generally high quality of outreach services and follow-up in five MSI programmes in Asia and Africa. Overall, the programmes are reaching the target women and providing them with the necessary information about when/where to go for removal or medical

assistance. Client satisfaction levels are high with over 80% of women in all countries reporting that they would recommend MSI to a friend or relative.

In spite of the successes demonstrated in this report, MSI has further to go in some areas to ensure consistent high quality family planning service provision through outreach. Areas in need of further investigation and immediate action include unacceptably high percentages of women reporting difficulty seeking medical assistance or a removal service in Sierra Leone and Ethiopia – perhaps because of a lack of quality health care providers in these countries. In Sierra Leone and Viet Nam the proportion of women who do not know when to remove their IUD needs to be reduced. Finally, the high discontinuation rate in Myanmar needs to be better understood and addressed.



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# Chapter 1: Introduction



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The last decade has seen increased contraceptive use in many countries. However, unmet need for modern contraception remains unacceptably high, with over 200 million women in developing countries who do not want to get pregnant having no access to family planning<sup>1-4</sup>. This unmet need is mostly due to a lack of access to services, in particular to long-acting and permanent methods (LAPM) as well as a lack of demand. This is despite increased investment into improving family planning awareness, knowledge and access. Women in rural settings in particular find it difficult to access family planning services. While short-term methods can be more easily distributed in rural areas, the clinical requirements of LAPM make them harder to provide in areas where health facilities are lacking<sup>5</sup>.

In order to increase access and to reach as many women as possible, Marie Stopes International

(MSI) has three main service delivery channels: Marie Stopes centres; mobile outreach programmes; and Social Franchises. The rural mobile outreach programmes, which began in the 1990s, are particularly designed to target poor, underserved, hard-to-reach women who have limited access to formal health facilities and high unmet need for family planning. Outreach programmes enable clinical health care to be brought to communities who would otherwise have little or no access to quality family planning services.

The MSI outreach model attempts to address the issues of both access and demand by providing affordable (or free), high-quality services to hard-to-reach populations, in addition to conducting sensitisation and demand-generation in advance of outreach visits, often with assistance from community health workers. In most MSI

programmes the mobile outreach teams make use of existing public health clinics or hospitals but in some cases they use other facilities such as schools. Where no facilities are available outreach teams work from a tent or a van. The frequency with which outreach teams return to certain locations as well as the duration of each visit will depend on the level of demand.

The general MSI mobile outreach team comprises of five individuals: two nurses, a sexual and reproductive health counsellor, one healthcare assistant, and one driver/nurse aid, but this varies by country. To ensure that women are given adequate care in outreach settings, MSI outreach programmes across the 43 countries in which MSI works are expected to implement high quality clinical standards as well as rigorous follow-up systems that are accessible to women who wish to seek medical advice post-procedure. According to MSI clinical standards, women should be given appropriate pre-and-post procedure counselling on how to deal with side-effects, when to come back for a follow-up visit, and where and how to seek medical advice when needed.

MSI outreach programmes provide the full range of contraceptive methods. In many cases, the government partner where outreach is taking place already offers short term methods and therefore MSI complements this service provision by focusing on unavailable methods (usually long acting and permanent contraceptive methods - LAPMs). Given this partnership, the majority of the services provided through outreach are LAPMs, that is, family planning methods that provide effective contraception for an extended period of time. Methods including intrauterine devices (IUD) and implants have a proven record of long-term effectiveness, convenience, cost-effectiveness, suitability for a wide variety of women, and high user satisfaction<sup>6,7</sup>.

Evidence has shown that family planning outreach can cost-effectively reduce fertility rates and increase contraceptive prevalence rate<sup>8-10</sup>. Furthermore, it can deliver high volumes of contraception in rural areas<sup>11</sup>. A study of women who received IUDs at an MSI Philippines outreach site found that 93% still had their IUD 24 months after insertion<sup>12</sup>, showing that services provided at outreach can achieve high continuation rates. A follow-up study of male circumcision provided at outreach sites in MSI Kenya found a complication

rate of just 1.3%, demonstrating that safe and high quality services can be provided at outreach<sup>13</sup>.

In 2009, MSI delivered a total of 1,733,897 LAPMs in 43 countries, of which 871,822 were IUDs, 509,338 were tubal ligations, 204,467 were implants and 148,270 were vasectomies. The majority (74%) of these procedures were delivered through MSI mobile outreach settings.

MSI ensures it is providing high quality services through each of its service delivery channels through a wide range of measures, including providing clinical standards guidelines and performing clinical audits. Since outreach mobile services take place in rural settings, an additional emphasis has been put on clinical quality, particularly implementing a sufficient follow-up system for women receiving services at outreach sites. However, to date MSI has lacked evidence (with the exception of the Philippines<sup>12</sup>) to show whether or not adequate follow-up mechanisms are available, including if women want to have an IUD/implant removed or experience problematic side effects.

In order to ensure that MSI outreach mobile services provide consistent high quality services for women living in rural settings, we conducted a retrospective cohort study to measure the levels of satisfaction; the availability of follow-up mechanisms in case of problems or for removal and; where applicable, reasons for discontinuation. This outreach evaluation took place in five MSI mobile outreach programmes: Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam. This report will focus on evaluating women who had either IUDs or implants fitted between March 2008 and September 2009.

The ultimate aim of this report is to provide information to programmes on the type of women they are reaching through outreach and whether or not they are providing a quality service, in particular with regards to the counselling provided and availability of follow-up mechanisms in case of problems or for removal.

# 1.1 Reproductive health information in five countries

According to the most recent Demographic Health Surveys (DHS) from the five countries, there is a high unmet need for family planning indicated by the low contraceptive prevalence rate (CPR) (<22%, with the exception of Viet Nam). As expected, there is high total fertility rate (TFR) in Ethiopia, Pakistan and Sierra Leone (there are no data available for Myanmar). LAPMs prevalence is extremely low in most countries, except for IUDs in Viet Nam (no data available for Myanmar). (Table 1)

## 1.2 Aims and objectives

The overall aims of this report are to assess the type of women coming for services at outreach sites and the overall quality of service provided, including quality of counselling and availability of follow-up mechanisms in case of problems or for removal.

The key objectives are to answer the following research questions:

### A. Are we reaching the under-served?

1. What was the age and education level of women seen at outreach?

2. What was women's contraception use prior to IUD/implant insertion (i.e. are they first-time users of long-term methods)?
3. How did women find out about the MSI outreach service?

### B. Are we providing good quality services, including where women need follow-up?

1. Overall satisfaction
  - a. Were women satisfied with the overall service they received?
2. Quality of counselling
  - a. What proportion of women had their IUD/implant removed and why?
  - b. What were the switching behaviours for women having their IUD/implant removed?
  - c. What is the level of knowledge about when and where to go for removals among continuers?
3. Availability of follow-up mechanisms
  - a. What are the side effects experienced and are the follow-up mechanisms for women adequate in case medical assistance is required?
  - b. How accessible are removal services for women using outreach services (location, cost, distance, 'ease')?

Table 1: Key reproductive health information

Country	DHS Year	TFR	CPR <sup>i</sup>	IUD prevalence <sup>ii</sup>	Implant prevalence <sup>ii</sup>	MMR (Hogan et al 2010)
Ethiopia	2005	5.4	13.9	0.2	0.2	590 [358–932]
Myanmar	--	--	--	--	--	219 [87–495]
Pakistan	2006-2007	4.1	21.7	2.3	0.1	376 [230–587]
Sierra Leone	2008	5.1	6.7	0.2	--	1033 [635–1627]
Viet Nam	2002	1.9	56.7	37.7	--	64 [42–95]

**Notes:** -- Data not available  
 i All married women (aged 15-49) currently using any modern method  
 ii All married women (aged 15-49) currently using IUD/Implant

## Chapter 2: Methodology

This retrospective follow-up study was conducted in April 2010. Researchers attempted to contact all women who had an IUD or implant inserted during a specified time period (within the overall time frame of March 2008-September 2009) at outreach sites in Ethiopia, Myanmar, Pakistan, Sierra Leone and Viet Nam. These countries were selected because they represent a range of MSI programmes with high numbers of IUD and/or implant provision at outreach sites.

A multi-stage sampling approach was used. First, a number of districts, outreach sites or outreach teams were selected (depending on the outreach model). Sites or teams were selected with high client flow and, where possible, were not confined to one geographic location. All women from those sites or teams who had had their implant/IUD inserted within a specified timeframe were then

selected. The timeframe was selected to be at least six months prior to the data collection (so that sufficient time had passed to capture early discontinuation), but no longer than two years prior (to increase likelihood of making contact). Based on information from client records, these women were re-contacted and asked to take part in a face-to-face survey. Data collection teams were asked to make every effort to contact all women but, given the lack of quality contact information for many and the short data collection period, it was expected that there would be significant non-contact rates. The questionnaire included questions about women's satisfaction with the implant/IUD service, side-effects they had experienced, reasons for discontinuation (if applicable) and ease of finding medical advice/treatment if needed. The study design specific to each country is detailed in Table 2.

**Table 2: Detailed methodology for each country**

Country	Period from which women were selected	Sampling Strategy			Total number of women contacted for interview	Total women interviewed	Co-operation rate (%)
		Stage 1	Stage 2	Stage 3			
Sierra Leone	Jul-Sep 2009	6 sites	All women		392	IUD: 307	78.3
					506	Implant: 433	85.6
Ethiopia	Feb-Mar 2009	3 outreach teams	10 sites	All women	643	Implant: 562	87.4
Pakistan	Jul-Aug 2009	6 districts	All women		681	IUD: 639	93.8
Viet Nam	Mar-May 2009	5 sites	All women		1000	IUD: 1000	--*
Myanmar	Mar 2008-Sep 2009	5 sites	All women		1459	IUD: 1332	91.3

**Notes:** The sampling stages depended on the outreach model in each country. Some are organised by visits to regular sites, others by outreach teams, others by district.

\* = cooperation rate cannot be calculated for Viet Nam. See below.

There are some limitations with this methodology. The selection of outreach sites was based primarily on high client flow. A random selection of all women who had IUDs/implants at all outreach sites would have been preferred but would have been very expensive and time-consuming, especially in countries with large distances between sites. With the exception of Viet Nam, all countries attempted to contact all women who had an IUD or implant inserted during the specified timeframe at the specified sites. In Viet Nam, the sampling strategy was for five sites with a target sample size of 1,000 women who had insertions

between March and May 2009\*.

Furthermore, the time-frames selected differed across countries, primarily due to the feasibility of contacting women. Because of the different time-frames selected, comparisons across countries should be treated with caution (in particular discontinuation prevalence). Due to the retrospective study design, there is a higher chance of re-call bias, which is to say women may report inaccurately based on their memory of past events.



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# Chapter 3: Findings

## 3.1 Are we reaching the under-served?

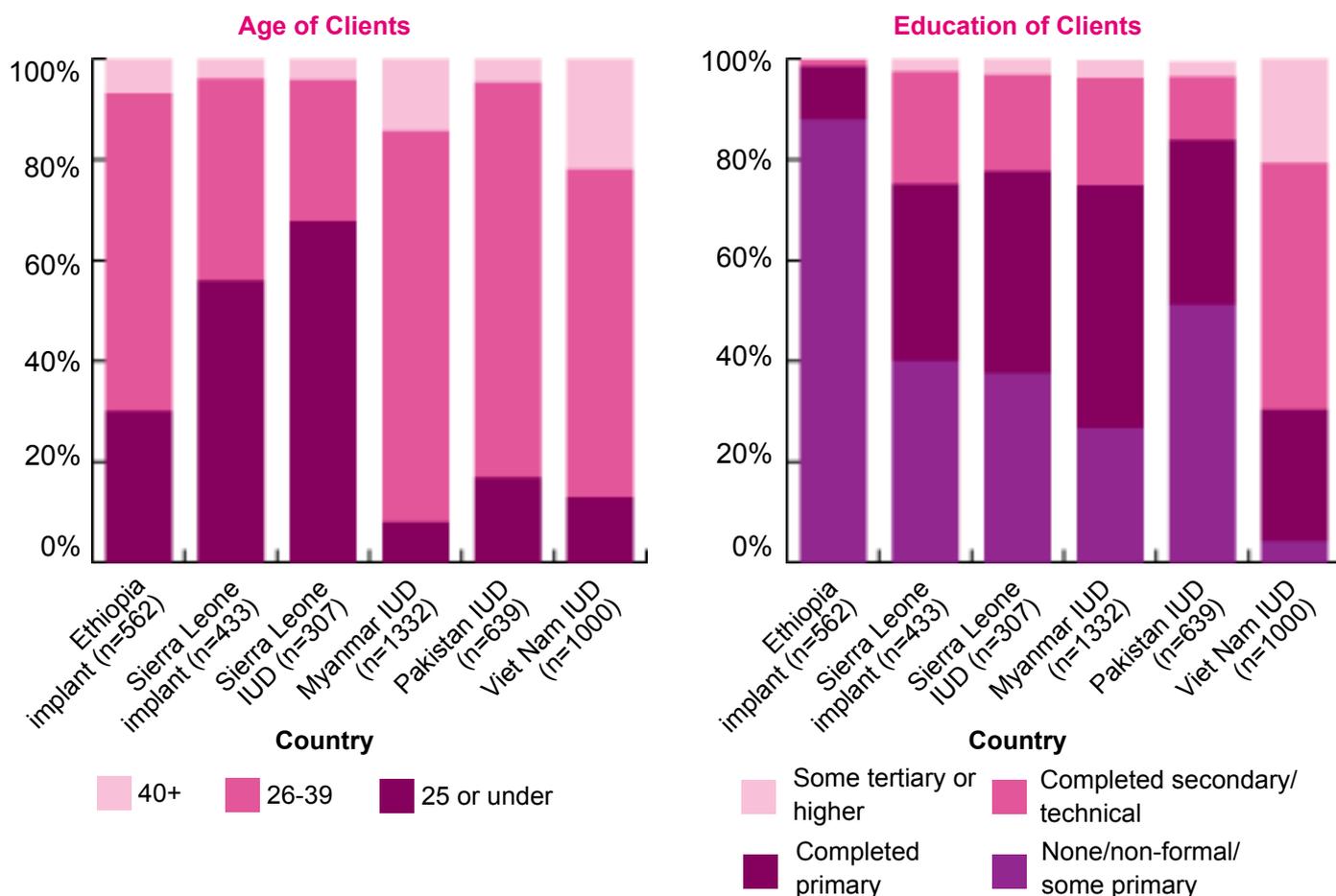
### A. Demographic characteristics of women seen at outreach sites

A total of 4,273 women were successfully re-contacted across the five countries (n=995 implants; n=3278 IUDs). The distribution for IUD and implant adoption among the five countries was as follows: Ethiopia 562 implants; Sierra Leone 433 implants and 307 IUDs; Myanmar 1332 IUDs; Pakistan 639 IUDs; and Viet Nam 1000 IUDs.

The outreach programme in Sierra Leone has been successful in providing a complementary methods mix service including roughly equal provision of IUDs (41.5%) and implants (58.5%).

Figure 1 shows that MSI outreach programmes in different settings are serving women across the reproductive age spectrum (15-49 years). In Sierra Leone most women were 25 or under. This is true for both IUDs (67.8%) and implants (55.9%). In all other countries, the majority of women were aged between 26 and 39 (63-78.4%).

Figure 1: Age and education distribution among women who received an IUD or implant



Among the 3,273 women from four countries (Ethiopia, Sierra Leone, Myanmar and Pakistan), about 80% had no education or had only completed primary education. In Ethiopia, Sierra Leone, Myanmar and Pakistan, 88%, 39%, 27%, and 51% had no formal education, respectively (Figure 1). In Viet Nam women were more highly educated with just 30% having primary education or less<sup>i</sup>.

## B. Contraceptive use prior to IUD/implant insertion

Table 3 shows that most women who came to obtain IUDs/implants from MSI mobile outreach services in the five countries previously used either no form of contraception/traditional methods (17.7-75.6%) or short-term methods such as the pills or injections (15.6-81.3%). In all countries less than 3% had previously been using a long-term method (implant or IUD).

## C. Information Channels for Outreach Facilities

Figure 2 shows the most common ways in which women found out about the outreach services. In some cases the channels of communication are directly from MSI, in others they are from local stakeholders. It is expected that different communication mechanisms will target different women. For example, television and newspaper campaigns may be less likely to reach the poorest women.

Community health workers (or community based motivators) were an important source of information for outreach facilities for Ethiopia, Pakistan and Viet Nam. For Myanmar, MSI staff and word-of-mouth (via neighbours, friends and relatives) served as an effective communication channel. Community mobilization using loudspeakers and radio were also useful in Sierra Leone and Viet Nam. These are all methods aimed at targeting poor, rural, and hard-to-reach women. Referrals from friends, relatives or satisfied clients were particularly important in Sierra Leone and Myanmar.

## 3.2 Are we providing consistently high quality services?

### A. Client satisfaction

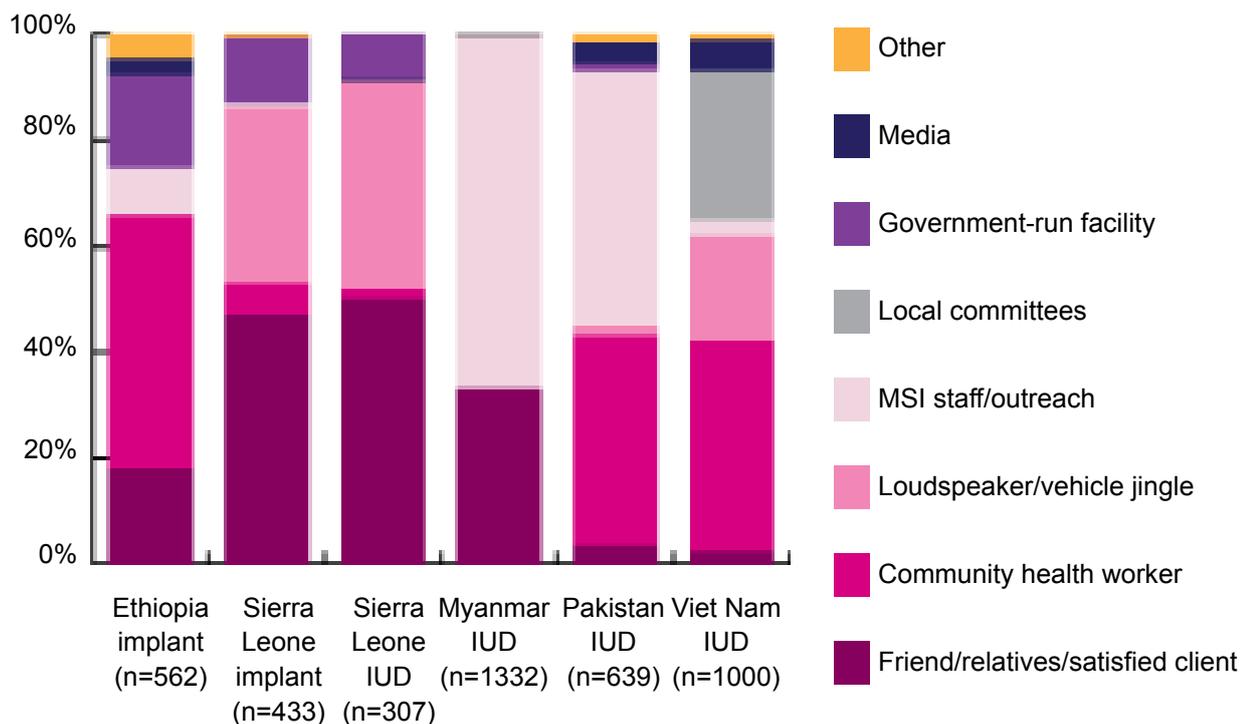
Overall, client satisfaction was very high in all five countries (Figure 3). The vast majority of women reported that they were satisfied with the whole mobile outreach service experience (range: 72.5-93%) and that they would re-use the services in the future (range: 66.7-98.2%). At least 78% of all women in all five programmes would recommend the service to a friend, and in some countries nearing 100%. “Recommending to a friend” is a good proxy for measuring client satisfaction (as the client would not recommend if they did not think highly of the service).

Table 3: Contraception use prior to IUD/implant insertion

Contraception use prior to IUD/implant (%)	Implant		IUD			
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam
None	17.7	62.4	75.6	25.1	52.9	44.9
Pills	7.4	10.9	6.5	24.5	10.4	16
Condoms	0	0.2	1	0.2	15	13.6
Injection	73.9	19.6	8.1	49.3	13.9	2
IUD/implant	0.9	2.3	0	0.6	1.3	0.1
Fertility awareness methods	0	0	0	0	6.6	23.4
Other	0	4.7	8.8	0.2	0	0
<b>Total (n)</b>	<b>562</b>	<b>433</b>	<b>307</b>	<b>1332</b>	<b>635</b>	<b>1000</b>

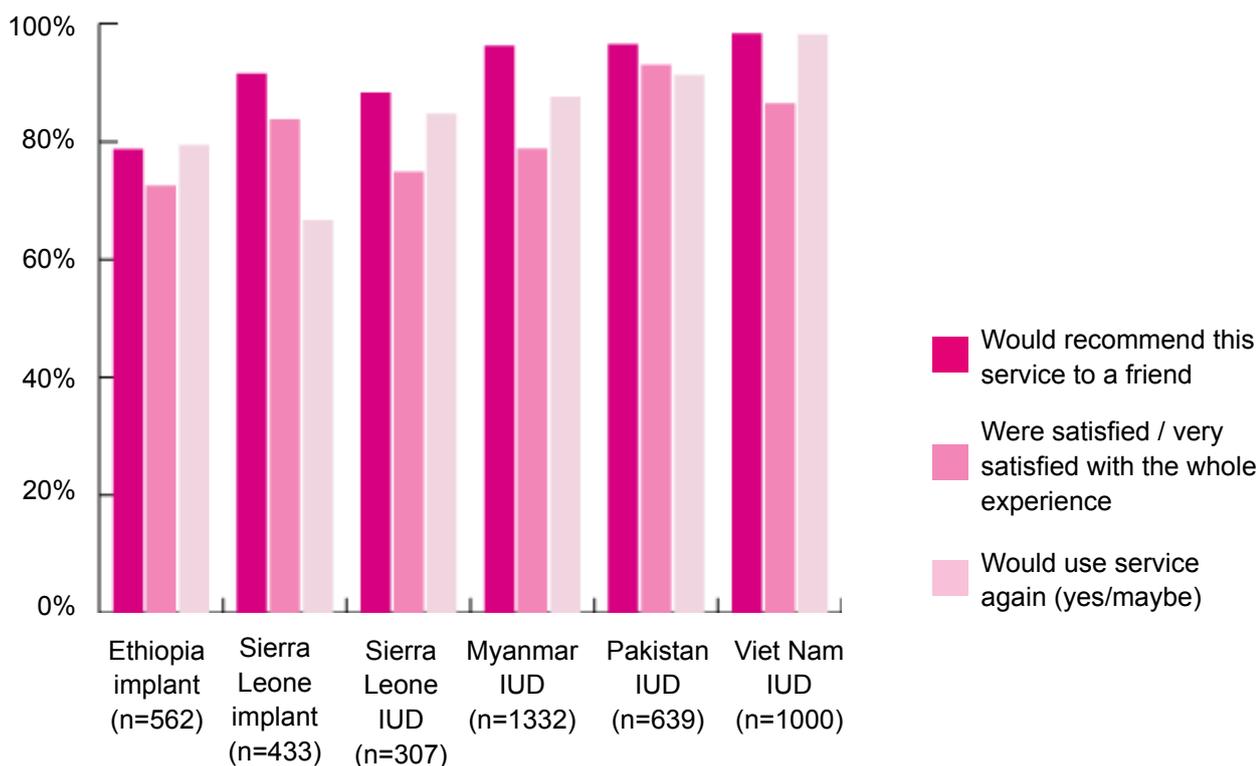
<sup>i</sup> According to UNICEF, the primary school attendance ratio 2003–2008 for females in Viet Nam is 94%. [http://www.unicef.org/infobycountry/Viet\\_Nam\\_statistics.html](http://www.unicef.org/infobycountry/Viet_Nam_statistics.html)

Figure 2: Information channels for outreach facilities



Note: Women were able to select more than one answer.

Figure 3: Satisfaction with MSI mobile outreach programmes



## B. Quality of counselling

Viet Nam DHS (2.3% versus 12.5%, respectively).

### Prevalence of IUD/implant discontinuation

The prevalence of discontinuation of implants after six months was 0.7% in Ethiopia and three percent in Sierra Leone. IUD discontinuation prevalence after six months was 13% in Sierra Leone, 9.7% in Myanmar, 7.7% in Pakistan and one percent in Viet Nam (Table 4). The eight months + figure is not truly comparable across countries because the upper limit differs depending on how far back women were contacted (ranging from eight months to two years - see Table 2). In Sierra Leone, Ethiopia, Pakistan and Viet Nam women were contacted who had had their IUD/implant fitted for between eight and 15 months but for Myanmar the range was between eight months and two years.

In Sierra Leone and Ethiopia, the proportion of women who had had their implant removed at eight months+ is low (6.2% and 5.7% respectively). The proportions of IUD removals in Sierra Leone, Myanmar and Pakistan were 16.9%, 20.9% and 18.9% respectively. The lowest proportion of removals was in Viet Nam (2.3%).

In Viet Nam data were collected from women who had had their IUD/implant fitted approximately 12 months previously and comparable figures are available in the DHS. We observed much lower 12-months discontinuation among the mobile outreach programme in Viet Nam compared to the

### Reasons for discontinuation

Among those women who had had their IUD/implant removed, the top three reasons for discontinuation were: experience from side effects (53.1-81.1%); followed by expulsion (6.2-16.7%); and the desire to become pregnant (3.7-17.4%) (Table 5). Except for Viet Nam, a small proportion of women (2.4-8.3%) reported that they had the method removed because their partners or another family member were opposed to using contraceptive methods. About 4.7% of women in Pakistan removed the IUD to switch to tubal ligation.

### Switching behaviour

Of those women who had had their IUD/implant removed but did not want to get pregnant, the vast majority switched to either no or short-term family planning methods, except in Viet Nam where a large proportion moved to 'fertility awareness methods'. Few women switched to another long-term, or a permanent method suggesting that many were left with unmet family planning need (Table 6).

**Table 4: Overall discontinuation prevalence after 3, 6 and 8+ months**

Discontinuation prevalence (%)	Implant		IUD			
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam
<b>3 months</b>	0.4	0.7	4.6	4.8	3.1	0.6
<b>6 months</b>	0.7	3	13	9.7	7.7	1
<b>8 months +</b>	5.7	6.2	16.9	20.9	18.9	2.3
<b>Total (n)</b>	<b>562</b>	<b>433</b>	<b>307</b>	<b>1332</b>	<b>639</b>	<b>1000</b>

<sup>ii</sup> Expulsion is rare for implants (World Health Organization Department of Reproductive Health and Research and John Hopkins Bloomberg School of Public Health/Center for Communication Programs INFO Project (2007). Family Planning: A Global Handbook for Providers. Baltimore and Geneva, CCP and WHO. p.112) and occurs in around 1 in 20 IUDs (Faculty of Sexual and Reproductive Healthcare (2007). Clinical Guidance. Intrauterine Contraception, Faculty of Sexual & Reproductive Healthcare. p.5). The rates found in this study are as follows: Ethiopia 0.4%; Sierra Leone implant 0.9%; Sierra Leone IUD 1.6%; Myanmar 2%; Pakistan 1.3%; Viet Nam 0.4%. In all cases they are in line with, or well below, the expected rates.

**Table 5: Reason for IUD/implant discontinuation**

Reasons for discontinuation (%)	Implant		IUD			
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam
Expulsion	6.3	14.8	10.4	9.7	6.2	16.7
Wanted to get pregnant	6.3	3.7	8.3	17.4	14.1	12.5
Side effects (bleeding, pain, infection)	81.1	70.4	58.4	53.1	70.3	70.8
Opposed by partner/family	6.3	3.7	8.3	2.4	3.9	0
Switch to tubal ligation	0	0	0	0	4.7	0
Other	0	7.4	14.6	17.4	0.8	0
<b>Total (n)</b>	<b>32</b>	<b>27</b>	<b>48</b>	<b>288</b>	<b>127</b>	<b>24</b>

**Table 6: Switching behaviour of women who had their IUD/implant removed**

Contraception use after IUD/ implant (%) <sup>i</sup>	Implant		IUD			
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam
None	38.7	60	75	23.2	48.1	0
IUD/implant	0	0	12.8	0.4	0	0
Injection	42	8	4.3	54	13.5	9.5
Pills	12.9	24	4.3	22.4	10.6	19
Condoms	0	0	2	0	11.5	28.6
Sterilization	6.4	8	2	0	8.7	0
Fertility awareness methods	0	0	0	0	7.7	42.9
<b>Total (n)</b>	<b>31</b>	<b>25</b>	<b>44</b>	<b>237</b>	<b>104</b>	<b>21</b>

**Notes:** <sup>i</sup>This includes only women who had their IUD/implant removed and with unmet need – that is, not women who wanted to get pregnant.



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## Knowledge of place and time of removal among continuers

Of women who had not had their IUD/implant removed, the vast majority (79-99%) knew when it should be removed (Figure 4), suggesting high quality counselling. The exception was Sierra Leone, where a high proportion of women did not know when their IUD should be removed (41%).

Similarly, the vast majority of women also knew where to go to have their implant/IUD removed (Figure 5a). In Sierra Leone, Myanmar, Pakistan and Viet Nam only between zero and 10% of women stated that they did not know where to go for removal. In Ethiopia this proportion was much higher with almost one in five women saying they did not know. In Sierra Leone, almost all women stated they would go to a Marie Stopes clinic or outreach site for removal services. The large proportion of women (54.6% for implants and 64.5% for IUDs) who stated they would go to an MSI outreach site may suggest that there are no other facilities available to them to provide this service. In other countries there was a wider range of facilities mentioned, suggesting a stronger

health facility infrastructure including government clinics and hospitals, rural health centres and private clinics (Figure 5a).

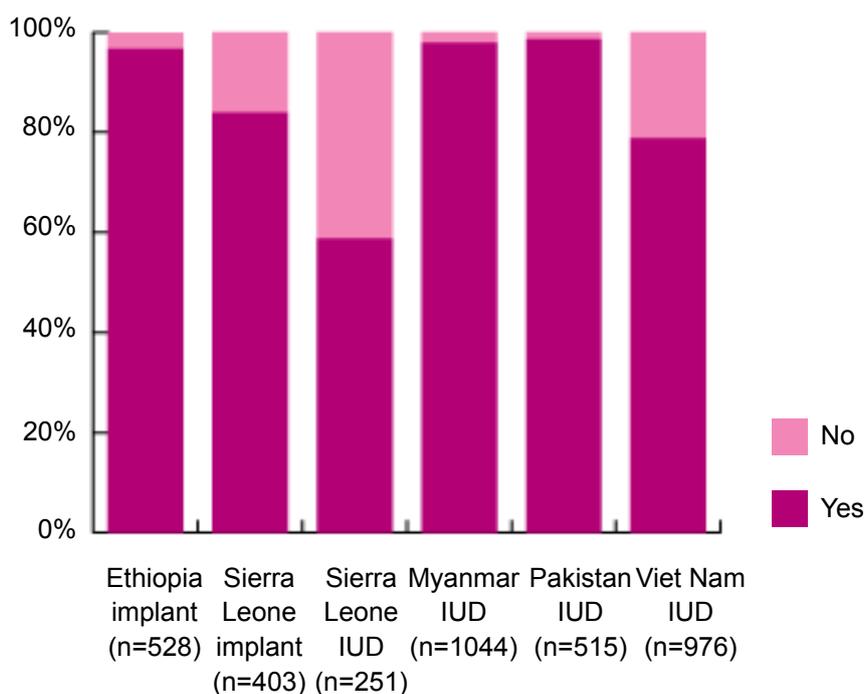
Of those women who did not know where to go for removal services, most (except in Myanmar) did know where they should seek help (Figure 5b). The places the women indicated they would go for help (community health workers and government centres) are likely to be places where they would get good quality advice and/or services.

## C. Follow-up mechanisms

### Side-effects and available follow-up for medical assistance

Certain side effects are expected and normal in both IUDs and implants, including headaches, heavy or irregular bleeding and some pain. So long as sufficient counselling has been provided, and these side effects are not severe, women should be prepared for them and know how to deal with them. Although a key indicator of quality

Figure 4: Knowledge about when to have IUD/implant removed



of service would be the proportion of serious complications, this cannot be investigated in this study as self-reports of complications may be inaccurate. For example, some heavy bleeding after insertion is an expected *side effect*, whereas excessive heavy bleeding (possibly secondary to perforation of the wall of the uterus), is considered a complication. Women self reporting excessive

bleeding would be unlikely to know the distinction. As a result, we will not report rates of complication here. Instead we will consider self-reported side effects and health seeking behaviour in cases of side effects (as a proxy for the severity). We will also look at the ease with which medical assistance could be found in order to assess the follow-up mechanisms that are in place.

Figure 5a: Knowledge about where to have IUD/implant removed

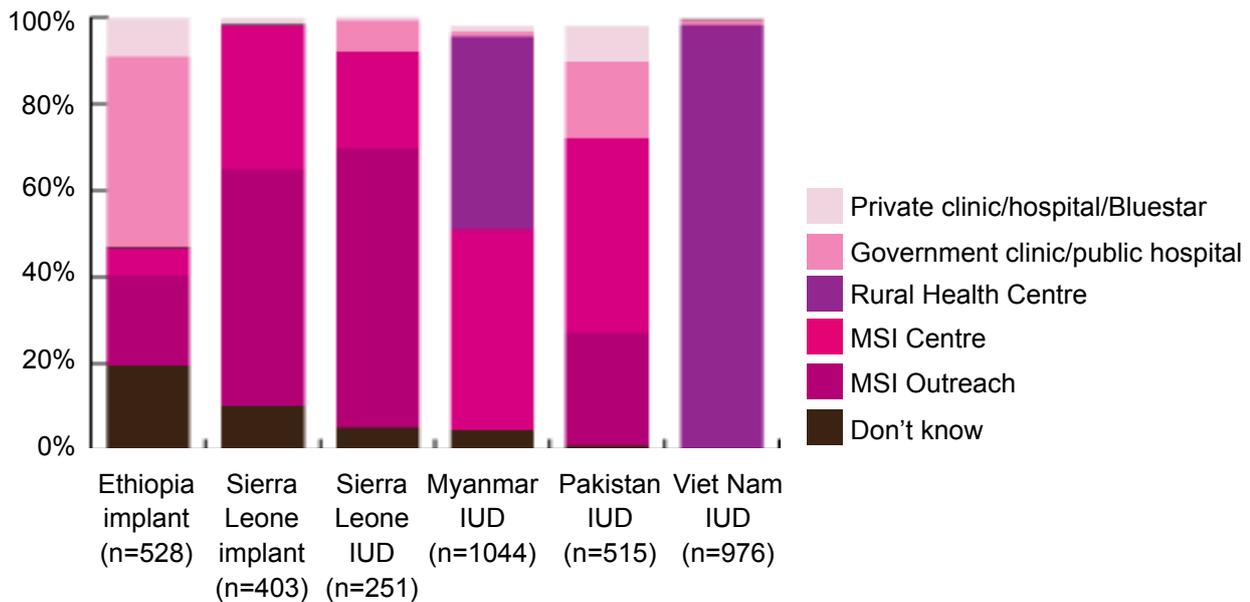
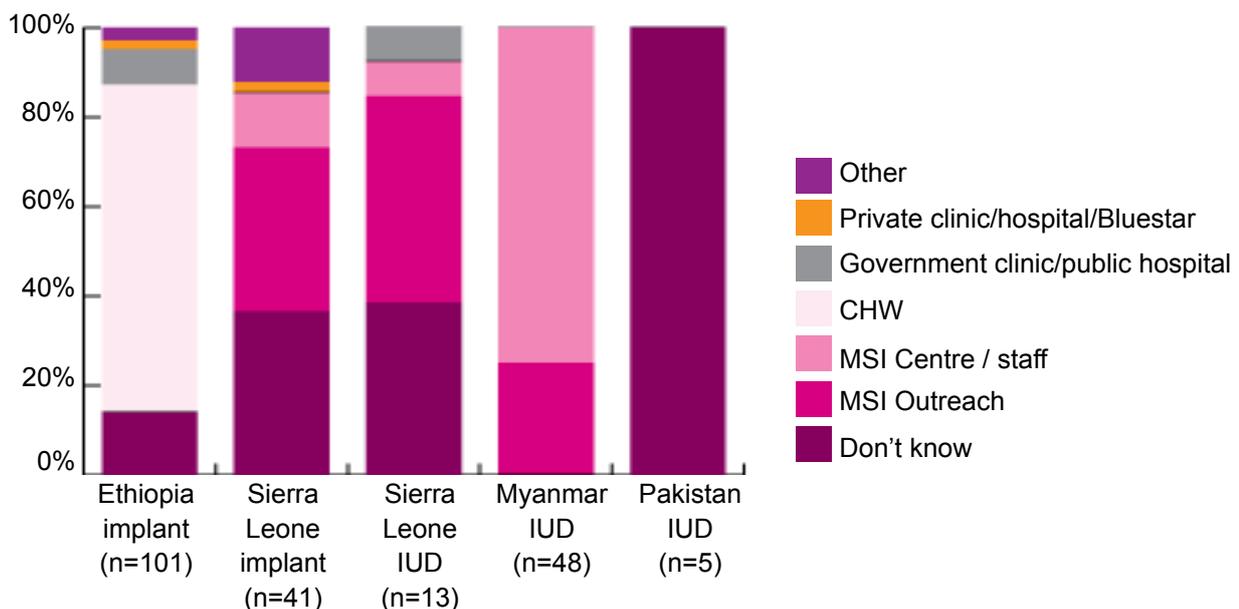


Figure 5b: Knowledge about where to seek help<sup>i</sup>



Notes: This includes only women who didn't know where to go for removal.

Figure 6: Proportion of women reporting side effects

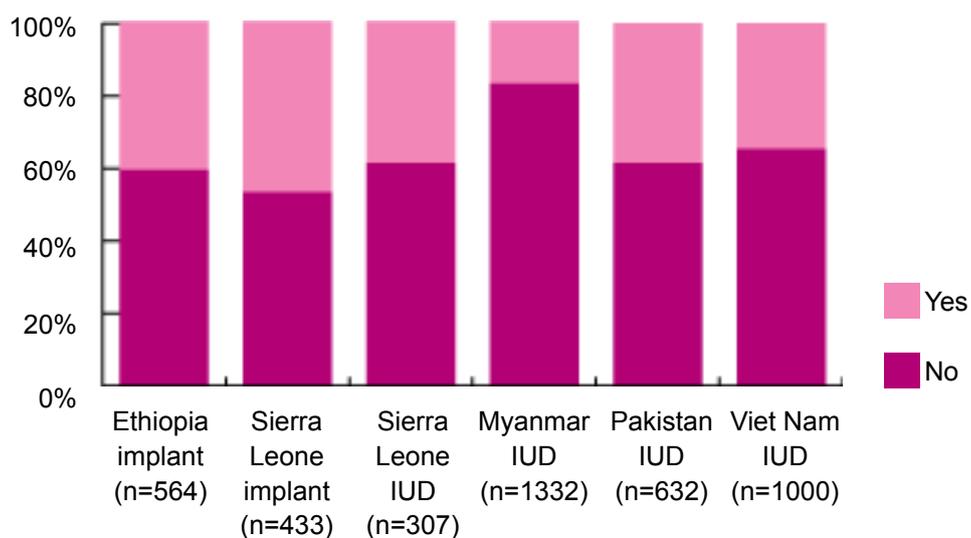


Table 7: Care-seeking behaviours among women who experienced side effects

Care-seeking behaviour among those who experienced side effects (%)	Implant		IUD			
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam
Did not seek medical advice	63.6	58.4	41.7	60	21	34.6
Took medication yourself	3.1	11.2	19.2	17.3	23	9.1
Went to the doctor/hospital/CHW	33.3	30.5	39.2	22.7	56	52.5
<b>Total number experiencing side effects</b>	<b>225</b>	<b>197</b>	<b>120</b>	<b>220</b>	<b>243</b>	<b>353</b>
<b>Total number of respondents</b>	<b>562</b>	<b>433</b>	<b>307</b>	<b>1332</b>	<b>639</b>	<b>1000</b>

Figure 7: Ease of finding medical assistance

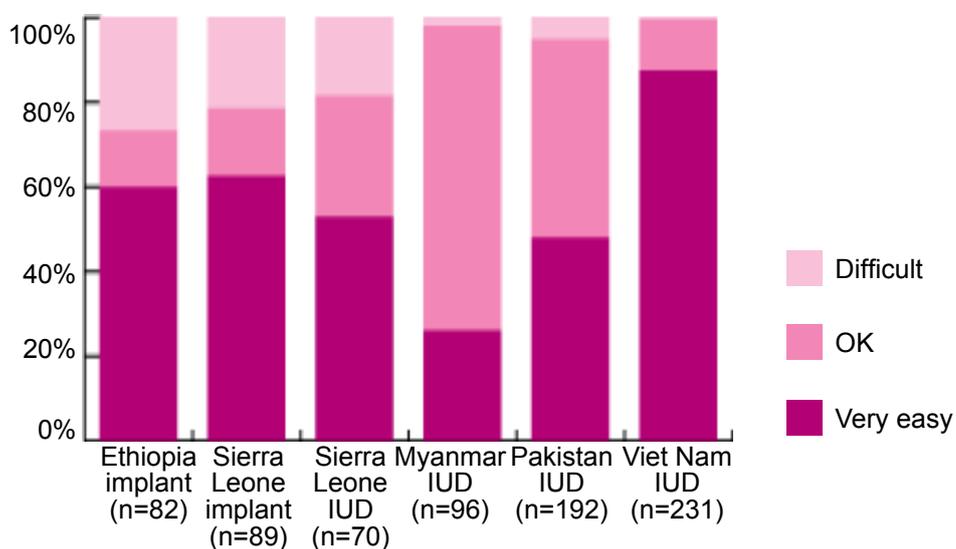


Figure 6 shows that a high proportion of women reported experiencing side effects (except in Myanmar where just 17% did). Most side effects, although uncomfortable for the woman, are not dangerous to their health. These symptoms include headache, abdominal pain, acne, weight change, breast tenderness, dizziness, mood changes and nausea.

The proportion of women seeking medical advice when experiencing side effects from IUD/implant insertion varied across the five settings (22.7-56%) (Table 7). This may be associated with differences in cultural norms regarding care-seeking behaviours for medical related symptoms, differences in the quality of service provided at the outreach site, or differences in the underlying health infrastructure of each country and availability of services.

Among women who received IUD/implant services in the five outreach settings, the majority had no

problem finding medical assistance when needed (range: 73.2% in Ethiopia to 99.6% in Viet Nam) (Figure 7). These figures include individuals who reported that seeking medical assistance was either 'very easy' or 'ok'. In three countries (Myanmar, Pakistan and Viet Nam) only small proportions of women found it difficult to find medical assistance (2%, 5.2%, 0.4% respectively). However, in Sierra Leone and Ethiopia the proportions of women who reported finding it difficult were higher (26.8% in Ethiopia and an average of 20.1% for IUDs and implants in Sierra Leone).

### *Accessibility of removal services for outreach women*

Women mentioned a range of options for removal services available in the five countries. These include government clinics, community health stations and MSI clinics or outreach sites and the use of these differs across countries (Table 8).

**Table 8: Evaluation of removal services**

	Implant		IUD			
	Ethiopia	Sierra Leone	Sierra Leone	Myanmar	Pakistan	Viet Nam
<b>Location of removal (%)</b>						
MSI clinic	0	36	20	13.9	9	0
Government clinic	53.3	0	54.5	0	0	50
Private clinic/ BlueStar/ hospital	20	16	3.6	5.6	35.2	8.3
Community/ rural health station	0	0	0	27.8	9.8	33.3
MSI outreach	26.7	36	20	0	0	0
Midwife	0	0	0	22.2	0	0
Public/District hospital	0	0	0	1.7	41	4.2
It fell out at home	0	0	0	12.8	4.9	4.2
Other	0	12	1.8	16	0	0
<b>Cost of removal (%)</b>						
Free	50	30	32.7	26.7	59.8	75
Not free	50	68	67.3	73.3	40.2	25
<b>Total number of removals</b>	<b>30</b>	<b>25</b>	<b>55</b>	<b>288</b>	<b>122</b>	<b>24</b>

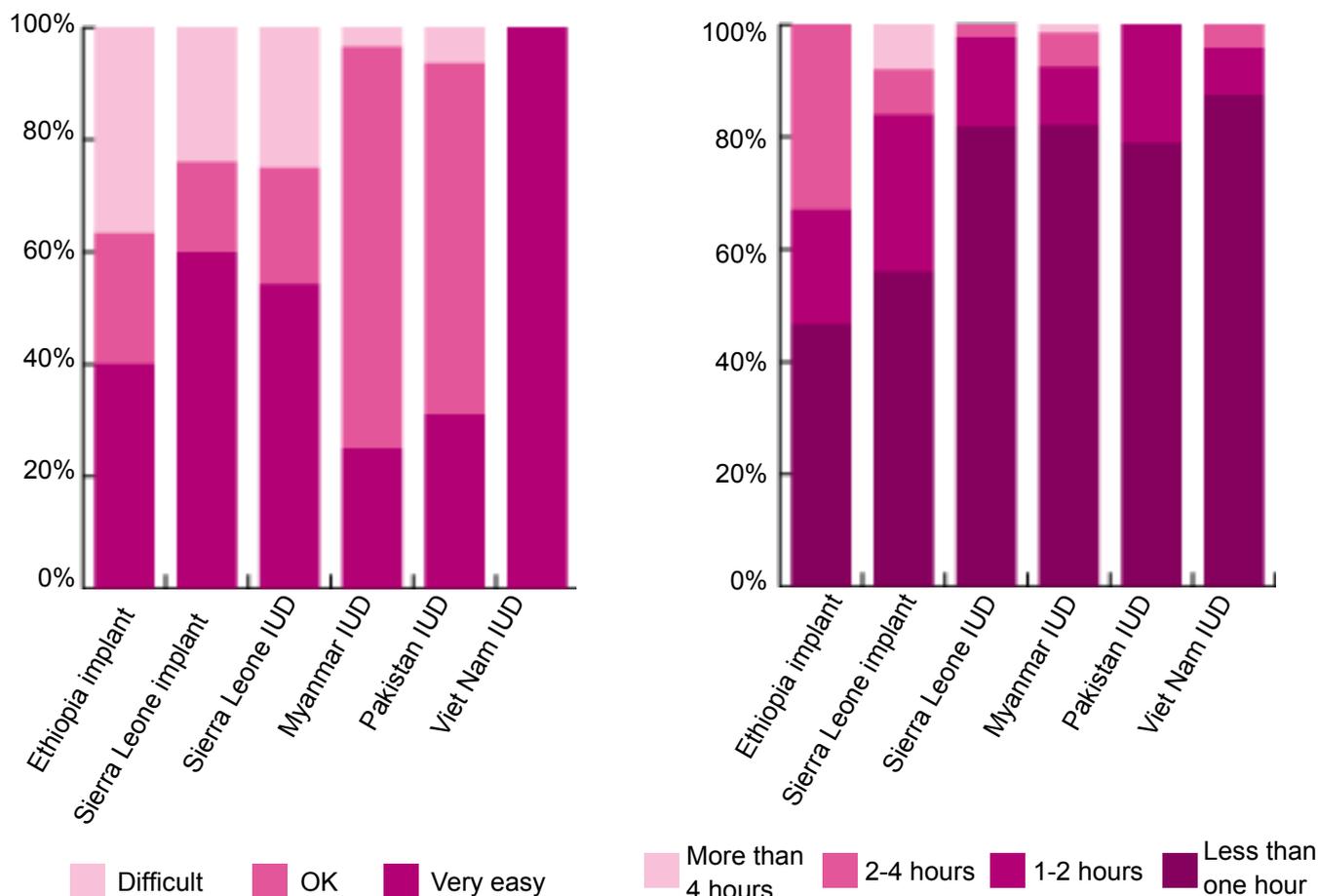
In Sierra Leone and Ethiopia between one fifth and one third of women returned to MSI outreach for their removal services, while in Myanmar, Pakistan and Viet Nam women utilized government health care facilities (whether hospitals or clinics) (51.7%, 50.8%, 87.5% respectively). In Ethiopia, Sierra Leone (IUD) and Viet Nam roughly half of women went to government clinics for removal. In Sierra Leone, the majority of implants were removed by a Marie Stopes provider (either outreach or clinic). In Pakistan, most women went to either private clinics/hospitals or public hospitals (76.2%).

It is understandable that women do not always return to an MSI outreach site for removal because these are not available all the time. What is important is that there are available facilities for them to use when there are no MSI outreach services. In Pakistan, Viet Nam and Myanmar, less than 6% of women found it difficult to get their IUD removed. In these countries, most women travelled less than one hour for their removal.

However, in Ethiopia more than a third of women found it difficult to get their implant removed and a third had to travel two to four hours. In Sierra Leone, approximately one quarter found it difficult and for implants roughly one in six women had to travel more than two hours (Figure 8).

In Ethiopia, the level of difficulty did not seem to be related to the distance travelled. Indeed, a third of those who stated that they found it very easy to get their implant removed had travelled between two and four hours. Similarly a third of those who reported finding it difficult travelled less than one hour. However, in Sierra Leone for women having their implant removed there does seem to be a relationship between the distance travelled and how easy or difficult they reported it was to find someone to perform the removal.<sup>iii</sup> Of those who reported it was very easy or ok, none travelled for more than two hours. Of those who reported it was difficult, none travelled less than an hour.

Figure 8: Ease of finding removal services and travel time



<sup>iii</sup> Significant at p<0.01

# Chapter 4: Discussion and recommendations

Mobile outreach programmes offer huge potential to reach rural populations with high quality contraceptive services. To date, little evidence has existed to show how successful outreach programmes are in ensuring services actually do reach the under-served and what happens once the outreach mobile team leaves the community. This research has been important in highlighting the successes and areas in need of improvement in MSI's outreach model.

The evaluation attempted to answer two main questions:

1. Are we reaching the under-served?
2. Are we providing high quality services in terms of:
  - a. Counselling provided?
  - b. Adequate follow-up mechanisms?

## 1. Are we reaching the under-served?

We would expect the women that come for services at outreach sites to be among the poorest women with high unmet need. Ways of measuring this include looking at the education level of the women (as a proxy for poverty) and finding out if they are first-time users of long-term contraception (indicating unmet need). Our study found that most women receiving services at outreach have little or no education, except in Viet Nam where education levels are higher. The vast majority (more than 97%) of women had not been previously using a long-term method, showing that they were either new to modern family planning or had been using short-term methods.

These numbers demonstrate that MSI outreach services are provided to those who have high unmet need for family planning and to individuals who require a long-acting method rather than a short-term method of family planning.

## 2. Are we providing high quality services?

Overall client satisfaction was high in all five countries across all three measures (would recommend to a friend, overall satisfaction and would use the service again). However, based on reported satisfaction levels it is clear that in some countries (Sierra Leone and Ethiopia in particular) efforts need to be made to improve the service provided.

### 2.a. Are we providing high quality counselling?

Discontinuation prevalence was lower than, or in line with, discontinuation figures available from the DHS (where figures were available). As part of a high quality service, women should be properly counseled on their choices of contraceptive methods and expected side effects. Two of the main reasons given for removal (wanting to get pregnant and side effects) may highlight problems with the amount and/or type of counselling that was provided during the outreach services. It is concerning that such a high proportion of women removed their IUDs due to side effects (which they should have been counselled to expect) or to get pregnant (in which case an IUD/implant may not have been the correct form of contraception for them).

The vast majority of women who had their IUD/implant removed, and did not want to get pregnant, switched to a short-term method, a traditional method, or no family planning method. This is possibly due to partners/family members opposing contraceptive use (Table 5), although it may also be due to additional barriers such as lack of access to or knowledge about alternative long-term methods. Other than Sierra Leone, most countries focus on providing just one of the long-acting reversible methods. In Sierra Leone, almost 13% of women who had their IUD removed switched to either another IUD or an implant,

suggesting that where an alternative method is available, women will adopt it (although this is not true of women in Sierra Leone who had their implant removed).

## *2.b. Are the follow-up mechanisms adequate?*

The vast majority of women across the five countries had knowledge of both when and where to go for follow-up or removal. Of those who didn't know where to go for medical assistance if needed, almost all knew of somewhere that they could go for help and these tended to be trustworthy options, such as community health stations and government centres. However, problems were identified in Sierra Leone and Ethiopia with worryingly low levels of knowledge about either when or where to go for removal. Similarly, it was in these countries where a high proportion of the women who had sought medical assistance reported that that assistance had been difficult to find. In Sierra Leone this difficulty seems to be related to the distance that women had to travel to access services. In Ethiopia the reasons are less clear. However, it seems that in these two countries there are fewer non-MSI options for where to go for this service. In Ethiopia and Sierra Leone no women went to a rural health station or public hospital, possibly because there are very few available.

This retrospective cohort study has been valuable in assessing MSI's outreach model in five countries. It is clear that there are variations between countries. This highlights the importance of undertaking this type of evaluation in all MSI programmes to ensure consistent high quality services for women who attend outreach.

The high quality of outreach services was supported by the following findings:

- there are adequate and sufficient follow-up mechanisms in place across all five countries in terms of providing services to women when needed, such as medical attention for side effects and removal services. This is demonstrated by the vast majority of women who indicated that it is fairly easy to access health facilities and who know where to obtain medical assistance when required

- the high proportion of women who know when and where to go for removal services revealed that MSI counselling was of high standard. Successful and effective public-private partnership is demonstrated where women are able to seek medical assistance or removal services from government clinics
- women's demographic information and contraception use prior to obtaining outreach services demonstrates MSI outreach services are provided to those who have high unmet need for family planning and to individuals who require a more effective method of family planning.

The results also highlight programmatic areas in need of strengthening and further investigation. These include:

- high discontinuation prevalence in Myanmar, Pakistan and Sierra Leone (IUD)
- 'side effects' and 'desire to become pregnant' were the top reasons for removal, suggesting the need to improve the type/amount of counselling provided
- high percentages of women reporting difficulty seeking medical assistance or a removal service (Sierra Leone and Ethiopia)
- a high proportion of women are not sure when to remove the IUD in Sierra Leone and Viet Nam
- in several countries (Ethiopia, Sierra Leone and Myanmar) the majority of women pay for a removal service. It is important to investigate this cost issue further to determine to what extent it may act as a barrier to access or removal
- once discontinuing, the majority of women in all countries are not switching to another form of contraception despite having an identified unmet need. This result is similar to our findings from tracking removals in clinics (Dasgupta 2010).

MSI continuously strives to improve the quality of its programmes. This evaluation provides evidence of the effectiveness of outreach programmes and highlights areas in need of improvement. Based on the results of this study, MSI will continue to provide high quality outreach services and will take action on areas in need of strengthening.

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