(re)solve IN ETHIOPIA
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INTRODUCTION TO (re)solve

1

+ What is (re)solve?
+ Why is (re)solve unique?
+ Why work in Ethiopia?
+ What is the (re)solve approach?
WHAT IS (re)solve?

Launched in 2016, (re)solve is a four-year project funded by the Bill & Melinda Gates Foundation. It is led by Pathfinder International in partnership with Camber Collective, The International Center for Women, and ideas42, and is active in Bangladesh, Burkina Faso, and Ethiopia.

(re)solve combines expertise from consumer insights, behavioral design, and public health to discover what stops women from using contraception when they express a desire to avoid pregnancy, and yet do not use a modern contraceptive method.

(re)solve challenges current assumptions about contraceptive decision-making; tests new approaches based on local, contextualized behavioral insights; and generates adaptable, scalable user-responsive solutions that address unmet need for family planning.

PATHFINDER INTERNATIONAL uses large-scale evidence-based family planning programming approaches through existing country projects. These projects provide the platform from which (re)solve implements its solutions.

CAMBER COLLECTIVE uses a market segmentation approach to identify population segments marked by behavioral and/or attitudinal differences which inform solutions catered to each segment’s needs. Camber typically identifies segments through large-scale, quantitative surveys.

IDEAS42 uses behavioral design to develop and test innovative solutions that reshape people’s environment to positively influence their behavior. ideas42 designs for behavioral bottlenecks identified through qualitative interviews and observations.

INTERNATIONAL CENTER FOR RESEARCH ON WOMEN (ICRW) uses a gender-focused research and evaluation approach to determine the efficacy and impact of programs. ICRW is conducting process and impact evaluations of (re)solve solutions.
WHY IS (re)solve UNIQUE?

Although much progress has been made in addressing non-use of contraception through traditional behavior change programming, these programs are limited by assumptions about what prevents women from using contraception.

At (re)solve’s heart is the conviction that one size does not fit all. (re)solve designs and customizes data-informed family planning solutions to the needs, motivations, and lived experiences of the women and girls we serve. We believe that women and girls deserve products and services designed for them.

Innovative approaches

+ Segmentation & Consumer Insights
+ Learning Loops & Adaptation
+ Behavioral Design
+ Testing Solutions

DEFINITIONS

BEHAVIORAL BOTTLENECK: barrier that prevents an individual from making a decision or taking action that would otherwise meet their needs (i.e. using a contraceptive method to avoid unintended pregnancy).

CROSS-DISCIPLINARY APPROACH: mixing of various disciplines—public health/demography approaches, market segmentation, and behavioral science/behavioral design—that address the age-old question of why women at risk of pregnancy are not using modern contraception.

CONSUMER INSIGHTS: a field that focuses on interpreting trends in human attitudes, beliefs, and behaviors, which aims to increase the effectiveness of a product or service. Its main purpose is to understand why the consumer cares for the product or service, as well as their underlying mindsets, moods, motivations, desires, and aspirations that motivate and trigger consumer behaviors.

INSIGHT: data-driven understanding about behaviors or the drivers of behaviors related to contraception.

SEGMENTATION: the activity of dividing a larger population into subgroups of people (known as segments) based on some type of shared characteristics such as shared needs, common interests, similar lifestyles or even similar demographic profiles.

BEHAVIORAL DESIGN: an approach that leverages insights from behavioral economics, social psychology, human-centered design, and other disciplines to develop and test innovative solutions that reshape people’s environment to positively influence their behavior.
WHY WORK IN ETHIOPIA?

Postpartum Family Planning
Over the last few decades, Ethiopia has experienced a notable increase in modern contraceptive prevalence rate—from 6% of women between the ages of 15 and 49 in 2000 to 35% in 2016.

Postpartum women, in particular, experience low contraceptive prevalence rates. In Tigray, where (re)solve works, the modern contraceptive prevalence rate for married women between 15 and 49 is 35.2%.

Pathfinder presence
In Ethiopia, (re)solve works with the USAID-funded, and Pathfinder-led Transform: Primary Health Care project, which aims to improve health care outcomes and end preventable child and maternal deaths in Ethiopia. In the Tigray region, Transform: Primary Health Care operates in 19 woredas (districts) in four clusters (Mekelle, Axum, Shire, and Welkait).


WHAT IS THE (re)solve APPROACH?

The (re)solve Framework

BEHAVIORAL LANDSCAPE ANALYSIS
- Intervention Analysis
- Segmentation Analysis

BEHAVIORAL DIAGNOSIS
- Mapping
- Refinement/ Prioritization
- Field Research

DESIGN AND USER TESTING
- Ideation and rapid prototyping
- User Testing
- Solution Development

INTERVENTION TESTING
- Implementation
- Evaluation

Defined Problem
Analysis of Barriers and Bottlenecks
Proposed Solutions
Scalable Solutions
Strategy & Scale Up Framework

Research and Knowledge Management
QUANTITATIVE ANALYSIS AND SEGMENTATION IN ETHIOPIA

1. General insights from quantitative analysis
2. Goal of segmentation
3. Approach to segmentation
4. Segments identified
Generally, women prefer the public sector for services and have a positive outlook toward health providers.

**ATTITUDES TOWARDS HEALTH PROVIDERS**

- **Feel respected**
  - Health Extension Workers: 90%
  - Doctors and Nurses: 96%
- **Always trust information**
  - Health Extension Workers: 90%
  - Doctors and Nurses: 96%
- **Get enough info**
  - Health Extension Workers: 84%
  - Doctors and Nurses: 93%
- **Helps understand care options well**
  - Health Extension Workers: 86%
  - Doctors and Nurses: 94%

Tigrayan women that were interviewed expressed high praise for health extension workers, doctors, and nurses alike.

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1 Sources of FP in the last 12 months; 2 Includes FP clinic, private hospital/clinic, and pharmacy; 3 Other sources included mother-in-law (11%) health extension worker (6%), and aunt (2%)
GENERAL INSIGHTS FROM QUANTITATIVE ANALYSIS

Only 34% of postpartum women are currently using FP\(^1\), despite 76% indicating a need.

**FP USE AND CONSIDERATION**

- 21% Not using, but have considered using FP
- 34% Currently using FP
- 45% Not using and have not considered using FP

Only one-third of postpartum women\(^2\) are currently using FP, although almost half of them have considered using FP since the birth of their last child.

**WHY PREGNANCY WOULD BE A PROBLEM**

- 60% For her health
- 29% Doesn’t have resources
- 9% Doesn’t have time
- 2% Other

When asked about the main reason why pregnancy would be a problem, women cite their health and resources as primary challenges.

**FAMILY PLANNING NEED**

- 24% Pregnancy would be somewhat of a problem
- 37% Pregnancy would be a big problem
- 39% Pregnancy would not pose a problem

But 76% of these women\(^1\) say that being pregnant now would be a problem, with over one-third stating it would be highly problematic.

Of those who state pregnancy would be problematic, 68% want to wait at least 2 years.

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1 FP in this context refers to modern methods of contraception. 2 This question was not asked to pregnant women due to relevance.
(re)solve seeks to reach postpartum women in Tigray with an unmet demand\(^1\) for contraception.

Through segmentation, (re)solve sought to better understand who the target populations are—that is, where the unmet demand exists in Ethiopia—and what key behavioral dynamics define them.

Segmentation, in this case, focused on the needs, behaviors, and attitudes of different subgroups within a population since those are determinants that have the most impact on behavior and addressing unmet demand.

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\(^1\) Unmet demand constitutes those women who are sexually active, who say that pregnancy would be a problem, and are not using a modern contraceptive method.
APPROACH TO SEGMENTATION
(re)solve identified six segments or archetypes based on demographics, personal agency, and attitudes and norms

1,000 OBSERVATIONS
(335 PREGNANT, 665 POSTPARTUM)

LATENT CLUSTER ANALYSIS

YIELDING 6 DISTINCT SEGMENTS
- FULL-HOUSE PASSIVES
- UNCERTAIN IMPRESSIONABLES
- ADAPTABLE MATRIARCHS
- WITHDRAWN SKEPTICS
- STRESSED BYSTANDERS
- CONSCIOUS CONTROLLERS

KEY SEGMENTATION VARIABLES

ATTITUDES
- Adaptability of ideal # of children / strength of fertility preferences
- If pregnancy would be a problem
- When she would ideally like to have another child
- Would be embarrassed if others knew she was using FP
- If she feels uncomfortable discussing FP with her health provider
- Who decides FP use
- Who decided when to have children

SOCIAL NORMS
- If she has considered using FP since the birth of her child
- Most important consideration for delivery of child is provider’s skill/experience
- Belief that other women are using FP
- Perception of husband’s expectation for when to have first child compared to her own ideal timeline
- Identity with religion
- Who decided when to resume sex after childbirth
- If she has had an FP consultation in the past

AGENCY

Determines each segment’s level of unmet demand, agency, strength of fertility preference, and perception of FP acceptance
(re)solve identified six segments or archetypes based on attitudes, norms, and agency. Women in each segment experienced these drivers of intention to different degrees. (re)solve used four multi-driver axes to compare segments:

**UNMET DEMAND**: gap between want and use of modern FP (for whom pregnancy would pose a problem)

**AGENCY**: who decides FP use, who decided when to have children, who decided when to resume sex after childbirth, and if she has had an FP consultation in the past

**STRENGTH OF FERTILITY PREFERENCES**: Strength of fertility preferences / adaptability of ideal # of children

**PERCEPTION OF FP ACCEPTANCE**: Belief that other women are using FP, Would be embarrassed if others knew she was using FP, If she feels uncomfortable discussing FP with her health provider

Our solutions address many of these drivers of intention and their variable influence across segments.
3

+ Goal of behavioral diagnosis
+ Approach to behavioral diagnosis
+ Multiple bottlenecks
+ Mapping the bottlenecks by segment
GOAL OF BEHAVIORAL DIAGNOSIS

Generate hypotheses and test them empirically

Through the structured process of behavioral mapping we generate hypotheses on the behavioral drivers (bottlenecks) of nonuse which stretch our thinking. Qualitative research and observation enables us to test and refine these behavioral bottlenecks and their underlying drivers.

Enrich insights from segmentation

A mixed methods approach allows us to more fully understand the lives of girls and how they make decisions, not only about contraceptive use, but how these decisions fit into her life. Using a profiling tool to link respondents to segments helps us understand which bottlenecks affect which segments and where they may share challenges.

Establish direction for design

The ultimate objective of diagnosis is to set the direction for design. The underlying drivers that we identify as triggering bottlenecks are what we will be looking to change or affect through our designs. This allows us to move into design with evidence-based design challenges.

UNDERLYING DRIVERS are elements in the environment that trigger or contribute to the behavioral bottleneck.
### APPROACH TO BEHAVIORAL DIAGNOSIS

**Behavioral Mapping**
generate hypotheses around the behavioral bottlenecks that may be contributing to the problem of nonuse and aspects of the underlying drivers that trigger those bottlenecks.

**Instrument Development**
develop interview, focus group, and observation guides based on the hypotheses generated during behavioral mapping.

**Fieldwork**
conduct site visit in districts with high concentrations of priority segments and strong PYY presence.

**Priority bottlenecks**
Refine and prioritize the hypothesized bottlenecks and underlying drivers to target during design using evidence from fieldwork.

<table>
<thead>
<tr>
<th>TYPE OF INTERVIEW</th>
<th>NUMBER*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postpartum women</td>
<td>42*</td>
</tr>
<tr>
<td>Partners of postpartum women</td>
<td>25</td>
</tr>
<tr>
<td>Health providers</td>
<td>6</td>
</tr>
<tr>
<td>Health extension workers</td>
<td>10</td>
</tr>
<tr>
<td>Key informants in the community</td>
<td>5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>88</strong></td>
</tr>
</tbody>
</table>

+ 3 focus groups with postpartum women

8 observations at health facilities

*Segments represented: Adaptable Matriarchs: 24; Uncertain Impressionables: 2; Full-house Passives: 13; Withdrawn Skeptic: 0; Stressed Bystander: 2; Conscious Controller: 0
MULTIPLE BOTTLENECKS prevent postpartum women from making and acting on pregnancy and contraceptive use decisions*

I have never seen or heard of a woman becoming pregnant while she’s breastfeeding

Injectables made my neighbor’s sister-in-law infertile.

The implant causes weight loss and will make me very tired. We are farmers. I cannot afford that.

I want a child within the next 2-3 years. The “5-year method” is not for me.

I am protected by breastfeeding and waiting for my menses to return.

My menses have not returned. I will not get pregnant.

My husband thinks that if I have more children, then I will stay with him. He does not want me to leave him.

My biggest worry is that a contraceptive will delay my next pregnancy.

I want to keep my spacing decision from my husband. What if he finds out I am using a method?

I’ve heard that contraceptives will make me lose my hair.

I want to have regular menses. Injectables are not for me.

I fear bleeding too much, too often, or not enough.

Note: Examples of barriers reported by women
Illustrations by Jamie Hogan
### MAPPING THE BOTTLENECKS BY SEGMENT

<table>
<thead>
<tr>
<th>BOTTLENECK</th>
<th>Adaptable Matriarch</th>
<th>Uncertain Impressionable</th>
<th>Full-House Passive</th>
<th>Withdrawn Skeptic</th>
<th>Stressed Bystander</th>
<th>Conscious Controller</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BOTTLENECK 1:</strong> Postpartum women do not think they need to consider contraceptives because they perceive that there is a low risk of getting pregnant</td>
<td>X  X  X  X  X  X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>BOTTLENECK 2:</strong> Postpartum women decide not to use contraceptives because the risk of infertility, no matter how small, is too great</td>
<td>X  X  X  X  X  X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>BOTTLENECK 3:</strong> Postpartum women decide not to use contraceptives because there are more appealing options in the choice set to avoid pregnancy</td>
<td>X  X  X  X  X  X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>BOTTLENECK 4:</strong> Postpartum women decide not to use contraceptives to avoid pregnancy because their husbands disapprove</td>
<td>X  X  X  X  X  X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>BOTTLENECK 5:</strong> Postpartum women do not use long-acting contraceptives because they want to have a child sooner than the stated duration of efficacy of the method</td>
<td>X  X  X  X  X  X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
DESIGN & USER TESTING OF INTERVENTIONS IN ETHIOPIA

+ Design process

+ Solutions
  EVOLUTION OF PROTOTYPES
  FAILED PROTOTYPES
  SOLUTION: PART 1
  SOLUTION: PART 2

+ (re)solve progress in Ethiopia & plans for future
DESIGN PROCESS

The prioritized behavioral bottlenecks and underlying drivers served as the primary input to designing solutions.

**Ideation**
In the first phase of design, ideation, the project team generated myriad potential solution ideas to address each contextual feature in play. ideas42 staff generated design ideas individually. We conducted ideation exercises with postpartum women and health providers concurrently. Afterward, the project team participated in group ideation exercises to generate additional ideas and strengthen existing ones.

**Synthesis**
During the next phase, synthesis, we first consolidated ideas and design concepts. The project and the Transform: Primary Health Care team then rated each overarching design concept across several criteria. As a set, the top selected ideas were prototyped for user testing.

**Prototyping**
Prototyping the designs involved elaborating on each idea at a greater level of detail. We then built rough prototypes of each idea using everyday materials.

**User Testing**
We conducted user testing activities at 12 health facilities in Tigray. We gathered direct feedback from providers and clients in response to the prototypes. We solicited feedback on the general concepts, their content and format, as well as acceptability and perceived usefulness. We observed the simulated use of our solutions in the clinical setting. We solicited further design ideas to prototype in the field based on providers’ and supervisors’ suggestions.

Based on these conversations and observations, we iterated on prototypes, making changes to content and format on a daily basis.

As we refined the prototypes, we conducted many more rounds of user testing led by the (re)solve program manager to ensure that the solutions we were designing could be easily integrated into the Ministry of Health’s Family Health Card, the Family Health Guide, and other tools endorsed by the Federal Ministry of Health.

**Piloting**
We conducted an additional and intensive stage of testing to see how the solutions would work together on a small scale for 2 months. We refined the solutions and the implementation processes and procedures based on the findings. During piloting, we collected qualitative and quantitative data to answer outstanding questions around feasibility, acceptability, etc.
eliminate multiple barriers for postpartum women in Ethiopia

PPFP PLANNING PROMPT

Provide a moment of action, during antenatal care, for clients to consider family planning counseling at a later date.

REFERRAL CARD

Simple assessment tool that providers complete during immunizations.

Clients answer questions and need-level scores prompt providers to initiate or refer to family planning counseling.

The screening is applied at each immunization to increase perceived risk over time.

HOME VISIT TRACKING TOOL

Notebook for health extension workers (HEWs) to use during home visits after delivery to systematically track women at risk of pregnancy in the postpartum period.

Promotes integration of the solutions by prompting HEWs to use other tools.

COUNSELING SHEET

Reference sheet format serves as a quick reminder of key messages for busy providers and allows them to deliver more effective counseling.

Emphasizes risk by highlighting stories of local women who became pregnant while breastfeeding before their menses returned.
**EVOLUTION: PLANNING PROMPT**

**FEEDBACK**

The planning prompt was easily understood with little to no explanation.

Some providers mentioned that the planning prompt could be more effective if both a husband and wife completed it together during an antenatal care (ANC) visit.

We removed an area for clients to apply a thumbprint to avoid this being perceived as providing premature consent to counseling.

**SOLUTION**

The final version is designed to fit into the Health Appointment Booklet that each new client receives and retains.

**UPDATES BASED ON FEEDBACK**

1. **FEEDBACK**
   - We added space to include the actual date(s) for future counseling to make planning more concrete.

2. **FEEDBACK**
   - During piloting, we learned that women did not want to think about FP before delivery, particularly at early ANC visits. Our training recommends use only during ANC visits in the third trimester.

3. **SOLUTION**
   - Our training reinforces that the card is to return for FP counseling and not for taking up a method.
EVOLUTION: COUNSELING SHEET

UPDATES BASED ON FEEDBACK

1. FEEDBACK

Providers appreciated the messages on the reference sheet.

Providers sometimes used the script verbatim rather than as talking points.

2. FEEDBACK

We altered the graphic design of the sheet to divide the content into different sections as discrete talking points to facilitate quick reference, rather than making it appear as a script.

Messages address issues that are relevant to each of the segments (e.g., concerns about side effects and infertility, community norms around contraceptive use, correct and consistent use of Lactational Amenorrhea [LAM] criteria, etc.).

During piloting, health providers were able to incorporate all messages into counseling.

3. SOLUTION

Final design incorporates images that mirror the Family Health Guide.

Training of health workers clarifies how to integrate the counseling sheet with the REDI (Rapport Building, Exploring, Decision Making, and Implementing the Decision) Counseling framework.
EVOLUTION: REFERRAL CARD

1. FEEDBACK
   Health workers understood the purpose and content with very little to no explanation.

   They were not always clear where to mark an ‘X’ or a ‘✓’ so we greyed out the irrelevant cells in the table and emphasized the cells that could be marked.

   It took providers some time to understand how to classify risk in this format.

2. FEEDBACK
   Health providers instantly recognized the red-yellow-green colors and their meaning. Health workers and mothers are familiar with these colors in the middle upper arm circumference band used to detect malnutrition.

   Women and HEWs think the card should not be used in the immediate postpartum period.

   Included instructions on ‘scoring’ to ensure correct use.

3. SOLUTION
   Designed as a triple fold to allow for use at multiple immunization visits. One of the folds includes scoring instructions.

   Designed to fit into the Federal Ministry of Health’s Family Health Card.

   Includes scoring instructions and space for household name and phone number of health extension worker for contact between visits.
FEEDBACK
HEWs reacted positively to the idea. They were using blank notebooks to take notes during home visits.

HEWs found this format confusing and asked us to mirror the ANC registers in the health posts and primary hospitals.

FEEDBACK
During piloting, HEWs reacted positively to this format, which mirrors the ANC register.

Health workers proposed modifications to the columns.

We incorporated verbal reminders for HEWs to use the other tools in the solution set – the Planning Prompt, Counseling Sheet, or the Referral Card.

Health workers asked that we laminate the booklet to prevent it from getting dirty or wet during field visits.

Most health workers asked for a bag into which all these solutions could be placed.

SOLUTION
We incorporated visual reminders of when to apply the Planning Prompt, Counseling Sheet, and the Referral Card.
Antenatal Care Counseling Tool

+ A flipchart to be used during ANC to enhance women’s perception of the risk of pregnancy in the postpartum period and to help begin the planning process for taking up postpartum family planning was dropped.

+ Respondents from a national Technical Working Group and health providers felt that the density of information to be covered during ANC made it unlikely that another tool would be consistently implemented.

We discarded this idea. We advanced its most important, simple, and actionable component—the postpartum family planning prompt for user-testing. Some of the messages were incorporated into the Counseling Sheet.

Lactational Amenorrhea Jingle and Leaflet

+ A jingle focusing on the conditions for LAM was intended to serve as a catchy, ubiquitous reminder of the criteria to highlight pregnancy risk in the postpartum period. We wanted to co-create this with health providers during user testing.

+ Most providers we spoke with expressed significant doubts that women would be able to adhere to LAM conditions even if they remembered the jingle (for instance, they might work in the fields or let their child sleep uninterrupted, thereby reducing the number of possible feeds in a day).

+ Given this context, it also seemed unlikely that providers would promote it.

We discarded this idea.
Family Pledge

+ In taking the pledge, both the husband and wife make the same number of commitments to affirm equality in the partnership.

+ The pledge helps to frame the male partner’s identity as the baby’s father, rather than as a husband alone, to distance him from the identity threatened by family planning and instead prime the identity threatened by failing to use family planning.

+ HEWs did not feel comfortable administering this pledge to husbands.

We discarded this idea.

Exemplary Family Certificate

+ The certificate similarly frames men and women as having joint responsibility for their family’s wellbeing.

+ Like the pledge, the certificate frames parental use of family planning as similar in importance to immunizations for an infant’s health.

+ The certificate also capitalizes on parental identity, since parents, keen to uphold their self-perception as responsible mothers and fathers.

+ HEWs liked the idea and asked that we consider adding ceremonies to felicitate these families – this made it unsustainable.

+ HEWs were also concerned about including husbands in conversations if the wife was using a method discreetly.

We discarded this idea.
PLANNING PROMPT

+ The Planning Prompt provides a moment of action, during ANC visits, for clients to take up family planning.

+ The Prompt allows the woman to solidify a plan by making a promise to return for FP counseling at delivery, the 45 day or 10 week immunizations, when women are already in contact with health services.

COUNSELING SHEET

+ The Counseling Sheet provides talking points for postpartum FP counseling.

+ Easily integrated into existing counseling tools, which do not have messages geared for postpartum clients.

+ Providers use the sheet to guide a conversation about postpartum pregnancy risk by sharing a story of an anonymous local client who became pregnant while breastfeeding before her menses returned.

+ Other talking points assure the client that the provider can help address side effects of modern contraceptives and that the method can be discontinued at the client’s discretion.
SOLUTION: PART 2

REFERRAL CARD

+ The Referral Card is a simple assessment tool that providers complete before or during the immunization process.

+ Clients answer questions based on LAM criteria and need-level scores (low, medium and high) prompt providers to initiate or plan family planning counseling.

+ Each time the patient returns for an immunization, the screening is applied again so patients feel the increasing risk with each visit.

HOME VISIT TRACKING TOOL

+ The Home Visit Tracking Tool mirrors relevant columns from the ANC/PNC/Immunization registers available at the health posts and primary health centers.

+ It can be easily carried by the HEW during home visits.

+ The Home Visit Tracking Tool makes it easier for HEWs to follow up with women in the postpartum period who may be at risk for pregnancy and focus home visits on these women.
The target population of the research will be pregnant and postpartum women ages 18+, as well as health providers trained to implement the (re)solve solutions.

This study consists of three design components: a quantitative component, a qualitative component, and secondary analysis of program monitoring data such as the number of providers trained and the number of solutions printed and delivered to health facilities. 8 other randomly selected PHCU's will serve as controls.

Our hypothesis is that postpartum women living in the main intervention PHCU's will demonstrate significantly higher.

RESULTS FORTHCOMING.