(re)solve IN TIGRAY, ETHIOPIA

(re)solve PATHFINDER CAMBER COLLECTIVE ICRW INTERNATIONAL CENTER FOR RESEARCH ON WOMEN PASSION. PROOF. POWER. ideas42

CONTENTS

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.

(re)solve PARTNERS

PATHFINDER INTERNATIONAL uses large-scale *evidence-based* family planning programing 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**

(re)solve 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 sub-groups 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

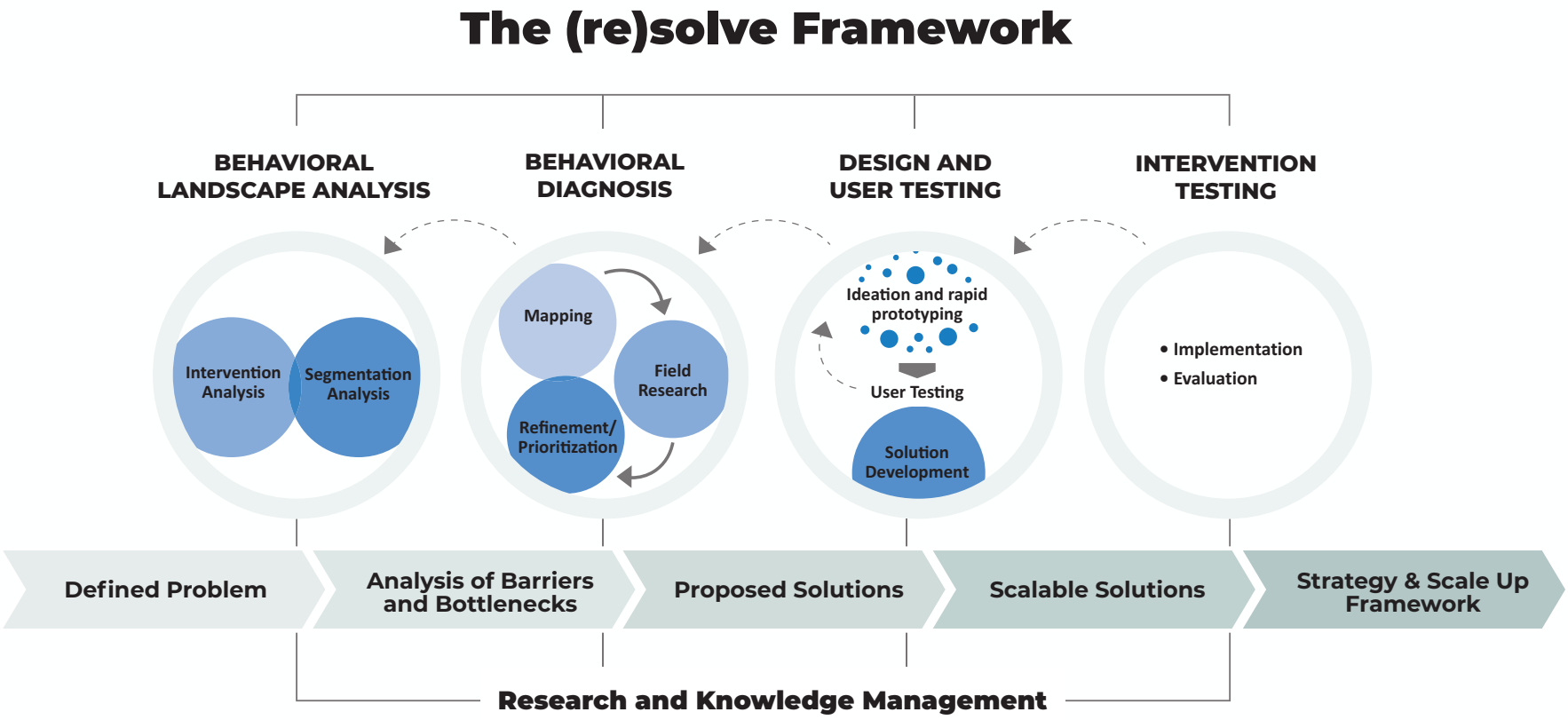
In Ethiopia, (re)solve works with the USAID-funded, and Pathfinder-led Transform: Primary Health Care project, which aims to improve health care outcomes and end preventable child and maternal deaths in Ethiopia. In the Tigray region, Transform: Primary Health Care operates in 19 woredas (districts)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

Photo by Sarah Lance

Central Statistical Authority [Ethiopia] and ORC Macro. 2001. Ethiopia Demographic and Health Survey 2000. Addis Ababa, Ethiopia and Calverton, Maryland, USA: Central Statistical Authority and ORC Macro; Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

Central Statistical Agency (CSA) [Ethiopia] and ICF. 2016. Ethiopia Demographic and Health Survey 2016. Addis Ababa, Ethiopia, and Rockville, Maryland, USA: CSA and ICF.

WHAT IS THE (re)solve APPROACH?



QUANTITATIVE ANALYSIS AND SEGMENTATION IN ETHIOPIA

2

+ General insights from quantitative analysis
+ Goal of segmentation
+ Approach to segmentation
+ Segments identified

GENERAL INSIGHTS FROM QUANTITATIVE ANALYSIS

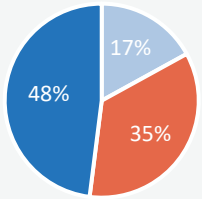
Generally, women prefer the public sector for services and have a positive outlook toward health providers.

QUALITY

90% agree with the statement: "when I go to health clinics, I am confident that I'm going to get the care that I need"

PAST SERVICE POINTS FOR FP1

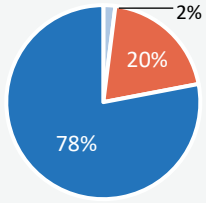
women who have used FP



Two sources in particular are preferred by Tigrayan women: government health centers and government hospitals

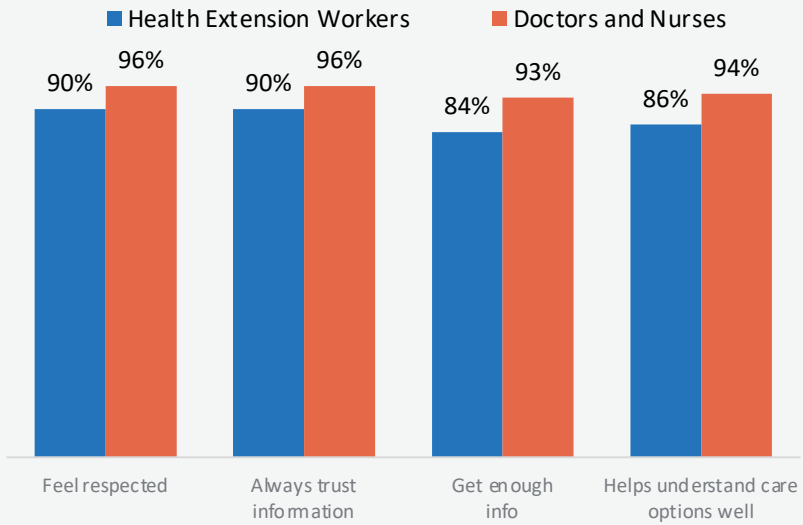
INTENDED SERVICE POINTS FOR FP

women who have never used FP



Government Health Center Government Hospital

ATTITUDES TOWARDS HEALTH PROVIDERS



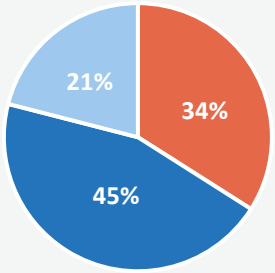
Tigrayan women that were interviewed expressed high praise for health extension workers, doctors, and nurses alike

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, despite 76% indicating a need.

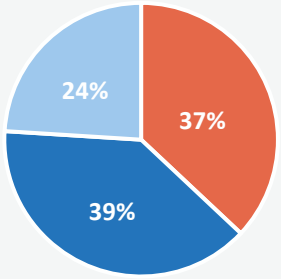
FP USE AND CONSIDERATION



- Not using, but have considered using FP
- Currently using FP
- Not using and have not considered using FP

Only one-third of postpartum women[1] are currently using FP, although almost half of them have considered using FP since the birth of their last child

FAMILY PLANNING NEED

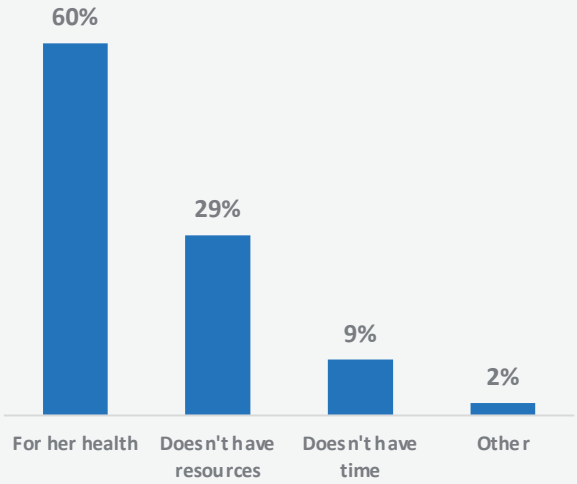


- Pregnancy would be somewhat of a problem
- Pregnancy would be a big problem
- Pregnancy would not pose a problem

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

WHY PREGNANCY WOULD BE A PROBLEM



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

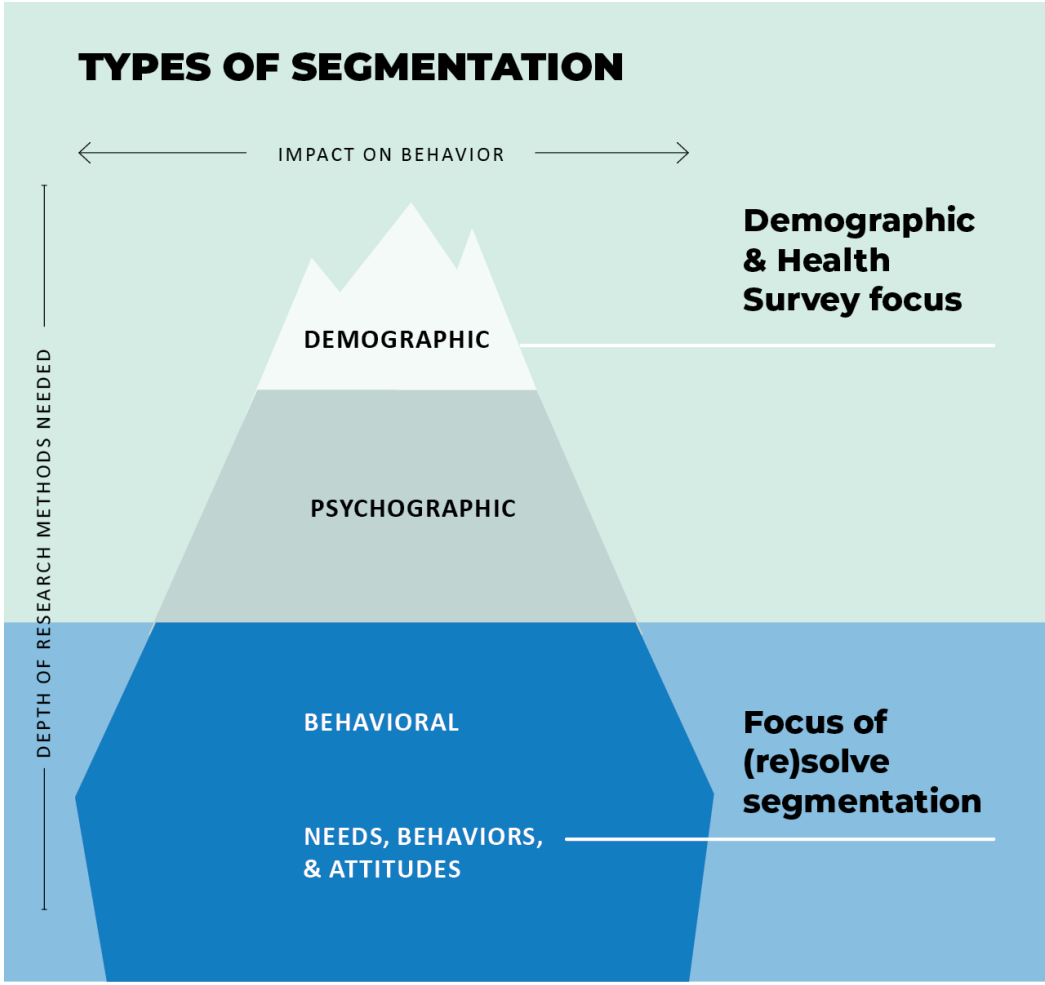
1 This question was not asked to pregnant women due to relevance

GOAL OF SEGMENTATION

(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.

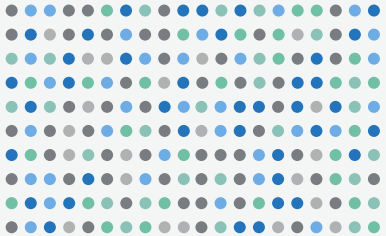


1 Unmet demand constitutes those women who are sexually active, who say that pregnancy would be a problem, and are not using a modern contraceptive method.

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)



KEY SEGMENTATION VARIABLES

LATENT CLUSTER ANALYSIS

YIELDING 6 DISTINCT SEGMENTS

FULL-HOUSE PASSIVES	UNCERTAIN IMPRESSIONABLES	ADAPTABLE MATRIARCHS
WITHDRAWN SKEPTICS	STRESSED BYSTANDERS	CONSCIOUS CONTROLLERS

INFLUENCING DRIVERS OF INTENTION

ATTITUDES

- Adaptability of ideal # of children / strength of fertility preferences[1]
- If pregnancy would be a problem
- When she would ideally like to have another child

SOCIAL NORMS

- Would be embarrassed if others knew she was using FP
- If she feels uncomfortable discussing FP with her health provider

AGENCY

- Who decides FP use
- Who decided when to have children
- 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[3]
- Who decided when to resume sex after childbirth
- If she has had an FP consultation in the past

Determines each segment's level of unmet demand, agency, strength of fertility preference, and perception of FP acceptance

SEGMENTS IDENTIFIED

(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:

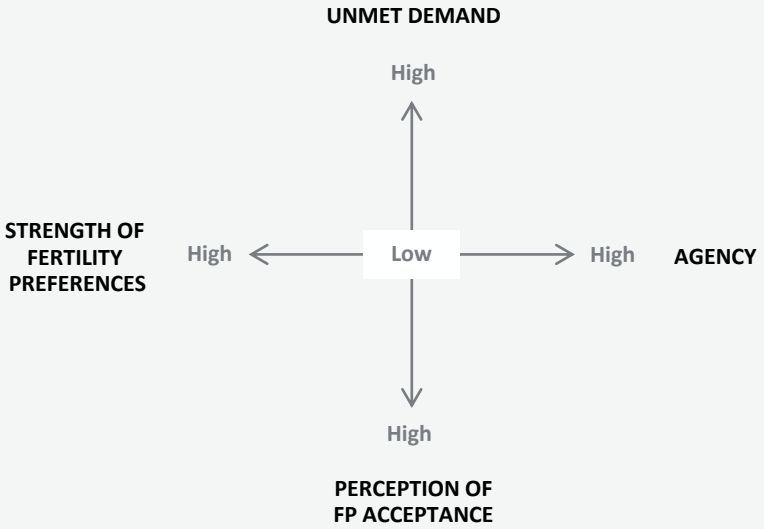
UNMET DEMAND: gap between want and use of modern FP (for whom pregnancy would pose a problem)

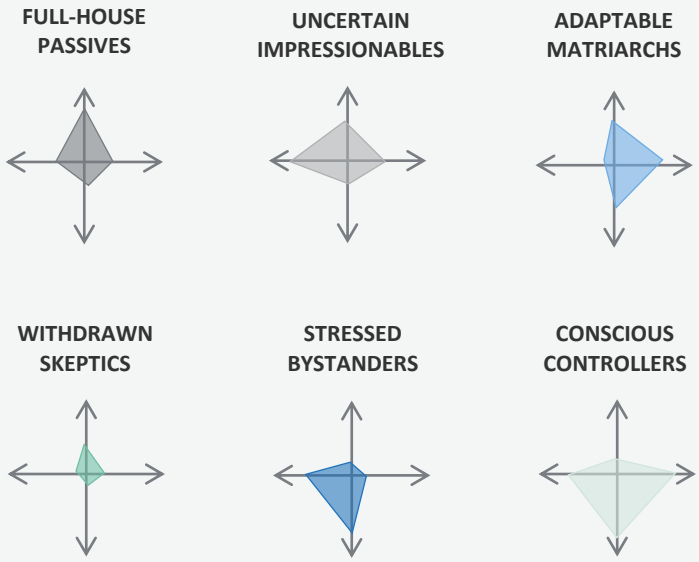
AGENCY: who decides FP use, who decided when to have children, who decided when to resume sex after childbirth, and if she has had an FP consultation in the past

STRENGTH OF FERTILITY PREFERENCE: 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.





BEHAVIORAL DIAGNOSIS IN ETHIOPIA

3

+ Goal of behavioral diagnosis
+ Approach to behavioral diagnosis
+ Multiple bottlenecks
+ Mapping the bottlenecks by segment

GOAL OF BEHAVIORAL DIAGNOSIS ON (re)solve

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

TYPE OF INTERVIEW	NUMBER*
Postpartum women	42*
Partners of postpartum women	25
Health providers	6
Health extension workers	10
Key informants in the community	5
TOTAL	**88**

+

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

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

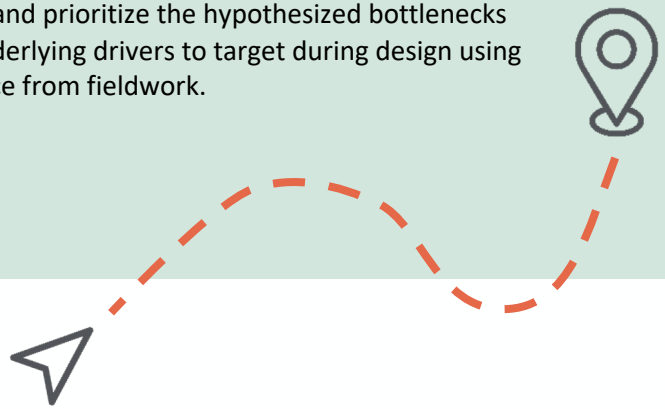
develop interview, focus group, and observation guides based on the hypotheses generated during behavioral mapping.

Fieldwork

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

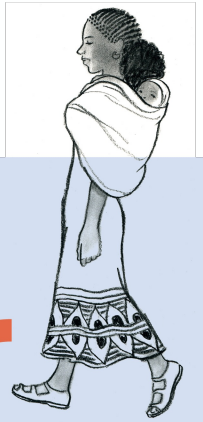
Priority bottlenecks

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



MULTIPLE BOTTLENECKS

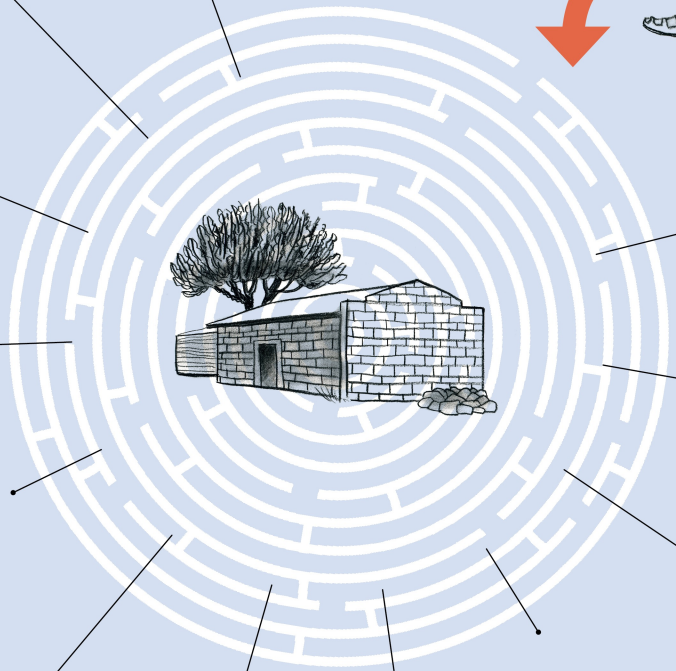
prevent postpartum women from making and acting on pregnancy and contraceptive use decisions*



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

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

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



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

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

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

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

BOTTLENECK	Adaptable Matriarch	Uncertain Impressionable	Full-House Passive	Withdrawn Skeptic	Stressed Bystander	Conscious Controller
BOTTLENECK 1: Postpartum women do not think they need to consider contraceptives because they perceive that there is a low risk of getting pregnant	X	X	X	X	X	X
BOTTLENECK 2: Postpartum women decide not to use contraceptives because the risk of infertility, no matter how small, is too great	X	X		X	X	X
BOTTLENECK 3: Postpartum women decide not to use contraceptives because there are more appealing options in the choice set to avoid pregnancy	X		X	X	X	X
BOTTLENECK 4: Postpartum women decide not to use contraceptives to avoid pregnancy because their husbands disapprove	X	X	X	X	X	
BOTTLENECK 5: 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	X	X		X		X

DESIGN & USER TESTING OF INTERVENTIONS IN ETHIOPIA

4

+ **Design process**

+ **Solutions**

  EVOLUTION OF PROTOTYPES

  SOLUTION: PART 1

  SOLUTION: PART 2

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

DESIGN PROCESS

Photo by Reshma Trasi

Photo by Reshma Trasi

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.

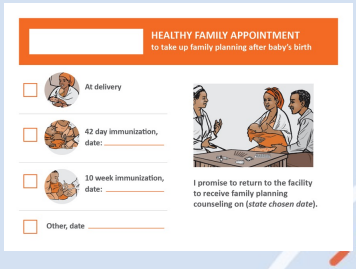
As we refined the prototypes, we conducted many more rounds of user testing led by the (re)solve program manager to ensure that the solutions we were designing could be easily integrated into the Ministry of Health's Family Health Card, the Family Health Guide, and other tools endorsed by the Federal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

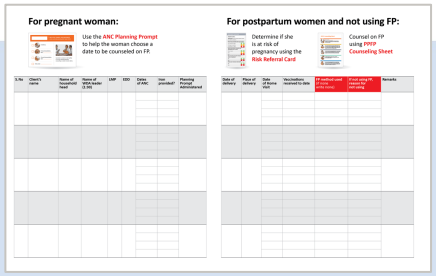
Piloting

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.

(re)solve SOLUTIONS

eliminate multiple barriers for postpartum women in Ethiopia





ANC PLANNING PROMPT

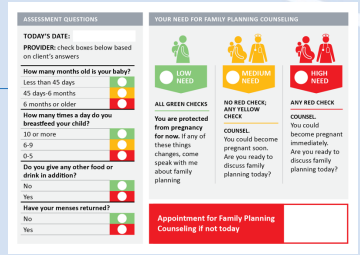
Provide a moment of action, during antenatal care, for clients to consider family planning counseling at a later date.

RISK 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 LOG

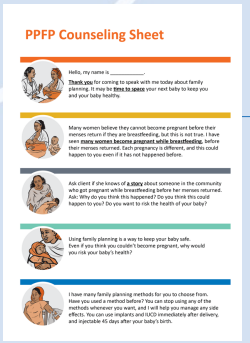
Notebook for health extension workers (HEWs) to use during home visits after delivery to systematically track women at risk of pregnancy in the postpartum period.

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

PPFP COUNSELING SHEET

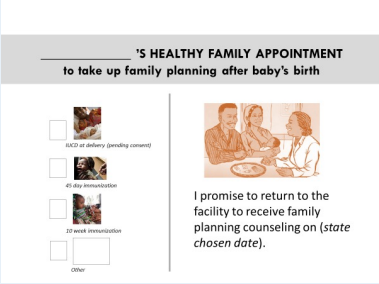
Reference sheet format serves as a quick reminder of key messages for busy providers and allows them to deliver more effective counseling.

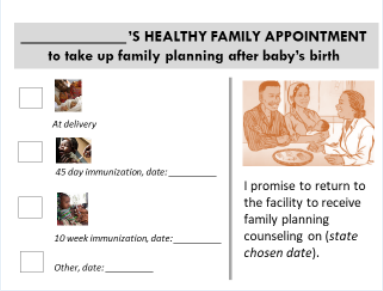
Emphasizes risk by highlighting stories of local women who became pregnant while breastfeeding before their menses returned.

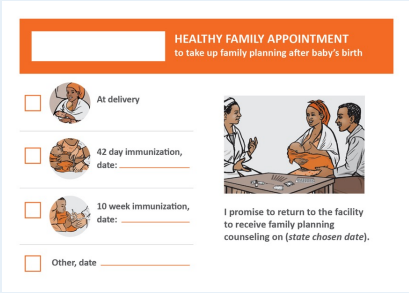


EVOLUTION: ANC PLANNING PROMPT

UPDATES BASED ON FEEDBACK







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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.

2

FEEDBACK

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

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.

Our training reinforces that the card is to return for FP counseling and not for taking up a method.

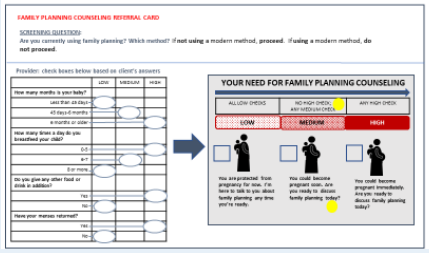
3

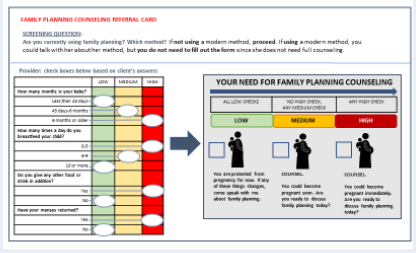
SOLUTION

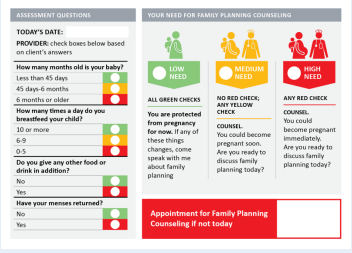
The final version is designed to fit into the Health Appointment Booklet that each new client receives and retains.

EVOLUTION: RISK REFERRAL CARD

UPDATES BASED ON FEEDBACK







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

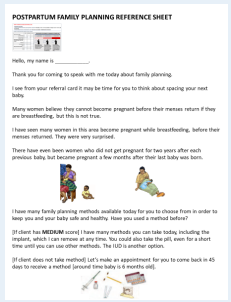
Designed as a triple fold to allow for use at multiple immunization visits. One of the folds includes scoring instructions.

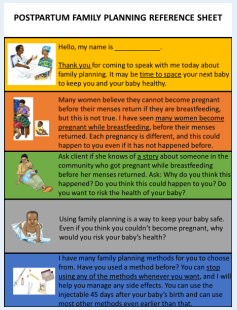
Designed to fit into the Federal Ministry of Health's Family Health Card.

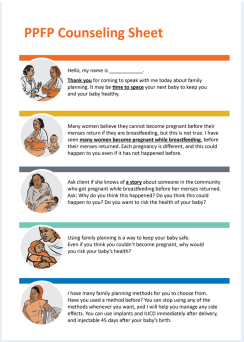
Includes scoring instructions and space for household name and phone number of health extension worker for contact between visits.

EVOLUTION: PPFP 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

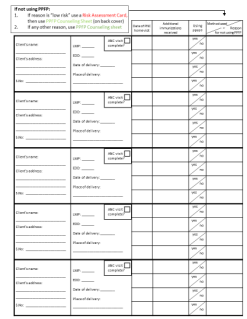
SOLUTION

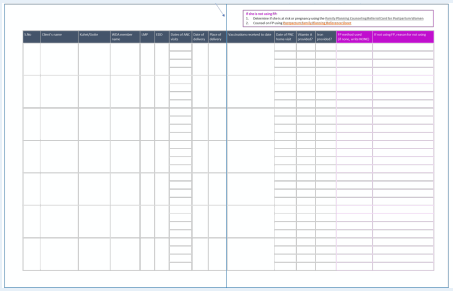
Final design incorporates images that mirror the Family Health Guide.

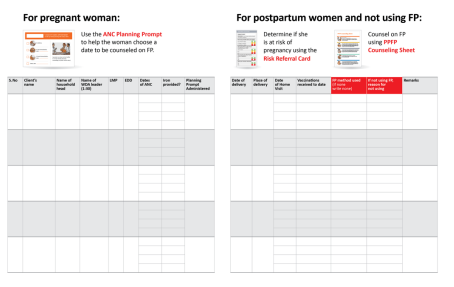
Training of health workers clarifies how to integrate the counseling sheet with the REDI (Rapport Building, Exploring, Decision Making, and Implementing the Decision) Counseling framework.

EVOLUTION: HOME VISIT TRACKING LOG

UPDATES BASED ON FEEDBACK







1

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.

2

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 ANC Planning Prompt, Risk Referral Card, or the PPFP Counseling Sheet.

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

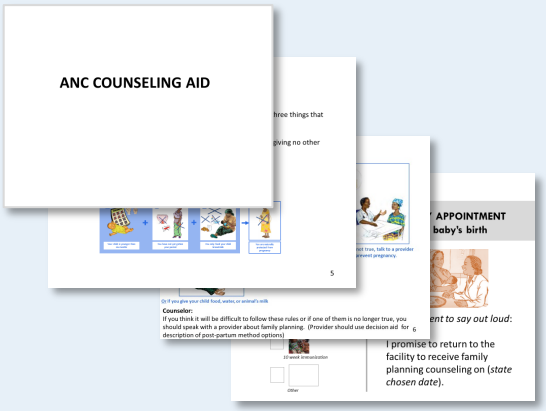
Most health workers asked for a bag into which all these solutions could be placed.

3

SOLUTION

We incorporated visual reminders of when to apply the ANC Planning Prompt, Risk Referral Card, and PPFP Counseling Sheet.

FAILED PROTOTYPES



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.

FAILED PROTOTYPES

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.**

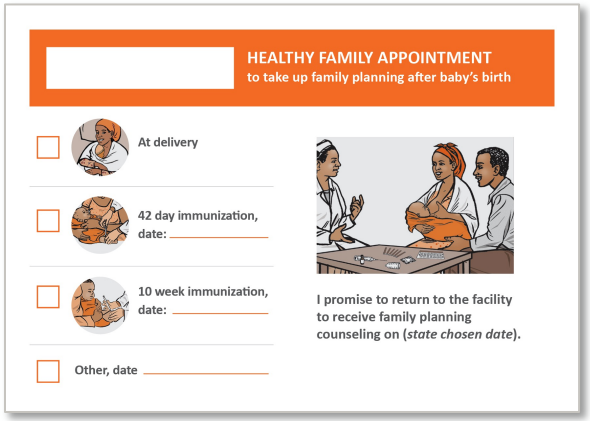
We discarded this idea.

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.

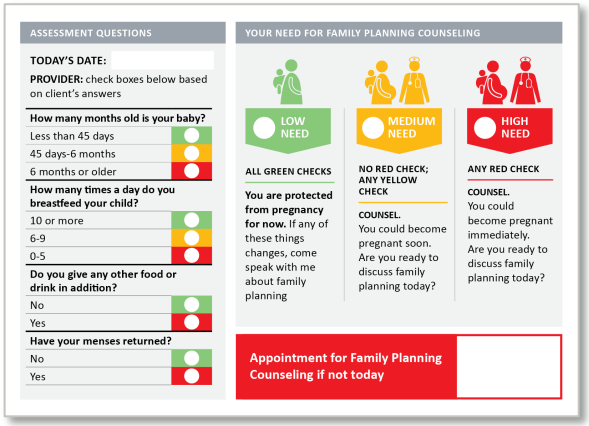
We discarded this idea.

SOLUTIONS: PART 1



ANC PLANNING PROMPT

+ The ANC 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.



RISK REFERRAL CARD

+ The Risk 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.

SOLUTIONS: PART 2


PPFP Counseling Sheet

Hello, my name is _____.

Thank you for coming to speak with me today about family planning. It may be time to space your next baby to keep you and your baby healthy.

Many women believe they cannot become pregnant before their menses return if they are breastfeeding, but this is not true. I have seen many women become pregnant while breastfeeding, before their menses returned. Each pregnancy is different, and this could happen to you even if it has not happened before.

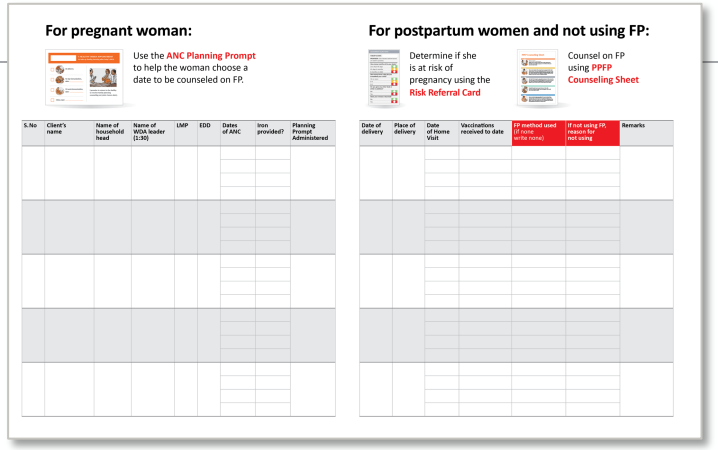
Ask client if she knows of a story about someone in the community who got pregnant while breastfeeding before her menses returned. Ask: Why do you think this happened? Do you think this could happen to you? Do you want to risk the health of your baby?

Using family planning is a way to keep your baby safe. Even if you think you couldn't become pregnant, why would you risk your baby's health?

I have many family planning methods for you to choose from. Have you used a method before? You can stop using any of the methods whenever you want, and I will help you manage any side effects. You can use implants and IUCD immediately after delivery, and injectable 45 days after your baby's birth.

PPFP COUNSELING SHEET

+ The PPFP 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.


For pregnant woman:

Use the ANC Planning Prompt to help the woman choose a date to be counseled on FP.

For postpartum women and not using FP:

Determine if she is at risk of pregnancy using the Risk Referral Card

Counsel on FP using PPFP Counseling Sheet

S.No	Client's name	Name of household head	Name of WDA leader (1:30)	LMP	EDD	Dates of ANC	Iron provided?	Planning Prompt Administered

Date of delivery	Place of delivery	Date of Home Visit	Vaccinations received to date	FP method used (if none write none)	If not using FP, reason for not using	Remarks

HOME VISIT TRACKING LOG

+ The Home Visit Tracking Log 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 Log makes it easier for HEWs to follow up with women in the post-partum period who may be at risk for pregnancy and focus home visits on these women.

IMPLEMENTATION AND EVALUATION IN ETHIOPIA

5

+ Implementation and evaluation overview
+ Exposure to solutions
+ Contraceptive intentions, behaviors, and perceptions
+ Impact on outcomes of interest
+ Qualitative findings
+ Summary and recommendations

IMPLEMENTATION AND EVALUATION OVERVIEW

Photo by Sarah Lance

We conducted a quasi-experimental, mixed-method evaluation to test if the solutions would result in an increase in postpartum women reporting having a current intention to use contraception. We also collected data to better understand the implementation experience and perceived impact of the solution set.

IMPLEMENTATION:

+ **7 primary health care units (PHCUs)** in Tigray were purposively selected for implementation of the (re)solve intervention.
+ **183 providers and Health Extension Workers (HEWs)** were oriented to the tools in the solution set and practiced implementing them during training.

WE CONDUCTED:

+ **321 cross-sectional, facility-based surveys** with women between 16-24 weeks postpartum across 14 purposively selected PHCUs (7 intervention and 7 control).
+ **14 key informant interviews (KIIs) with health providers** across the 7 intervention PHCUs.
+ **14 KIIs with HEWs** across the intervention PHCUs.

NOTABLE DISRUPTIONS:

+ Implementation and evaluation were disrupted, rescheduled, and adapted due to the COVID-19 pandemic and the emergence of the conflict in Tigray in November 2020.
+ Travel and public gathering restrictions, personal protective equipment (PPE) requirements and social distancing, safety and security concerns, communications blackout, health posts closed or looted, damage to infrastructure and supply chains, fluctuation in client volumes.

It is important to note that the (re)solve solution set was not designed to be used in conflict or post-conflict settings.

EXPOSURE TO SOLUTIONS IN INTERVENTION PHCUS

OF WOMEN 16-24 WEEKS POSTPARTUM (N=162):

- 96% were exposed to ANC Planning Prompt.
- Near-perfect exposure to Risk Referral card (99%) at 45-day immunization visits, with a drop to 27% at 10-week visits.
- 97% and 100% exposure to the PPFP Counseling Sheet at the 45-day and 10-week immunization visits, respectively.
- The Home Visit Tracking Log, as a tool designed to support the HEWs, was not shown to clients and therefore there were no survey questions addressing it.

TABLE 1. Exposure to (re)solve intervention components (among intervention group women)

TOOL EXPOSURE	QUESTION ASKED IN SURVEY AND TIMING OF EXPOSURE (NUMBER OF ELIGIBLE WOMEN)	NUMBER OF WOMEN EXPOSED, (%)
ANC Planning Prompt	Provider completed planning prompt at **any ANC visit** (n=162; all postpartum women in intervention group)	156 (96%)
Risk Referral Card	Provider completed card and gave risk score at **45-day immunization visit** (n=76; postpartum women who had a 45-day immunization visit and were not using contraception)	75 (99%)
PPFP Counseling Sheet	Provider talked about contraception at **45-day immunization visit** (n=75, postpartum women who were assessed with risk referral card at 45-day immunization visit)	73 (97%)
Risk Referral Card	Provider completed card and gave risk score at **10-week immunization visit** (n=11, postpartum women who had a 10-week immunization visit and were not using contraception)	3 (27%)
PPFP Counseling Sheet	Provider talked about contraception at **10-week immunization visit** (n=3, postpartum women who were assessed with risk referral card at 10-week immunization visit)	3 (100%)

CONTRACEPTIVE INTENTIONS, BEHAVIORS, AND PERCEPTIONS

The distribution of our primary outcome, contraceptive intention, is shown below in Table 2, along with uptake of modern contraceptive and LARC methods. In all three cases, intention and uptake is high in the sample, and statistically significantly higher for intervention-group women as compared to comparison-group women.

We assessed three additional outcomes that theoretically would be impacted by exposure to the (re)solve solution set, including accurate fertility awareness, risk of pregnancy assessment and contraceptive self-efficacy.

Table 2 below shows the comparison of the scores on these three variables between intervention and comparison.

For all three variables, intervention group women scored higher than comparison group women; specifically, intervention group women were more likely to have answered the fertility awareness questions correctly and scored at the median or higher on the pregnancy risk assessment question set and the contraceptive self-efficacy question set.

TABLE 2. Outcomes in contraceptive intentions, use, and perceptions in comparison and intervention sites

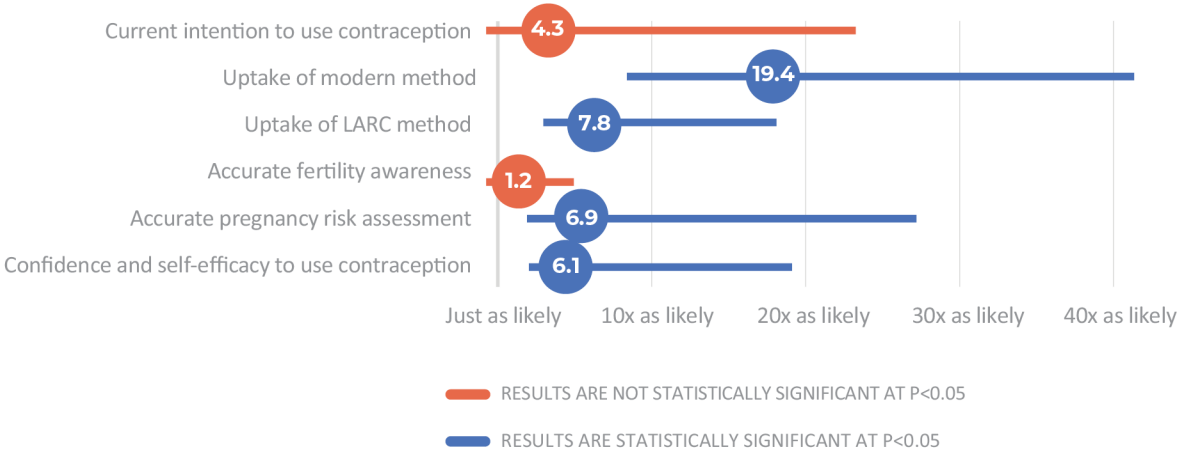
		COMPARISON N= 159 (49%)	INTERVENTION N= 162 (51%)	TOTAL N= 321 (100%)
Intention to use contraception*	Yes	147 (93%)	157 (98%)	304 (95%)
Reported uptake of modern contraceptive***	Yes	55 (35%)	138 (85%)	193 (60%)
Reported uptake of a LARC method***	Yes	52 (33%)	125 (77%)	177 (55%)
Accurate fertility awareness*	Answered correctly	24 (15%)	45 (28%)	69 (22%)
Pregnancy risk assessment ***	Scored at median, or higher	106 (67%)	137 (85%)	243 (76%)
Contraceptive self-efficacy ***	Scored at median, or higher	68 (43%)	118 (73%)	186 (58%)

Statistically significant at * p<0.05, **p<0.01, ***p<0.001

IMPACT ON OUTCOMES OF INTEREST

Figure 1. The potential effect of the (re)solve intervention on key behavioral outcomes of interest (presentation of adjusted odds ratio and corresponding 95% confidence interval for each behavioral outcome of interest)

Compared to postpartum women in the comparison group, postpartum women in the intervention group are more likely to exhibit the following behavioral outcomes:



Current intention to use contraception = 4.3 (0.8-23.0)
Uptake of modern method = 19.4 (9.2-41.1)
Uptake of LARC method = 7.8 (3.2-18.8)

Accurate fertility awareness = 1.2 (0.5-3.0)
Accurate pregnancy risk assessment = 6.9 (1.7-28.4)
Confidence and self-efficacy to use contraception = 6.1 (2.0-19.4)

+ Intervention group women had higher odds of having a current intention to use contraception (not statistically significant).
+ Intervention group women had significantly higher odds of both reported modern use uptake and LARC uptake.
+ Intervention group women had higher odds of having accurate fertility awareness (not statistically significant).
+ Intervention group women were more likely to be at the median or higher on both pregnancy risk assessment and contraceptive self-efficacy scores.

FACTORS ENABLING & INHIBITING SUCCESSFUL IMPLEMENTATION

FACTORS ENABLING IMPLEMENTATION:

+ Ease of use & designed in local language (Tigrigna).
+ Multiple touchpoints reinforced key FP messages and offered reminders to women at different timepoints.
+ ANC Planning Prompt raised awareness and importance of FP to the ANC clients and supported them to take charge of their own fertility.
+ The color scale of the Risk Referral Card helped mothers to easily understand and assess their pregnancy risk.
+ The PPFP Counseling Sheet provided practical, real-life examples of pregnancy risk while breastfeeding and made PPFP counseling more effective.

> **THE [ANC PLANNING PROMPT] IS EASY TO USE. You can easily counsel the mother without difficulty…because it is prepared in the local language. Mothers who can read and write can easily understand it by themselves; however, for those mothers who cannot read and write the health professional will read [it to them].”**
> (Health Extension Worker)

> **DURING THE CONFLICT PERIOD WE WERE NOT STABLE and sometimes we might fail to apply [the (re)solve tools] because it was the issue of life and we were not delivering services freely.”**
> (Health Extension Worker)

FACTORS INHIBITING IMPLEMENTATION:

+ Demanding workload for providers and high client volume.
+ Challenges of using multiple provider-based guides and tools as provided by the Regional Health Bureau and multiple organizations.
+ Influence of social and gender norms which limit women’s ability to make decisions around contraception.
+ Significant challenges and disruptions as a result of the regional conflict, including inconsistent service provision and difficulty completing home visits, which impacted use of the intervention tools.

POSITIVE PERCEPTIONS OF INTERVENTION IMPACT

Providers shared their perceptions of positive impacts of the intervention, as well as why they would advocate for scaling-up the (re)solve solution set.

+ **Improved quality of counseling.** The tools were beneficial in improving the quality of FP counseling and helped providers better connect with their clients.

+ **Improved changes in behavior.** The intervention was helpful in raising FP awareness and changing attitudes and intentions. Providers reported perceptions of postpartum women towards contraceptives have started to shift.

+ **Improved health outcomes.** Most providers believed the intervention resulted in increased FP uptake, a reduction in unintended pregnancies, and an improvement in birth spacing.

> **THERE IS A HUGE DIFFERENCE IN COUNSELING VIA THESE SUPPORTIVE MATERIALS** [rather] than that of blindly implementing the counseling process. Because of such [an] effect, it is advisable to scale up these tools to other facilities." (Health Extension Worker)

> **ALL THE TOOLS ARE HELPFUL IN COUNSELING AND REMINDING THE WOMEN [TO TAKE] CONTRACEPTIVES** especially if the are properly integrated with the existing health care system and with routine service… I am sure remarkable change can be seen if all the tools [are scaled up] with good follow up." (Health Extension Worker)

Photo by Sarah Lance

CONSIDERATIONS FOR FUTURE DESIGN AND SCALE

Although most providers found the (re)solve intervention tools highly acceptable and easy to use, opportunities for improvement were also noted.

+ **Make tools sturdier for durability and increase font size for ease of use.**

+ **Integrate additional reminders into the tools,** such as ANC follow up schedules and maternal and child health dangers signs to watch for.

+ **Incorporate additional sexual and reproductive health information from clients into the tools**, such as resumption of sexual activity and contraceptive method of choice.

Photo by Sarah Lance

> **I DO RECOMMEND ALL THESE SUPPORTIVE TOOLS TO BE INCLUDED AT EVERY SHORT COURSE TRAINING** like family planning and prevention of mother to child transmission of HIV/AIDs (PMTCT) guidelines. This is because these guidelines have contraceptive utilization as part of their course. Therefore, if we incorporate these tools within these guidelines, it will be simple to administer the short course training as part of it." (Health Provider)

+ **Integrate tools within the existing health system.** There was an overriding sentiment among providers that it is critical to find ways to further integrate the (re)solve tools within the existing health system. Proper integration within national health guidelines would streamline the training and deployment of these tools. It was also help to address the challenges providers expressed regarding working with multiple tools.

THE PERCEPTION OF MOTHERS TOWARDS CONTRACEPTIVES HAS ALREADY BEGUN TO CHANGE...

mothers start to understand the risk of unwanted pregnancy. The overall intention to use and utilization of contraceptives started to change, so it is really good to implement it in a large scale." (Health Provider)

COUNSELING USING THE TOOLS MAKES THE MOTHERS HOPEFUL AND HAPPY, **because they understand we are concerned about them. They will say: they educate me, they read the content of the tool for me and register me, so I should use family planning."**
(Health Provider)

THE (RE)SOLVE TOOLS IMPROVED COMMUNITY AWARENESS AND KNOWLEDGE.

The community belief was not supportive [of] postpartum family planning utilization, but after we start[ed] using the new solutions, uptake of PPFP has increased." (Health Provider)

SUMMARY AND RECOMMENDATIONS

SUMMARY OF FINDINGS

+ **The (re)solve intervention had a positive, but not statistically significant, association with contraceptive intention.** These exploratory findings indicate that the (re)solve intervention is able to move postpartum women along the intention-action continuum to actualize changes in key contraceptive behavior.
+ **Exploratory analyses showed a somewhat larger and statistically significant association with other outcomes** like modern contraceptive use, LARC use, contraceptive confidence and self-efficacy, and accurate pregnancy risk assessment.
+ **Qualitative data indicates providers had a positive experience** with the (re)solve tools and found them acceptable and easy to implement.
+ **Providers indicated that the behavior change mechanism associated with the solution set can contribute to contraceptive uptake.**
+ **Exposure to the intervention among women 16-24 postpartum was quite high.**

RECOMMENDATIONS

+ **Providers advocated for the scale-up for the solution set**, indicating their belief that the intervention was making a difference in improving counseling, behaviors, and FP outcomes.
+ **The intervention tools have the potential to fill gaps** in existing counseling, tools, and training related to PPFP.
+ **Future work should explore strategies to integrate and scale-up** the (re)solve solution set within the existing health system. Integration with existing tools, training, and systems will help to streamline the training and deployment of these tools and can facilitate their ownership by the Ministry of Health.
+ **Digital solutions can also be explored as part of the health system integration and scale up strategy.** mHealth interventions could digitize and streamline the (re)solve tools for providers, or an online repository could be created for MOH-approved and INGO-tested health tools.

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Cover photo by Sarah Lance

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