2022 CLA CASE COMPETITION

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Case Title:

On the drawing board: Honing family planning interventions before scale-up in two countries

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Community members identify challenges during pause-and-reflect meeting in Bangladesh
Credit: Save the Children Bangladesh

Summary:

Young first-time mothers (FTMs; ages 15-24) are most vulnerable to closely-spaced pregnancies and adverse outcomes for themselves and their newborns. The transition to parenthood provides opportunities to improve FTMs' use of health services, including voluntary postpartum family planning (PPFP). However, many existing efforts have involved complex interventions that prove challenging to scale and sustain.

The Connect project sought to develop sustainable FTM interventions by "enhancing" USAID projects in Bangladesh and Tanzania, embedding light-touch interventions targeting barriers to FTMs' PPFP use into those projects' activities. Interventions combine home visits led by community health workers (CHWs) with efforts to improve quality and responsiveness of facility services.

We used collaborating, learning, and adapting (CLA) approaches in small-scale testing to improve feasibility, acceptability, effectiveness, and scalability of the interventions and to inform strategic decision-making about scale-up. Following formative research and design processes, we developed preliminary theories of change underpinning implementation and evaluation efforts. Through pause-and-reflect meetings with CHWs and facility providers, "pulse check" sessions with FTMs and family members, using monitoring for learning, and consultation with health system stakeholders, we identified needed adjustments to tools and implementation approaches, and documented insights to inform scale-up. Rapid surveys assessed effectiveness and acceptability to FTMs.

CLA efforts proactively informed the identification of challenges and gaps to be addressed, collaborative scenario planning prior to scale-up, and strategic decision-making. We identified significant improvements in PPFP uptake among FTMs, and other outcomes of interest (couple communication, self-efficacy). We continue to apply CLA to further improve interventions during wider-scale implementation through internal and external collaboration.

Which two subcomponents of the Collaborating, Learning & Adapting (CLA) Framework are most reflected in your case? Please reference them in your submission.

- Internal Collaboration
- External Collaboration
- Technical Evidence Base
- Theories of Change
- Scenario Planning
- M&E for Learning
- Pause & Reflect
- Adaptive Management
- Openness
- Relationships & Networks
- Continuous Learning & Improvement
- Knowledge Management
- Institutional Memory
- Decision-Making
- Mission Resources
- CLA in Implementing Mechanisms

1. WHAT: What is the general context in which the case takes place? What organizational or development challenge(s) prompted you to collaborate, learn, and/or adapt?

In many low-and-middle income countries, high adolescent pregnancy and early marriage rates result in large populations of adolescent and youth first-time mothers (FTMs) ages 15-24. FTMs and their babies are more vulnerable to adverse health outcomes, and less likely to use health services, than older mothers. The transition to becoming a parent for the first time also offers opportunities to encourage positive health and parenting practices.

Holistic interventions have deepened insights into effective program responses, and demonstrated promise to improve FTMs' use of health services including voluntary postpartum family planning (PPFP). However, these complex initiatives have proven challenging to scale-up and sustain within government health systems.

With funding from the Bill & Melinda Gates Foundation, the Connect project developed sustainable interventions to improve FTMs' PPFP use by "enhancing" USAID projects in Bangladesh (MaMoni Maternal and Newborn Survival Project [MNCSP]) and Tanzania (Lishe Endelevu). We designed interventions that would address key barriers to FTMs' PPFP use identified in formative research, and also that could both be feasibly embedded into the USAID projects' activities, and sustainable within existing government platforms.

In Bangladesh, our interventions leverage MaMoni MNCSP's facility- and community-level approaches to strengthen pre-discharge counseling for FTMs who deliver in facilities, and to guide CHWs to use a targeted postnatal care (PNC) approach to prioritize home visits to mother-baby dyads meeting identified risk criteria. In Tanzania, we enhance Lishe Endelevu's community activities to improve the enrolment of FTMs in CHW-led community support groups (CSGs), conduct home visits to FTMs, and, at the facility level, introduce an on-the-job respectful care training to address disrespectful treatment of FTMs.

Following the initial formative and design processes, we developed preliminary theories of change to guide evaluation and learning efforts for each country, and launched small-scale testing informed by CLA efforts.

2. WHY: Why did you decide to use a CLA approach? Why was CLA considered helpful for addressing your organizational or development challenge(s)?

Despite a careful design process that relied on a strong technical evidence base, our project team recognized that tools and implementation strategies would require strategic decision-making about needed refinements before scale-up. For example, formative and design processes had underscored that CHWs are under-resourced and over-burdened, and that we would need to examine the feasibility and acceptability of our interventions. Prior experience had shown that even with pre-testing, materials would require adjustments to improve usability and clarity following use in a real-world setting. Further, designing sustainable interventions feasible for implementation at scale by the USAID projects required key trade-offs; i.e., dosage was limited due to limited provider bandwidth, and engagement of FTMs' male partners was limited. Also, we knew that the preliminary theories of change developed based on formative and design processes had gaps to be filled and assumptions to be validated.

In discussion with our donor beginning in the proposal stage, we decided to invest time and resources into CLA practices, with the aim of refining the interventions during small-scale testing, and gathering key insights to inform scale-up. A CLA approach was essential to identifying how our interventions needed to be refined to improve feasibility of implementation by government cadres, scalability within government platforms, acceptability to FTMs and providers, and effectiveness in improving FTMs' PPFP use. We planned some CLA efforts throughout our small-scale testing phase in the proposal, but plans expanded over time as our understanding of knowledge gaps grew.

3. How: Tell us the story of how you used a collaborating, learning and/or adapting approach to address the organizational or development challenge described in Question 2.

Throughout small-scale implementation, we used CLA approaches to gather insights from health system stakeholders, frontline implementers (facility providers and CHWs), FTMs, and key influencers to inform decisions about refinements to the interventions and to hone the theories of change. CLA approaches evolved iteratively based on learning. Early efforts explored key vulnerabilities identified in formative and design processes, and gathered open-ended feedback on what had worked well and what had not. Learning informed program activities (e.g., addressing identified issues through trainings/refreshers, adjusting tools) and subsequent CLA efforts (e.g., deeper exploration of lessons emerging in earlier CLA or program activities, follow-up on mitigation approaches introduced in response to identified challenges).

We used parallel methods across countries, with tailored data collection tools. We used an implementation matrix to track and synthesize learning across various sources and to facilitate action-based discussion amongst project teams. Learning approaches included the following:

• We fostered stakeholder inputs by establishing Technical Advisory Groups (TAGs) at project onset. TAGs, comprising national and regional health system stakeholders, implementing partners, and researchers, guided navigation of bigger-picture and system-level challenges. We routinely sought feedback and input from district-level stakeholders through joint supervision visits and coordination meetings leveraging existing mechanisms where feasible.

• Project staff convened pause-and-reflect meetings with frontline implementers. These quarterly meetings gathered insights on successes, challenges, how they overcame the challenges, and their recommendations for improvement. In Tanzania, we held six pause-and-reflect meetings, over two rounds, with CHWs in collaboration with district representatives. We used a breakout group format, with vignettes, to allow CHWs to freely share and discuss their experiences, then engage district representatives in navigating system-level challenges through plenary discussions. We convened two pause-and-reflect meetings in Bangladesh, with CHWs and facility providers separately.

• Project staff conducted brief qualitative pulse check sessions with FTMs to gather feedback about their interactions and experiences with interventions, and suggestions for improvement. In both countries, the exercise was initially held as a group discussion; however, in Tanzania, we conducted additional pulse checks using a one-on-one interview approach to help FTMs to feel more comfortable. We convened separate group pulse checks with older female relatives (mothers-in-law in Bangladesh; mothers and grandmothers in Tanzania) and individual interviews with male partners. These sessions explored the interactions and experiences that these key family members have had with the program, any concerns about the content, the level of their involvement and/or the involvement of FTMs, and their recommendations for improvements.

• We conducted two rounds of rapid quantitative surveys with FTMs, measuring progress on key outcomes, exploring FTMs' positive and negative experience with approaches, identifying areas for improvements before scale-up, and informing monitoring and evaluation efforts. Following preliminary analyses of each survey round, we convened pause-and-reflect workshops with project teams to discuss findings that were unexpected and/or that had potential implications for programming. Discussions sought to identify a clear way forward for refining the interventions, improving implementation strategies, and identifying areas for further exploration using CLA approaches.

Concurrently, we conducted routine monitoring and captured other feedback and observations from coordination meetings, community engagement activities, and supervisory visits. Triangulating findings from across learning sources, we evolved the theory of change, which will drive our wider-scale learning and evaluation efforts and underpin the overall learning emerging from this work.

4. ORGANIZATIONAL IMPACT: How has collaborating, learning and adapting affected your team and/or organization? If it's too early to tell, what effects do you expect to see in the future?

Applying an adaptive management approach cultivated a flexible and open-minded team dynamic as we moved through the small-scale testing and refinement phase. CLA both allowed flexibility and provided structure to gather insights through internal and external collaboration. At the start of the testing phase, we had a drafty set of interventions to test, and we knew that we had gaps—both known and unknown—that would need to be filled before moving to scale. Our context-aware monitoring, evaluation and learning systems were designed to embrace the collaborative and adaptive nature of our approach, and to foster continuous learning. By the end of testing, we had well-defined packages of tools and richly-documented how-to guidance drawn from experience. When triangulated with conventional information sources (monitoring data, survey findings), CLA approaches informed strategic decision-making, including improvements to the tools and implementation strategies throughout small-scale testing. This learning built confidence that the approaches could be feasibly and effectively implemented at scale, and that they were acceptable to frontline workers, clients, and health system stakeholders. Using CLA approaches allowed us to capture insights informing how-to programming guidance that may have slipped through the cracks of routine monitoring and evaluation efforts and encouraged more open discussion about what was not working well. We continue to use CLA to inform strategic decision-making during wider-scale implementation.

The benefits extend beyond the immediate project teams. For example, a district stakeholder in Tanzania shared that pause-and-reflect sessions deepened their understanding of the challenges CHWs experienced, and guided more effective support to CHWs, including advocating to address higher-level system issues identified.

5. DEVELOPMENT IMPACT: How has using a CLA approach contributed to your development outcomes? What evidence can you provide? If it's too early to tell, what effects do you expect to see in the future?

CLA contributed to strong outcomes by proactively identifying adjustments needed to improve feasibility, acceptability, scalability, and effectiveness. In both countries, surveys identified positive associations between interventions and PPFP use. In Tanzania, participating in more than one CSG meeting or receiving a home visit by a CHW were each associated with 59% increases in PPFP use. In Bangladesh, FTMs reached by CHWs were 20% more likely to use PPFP. Select CLA-informed revisions include:

In Bangladesh, providers described the pre-discharge counseling checklist as useful, with added benefits of documenting mother/baby status at discharge. However, it was long and onerous, deterring use. With providers and the TAG, we convened a collaborative re-design process, streamlining the tool. Concurrently, CHWs' workloads limited home visit coverage. Some shifted to phone follow-up to counsel, prioritize visits, and initiate referrals. This helped balance workloads and build rapport and trust with FTMs. Learning bolstered joint advocacy efforts, with MaMoni-MNCSP, for the MOH to fill vacancies, and train interim volunteers to fill vacancies.

In Tanzania, FTMs wished to receive FP methods at home, but some CHWs could not access methods due to facility managers' reluctance. The team successfully supported CHWs to negotiate access. In parallel, FTMs felt home visits allowed private discussion of concerns. However, surveys showed that most visits occurred during pregnancy or 6 months after delivery, missing critical windows to support early PPFP initiation and breastfeeding. Further, male partners were often busy or uninterested to participate, and FTMs' preferences on engaging partners varied. Through refresher trainings, we supported CHWs to develop a schedule to visit FTMs soon after delivery, while considering FTMs' preferences for partner participation. Subsequent pause-and-reflects explored challenges to timely visits and male engagement.

6. ENABLING CONDITIONS: How have enabling conditions - resources (time/money/staff), organizational culture, or business/work processes - influenced your results? How would you advise others to navigate any challenges you may have faced?

Opportunities to hone both program tools and learning approaches (e.g., pause-and-reflect methods and tools, rapid surveys) before scale-up were invaluable. Multiple factors shaped CLA efforts:

A CLA approach required a high degree of comfort with uncertainty, a willingness to openly share aspects that were not working well, and many budget scenario exercises. This presented a new way of working for many team members, and creating a flexible team culture took time. A supportive donor, flexible work plans, and team culture enabled this iterative approach.

At times, CLA identified substantive adjustments needed in response to challenges, which required unanticipated time and resources to address (e.g., the pre-discharge checklist was fully re-designed to improve feasibility and acceptability). Our team also grappled with findings that could not be fully addressed within our scope and resources. Notably, male partner engagement was challenging in both countries. While we ultimately concluded that we could not fully address underlying deeply-seated norms that limited male partner engagement, extensive discussions of findings that could not be addressed subsumed project time and energy.

While pause-and-reflect exercises were budgeted in the proposal, other CLA efforts developed organically as needs became more clear, and were under-resourced. It may be useful for teams to allocate placeholder funding for CLA activities in proposal budgets even if the specific needs are unclear, to be programmed as the project evolves. Further, most CLA exercises were led by project staff, who received a brief practical qualitative data collection training. The time needed to prepare, conduct, and interpret findings from CLA exercises exceeded expectations, and diverted time and resources from other activities. Moreover, the team's proximity to implementation likely colored perspectives. Improved resourcing of CLA efforts to bring in external perspectives with more distance will be important.