Feasibility Study Insights

Results from a 3-week feasibility study

Breakthrough ACTION Malawi, January – February 2020

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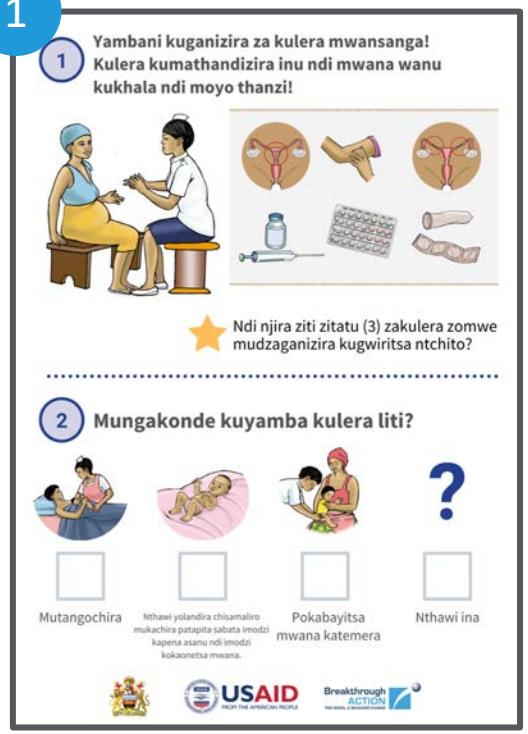
Purpose of the Feasibility Test

*We conducted a **3-week feasibility test in 7 health facilities** across Lilongwe and Machinga to **assess the operational feasibility** of a solution set intended to improve postpartum family planning services in Malawi.*

Overview of the solution set

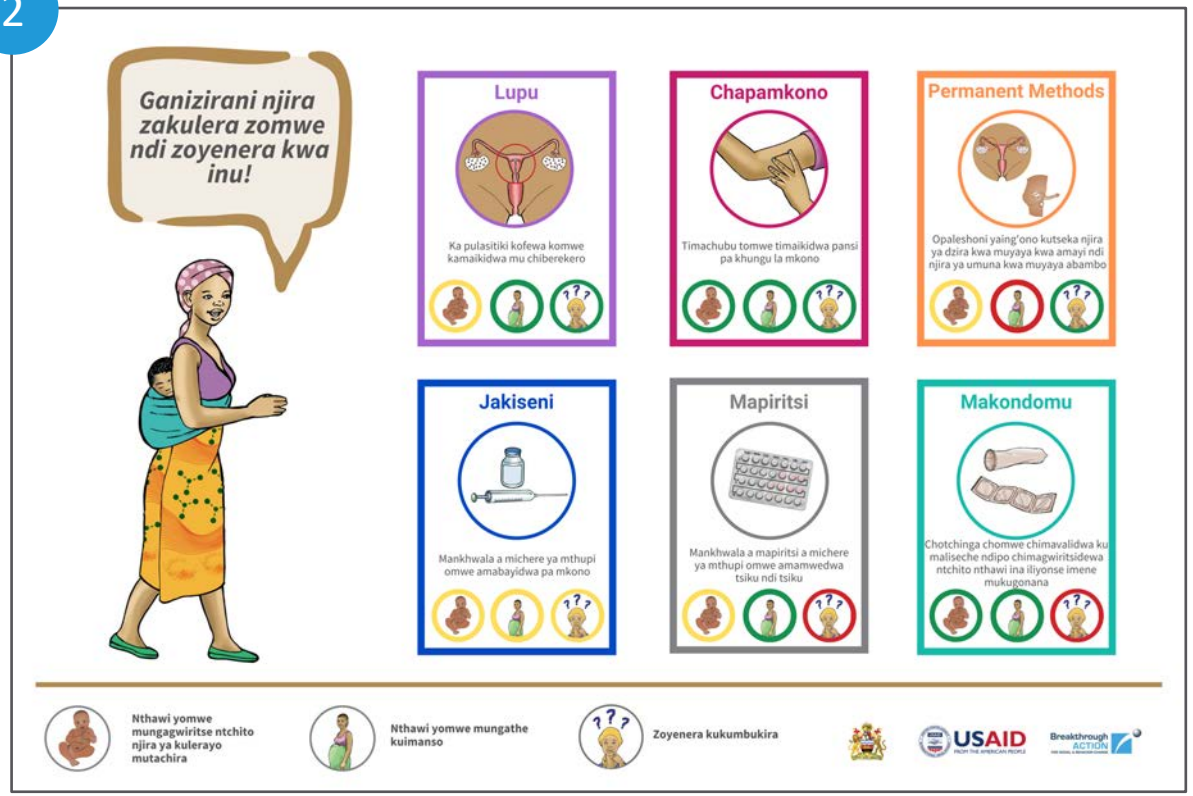
ANC Insert

1



Group Counselling Tool

2



Method Referral Cards

3

4

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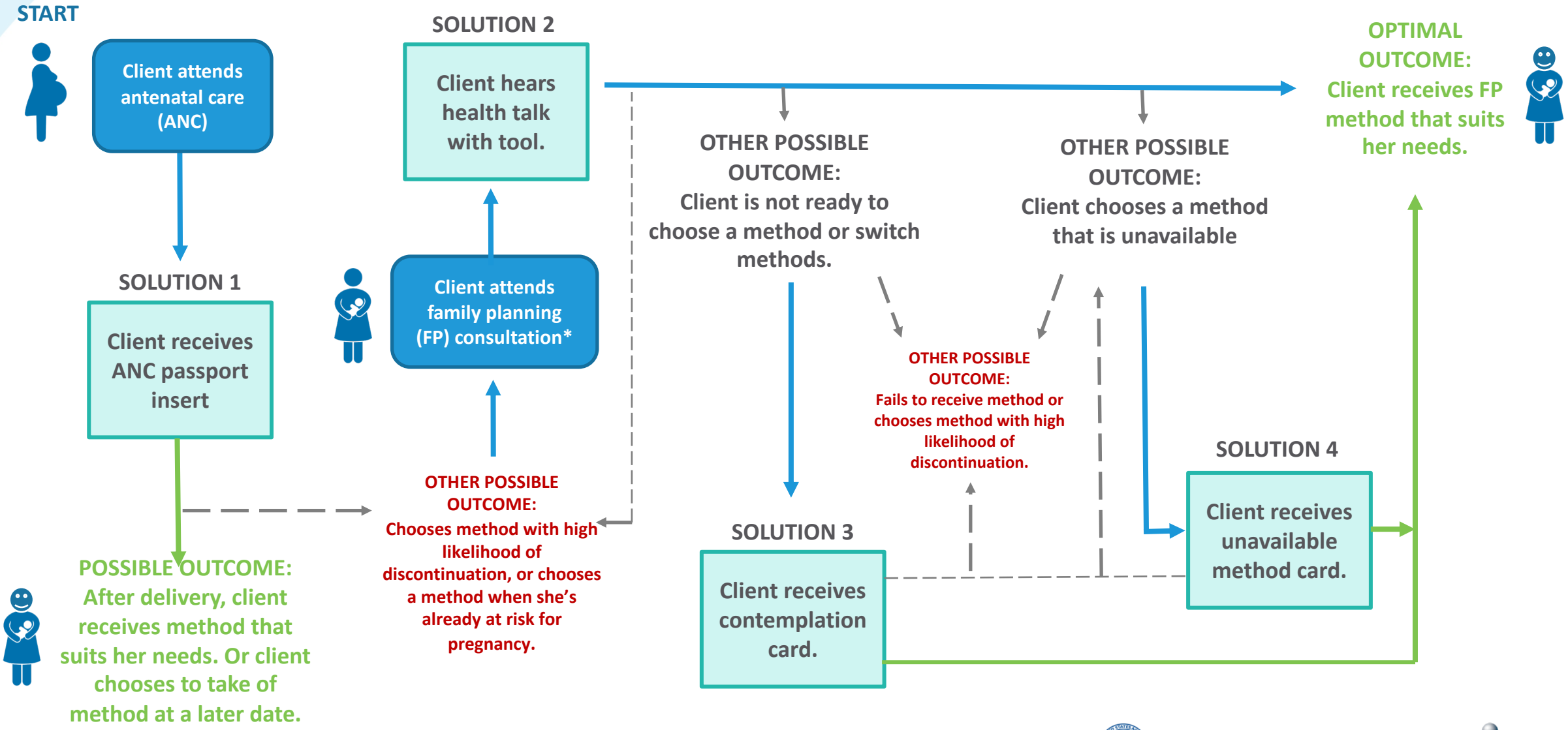
Women's engagements with the solutions

Solutions ensure we capture postpartum women at many points



** The solutions can also be used at postnatal care or immunization consultations to refer women to FP.*

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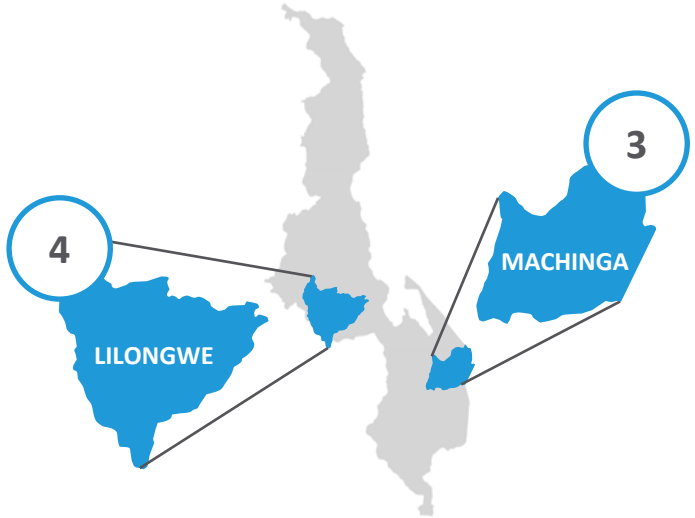
Solution set in practice

L to R: PM delivering the tools at the start of implementation; Participants in a training practice using the group counselling tool; A health talk with the group tool at Kawale Health Centre.

Study roll-out

- We rolled out the solutions to…
- 4 facilities in Lilongwe: Mitundu, Kawale, Chadza, Nathenje
- 3 facilities in Machinga: Mangamba, Ntaja, Chikweo
- These facilities were also involved in our diagnosis and user-testing research (with user-testing in Lilongwe only)



Study roll-out contd.

- We began implementation with a Training of the Trainers (ToT), where trained 18 individuals.
  - Organized Network of Services for Everyone's health (ONSE) clinical coordinators
  - ONSE district coordinators
  - Ministry of Health (MOH) FP coordinators
  - ONSE BLM nested providers
  - Reproductive Health Directorate (RHD) FP program officers
  - ONSE clinical director, FP advisor, Youth and gender advisor
- Those trained at the ToT and the BA project manager were responsible for training district-level facility staff and monitoring implementation throughout the study period.

How did we develop our testing plan?

Our feasibility test was designed to evaluate whether or not the solutions could be successfully implemented, based on the following criteria:

Success

- Solutions can be implemented by all FP and ANC providers at all facilities, with some slight tweaks that still allow the solutions to meet their objectives.
- Providers and supervisors express interest in sustained implementation.
- Clients are receptive to the solutions and demonstrate that they understand the purpose.

Failure

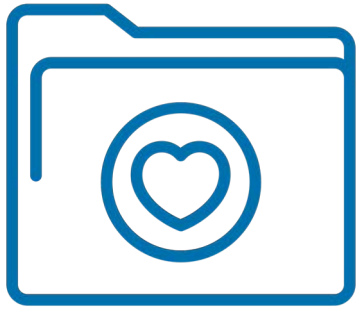
- Clients or providers do not trust the solutions or feel uncomfortable using them.
- Clients are unwilling to accept the solutions.
- Providers are unable to implement the solutions with fidelity.
- Providers are unable to complete their regular duties because of the solutions.
- Providers or supervisors do not want to move forward with implementation.
- The solutions have an unforeseen negative effect on clients' FP take-up or other health outcomes.

Research questions

1. To what extent is the counselling tool implemented effectively?
2. To what extent is the ANC passport insert implemented effectively?
3. To what extent are the contemplation cards implemented effectively?
4. To what extent are the unavailable method cards implemented?
5. How is the referral tracking drop box used in a feedback meeting?
6. What kind of modifications are health workers making to the designs?

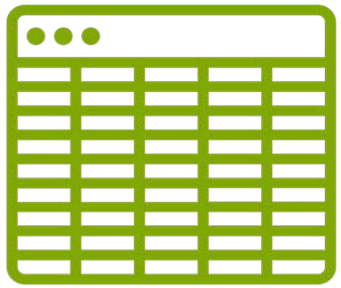
Data collection

Two research assistants and the BA project manager collected data



Administrative data on service delivery + stock remaining

n=7 facilities



Observations of FP consultation, ANC consultations, health talks and meetings

n=43 observations

Interviews with health providers and in-charges

n=27 service providers

Results from the trainings

Machinga Training

- 18 participants from 3 facilities
  - In-charges
  - Community nurse
  - Nurse midwife technician
  - Registered midwife
- Trainers were nested providers, MOH FP coordinator, MOH nurse service provider & ONSE coordinator

Lilongwe Training

- 25 participants from 4 facilities
  - In-charges
  - Community nurse
  - Nurse midwife technician
  - Registered midwife
  - Health surveillance assistants
- Trainers were nested providers, MOH FP coordinator, MOH nurse service provider & ONSE coordinator

Results from the trainings

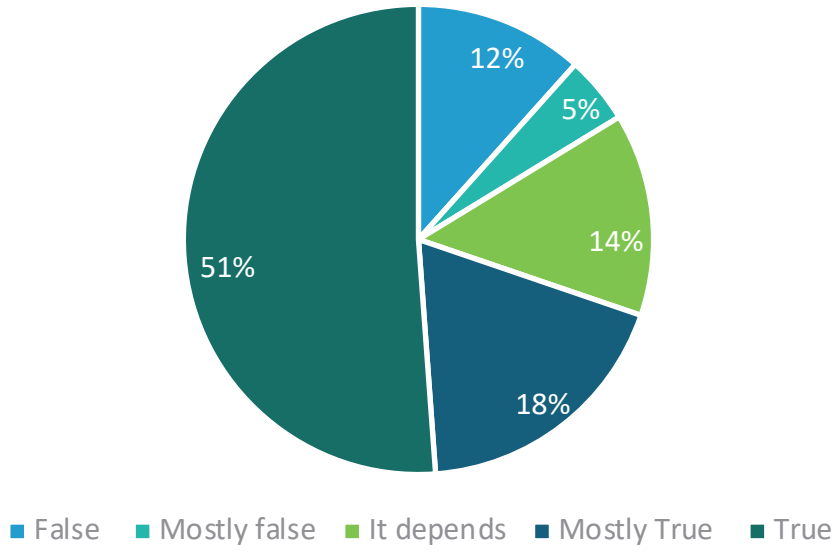
- One goal of the training was to to **clarify misperceptions about postpartum family planning (PPFP), long acting reversible methods and method satisfaction**.
- We collected pre-training surveys on perceptions and distributed a feedback form after the trainings.
- Pre-test results from the survey and feedback form show that the trainings were properly designed to address gaps in provider knowledge and misperceptions.
- Post-test, we also received feedback from the RHD, ONSE and MOH district level staff about successes and challenges with the trainings.

8 of 15

providers said that "a new idea they learned" during the training was that women can receive immediate PPFP 48 hours post-delivery in the pre-test survey

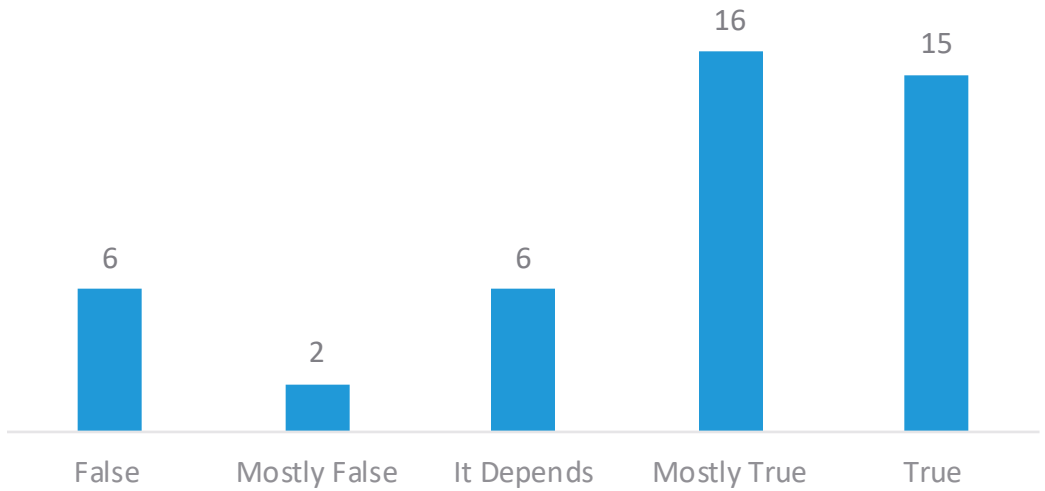
Pre-test results from the trainings

”Optimal birth spacing to ensure the health of a woman and her baby is 2 years”



31% *of providers did not answer true or mostly true prior to the training, suggesting limited knowledge about optimal birth spacing.*
Thus, discussion of PPFP is important.

"If a woman doesn't complain about bleeding, you know she is satisfied with her current method"



69% *of providers answered true or mostly true prior to the training, alluding to a limited perception of method satisfaction.*
Thus, discussion of method satisfaction is important.

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Takeaways from the trainings

Successes

The ToT provided a platform to collaboratively devise an implementation plan – during the training ONSE and MOH staff and supervisors worked together to come up with a sustainable implementation plan that made sense for each district's context, and this was facilitated by BA.

At the district level trainings, roles for managing the tools were clearly defined - we observed that there were discussions about how to manage provider schedules to make sure the tools were used in clinics that happen simultaneously.

Challenges

Not all facility staff were able to be trained – and in particular, we did not train any HSAs. We received feedback post-test, that the trainings for the field tests should be done in a few rounds, and at the facilities themselves to make sure that everyone (including HSAs) can attend.

It was difficult to schedule the trainings in advance, and as such ToT and district level trainings were held close together – meaning that not all the appropriate staff were available, and the trainers may not have had sufficient time to prepare for facilitation. We received feedback post-test that we should consider this for future trainings.

Q1: To what extent is the counselling tool implemented effectively?

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Q1 results

Group counselling tool

37 minutes was the average length of the health talk using the tool.

71% of providers observed using the tool *always* read the information on the card and asked women to guess before unveiling the method.*

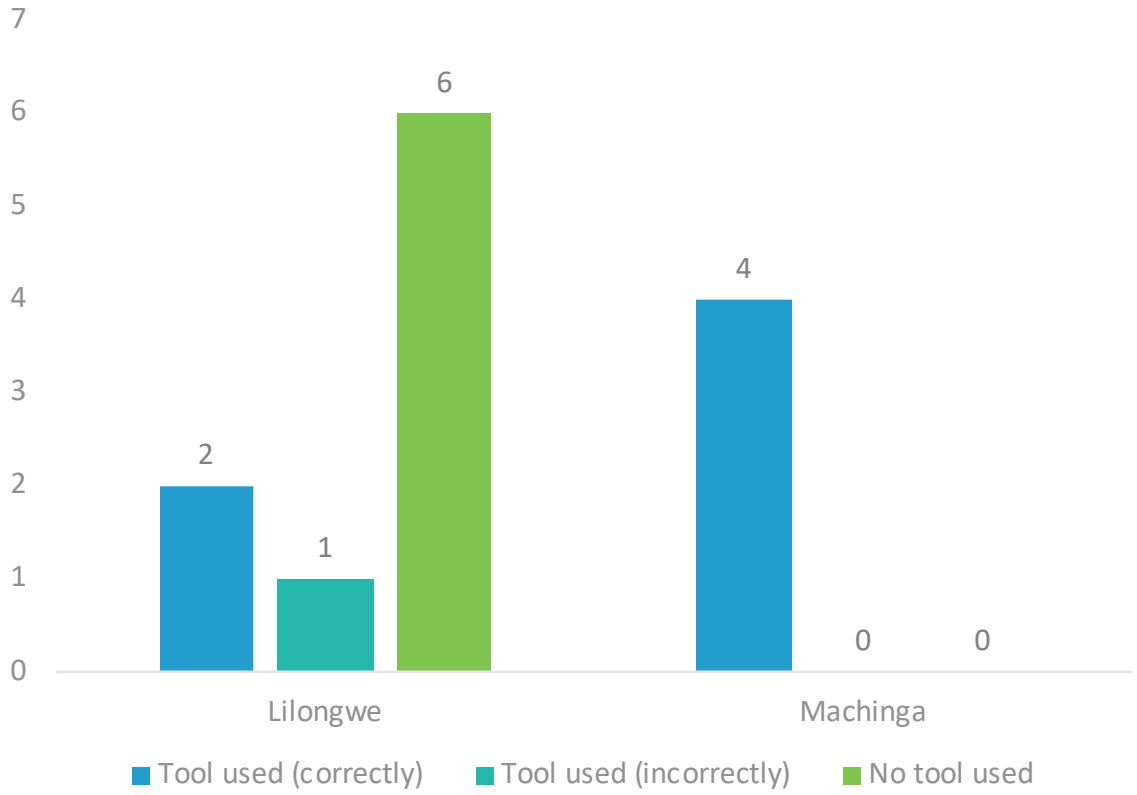
88% of providers interviewed said the categories were meaningful to women (i.e., return to fertility, things to remember, postpartum medical eligibility criteria). Two providers said they were "not sure."

**In one observation, the tool was hung up, but just used as a visual guide for a normal health talk with no-adherence to any protocol.*

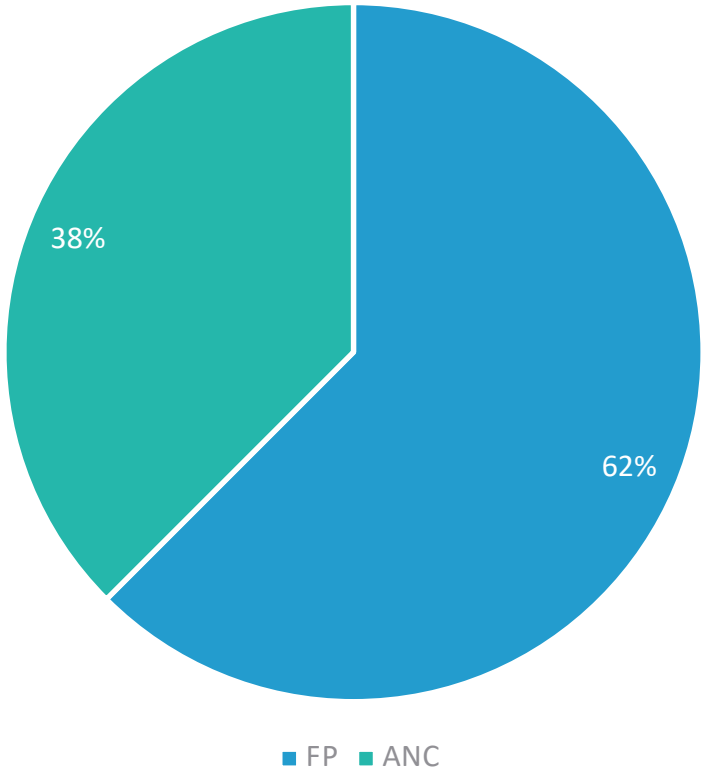
Q1 results

Group counselling tool

How many health talks were observed using the counselling tool?



Where did the health talks with the counselling tool take place?



Q1 results

Group counselling tool

"the health talk was so enjoyable and very educative and the women were so engaged and answered questions freely"

Data collector on how women react

"Group counselling (tool) has reduced workload for me. It summarizes all information and I reach out to all women at once with adequate info"

Provider in an interview

Q1 takeaways

Group counselling tool

Successes

Even if additional information on methods was shared, it was not biased – we tracked all the additional information shared about each method, and most was consistent with the information on the cards. Occasionally information on how to manage method-specific side effects was discussed.

All of the game elements function as intended – women participated in the dice rolling, they understood the colors and symbols, and the 3 criteria mattered them. Providers were able to implement the tool according to protocol.

The tool encouraged participation and follow up questions about the methods – and providers citied that this helped women learn and generated excitement across everyone at facilities (e.g., men in malaria, etc.).

Challenges

We did not observe many health talks with the tool in Lilongwe – and this may have been due to limited excitement from providers who didn't attend the trainings.

The colors printed on the dice, cards, and poster were slightly different shades – and this led to confusion amongst both women and health workers.

The tool encouraged participation and follow up questions about the methods – and this made the health talks longer than usual, which providers noted was a challenge.

Q2: To what extent is the ANC passport insert implemented effectively?

Q2 results

ANC passport insert

1980 ANC inserts were distributed throughout the study period, with **96% coverage.**

56% of providers who were observed used the PPFP method guidelines.

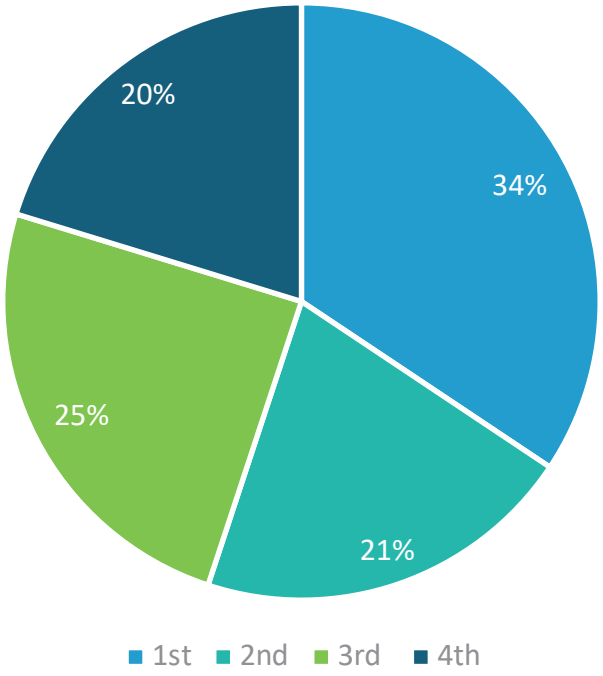
100% of providers observed administered the inserts according to protocol* (i.e., discussed 3 methods, timing, and benefits of birth spacing).

** However, one in-charge noted that sometimes protocol isn't properly followed.*

Q2 results

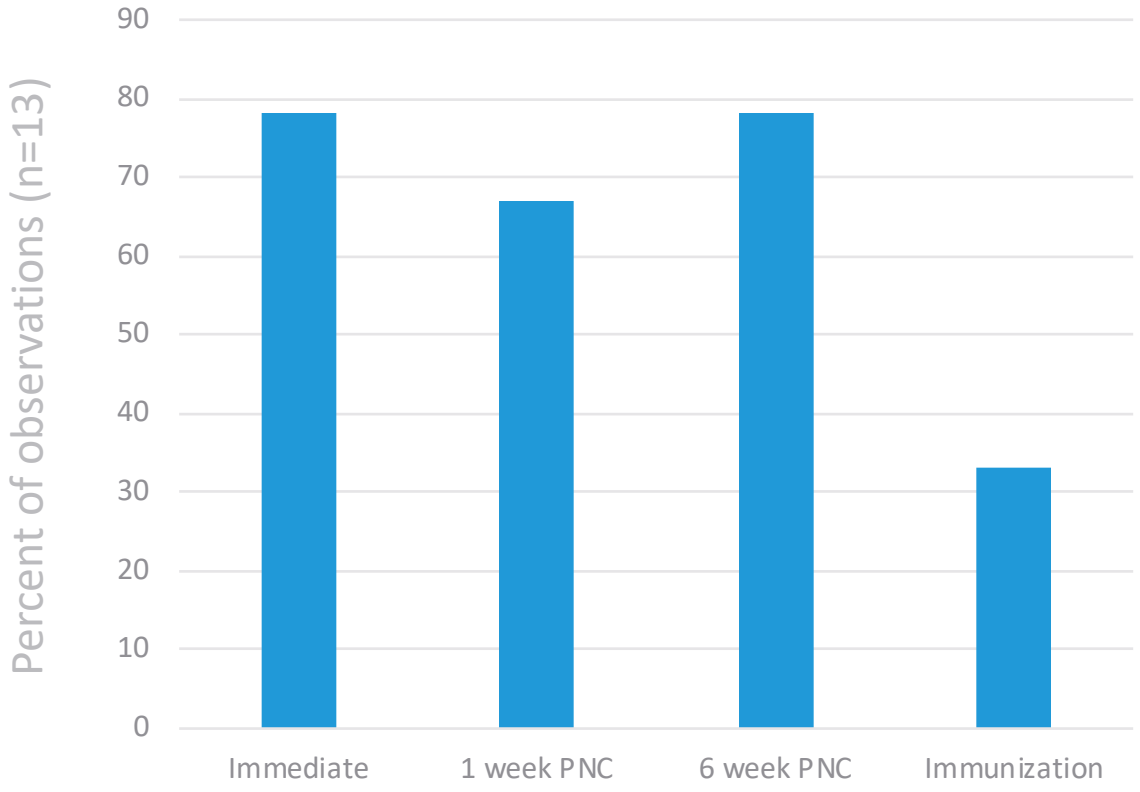
ANC passport insert

At which ANC visit did women receive the inserts during observations?



12 out of 17 providers interviewed say that they prefer to give out the insert during the ***3rd or 4th ANC visit***

What possible times for PPFP take-up did providers discuss during observations?



Q2 results

ANC passport insert

"It is quick, and it is really helping begin a conversation about FP. Women are even demanding for it because its helping them discuss with men. We have even run out of it."

Provider in an interview

"They were so happy that they can have a time to think"

Data collector's description of women

Q2 takeaways

ANC passport insert

Successes

Providers discuss multiple times for take-up - and mention immediate and 1 week PNC take-up almost as often as 6 week PNC. And 10 providers said women choose to take up 48 hours post delivery and at immunizations. This is a stark change from what we observed during diagnosis, where often the only time mentioned was 6 weeks, and is a promising result.

Our concerns about difficultly of insertion did not hold - during the ToT and district level trainings, there were concerns raised that it might be difficult for providers to stick the inserts, but only one provider mentioned this in practice.

Challenges

Card storage proved to be a challenge - and cards were often unorganized when providers were using them in ANC.

Some providers did not allow women to choose 3 methods to consider on the date they received the insert - for example, one data collector observed: *"one woman wanted to mention the 3 methods of her choice right away but the provider stopped her…as she needs to go home…and present them to the nurse on the next appointment."*

Q3: To what extent are the contemplation cards implemented effectively during consultations?

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Q3 results

Contemplation card

30% of all women who attended the observed FP consults received a card, 148 total cards were distributed during observations.

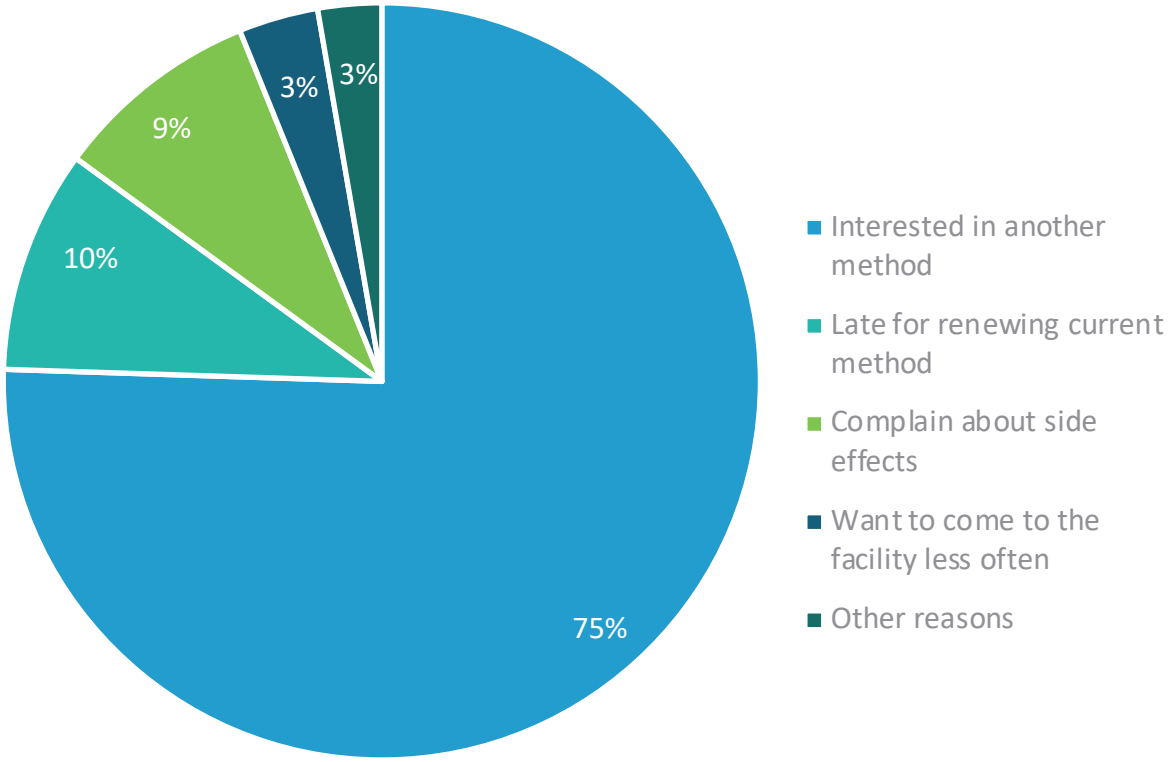
7 providers of 17 providers interviewed said that women request the card after seeing a health talk with the counselling tool.

100% of providers observed administered the cards according to protocol (i.e., told her to come back, gave a bridge method, and explained the drop box)

Q3 results

Contemplation card

Why did women receive the cards during observations?



22.6%

of all women who were observed attending FP consultations *were interested in considering a method other than their current method & received a contemplation card.*

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Q3 results

Contemplation card

"The service providers looked at ease using the tools"

Data collector's description of providers

"They (women) were so happy and they told us that it will help them to discuss better with their husbands as they will be showing them"

Interview with a provider

Q3 takeaways

Contemplation card

Successes

The contemplation card is filling a real need - during observations; a large proportion of women receiving FP services demonstrated interest in thinking about or switching to other methods, and many were specifically observed to say that they are considering switching from the injection (consistent with discontinuation data on injectables). 693 contemplation cards were given out during the study period, which is an estimated 19% of all women seen for FP.

Challenges

Sometimes this card was used in lieu of the unavailable method card – for example, during observations, 2 women were given this card when they did not yet meet the MEC for postpartum women though they had a method of choice in mind.

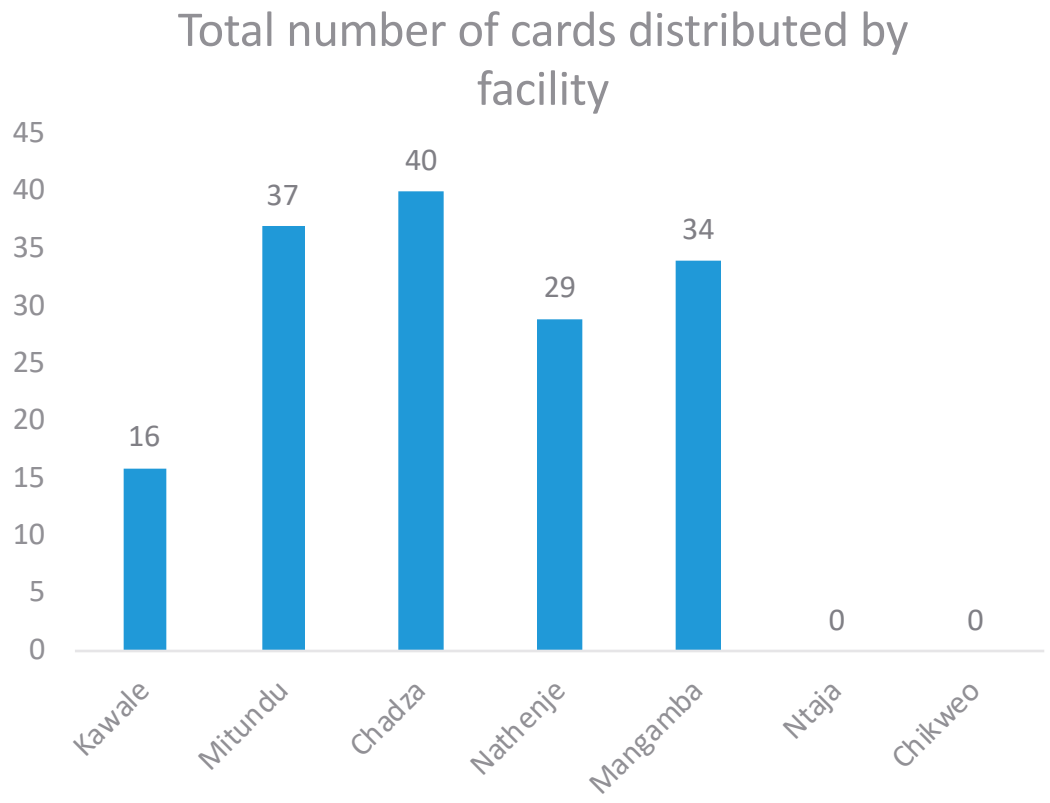
A few providers did not allow women to switch methods immediately – during observations, but rather used the card to defer service provision by suggesting that women return later on with the contemplation card after thinking more about their decision.

Q4: To what extent are the unavailable method cards implemented effectively during consultations?

Q4 results

Unavailable method card

- **145** total unavailable method cards were distributed during the study period.
- This was the least used of all of the solutions, and there was variation across facilities in both the number of cards distributed and reasons for distributing cards.
- We observed the cards being distributed at 3 facilities, and reasons cards were given were (in order of # of times reason was observed):
  1. The method requested was not provided at that facility
  2. Referring a woman to a LARC outreach, like Banja;
  3. A provider was unable to give the method
  4. Woman did not meet postpartum medical eligibility criteria
- Referrals were given for BTLs & IUCDs during observations.



Q4 results

Unavailable method card

Responses from provider interviews:
What are the reasons you decide to give women this card?

Mitundu	Nathenje	Kawale	Chikweo	Mangamba	Ntaja
"As they wait for BLM visits"	*"The facility does not provide that particular service"*	*"Referred to Banja because the clinician was not available"*	*"If the method is not available at the facility"*	*"If the method she wants is not available at the facility"*	*"After [women] explain to us what they want and then we realize that we don't have it at the facility"*

The providers interviewed in Chadza had not used the cards.

Q4 results

Unavailable method card

There was positive feedback on the cards….

"(The women were) determined to do it (return to get their method) as soon as possible."

Data collector observation

"The client and provider were being nice, open and understanding towards each other"

Data collector observation

…but there were also challenges mentioned.

"(I'm) not sure if women really go to that particular facility where they have been referred to. If they do not go, its a waste."

Health provider interview

Q4 takeaways

Unavailable method card

Successes

The card helped to set expectations - between the clients and the providers, and allowed women to feel empowered to get the method of their choice, allowing for more positive interactions.

The feasibility study achieved it's goal of showing us the limits of the card's acceptability and feasibility – and will allow us to pivot to a more sustainable solution for the upcoming field test.

Challenges

The cards aren't being used for all of the reasons available, or much at all – despite the fact that our diagnosis suggests a real need across facilities for each of referral types.

Some providers note that there is too much on the card – in terms of reasons and spaces to write. This may make it confusing for providers and contribute to its limited use.

Q5: How is the referral tracking drop box used in a feedback meeting?

Q5 results

Referral tracking system & meetings

- Meetings were held as stand alone meetings, led by in-charges or FP coordinators.
  - In one facility, the meeting was organized for “a time before knocking off when all of us would be available”
  - In another facility, staff also did a review meeting on their own halfway through implementation.
- All information on the tracking form was discussed.
- The meetings sparked conversation around challenges and successes with the tools, and other challenges to service delivery in the facilities.

“Very helpful”
In-charge on the meetings

“Very easy and simple, self calculating.”
In-charge on the tracking form

Q5 results

Referral tracking system & meetings

Topics discussed at the referral tracking meetings:

- **Solutions are promoting conversations about methods and encouraging women to think about LARCs.**
- Solutions are easy to use and reduce workload
- Cards simplify the referral process.
- Group tool is interesting for men as well (e.g., those who are there for malaria tests).
- Solutions encourage male involvement.

Successes with the tools

- **HSAs haven't been trained though it would be beneficial for them to use the tools in communities**.
- Group tool can be time consuming.
- Providers sometimes forget to give referral cards when they should.
- Workload can be a lot to give the cards and inserts out to each client.

Challenges with the tools

- **Lack of clarity on when BLM is coming.**
- Facilities unable to give BTLs or IUCDs.
- Stock outs of pregnancy tests, brufen speculums, torkars.
- Inconsistent stock of FP methods.
- Providers are rushing to deliver SARCs because of limited time, rather than helping women consider choices.

Other service delivery challenges

Next steps

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We recommend proceeding with implementation of all the solutions for the field test

(with a few slight modifications)

Modifications to the solutions

Training for solution set

Challenges

1. Not all facility staff were able to be trained based on the training schedule.
2. Due to the new year activities, it was difficult to schedule the trainings in advance, and as such ToT and district level trainings were held close together.
3. Some of the solutions were not being used according to protocol (i.e. providers giving the contemplation card instead of letting women change methods immediately),

Changes to address these challenges

1. We will schedule the field test trainings over multiple days so that all appropriate health providers can attend.
2. We will hold field test trainings at the health facilities so more providers are able to be trained.
3. We will build in time for the ToT to be held at least a week before the facility based trainings
4. We will stress points in the protocol for use of the solutions that were seen to be difficult for providers.

Modifications to the solutions

Group counselling tool

Challenges

1. We did not observe many health talks with the tool in Lilongwe due to limited motivation from providers who didn't attend the trainings.
2. The colors printed on the dice, cards, and poster were slightly different shades and this led to confusion.
3. The tool made the health talks longer than usual, and this may also have contributed to non-use.

Changes to address these challenges

1. We will expand the trainings to ensure all service providers receive training.
2. We have altered the colors, and also added numbers to the dice and flaps to remove confusion.
3. We have shifted information on MEC criteria for postpartum women to the instruction cards, to shorten the amount of information discussed.

Modifications to the solutions

Method referral cards

Challenges

1. The unavailable method cards aren't being used for all of the reasons available, or much at all.
2. Some providers note that there is too much on unavailable method card, making it confusing and contributing to limited use.
3. Sometimes the contemplation card was used in lieu of the unavailable method card.

Changes to address these challenges

1. We are combining the unavailable method card and contemplation card into one "method referral card" to simplify the process for providers.

Modifications to the solutions

Operational guidance and storage of solutions

Challenges

1. A few providers did not allow women who had already made a choice of their preferred FP method to choose immediately (at FP and ANC), but told the woman to wait until she returns.
2. Storage was a challenge for the ANC inserts.

Changes to address these challenges

1. We have updated the protocols in the Operational Guidance manual and will re-iterate during trainings that women can choose an FP method whenever they are ready. We have also added the statement choose “now or later” on the card, to remind providers that women can choose “now” if they’re ready.
2. We will provide a storage box for the ANC inserts.

Next steps with partners

- We disseminated these results to ONSE, RHD, District Health Offices (DHO), and facility supervisors.
- Dissemination events included:
  1. Discussions on what key stakeholders would like to learn from the field test in order for the tools to be sustainably integrated into standard MOH protocols after the field test
  2. Alignment on the timeline and potential handoff of the project after B-A's role ends.

Next steps with partners

- We will reorganize trainings and communicate with facility staff and supervisors
  - So all service providers who deliver FP, ANC, PNC and immunization can be trained fully (including HSAs).
- We will discuss how to better support providers during the first week of implementation
  - We will work with ONSE, RHD, District Health Office and facility supervisors to plan this,
  - with the goal of helping providers feel comfortable with the tools and correct protocols.

Structure of the field test

- 10 facilities in Lilongwe and Machinga
  - 3 month implementation period, with baseline and endline data collection
- We plan to use a similar qualitative approach to assess the feasibility and sustainability of the updated solution set, as well as:
  - Test the solutions in new contexts, where there has been limited exposure to BA
  - Test the updated training schedule and implementation support plan
  - Use “mystery clients” to see how the tools affect quality consultations over a longer period of time
  - Collect information on women from ANC through their postpartum journey
  - Collect information on method mix, timing of PPFP take-up, and discontinuation

Thank You

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