Determinants Related to Client/Provider Interaction for Family Planning

Behavioral Economics Research
Determinants Related to Client/Provider Interaction for Family Planning

Knowledge, Attitudes, and Practices Toward Family Planning and Reproductive Health Among Married Women of Reproductive Age in Selected Districts in Jordan

"Plan Your Pregnancies, Ease Your Burden"

Evaluation of the National Family Planning Campaign "Ante Al Hayat"

Evaluation of the National Anemia Prevention Campaign

Disclaimer: The authors' views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.
# Table of Contents

Acknowledgments ........................................................................................................... 3  
Acronym List .................................................................................................................. 4  
Executive Summary ...................................................................................................... 5  
I. Rationale for Research ............................................................................................... 8  
II. Research Design ...................................................................................................... 9  
   Phase 1: Qualitative Research to Identify Cognitive and Behavioral Biases ............. 9  
   Phase 2: Ideation and Co-design with Patients and Providers .................................. 13  
III. Limitations ............................................................................................................. 16  
IV. Phase 1- Key Findings and Insights ....................................................................... 18  
   Facility and Contextual Insights ................................................................................ 18  
   Provider Insights ....................................................................................................... 21  
   Client Insights .......................................................................................................... 25  
V. Phase 2- Opportunity Areas and Guidance ............................................................ 31  
   Insights to Opportunity Areas and Guidance ............................................................ 31  
   Facility Opportunity Areas and Guidance ................................................................ 31  
   Provider Opportunity Areas and Guidance ................................................................ 33  
   Client Opportunity Areas and Guidance ................................................................... 34  
VI. Phase 3- Recommended Interventions ................................................................... 39  
   Guidance and Concepts to Prototyping ..................................................................... 39  
   Prototyping to Recommendations ............................................................................ 41  
   Prototypes Not Recommended for Piloting ............................................................... 60
Appendices ........................................................................................................ 64

A-I. Final Research Protocol ........................................................................ 64
A-II. Client Interview Guide ........................................................................ 91
A-III. Provider Interview Guide ................................................................... 99
A-IV. Clinics Included in Research Study ..................................................... 105
A-V. Matrix of Insights, Guidance and Recommendations .......................... 107
A-VI. Mapping of Insights, Guidance and Recommendations ....................... 114
A-VII. Impact versus Feasibility Map ............................................................ 115
A-VIII. Sample of Standard Prototyping Feedback Grid ................................. 116
A-IX. Sample Monitoring Forms for Pilots ................................................... 117
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Last but not least, this research would not have been possible without the valuable cooperation and input from service providers and clients of the targeted health facilities.
### Acronym List

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>BE</td>
<td>Behavioral Economics</td>
</tr>
<tr>
<td>BSci</td>
<td>Behavioral Science</td>
</tr>
<tr>
<td>CHC</td>
<td>Comprehensive Health Center</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HCD</td>
<td>Human-Centered Design</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education and Communication</td>
</tr>
<tr>
<td>JCAP</td>
<td>Jordan Communication, Advocacy and Policy Activity</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MD</td>
<td>Physician/Doctor</td>
</tr>
<tr>
<td>MFP</td>
<td>Modern Family Planning</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MW</td>
<td>Midwife</td>
</tr>
<tr>
<td>MWRA</td>
<td>Married Women of Reproductive Age</td>
</tr>
<tr>
<td>SBCC</td>
<td>Social and Behavior Change Communication</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>WCHD</td>
<td>Woman and Child Health Directorate</td>
</tr>
</tbody>
</table>
Executive Summary

This report summarizes the two-phase project to identify and design solutions for behavioral barriers that inhibit the adoption and sustained use of modern family planning methods by Married Women of Reproductive Age (MWRA) in Amman, Jordan. The first phase used behavioral economics and behavioral science to discover and illuminate behavioral bottlenecks in the adoption and use of modern family planning methods. The second phase applied a human-centered design (HCD) approach to the insights from phase one: identifying opportunity areas to address, ideating, rapidly prototyping, and co-designing with clients and providers, all of which then led to a set of four recommended interventions to improve adoption or to sustain use of modern family planning methods.

The formative research in phase one included interviews with 57 clients and 12 family planning service providers in six Ministry of Health Comprehensive Health Centers (CHCs) in Amman, Jordan over two-weeks in June and July 2018. The research included general observations of each clinic and observations of client-provider interactions at five of the six clinics. An additional two days were spent at two of the research clinics for prototyping and co-design activities with 15 women and 3 providers.

Insights are categorized into facility insights, service provider insights, and client insights.

Facility insights found are:

- MCH clinics are open and public spaces that make intimate conversations about sensitive topics like family planning difficult. Although most facilities do have private areas for counseling, the space available is not managed well to ensure client privacy.

- Clients are not active participants during observed counseling sessions.

- The structure and efficiency of clinics vary widely, but a consistent element across clinics is that there is uneven client flow throughout the day.

Provider insights found are:

- Providers have intrinsic motivation and see themselves as champions of family planning.

- Some providers have their own personal mental models (biases) around methods.
• Providers sometimes worry about a woman’s method choice because they know false information is common and that some women may lack agency within their family.

• Providers face a very uneven workload throughout each day.

**Client insights found are:**

• Clients have varied mental models about what makes an information source valuable.

• There is a mismatch between information sources currently provided to clients and clients feeling informed.

• Clients reported that providers do not always provide detailed information on side effects of specific methods.

• The majority of clients who are going into the clinic to adopt a modern family planning method are going into the clinic with the intention to adopt a specific method.

• Some clients are not pre-planning for the counseling session with the provider and are not active participants during the sessions.

• There is a cycle occurring in some sessions that is difficult for traditional counseling to break - clients are going into a busy clinic having sometimes already made a decision on a method, thus not necessarily wanting or feeling they need to ask questions, whereas time-scarce providers expect that a client has already made her decision and may not want to learn about other methods.

Based on the ideation, prototyping and co-design sessions with clients, four interventions are recommended for piloting. They include:

• **Method Counseling Card:** This A5 sized card is designed to prompt an interactive and dynamic discussion during the client-provider session in which (1) the responsibility for counseling is shared between the client and the provider, (2) the client is facilitated and empowered to ask specific questions, (3) side effects are made salient for the client, and (4) the client is able to understand the different degrees and duration of side effects and write them in her own words.

• **Free phone hotline:** The high frequency with which decisions about family planning methods are being made by women outside of health facilities, prompts the need to tailor information and counseling to the context of women’s lives. Therefore a
phone hotline is recommended that provide information and counseling so that (1) information is on-demand, (2) information, as well as counseling, are available by trained and certified family planning providers, and (3) the type of information and counseling available over the phone covers the same range of information available through in-person sessions with providers. It is crucial to note that the hotline is not meant to be a substitute for an in-person session with a provider, but rather to give a first round of information to clients before meeting in-person with a provider as well as provide triaging for questions and issues. Moreover, it would be available for any follow up questions the client might have after the clinic visit.

- On-demand provider training: Service providers are experts in their field, yet they can benefit from training in client-centered counseling specifically related to rights-based counseling. Changing family planning methods and a lack of personal experience with some methods can make it difficult for service providers to adequately counsel clients on all methods. Hands-on training, especially for FP method insertion for Implanon, are crucial while refresher training can help reinforce knowledge and provide more confidence around the details of a method. Therefore, providers would learn about (1) rights-based counseling techniques that are client-centered (2) new methods or method changes when they do not feel comfortable with that method, including before full hands-on training and (3) a method even if they are not qualified to insert it.

- Revised BCC Materials: Revised BCC materials which reflect how women talk and learn from individuals they trust are recommended. This material should (1) include actual user testimonials or user personas that women can relate to, (2) tell stories that cover the experience women commonly have, including doubts and hesitations plus possible strategies to deal with or overcome them, (3) be accessible for clients to read or watch on their own by finding them online, (4) be possible for providers to use in counseling sessions with clients, and (5) be branded by a trusted source such as the Ministry of Health. The materials would ideally be both print and short videos.

The Jordan Communication, Advocacy and Policy Activity (JCAP) will hold a dissemination session of the findings and recommendations of the study and the set of interventions with the USAID Health Service Delivery team and with the Women and Child Health Directorate team at the MOH. JCAP will not implement recommended interventions from this study, but other stakeholders may choose to implement them if they are deemed feasible and appropriate.
I. Rationale for Research

Jordan’s population continues to grow and may be on track to meet the Government of Jordan’s target of a total fertility rate of 2.1 by 2030, according to the preliminary results of the Jordan Population and Family and Health Survey (DOS 2018)(1). However, prior to this most recent report, reported increases in family planning use over the past ten years were attributed to an increase in use of traditional methods of family planning instead of increases in more reliable modern methods (JPFHS 2012)(2). Previously, the total fertility rate in Jordan had stagnated following a decline from 5.6 in 1990 to 3.7 in 2002 (JPFHS 2012).

Behavioral economics, a relatively recent addition to behavioral science, provides a novel perspective to allow us to understand human decision-making and behaviors. Behavioral economics is built around the idea that human decision-making and how we translate our intentions to actions is imperfect. For example, as humans we go to the grocery store to buy eggs yet forget to buy them, we intend to go to the doctor but don’t actually make an appointment, or we make a “to do” list but keep putting off doing some of the items on it. These consistent patterns in our behavior are caused by our specific context and by imperfections in our thinking - referred to as cognitive and behavioral biases - which help us act efficiently at times but sabotage us at other times. Traditional behavior change theories or Social and Behavioral Change Communication (SBCC) methodologies do not always consider users’ context and the reality that humans are imperfect thinkers and actors.

In partnership with behavioral science, human-centered design (also referred to as participatory design or co-design) is a process that builds empathy with clients to understand their needs and desired goals. Merging these methods to better understand the context and to identify why and how these biases are occurring, then co-design programs allows us to improve behavioral outcomes for clients. In the context of Jordan, viewing family planning adoption and continuation through the lens of behavioral design has the potential to transform our understanding of the underlying issues of both the supply-side and demand-side of family planning and to design novel ways to tackle it.

(1) Department of Statistics (DOS) and ICF. 2018. Jordan Population and Family and Health Survey 2017-18: Key Indicators. Amman, Jordan, and Rockville, Maryland, USA: DOS and ICF.
II. Research Design

The research occurred in two phases: (1) qualitative research to identify context as well as cognitive and behavioral biases that either support or negate the behavioral hypotheses, and (2) a co-design phase to develop initial concepts, transform them to prototypes, and elicit feedback on those concepts to inform recommendations for pilot interventions.

Phase 1: Qualitative Research to Identify Cognitive and Behavioral Biases

The study team applied a behavioral design lens to the process a woman goes through when adopting and continuing on a family planning method. The scope of this activity included what happens after a woman forms the intention to adopt a method: how being at the health facility influences her adoption and how the interaction with the provider influences her adoption choice as well as her likelihood to continue her chosen method. The steps prior to arrival at the health facility - a woman forming an intention to start on family planning as well as forming an intention to go to a health facility - were outside the scope of this research activity. (3)

Initial Hypotheses

To begin the research phase, the consultant applied a behavioral science methodology called behavioral mapping (4), a process of identifying the barriers hindering a specific behavior, to two behaviors: (1) a client adopting and continuing on a method as well as (2) a provider correctly counseling a client to adopt a method. Behavioral mapping informed the development of the context around making decisions and taking actions and led to a handful of key hypotheses explored in the interview guides. The hypotheses are outlined below. (5)

(3) Some elements of a woman forming an intention to start on family planning and go to the clinic were partially explored during interviews but were not the main focus of this activity.
(5) Significantly more information on the hypotheses, including details of the multiple sub-parts for each hypothesis is included in Appendix A-I: Research Protocol. The Client Interview Guide is found in Appendix A-II and the Provider Interview Guide in Appendix A-III.
• **Client Hypothesis 1:** Despite the intention of speaking with the provider about family planning, the client may not ask specific questions about family planning or may end up speaking with the provider about other health issues, instead of family planning.

• **Client Hypothesis 2:** Clients may be overwhelmed with information during the discussion with the provider and find it difficult to choose between multiple methods. In addition, clients’ emotional state and how they perceive themselves during the interaction with the provider could reduce the likelihood they start a method.

• **Client Hypothesis 3:** Clients’ lives make it difficult to remember to continue on family planning and increase the likelihood they may discontinue use. This could be due to their busy lives or (mis)attributing any side effects or new health ailments to their family planning method.

• **Provider Hypothesis 1:** Providers may have preconceived notions around methods and the “types” of people who should be using those methods, which affect the way they counsel clients. Since they have numerous clients to see during a day they could also limit the information they give to clients or confuse clients with too much information.

• **Provider Hypothesis 2:** Family planning is only one element of a provider’s job so they may not prioritize family planning activities when with clients or see themselves as champions of birth spacing/family planning and therefore may not provide high-quality services.

**Data Collection**

The consultant and a female local researcher hired by JCAP, both trained in qualitative methods, conducted a total of 69 interviews, 57 interviews with clients and 12 with providers, as well as conducting 10 direct observations of patient-provider family planning interactions over the course of seven days at six clinics. A target of (55-60) interviews was selected as a sample size to ensure that the research could reach saturation and that there would be a diversity of clients across multiple client characteristics, such as demographics and method use.

JCAP and USAID Health Service Delivery jointly identified the six CHCs/clinics as appropriate for this study based on the relationship USAID Health Service Delivery has with the facility, their location within Amman, number of family planning visits (first and recurrent), diversity in client volume, and diversity in client demographics.
Details of interviews are shown in Table 1 below with details further broken down by method user type in Appendix A-IV.

**Table 1. Interviews of Clients and Providers by Day**

<table>
<thead>
<tr>
<th>Day</th>
<th>Clients</th>
<th>Providers</th>
<th>Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>14</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Day 2</td>
<td>5</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Day 3</td>
<td>10</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Day 4</td>
<td>7</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Day 5</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Day 6</td>
<td>9</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Day 7</td>
<td>5⁶</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>57</td>
<td>12</td>
<td>10⁷</td>
</tr>
</tbody>
</table>

Two teams conducted interviews. The first team included the consultant and the JCAP Senior RME Specialist and the second team included only the local research consultant. JCAP RME staff acted as a translator (Arabic <> English) while the local researcher was fluent in both Arabic and English. All interviews occurred primarily in Arabic, with some providers preferring to give some answers in English.

Each clinic was contacted multiple times prior to the scheduled visit to confirm the research with the appropriate authorities, select private space for interviews, and pre-schedule interview times with the family planning service providers and the clients.

Providers were recruited based on their availability. Informed consent was obtained at the beginning of the interview and the provider was informed of the purpose of the interview as well as their right to leave during the interview. The interviews were recorded using an audio recorder and the researchers took hand-written notes. Provider interviews lasted on average one hour and occurred in a private room of the clinic without any supervisors present.

(6) One additional client was interviewed on Day 7 for a total of 6 clients on that day (58 clients overall) but was excluded from the analysis due to the fact she was currently trying to get pregnant.
(7) Two unexpected client-provider observations also occurred during the days designated for prototyping sessions with clients while researchers were waiting in the waiting room areas of the clinic. They are noted in Table 3, bringing the total number of observations to 12.
**Table 2. Interviews of Clients and Providers by Method and Day**

<table>
<thead>
<tr>
<th></th>
<th>None/Traditional</th>
<th>Pills</th>
<th>Condoms</th>
<th>Injectables/Implants</th>
<th>IUDs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Day 2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Day 3</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Day 4</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Day 5</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Day 6</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Day 7</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td><strong>20</strong></td>
<td><strong>10</strong></td>
<td><strong>8</strong></td>
<td><strong>9</strong></td>
<td><strong>10</strong></td>
</tr>
</tbody>
</table>

Clients were recruited prior to the interviews and interviews were scheduled for a specific date and time using various methods. The local researcher - trained in confidentiality protocols - reviewed patient registries, received eligible client names from service providers, and contacted clients directly via phone. Information about the formative research was also posted in the waiting areas of the health facilities, including the fact that individuals would receive reimbursement for transportation costs as part of the interview. The individual was screened during scheduling for if they have attended the clinic at least once during the past 6 months and were currently using a modern method or not. Client recruitment was stratified by their current method use with a mix of nonusers and traditional users as well as a mix of modern FP users across the different method types. A breakdown of clients by method use is shown in Appendix A-IV. Additionally, women were screened for their age to obtain an even mix of individuals younger than and older than 30 years of age. The study excluded women younger than 18 or older than 49, women trying to get pregnant, and women who were not using a method because they had trouble conceiving in the past. Women were informed that the interview would last approximately one hour and that they would receive a small snack and reimbursement for transport to the health facility for talking with the researchers.

The interviews occurred in a private room at each health facility in which the conversation could not be overheard by others. Informed consent was obtained at the beginning of the interview and the client was informed of the purpose of the interview as well as their right to leave during the interview. The interviews were recorded using...
an audio recorder and the researchers took hand-written notes. Client interviews lasted approximately 45 minutes, on average.

At each health facility, the research team attempted to conduct direct observations of a visit between a family planning provider and client. The limiting factors on direct observations were the types of clients that day as well as the timing of the scheduled interviews and the client flow. Informed consent occurred with both the provider and the client. Any physical examinations occurred behind a curtain or in a separate room.

Written notes from interviews only contained numerical codes for each interview and did not record any identifiable information about respondents. Audio copies of all interviews were kept on password-protected computers owned by JCAP and the consultant during the research phase, transferred by the consultant to JCAP staff at the end of the in-country research phase, and then deleted from the consultant’s computer.

**Phase 2: Ideation and Co-design with Patients and Providers**

The study team debriefed at the end of each day, discussing key themes from the interviews, and transcribed interview notes for review by all team members. Following all interviews, the consultant led the study team in a targeted review of interviews, highlighting additionally behavioral and cognitive biases in the interviews. The consultant then synthesized research findings into behavioral and contextual insights, highlighting patterns in data to inform the ideation and design stages. Following insight synthesis, the consultant led a half-day session with JCAP staff that included a presentation of the research activities conducted the previous two weeks, research findings, insights, and two ideation (brainstorming) sessions.

Brainstorming, or creative ideation, is a facilitated process in design thinking to create as many concepts as possible, ideally without regard to realism. Some of the concepts may not be feasible, such as flying all women seeking family planning to Turkey for counseling and treatment, but in an ideation session a concept such as this can then spur other ideas which spur other ideas. The next step following an ideation session is to rapidly evaluate the concepts, typically using rough criteria around feasibility and expected impact. The definitions of feasibility and expected impact can vary based

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(8) In fact, part of a good ideation session should be to remove all current constraints on the problem, for example by thinking of how the problem could be solved in the future with new technologies or how it could be solved with infinite resources. This mental exercise can be very difficult for skilled global health practitioners to do since the field conditions them to operate in a world with many constraints and design programs using limited resources.
on the context, budget, and timeframe of a project. For this activity feasibility was
determined by what could be rapidly prototyped for feedback and co-design with
clients. The consultant reviewed the ideated concepts and selected concepts that were
feasible, potentially impactful, and could be iterated with clients and providers during
the subsequent two days at health facilities. More details, with specific examples, are
discussed in Section V.

Prototyping

Prototyping, the next stage, is a process to help understand the interaction between
a concept and a user in situations that are as “real” as possible. A prototype starts as
something very rough so the user can then guide and inform the iteration process.
Prototypes are frequently basic, especially in the initial stages so that users have the
feeling that they can contribute to the idea. When presented with more finalized
images and concepts, people tend to feel that they are being asked to validate them -
frequently by just saying yes - rather than providing constructive and honest feedback
about the concept itself, which is one reason to begin prototyping with simple icon-
based images instead of beautiful, graphically designed images. If the concept is a
revised counseling session, then initial prototyping would involve creating a script
for the session and presenting it to users. For example, if the concept is a counseling
tool, then initial prototyping would involve selecting a handful of rough images and
outlining the structure of the tool. It is always possible to make something visually
attractive and appealing, but before that, it is crucial to understand how users feel
about a concept’s key elements - like how they would feel completing an information
card - before they are distracted by the fact it is visually appealing and very formal.

The study team returned to two clinics and conducted feedback and co-design sessions
with 15 clients and three providers. Clients were interviewed either individually or in
pairs and asked to provide feedback on the various concepts. Informed consent was
obtained prior to starting the sessions. They were asked questions such as how they
would interact with the concept, when they would use or would have used it, as well as
how they would change or improve it, including being given the opportunity to write
their own version of the card. Providers were interviewed individually.
Table 3. Prototyping Feedback Sessions of Clients and Providers by Day

<table>
<thead>
<tr>
<th></th>
<th>Clients</th>
<th>Providers</th>
<th>Observations&lt;sup&gt;9&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>5</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Day 2</td>
<td>10</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>

Written feedback from clients was captured using the Feedback Grid shown in Appendix A-VIII, a standard tool in design thinking. This tool captures pluses (elements that the user liked), deltas (constructive feedback and elements to change), questions (elements that are unclear or still need to be considered), and ideas (new ways to change or modify the prototype). No names or audio were recorded during the sessions. The consultant then reviewed feedback from prototyping as well as insights from the formative research to design the recommended pilot interventions.

<sup>9</sup> Two client-provider observations also occurred during the days for prototyping sessions following sessions with clients. They were not scheduled but were unexpected observations that occurred while researchers were waiting in the waiting area of the clinic. They were not used to inform the prototyping and were included in the data of the Phase I formative research. They are noted in Table 3 because they occurred during prototyping days.
III. Limitations

As with all investigative research, there are limitations to the research process and findings, which are detailed here. Social desirability bias - respondents providing answers they think portray themselves in a favorably light with the interviewer - could affect the honesty of answers from participants. To mitigate this effect, participants were reminded that their honesty was important and there were no judgments being made about their answers. The diversity of answers from clients and the range of both positive and negative answers implies that social desirability bias was not extensive. Another bias, the Hawthorne effect, could have affected observations of patient-provider interactions. (10) However, given the shortness of patient-provider interactions (ranging from 3 to 15 minutes and averaging 7-8 minutes) and the fact that full counseling did not occur during most observations, we believe that the Hawthorne effect was also minimal.

Qualitative research is context specific, for which sample selection is non probabilistic, thus the sample of FP providers and women selected for the study are not representative of all MOH FP providers and all women who attend MOH clinics and are using family planning methods. Women selected were only those who (1) had given correct phone numbers to reception and (2) were willing to come in to the facility for interviews. Additionally, the sampling method of reviewing patient registers to identify these women for recruitment was the most feasible sampling method given the time and budget constraints. Because of bias in the sample population, findings should be viewed with this sampling bias in mind. However, the range and diversity of women’s answers provides strong evidence that these women’s journeys to adoption and continuation of family planning could be representative of other women in Amman.

Provider and client suggestions were included in the list of guidance and concepts, but it may also have been fruitful to include a handful of these individuals in the formal ideation session at JCAP to harness their full brainstorming potential. But because the behavioral design process is new in the Jordanian context, to maximize efficiency the ideation session was composed of senior JCAP staff who had already been exposed to the behavioral design process through an introductory presentation and review of

(10) The Hawthorne Effect is the name given to the phenomenon that people act more “ideally” when they are being observed. For example, a worker may appear to work harder or may appear busier when a supervisor is watching. For this research, there was the possibility that service providers would behave in ways they think the study team would want to see, such as spending more time with clients or making sure to use counseling tools with clients.
the research protocol. These individuals are, by the nature of their job responsibilities, not as familiar with the day-to-day operations of clinics and thus have a different perspective on ways to modify the clinic interactions. The exclusion of service providers or clients from the ideation session does not adversely affect the recommendations or prototypes as their feedback from the initial interviews is included in the guidance and their feedback on the prototypes shaped the refinement and recommendation process.
IV. Phase 1 - Key Findings and Insights

Key findings from the interviews conducted over two weeks in Phase 1 are categorized into three themes: facility and contextual insights from the clinic itself, provider insights, and client insights. The study team used these insights in its ideation session with the JCAP team to inform design of prototypes.

Facility and Contextual Insights

Insight Facility 1 (IF1\(^{(11)}\)) - MCH clinics are open and public spaces that make intimate conversations about sensitive topics like family planning difficult. MCH clinics are separate spaces from the rest of the health facility, and although there are private areas for counselling in MCH clinics, the space available is not managed well to ensure privacy for clients. There are men in the clinics, people interrupting counseling sessions, and clients are seen by other visiting community members.

There were men in each of the waiting rooms that the study team visited since men frequently attend appointments for their children. Additionally men may sometimes come to a family planning visit, either with their wife or they may visit the clinic to pick up a refill in place of their wife.

Sessions with clients frequently did not have closed doors and people entered and exited the patient-provider sessions to hand the provider charts or information or to ask a question. In some cases it was a nurse or midwife interrupting the session but in many cases it was other patients. In two cases, the study team saw men (who were there with their children) interrupting a session.

Clients attended their specific clinic because of its accessibility to their house, and it would not be uncommon to see relatives/neighbors or other community members at the clinic. Running into people she knows limits a woman’s privacy around a sensitive issue like family planning because there are only a handful of reasons to be in the MCH clinic. While many women reported discussing family planning with female relatives, friends, and neighbors, some also reported that their own specific use was a private matter and that they only discussed their specific use with close

\(^{(11)}\) Insights are categorized by Facility (F), Provider (P) and Client (C) and are numbered accordingly. For example, the first insights from the facility, Insight Facility 1, is designated IF1, whereas the first insights from the Providers is designated IP1.
relatives. Therefore having neighbors present at the MCH clinic might make women uncomfortable discussing their own family planning use, especially if neighbors can overhear conversations with providers or make judgments about why a woman is visiting the provider.

<table>
<thead>
<tr>
<th>It’s private so I only discuss with family. [Client Day1, D1]^{(12)}</th>
</tr>
</thead>
<tbody>
<tr>
<td>I talk with cousins and mother about FP… People ask me why I only have 1 child. But I don’t discuss FP methods with them. [D1]</td>
</tr>
<tr>
<td>I spoke only with my husband. [D5]</td>
</tr>
<tr>
<td>No, I didn’t discuss [modern family planning] with anyone else. Only with my sister. [D5]</td>
</tr>
</tbody>
</table>

Given this insight about the facilities being public spaces, it is interesting to highlight a USAID Health Service Delivery intervention that was mentioned at two clinics. One provider reported that her clinic had a new USAID Health Service Delivery intervention in which the receptionist asks each female patient during registration if they are currently using a family planning method and if they are not, to then ask if they want to see a family planning provider and then give her a referral for family planning.

| A woman only gets FP service if asked for it at registration. Now that’s changing. There is an USAID Health Service Delivery intervention to ask all women if they’re on a method and if they want one, then they refer them to FP session. [Midwife, MW] |

Another clinic reported a similar policy but reported that its occurrence was dependent on the workload of the receptionist.

| Seeing a woman depends on receptionist’s workload. There’s no clear/set protocol if a woman does not request FP service. If the receptionist isn’t busy she will ask if the woman’s on a method and if not, if she wants to talk and if she does then give her a FP referral. [MW] |

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(12) To ensure confidentiality for clients, quotes from clients are designated by only the day of the interview, DX, where X is the day. For example, a quote from a client on day 1 would be designated D1 and a quote from a client on day 5 would be designated D5. To ensure confidentiality for providers, their quotes are designated by MW for midwife and MD for doctor. Provider quotes cannot be attributed to days since only two providers per facility were interviewed.
Further research could investigate if women feel comfortable being asked about family planning use in such a public space, since in some cases the reception desk is a few feet away from people sitting in chairs waiting for their appointments, and if after the questioning women acknowledge that they would like to talk to a provider.

**IF2- Clients are not active participants during observed counseling sessions.**
During observed patient-provider interactions for family planning, clients were asked medical history questions by providers but it was typically a unidirectional dynamic with the provider being in charge during the conversation and clients simply answering questions. Clients’ body language was typically hunched over and few clients appeared relaxed. The duration of the observed sessions lasted from less than 5 minutes to about 15 minutes for a session during which there was a physical exam.

**IF3- The structure and efficiency of clinics vary widely but a consistent element across clinics is that there is an uneven client flow throughout the day.** Overall, all of the facilities were visibly clean with necessary resources. Three out of the six facilities visited were newly renovated and staff and clients complimented the renovations and additional space. All clinics had posters on family planning methods in either the MCH waiting room or in other areas of the facility. The study team observed family planning brochures on display on a table in one waiting room and in a handful of counseling rooms. But in some clinics they did not observe any brochures for clients to easily pick up or take. The study team could not determine if brochures have run out earlier or have had them stored elsewhere.

The room and resource layout was not always convenient to providers and clients. For example, in one clinic an adult scale was located in the IUD procedure room, therefore during a basic counseling session a woman and provider would need to start the session in the counseling room, walk across the hall to the procedure room to take the woman’s weight, and then return to the counseling room to finish their session. If there was a procedure occurring, they would either have to wait or to not take the woman’s weight.

The study team arrived at clinics between 8 am and 9 am and observed that waiting rooms were most full during these hours, which is when clinics opened. In some cases seats were full and clients were standing in the halls or leaning against the walls. But by later mornings, 10 am or 11 am, clinics began to empty out and were empty by noon or 1 pm. Overall, providers reported that they left by 1:45 or 2 pm from Sunday to Wednesday and by 1 pm on Thursdays; some MDs would stay till 4 pm. Clients reported that wait times in the morning could be an hour or more, even for a short
visit with the provider. One client reported she planned her visits specifically for later in the morning when she knew the clinic would be empty and she could be seen quickly, but by observation it was clear that most clients came in the early morning for appointments. At one clinic the gynecologist was only there select days and the midwives reported that their workload was light on days there was no gynecologist and much heavier on days she was there.\(^{(13)}\)

### Provider Insights

**IP1- Providers have intrinsic motivation and see themselves as champions of family planning.** They conduct counseling sessions where they provide information about available methods suitable for a woman.

| Happy because this is my purpose and service I've come to offer. [MW] |
| [When recommending FP] I'm very happy. But I cannot say to her [that I'm happy she wants to use FP] [MD] |
| I feel less enthusiastic when a woman comes with existing decision. I feel happier and empowered when I provide information about the correct method... [MW] |

Two providers expressed frustrations with the way managers provide feedback and supervision.

| I'm a champion for my family but not at the center [health facility]. Many people intervene in the work here. Sometimes I put a lot of effort into work but it feels like it doesn't count because it doesn't show up in CYP. But people focus only on CYP. [MW] |
| [My] Only call [from supervisors to monitor family planning numbers] was about Implanon and supervisor said if no Implanon prescribed then Midwives would have to provide an explanation. I was not happy. The way it was communicated was not appropriate given the amount of effort I put into my job. It was discouraging. [MW] |

One provider got the feeling that her promotions were in part due to her services in response to the high demand for IUDs.

\(^{(13)}\) At clinics with heavy and light days the study team specifically chose days that would be lighter so that they would be able to interview providers without causing excessive waiting time for clients.
I was promoted 1 grade in 3 years instead of 5 years because of my performance on FP programme and success in the IUDs insertion. [MW]

The Study Team feels this needs further explanation from the MCH supervisor because there is no promotion, incentives or punishment for a provider who provides FP in the MOH system.

**IP2- Some providers have their own personal mental models (biases) around methods.** Providers’ own favorites are based on their own personal experiences with a method, continuing to provide the same recommendations as they have been doing for years (known as status quo bias), and based on their own belief about a method’s efficacy or side effects (provider bias).

I’m very much in favor of offering IUD. I myself use it. Side effects are minimal and people aren’t prone to forgetting like with pills. … Except in cases with heavy bleeding, IUD is preferred. [MW]

I’m pro recommending IUD. It’s based on 14 years of work and my own experience as an IUD adopter. I’m pro non-hormonal methods. IUD and condoms are better than hormonal IUD, pill, Implanon and injections. [MW]

I like to keep IUDs and Implanon at a high use. I believe these two [methods] give good results. [MW]

If it’s a female doctor they may have their own personal experience with a method and be biased in their recommendations. A male doctor is not biased. [D9]

Provider’s own use and their comfort level based on their own use is important because many providers reported that clients ask about the providers’ own FP method use, and that providers do tell patients about their own FP use and experiences.

My husband and I use FP. They [clients] ask me frequently. They even ask why my method is different from what I provide information about. They’re suspicious that I stayed away from it because it’s harmful. I tell them what suits me might not work for them. [MW]

Women ask me if I’ve tried the method and what method I’m on. I tell them that IUD is an excellent method. There’s irritation on insertion but then great. [MW]
They ask me a lot if I adopt a MFP and inquire about my experience with them [the methods]. [MW]

Additionally, a few providers informed clients about their own FP method use, hence sometimes acting as a peer user to reassure women regarding their chosen method.

Clients never ask about my own method but I tell them. I choose to tell based on client and use myself as an example. I used IUD and was not happy. I used pills and was not happy but I am still using them. [MW]

I tell patients of my own IUD use. If a woman's already made the decision for IUD, I say 'me too' to comfort her. If she's not decided, the woman asks me which method I'm using. [MW]

Providers making the same “tried and true” recommendations is in part because they do not feel fully confident in their own knowledge or skills for all methods, which affects their ability to counsel clients. This is particularly true of Implanon.

Implanon is new. I'm not comfortable recommending it [Implanon]. However, I explain to women what it [Implanon] does what is required. [MW]

[I don't feel comfortable with] Implanon. I have a lot of experience, yet I did not get trained. I feel not fully knowledgeable and that I know only the basics. [MW]

I used to be uncomfortable recommending Implanon because I didn't have enough information. Now I hear positive stories from women about Implanon so now I'm more comfortable recommending it. [MW]

I feel service providers with long experiences start getting more comfortable with certain methods and they focus more on them [the specific methods]. [MW]

IP3- Providers sometimes worry about a woman’s method choice because they know false information is common and that some women may lack agency within their family. Providers are constantly hearing nonfactual information about methods and side effects from clients, such as that Implanon or other hormonal methods cause cancer, that IUDs do not work because it is easy to get pregnant on them, or that IUDs easily move to other parts of the body.

In a counseling session, all matters are discussed and I explain about side effects but then a woman goes out and interacts with others and learns wrong things and comes back and talks to me. [MW]
Sources of information on incorrect side effects usually come from neighbors, hearsay, mother-in-law and family. [MW]

They also worry that other people - the husband, the mother-in-law, or other family members - are making the decision instead of the woman taking her own needs into account.

[When a client disagrees] I’m irritated deep inside. If the method is suitable I don’t object but if it’s not suitable I would be irritated. As long as it doesn’t affect her health, I’ll just move on. Sometimes it’s not the woman’s sole decision. [MD]

[When client disagrees], I’m worried and upset because someone has influenced her decision but method is not suitable, so I worry. [MW]

There is a tangible difference when husband is around. I feel he wants to decide, not her. [MW]

I’ve had situations where the mother-in-law decides on behalf of the wife in spite of what she [the client] wants or thinks. [MW]

IP4- Providers face a very uneven workload throughout each day. As mentioned in Facility Insight 3 (IF3), clinics are not consistently busy during the entire day or across days which means that providers typically experience both time scarcity and free time because of uneven clinic loads. Early mornings are extremely busy and later in the day clinics are empty with no clients. Uneven workloads and the very busy and stressful periods they create, can lead to higher stress for staff and sometimes an offensive attitude towards clients.

Women showing up here need all the information, should have all information not just benefits. … Sometimes when [they are] busy [service providers] don’t spend time explaining. [D5]

Yes, they [FP service providers] might act unpleasantly with me because if my husband is around he rushes them and they react. [D6]

A good day is an organized day, [with] low crowdedness. … Tuesdays make me overwhelmed- we have newborns, BCG [vaccinations], clients who gave birth recently, pregnant clients and others! [MW]
As simple as it [being a doctor] sounds, it can be nerve-wracking and I leave the clinic drained and exhausted from the stress I’m under. [MD]

**Client Insights**

**IC1- Clients have varied mental models about what makes an information source valuable.** These include personal relationships (such as a husband, mother, sister, sister-in-law, friend or neighbor), person’s expertise/credentials (doctor or midwife, especially private doctors), person’s breadth of experience (people who have many years’ experience talking or working with family planning users), and a person’s own personal experience (people who have used the method themselves).

*I rely mostly on what my mother advises out of every source I seek.* [D1]

*The source of information that I rely on is myself. Nobody else.* [D1]

*I talked with pharmacist and private doctor about side effects [from pills].* [D5]

*If a woman has the same experience as me she’s a trustworthy source.* [D1]

*Private doctor is trusted source for family planning information. I never went to see or discussed FP with a MOH provider.* [D6]

*Rely on husband as a source of knowledge. He is knowledgeable and has experience in different sectors.* [D2]

Clients trust multiple sources at the same time instead of necessarily thinking that there is a single best source for all information about family planning. For example, a woman may trust a friend because of her personal experience with a specific method while at the same time trusting a doctor because of the doctor’s medical knowledge, but she did not report these as contradictory sources. The assumption that a woman may have a single most trusted source in all contexts is a traditional assumption that assumes individuals are fully “rational”. Behavioral science shows that people do not
necessarily reconcile or weigh information from multiple sources in a cost-benefit analysis.(14)

**IC2- There is a mismatch between information sources currently provided to clients and clients feeling informed.** Women want more information and they want that information from a trusted source. There is a gap between the information currently provided to clients and clients feeling informed. Despite being exposed to information through brochures, posters, their friends and family, their providers (both public and private), and from the media, many still feel that they themselves want or that women in general need more trusted information.

<table>
<thead>
<tr>
<th>I hear about side effects from friends or relatives. I’ve never heard about them from a provider. [D1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve psychological support, give us assurance that it [side effects] might happen for a little while. [D5]</td>
</tr>
<tr>
<td>I wish they would specify one MW to explain to us in greater depth and advise us on the methods with more details. [D5]</td>
</tr>
<tr>
<td>I don’t know [about information], I didn’t notice MFP information around the CHC [despite the fact that CHC had posters on the wall]. [D5]</td>
</tr>
<tr>
<td>I asked about side effects and she explained. I wish now they had given more specific advice. [D5]</td>
</tr>
<tr>
<td>I read the brochure they distribute when we are pregnant. … I heard nothing on side effects apart from other women. [D5]</td>
</tr>
</tbody>
</table>

**IC3- Information is not available to clients to access as needed, so clients turn to different sources of information at different points during the journey to adoption and continuation.** The “correct” information, especially regarding side effects, is not always available to them when they need it. A woman may typically rely on information from family and friends when making the decision to adopt, whereas

(14) The traditional assumption that people knowingly categorize and rank their sources of information appears on interview guides with questions that ask respondents to make a selection on the source of information they trust most highly. However, this is creating a “moment of decision” specific to the interview context and does not reflect that the individual frequently does not actively make decisions in this way in real life.
during counseling sessions she receives information from the midwife and doctor, but when experiencing side effects, her first line of information is again her friends and family since going to a clinic is time consuming and a hassle.

I used pills for 1 week but got nervous and headaches so I stopped. … My husband and children noticed effects. I didn’t consider coming to doctor when I felt side effects. I talked with my sister-in-law and stopped on my own. … Women on pills are nervous. That’s what I’ve heard and noticed. [D7]

I took pills only for 15 days … I stopped for condoms. I didn’t talk to any doctor. I bought [condoms] from the pharmacy. [D5]

I stopped without going back to the clinic. I read some information. I knew [the side effects were caused by the method] because headaches stopped when I stopped the method. [D5]

Emotionally charged stories, such as kidnappings or shark attacks, are easier for people to remember when they are mentally searching for information to make a decision, which is referred to as availability bias. So stories of adverse outcomes told by friends and family, such as having very painful periods, developing cancer, or getting pregnant unexpectedly, can make those stories more vivid and more available in clients’ minds, thus negatively affecting how women perceive the frequency of side effects and the advantages of various methods. To be memorable the story does not necessary have to have occurred to a person the woman knows, it could have occurred to a friend-of-a-friend. In the absence of other trusted information, this potentially inaccurate information is easiest to recall.

I only heard about side effects from women who felt them. I also heard about the IUD moving and women who got pregnant over the IUD. I think side effects are very common. [D7]

A neighbor is on Implanon but it affected her and led to her getting breast cancer. She [neighbor] was on it five years. It’s also painful to insert. [D5]

I also sometimes feel pain in my legs- a lot of people say it causes them pain in their legs and nervousness. But I also worry, is it my nature or the pills? I am not sure. [D1]
IC4- The majority of clients who are going into the clinic to adopt a modern family planning method are going into the clinic with the intention to adopt a specific method. At the clinic, they frequently ask providers for that method directly. They are typically relying on information and advice received from friends and family prior to attending the clinic to make that decision. In some cases they are making the decision with their husband’s approval and in other cases without it, but what is important is that they are making the decision prior to coming into the clinic.

*I came to the provider with intention to start on FP. Specifically to start IUD. I told the provider I want IUD.* [D1]

*We [my husband and I] had the discussion about using family planning and we agreed for no IUD, so we agreed on the condom.* [D1]

*7 of 10 have decided on method already. So I review history and supply method. 3 of 10 are undecided so I cover all methods and provide brochures.* [MW]

Because clients are coming into the clinic with an intention for a specific method, they are susceptible to confirmation bias, meaning they want to hear their decision confirmed and can react negatively when it is not confirmed. This applies to cases when women are going to the clinic to start a method as well as when they are experiencing side effects from the method they are currently using.\(^{(15)}\)

*She came and I explained, yet I feel she came with a preconceived thought and I still didn't succeed to combat hearsay and change her mind.* [MW]

*And after the spacing plan, we discuss methods. Sometimes, even if you talk about side effects, they chose the method and insist on it if it was a family recommendation and refuse others due to faulty thinking…* [MW]

\(^{(15)}\) A thought exercise shows how this insight relates to Provider Insight 2, that providers may feel uncomfortable recommending certain methods. When a client comes into a clinic with a specific method in mind, it could either cancel out or exacerbate a provider's discomfort with a specific method. In cases when the client’s choice matches what the provider feels comfortable with and would have recommended, there would most likely not be an effect on the client’s choice as they are identical. However, in cases when a client wants a method the provider does not typically recommend and does not feel comfortable recommending, the provider may feel uncomfortable and the client could possibly leave the session without adequate understanding of that method.
I consulted provider about side effects. Provider said pills have nothing to do with hair loss. But why haven't they read warnings? But I tell them there are warnings. [D5]

I know it was from Implanon because as soon as I removed it, all [side effects] disappeared. I talked with my sister, friends and cousin who all complained about Implanon. [D5]

IC5- Some clients are not pre-planning for the counseling session with the provider and are not active participants during the sessions. Some clients are not planning for the counseling sessions with providers past the fact they are requesting a specific method. Prior to attending sessions, clients did not commonly think about or consider how the interaction would proceed or what questions they would ask during the session.

I was unprepared. When my MFP visit happened I didn’t have a preferred method or specific questions. [D6]

In fact, clients arrived with misinformation concerning when they could start on their method and what the requirements for the method were. Not only is this frustrating for the client, it adds unnecessary visits for the provider and the clinic.

On the 40th day post-delivery, I came to ask for IUD. MW said I had to have period before she can insert it. I thought it could be inserted before that. I’ll come back for the IUD. [Woman was still waiting for her period therefore did not have an IUD.] [D1]

Providers and clients reported that IUDs are inserted on the 3rd or 5th day of a woman’s period. For one of the observed patient-provider interactions a client was given an appointment to return for an IUD insertion on a different day because she did not yet have her period, which is a hassle for everyone involved. A different client reported that she changed her mind on getting an IUD between her first appointment and when she was scheduled for her insertion.

Two observations included instances in which a woman wanted to start on a specific method but that method was contraindicated, which neither of the women knew prior to coming in. In both cases, the provider talked about at least one alternative method but in neither case did an interactive counseling session occur - neither client asked a lot of questions about the contraindication issue or about the alternative method. In both cases the client was given a future appointment.
IC6- There is a cycle occurring in some sessions that is difficult for traditional counseling to break - clients are going into a busy clinic having already made a decision on a method, thus not necessarily wanting or feeling they need to ask questions, whereas time-scarce providers expect that a client has already made her decision and may not want to learn about other methods. The fact clients are coming into the clinic and some are not necessarily interested to listen to alternative options can lead to a cycle that is difficult to break: time-scarce providers expect that clients have already made their decision and are unwilling to learn about other methods. Clients feel that they already have a lot of knowledge and information from friends and family, and at the same time may want more information but may not feel empowered enough to ask questions to the provider.

We didn’t discuss every method [during the counseling with MW]. I just told her I wanted birth control- condoms. … They didn’t tell me about others. Maybe she wants to get it over with. [D1]

At this clinic, we didn’t discuss [different/alternative] method [in the counseling session]. I asked for pills. They took my medical information [and I got the method]. [D1]

MWs are not empowered enough to provide complete counseling. They don’t provide complete counseling of all methods but rather validate a woman’s choice. [MD]

With this context for the client-provider interaction, existing counseling tools are not overly useful to change the dynamic of the session - they provide information but do so in a uni-directional way that does not empower the client or address confirmation bias. They were observed being used in only one of the client-provider observations. Providers reported that midwives have the flipchart tool and in some cases the contraindications tool for counseling while doctors have the contraindications tool. Both types of providers have samples of the physical devices, such as IUDs, to show clients.

Yes, I use the flipchart as well as the disc [contraindications wheel] which helps with reassessing the health profile. [MW]

Yes, I use the flipchart which talks about all the methods in Arabic. [MW]
Insights to Opportunity Areas and Guidance

For Phase 2, each of the insights from Phase 1 was converted into an opportunity area. For example, the Facility Insight 1 around the fact that clinics are public spaces is transformed into an opportunity statement to provide more privacy in clinics. General guidance is then provided for each opportunity area. The guidance should be seen as concepts that could be further developed - fleshed out more, refined, prototyped, tested with clients, and iterated - and possibly turned into recommendations for interventions and programs. Given the limited scope of this activity, not all concepts could be developed or prototyped but all opportunity areas and guidance are shown here.

While opportunity areas come directly from insights, guidance comes from three sources: direct statements from interviewed women and providers, the internal ideation session with JCAP team members, and internal conversations with the JCAP research team. Guidance does not map on a one-to-one basis with opportunity areas. In some cases, guidance may address only one or more than one opportunity area. A matrix of Insights, Opportunity Areas and Guidance is shown in Appendix A-V with a map showing the relationships in Appendix A-VI.

Facility Opportunity Areas and Guidance

**IF1**- MCH clinics are open and public spaces that make intimate conversations about sensitive topics like family planning difficult.

**OF1-1**(16) Clinic spaces could be better managed to ensure more privacy for clients so that a client can sit privately with a provider knowing they will not be overheard or interrupted. This could be accomplished by:

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(16) Since each opportunity area is directly linked to an Insight, the numbers are designed to correspond. For example, Opportunity Client 2 (OC2) corresponds back to Insight Client 2 (IC2). In the case where there is more than one opportunity for an insight, such as with Insight Facility 1, the opportunity areas are numbered: Opportunity Facility 1 (OF1-1) and 2 (OF1-2) correspond to Insight Facility 1 (IF1).
• Guidance 1, G1\(^{(17)}\) - Revising the current system of giving clients numbers to designate the order in which they will be seen so that clients or staffs are not entering rooms during client sessions. For example, by having client charts put on the outside of doors or having numbers designating clients placed outside the provider’s door.

• G2 - Accounting for different levels of comfort with men in the facility by having both designated women-only days when men cannot attend the MCH clinic as well as days designated for men to attend.

**OF1-2-** Counseling sessions by trained staff could occur in a private space outside of the existing MCH clinic. This could be accomplished by:

• G3 - Better management of the MCH space available within health facilities to ensure more privacy; providing counseling in private spaces not within the public health facility, such as counseling with community counselors or via a free informational phoneline.\(^{(18)}\)

**IF2-** Clients are not active participants during observed counseling sessions.

**OF2-** Clients could be encouraged to be more active participants in counseling sessions. This could be accomplished by:

• G4 - Providing a pre-printed list of questions to clients visiting the MCH clinic for them to ask the provider.

• G5 - Providing an empathetic client advocate to accompany the client to the visit.

**IF3-** The structure and efficiency of clinics vary widely but a consistent element across clinics is that there is uneven client flow throughout the day.

**OF3-** Clinic hours could be restructured to smooth the workload for providers and make it more efficient for clients to attend clinics. This could be accomplished by:

\(^{(17)}\) Each guidance is designated as GX, with X being the number. For example, Guidance 1 is designated G1.

\(^{(18)}\) There have been previous programs in Amman that provided community-centric and/or home-based counseling, including programs previously run by JCAP and currently run by USAID Health Service Delivery. While a client’s knowledge of or interaction with these programs was not specifically asked about during interviews, few clients mentioned the programs spontaneously. Insights from this study could be used to inform and refine the existing programs.
• G6- Blocking appointment times and clients are requested to show up in blocks, for example from 8-10, 10-12, or 12-1. Many appointments are not currently scheduled, but specific types of appointments such as follow-up family planning visits could be scheduled for blocked times to decrease the morning workload.

• G7- Extending clinic hours past 2 pm one day per week, for example to 5 or 6 pm could allow working women to more easily attend the clinic.

Provider Opportunity Areas and Guidance

IP1- Providers have intrinsic motivation and see themselves as champions of family planning.

OP1- Harness the intrinsic motivation of providers and their desire to be champions of family planning. This could be accomplished by:

• G8- Changing the dynamic of counseling sessions so that clients are actively seeking a provider's knowledge and expertise, instead of placing the burden solely on the service provider to provide counseling. An example of how this could be accomplished is by structuring the session, for example by providing checklists, or by empowering a client by encouraging them to ask specific questions of providers.

• G9- Focusing on holistic measures of quality of care.

• G10- Creating opportunities for clients to rate or thank service providers for excellent service, such as thank you cards they can write and display in their office.

IP2- Some providers have their own personal mental models (biases) around specific methods.

OP2- Providers could benefit from additional hands-on training on all available methods with continuing education for all methods. This could be accomplished by:

• G11- Providing information in ways that they trust and can explain to their own clients, such as during trainings having individuals who use that method attend the training to share personal experiences.

• G12- Providing remote and on-demand training for providers, such as online tutorials and quizzes for providers to complete on a regular basis.

• G13- Providing interactive learning groups for providers with providers presenting and sharing recent case studies to other providers.
**Determinants Related to Client/Provider Interaction for Family Planning**

**IP3-** Providers sometimes worry about a woman’s method choice because they know false information is common and that some women may lack agency within their family.

**OP3-** Give providers the ability to refer clients to information sources that they themselves have confidence in, so that they are more confident women have access to trusted information sources. This could be accomplished by:

- **G14-** Creating online information (either through a website or a smartphone-based app) for women to access, branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.\(^{19}\)

**IP4-** Providers face a very uneven workload throughout each day.

**OP4-** Clinic hours could be restructured to smooth the workload for providers so they are not rushing with some clients. This could be accomplished by:

- **G6-** Blocking appointment times and clients are requested to show up in blocks, for example from 8-10, 10-12, or 12-1. Many appointments are not currently scheduled, but specific types of appointments such as follow-up family planning visits could be scheduled for blocked times to decrease the morning workload.

**Client Opportunity Areas and Guidance**

**IC1-** Clients have varied mental models about what makes an information source valuable.

**OC1-** Provide information to clients in ways that mimic how they currently value and receive information. This could be accomplished by:

- **G15-** Providing information in a non-technical way in women’s own words, such as through testimonials from real current users or from actual positive deviants.

- **G16-** Providing information in a non-technical way using client personas - “sample” individuals made from aggregations of real stories and experiences from

\(^{19}\) The majority of clients did not report relying on existing MOH resources. They knew of campaigns and of brochures and flyers in clinics but a minority reported reading them or learning information from them. Clients repeatedly stated their desire to have interactive resources.
clients - using examples that highlight clients’ own fears or misinformation and how the persona overcame them.\(^{(20)}\)

- G17- Creating a (moderated) “club” or group of women using modern methods, either via WhatsApp or a community group, in which women can chat and share side effect coping strategies. A moderator could be used to keep the discussion on track and provide any additional medical advice.

**IC2**- There is a mismatch between information sources currently provided to clients and clients feeling informed.

**OC2**- Provide information to clients in new ways or through new delivery channels. This could be accomplished by:

- G14- Creating online information for women to access (either through a website or a smartphone-based app), branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

- G15- Providing information in a non-technical way in women’s own words, such as through testimonials from real current users or from actual positive deviants.

- G16- Providing information in a non-technical way using client personas - “sample” individuals made from aggregations of real stories and experiences from clients - using examples that highlight clients’ own fears or misinformation and how the persona overcame them.

- G17- Creating a (moderated) “club” or group of women using modern methods, either via WhatsApp or a community group, in which women can chat and share side effect coping mechanisms. A moderator could be used to keep the discussion on track and provide any additional medical advice.

- G18- Creating a free interactive informational phone line, WhatsApp group or live online chat for women to access family planning counselors.

- G19- Modifying language on side effects to highlight their normality or a woman’s strength when she deals with them.

\(^{(20)}\) Guidance 15 and 16 are very similar; they are both telling stories about using family planning from the perspective of a woman. The difference is in whether the stories are from real people and have their names attached to them (the case with G15) or are stories modeled after real people and may not have real names (the case with G16).
• G20- Creating an online learning system for women to teach themselves about family planning, such as online tutorials and quizzes with certificates for high achievers.

• G21- Creating information and sharing stories about family planning use in other countries.

**IC3-** Information is not available for clients to access as needed”, so the “correct” information, especially regarding side effects, is either not always available to clients when they need it or could have been delivered and not being understood by them. There is a mismatch between information sources currently provided to clients and clients feeling informed.

**OC3-** Provide information that women can access quickly whenever they need it, for example when they are making a decision with their family prior to going to the health facility or when they are at home and begin experiencing side effects. (This information should also be accessible by other individuals involved in making the family planning decision, such as husbands and mothers-in-law, who may not have up-to-date information and/or may not feel comfortable going into the health facility to talk with a service provider.) This could be accomplished by:

• G14- Creating online information for women to access (either through a website or a smartphone-based app), branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

• G17- Creating a (moderated) “club” or group of women using modern methods, either via WhatsApp or a community group, in which women can chat and share side effect coping mechanisms. A moderator could be used to keep the discussion on track and provide any additional medical advice.

• G18- Creating a free interactive informational phone line, WhatsApp group or live online chat for women to access family planning counselors.

• G20- Creating an online learning system for women to teach themselves about family planning, such as online tutorials and quizzes with certificates for high achievers.

• G22- Providing clients with a way to track or record common/typical side effects and signs they should come back to see a provider, possibly with a pain management metric.
• G23- Creating a side effects “tool-kit” with information on side effects and items to provide comfort (such as heating pads) in the event of sides effects.

• G24- Providing personal follow-up calls or messages to users concerning continuation and addressing any questions they may have.

IC4- The majority of clients who are going into the clinic to adopt a modern family planning method are going into the clinic with the intention to adopt a specific method.

OC4- Empower clients by guiding them with questions for the provider in a way that encourages them to think through their own future steps for continuation and what they would do if they experience side effects. This could be accomplished by:

• G4- Providing a pre-printed list of questions to clients for them to ask the provider.

• G22- Providing clients with a way to record common/typical side effects and signs they should come back to see a provider, possibly with a pain management metric.

IC5- Some clients are not pre-planning for the counseling session with the provider and are not active participants during the sessions.

OC5- Empower clients prior to their discussion with the provider. This could be accomplished by:

• G4- Providing a pre-printed list of questions to clients for them to ask the provider.

• G14- Creating online information for women to access (either through a website or a smartphone-based app), branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

• G18- Creating a free interactive informational phone line, WhatsApp group or live online chat for women to access family planning counselors.

• G20- Creating an online learning system for women to teach themselves about family planning, such as online tutorials and quizzes with certificates for high achievers.

IC6- There is a cycle occurring in some sessions that is difficult for traditional counseling to break - clients are going into a busy clinic having already made a decision on a method, thus not necessarily wanting or feeling they need to ask questions, whereas time-scarce providers expect that a client has already made her decision and may not want to learn about other methods.
OC6- Creating a moment during which clients and providers need to interact regarding the clients’ concerns and the clients’ future. (Current paperwork during the session deals with information the provider needs, such as medical history, but not information the client needs.) This could be accomplished by:

- G4- Providing a pre-printed list of questions to clients visiting the MCH clinic for them to ask the provider.
- G5- Providing an empathetic client advocate to accompany the client to the visit.
- G8- Changing the dynamic of counseling sessions so that patients are actively seeking a provider’s knowledge and expertise, instead of placing the burden solely on the service provider to provide counseling.
VI. Phase 3- Recommended Interventions

The following recommendations should be intuited within the methodological limitations of the study, as well as existent contextual factors i.e. high turnover/rotation of MOH staff.

Guidance and Concepts to Prototyping

The consultant then mapped the guidance concepts to a standard “Prioritization Matrix”, also known as an “Impact versus Feasibility” matrix. The matrix is shown below in Figure 1 and shown larger in Appendix A-VII, a common practice in design thinking to prioritize concepts to prototype and take to users for co-design.

Figure 1. Prioritization Matrix

Figure 1 Note: Shaded elements were part of prototyping activities, as explained below.

In behavioral design prioritization, impact and feasibility are defined relative to the problem at hand; guidance/concepts are mapped relative to one another and then higher impact and higher feasibility concepts are considered for initial prototyping. The purpose of this exercise is not to conclusively categorize concepts in the long-term but instead to prioritize prototyping opportunities - higher impact and higher
feasibility (i.e. low hanging fruit) can be prototyped as a first step. Impact can be loosely defined as how likely the concept is to encourage a desired behavior, based on the insights to which it maps back to. Feasibility can be loosely defined as how easy it is to turn that concept into an experiential prototype for use with clients and/or providers as well as how easy it would be to implement based on resource constraints.

For example, G5 - having an empathetic client advocate in the counseling sessions - would rank as higher impact but lower feasibility. Having this individual in sessions with patients and providers could be potentially impactful because that advocate could provide comfort and help translate unclear issues to the client and ensure that a busy and time-strapped provider covers all of the necessary topics and information, thus helping both the client and the provider. However, it ranks as lower feasibility because the ability to test or implement this concept easily would be harder to do- not only to find an individual with the skills to interact well with both providers and clients but also the longer term costs of recruiting, training, and hiring this extra level of staff for each clinic.

As a second example, G4 - having pre-printed questions for the client to take into the counseling session - would rank as higher impact and higher feasibility. It would be higher impact because it could address some of the same issues as the client advocate would but it would be very easy to create a set of sample questions and work with women and providers to add questions and elements to it, thus it would be higher feasibility. It would take resources to print and distribute the questions, but it would require significantly fewer resources than creating a cadre of client advocates would take to create.

Following categorization, the consultant selected the following higher impact and higher feasibility concepts for prototyping and co-design over the two days of additional interviews with clients and providers. These items were selected based on conversations with JCAP staff from the ideation sessions and the daily debrief sessions.

- **G3**- Better management of the MCH space available within health facilities to ensure more privacy; providing counseling in private spaces not within the public health facility, such as counseling with community counselors or via a free informational phone line.(21)

- **G4**- Providing a pre-printed list of questions to clients for them to ask the provider.

(21) Since community-centric and home-based counseling programs exist in Amman but were not spontaneously mentioned by many clients, an informational phone line was prototyped from this guidance.
• G8- Changing the dynamic of counseling sessions so that patients are actively seeking a provider’s knowledge and expertise, instead of placing the burden solely on the service provider to provide counseling.

• G10- Creating opportunities for clients to rate or thank service providers for excellent service, such as thank you cards they can write and display in their office.

• G11- Providing information in ways that providers trust and can explain to their own clients, such as during trainings having individuals who use that method attend the training to share personal experiences.

• G14- Creating online information for women to access, branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

• G15- Providing information in a non-technical way in women’s own words, such as through testimonials from current users or positive deviants.

• G16- Providing information by creating personas of users - aggregations of real stories and experiences from clients that users would identify with - using examples that highlight clients’ own fears or misinformation and how to overcome them.

• G18- Creating a free interactive informational phone line, WhatsApp group, or live online chat for women to access family planning counselors.

• G19- Modifying language on side effects to highlight their normality or a woman’s strength in dealing with them.

• G20- Creating an online learning system for women to teach themselves about family planning, such as online tutorials and quizzes with certificates for high achievers.

• G22- Providing clients with a way to track or record common/typical side effects and signs they should come back to see a provider, possibly with a pain management metric.

Prototyping to Recommendations

Prototyping is a flexible process of constantly iterating on feedback. Therefore the selected concepts were in some cases presented to clients and providers as individual concepts and in some cases presented as grouped concepts. During prototyping, the
groupings for concepts solidified and those groupings (referred to as prototypes in this document) are presented below as the formal recommendations for interventions to pilot. Following the discussion of recommended interventions, prototypes that did not show promise are also detailed.

**Prototypes Recommended for Piloting**

The recommended interventions are complimentary and could be piloted and implemented together or individually. Each intervention includes a proposed implementation plan, expected outcomes, a monitoring plan, and key performance indicators. The quantitative indicators are either available using existing data collection systems or designed to be simple and minimize any disruption to current service provision.22

The piloting plan assumes that any intervention assessment will occur in two stages: short piloting (which is outlined in this document) and then if the pilot test shows positive benefits, a larger quasi-experimental evaluation can be conducted on a regional or national level. The design of a larger evaluation is not discussed here, since it would be highly dependent upon the findings of any pilots.

The general recommendation for piloting is to involve from four to six centers for each intervention and have an equal number of similar centers as a control. Centers should be matched by a few key characteristics - MCH clinic client volume, number and type of family planning staff available, and demographics of clients. Eight to twelve clinics are suggested as a minimum to allow for clinic diversity so that both clinics with higher and lower volume and clinics from higher and lower socioeconomic status areas are included in the pilot. This diversity will provide valuable information on the generalizability of the interventions and the potential for scale-up. In addition to the performance indicators detailed for each intervention, qualitative feedback should be captured at the end of the pilot.

**R1- Method Counseling Card**

Despite the fact that no program relishes additional paper or additional paper documents, there needs to be a way to prompt an interactive and dynamic discussion.

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(22) Piloting any of the recommended prototypes was not discussed by the study team with the staff at clinics, who will be crucial for accurate data collection. To minimize the burden on staff, the data collection systems are designed to be as simple as possible. For example, data will only need to be recorded at the end of each day, not during busy times when the providers are already overwhelmed.
during the client-provider session in which (1) the responsibility for counseling is shared between the client and the provider, (2) the client is facilitated and empowered to ask specific questions, (3) side effects are made salient for the client in a way she can understand so she can calmly consider how she will deal with them prior to experiencing them, and (4) the client is able to understand the different degrees and duration of side effects and write them in her own words.

With these aims in mind, a half-page (front and back) counseling card was created for women to take into the session with the provider. The information and questions on the card was initially based on comments from women from the formative research about their perceived gaps in the counseling session with providers. During prototyping, providers and clients were shown versions of a physical care and they added and removed some of the initial questions, resulting in the elements and questions shown below. The sample is shown in Figure 2 below in English:

![Figure 2. Prototyped Discussion Card](image)

**Opportunity areas addressed**

- IF2: Clients are not active participants during observed counseling sessions.
• IP1: Providers have intrinsic motivation and see themselves as champions of family planning; they enjoy providing information to women about available methods that maybe suitable to them.

• IC2: There is a mismatch between information sources currently provided to women and women feeling informed.

• IC3: Information is not available for women to access as needed, so women turn to different sources of information at different points during the journey to adoption and continuation. The right information - especially regarding side effects - is not always available to them when they need it.

• IC4: The majority of women who are going into the clinic to adopt a modern family planning method are going into the clinic with the intention to adopt a specific method.

• IC5: Some clients are not preplanning for the counseling session with the provider and are not active participants during the sessions.

• IC6: There is a cycle occurring in some sessions that is difficult for traditional counseling to break - women are going into a busy clinic having already made a decision on a method, thus not necessarily wanting or feeling they need to ask questions, whereas time-scarce providers expect that a woman has already made her decision and may not want to learn about other methods.

Concepts included in prototype

• G4- Provides a pre-printed list of questions to clients for them to ask the provider.

• G5- Provides an empathetic client advocate to accompany the client to the visit.(23)

• G8- Changes the dynamic of counseling sessions so that patients are actively seeking a provider's knowledge and expertise, instead of placing the burden solely on the service provider to provide counseling.

• G19- Modifies language on side effects to highlight their normality or a woman’s strength in dealing with them.

(23) While the card is not a physical client advocate, the language in the introduction is designed to provide the feeling of having an advocate to walk the woman through the session.
• G22- Provides clients with a way to track or record common/typical side effects and signs they should come back to see a provider, possibly with a pain management metric.

**Prototyping Feedback**

This prototype was tested and iterated during the two days of prototyping and co-design with clients. Feedback was overwhelmingly positive for this design idea.\(^{(24)}\)

<table>
<thead>
<tr>
<th>Feedback</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>It would have helped conversation with doctor. Sometimes you’re hesitant to say something so it’s easier if you see it and you write it down.</td>
<td>[D1](^{(25)})</td>
</tr>
<tr>
<td>Have pictures on the card instead of writing. When I saw breast cancer information I knew how to do exam because of pictures.</td>
<td>[D1]</td>
</tr>
<tr>
<td>If you don’t prompt [the doctor] then it doesn’t happen. So the card would help women.</td>
<td>[D1]</td>
</tr>
<tr>
<td>Would need other questions for a recurrent user. I don’t think this is appropriate for recurrent users.</td>
<td>[D1](^{(26)})</td>
</tr>
<tr>
<td>Table helpful if provider follows-up during next visit to see if side effects are from method.</td>
<td>[D2]</td>
</tr>
<tr>
<td>This helps us a lot because they don’t tell us about side effects. That’s why we ask each other. I wish there was this kind of help and assistance when we went the first time. The leaflet [the printed brochure currently provided] doesn’t help.</td>
<td>[D2]</td>
</tr>
<tr>
<td>From day to day side effects differ so having a schedule is really good. These questions we ask them but some of them I forget.</td>
<td>[D2]</td>
</tr>
</tbody>
</table>

\(^{(24)}\) Feedback on the overall prototype is included for each prototype. Additionally, feedback on design details that were not incorporated during iterations and revisions is shown. Feedback that was incorporated into changes is not shown here because it was included in the recommendations.

\(^{(25)}\) Quote attribution follows the same system as with the formative research interviews. DX designate that it was a quote from a client on Day X of prototyping sessions, MW designates it was from a midwife, and MD designates it was from a doctor.

\(^{(26)}\) For the purpose of a pilot, this discussion card only includes details and questions on the initial visit with the provider. If the pilot shows success, a second card could be designed for follow-up visits.
I’m human and can forget points [to cover during session with client]. So this reminds me. Distractions make you forget because a baby cries or a woman comes in and I get distracted. [MW]

It acts as a reminder for the patient. … I like it a lot. It helps focus the conversation. … It wouldn’t make counseling longer. I think clients would feel we care. [MW]

It makes the job easier because the patient knows and knows to ask about this and what to expect. It guides and structures the conversation. [MW]

Piloting, Expected Outcomes and Key Performance Indicators

To pilot the card, six health facilities can be selected for inclusion into a pilot study with a duration of at least three months. Six similar health facilities can be matched with each selected health facility to serve as a control in which the intervention is not being implemented. Cards would ideally be handed out at the registration desk, which would give the client time to review the card before meeting with the provider. Cards would not be collected since the card is for clients’ personal use – it is for them to write down information in their own words and take home with them to reference if they need it.

Expected Outcomes

The discussion card is expected to lead to the following short-term outcomes:

1. Improve the interaction of the counseling session by empowering the client and not making the burden of counseling fall solely on the provider

2. Improve the knowledge of the client on the method and its side effects

The discussion card is expected to lead to the following medium-term outcomes:

1. Increase in proportion of women adopting modern family planning methods

(27) If early piloting shows that clients are not comfortable receiving the card at the registration desk, the cards could be handed to clients by the provider at the beginning of their counseling session. Alternatively, the cards could be provided to women during postnatal counseling sessions in the hospital.

(28) These medium and longer-term outcomes cannot be measured during the course of the pilot.
2. Decrease in proportion of women discontinuing methods within first year

Process Indicators

• Number of cards handed out [Only at centers distributing the card]
• Number of days of stock-outs of cards [Only at centers distributing the card]
• Number of clients asking for card [Only at centers not distributing the card]

Outcome Indicators

• Percentage of new family planning counseling sessions during which a client completes card during visit
  
  • [numerator: number of sessions with card reported completed / denominator: number of cards handed out (if client hands back card or does not fill it out, it should be counted as handed out but not completed)] [Only at centers distributing the card]

• Percentage of follow-up sessions in which a client brings the card from her first family planning counseling session back to the facility with her
  
  • [numerator: number of follow-up sessions with card brought / denominator: number of follow-up sessions with card brought + number of follow-up sessions with client who received card but did not bring it] [Only at centers distributing the card]

• Qualitative interviews with providers to understand if they feel the card has made it easier for them to counsel clients on methods during initial and follow-up visits

• Qualitative interviews with clients to understand if they feel the card has made it easier for them to ask questions and better understand methods and their side effects

**Monitoring plan**

A simple chart, shown in Appendix A-IX, designed like a calendar for staff and service providers to put daily totals can be distributed to clinics for the duration of the pilot
study. For health facilities that are distributing the cards, the chart would include spots for the four key raw data points that will be inputs to calculate the outcome indicators specified above: the number of cards handed out, the number of sessions in which cards were completed, the number of follow-up sessions with card brought, and the number of follow-up sessions with women who received the card but did not bring it. For health facilities that are not distributing the cards, the chart - also designed like a calendar - would include the number of clients asking about the card.

A research staff member would need to visit each of the health facilities at least two to three times in the first few weeks of implementation to ensure that the charts are being completed daily and answer any questions the service providers may have. At the end of the three-month period, the charts could be collected from each health facility and key indicators would be calculated on a weekly basis by research staff. Qualitative interviews would also be conducted at endline with the service providers. Additionally, qualitative interviews with a random selection of clients in the waiting room should also be conducted during monitoring visits and at endline to determine clients’ views on the card.

**Possible Challenges**

Challenges for this pilot include:

- Difficulty keeping cards in stock at all clinics during the pilot
- A possible lack of consistency in reception procedures for handing out cards between clinics
- Possible issues with literacy for some clients
- Difficulty in tracking/monitoring the cards after being filled up by the client
- Workload of the service provider and difficulty in monitoring relevant indicators

**R2- Free phone hotline**

The high frequency with which decisions about family planning method adoption and discontinuation are being made by women outside of health facilities (and prior to talking with a provider), prompts the need to tailor information and counseling to the context of women’s lives, when they and their families are making those decisions.

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(29) In a three-month pilot, the indicators around distribution and use of the cards during the initial counseling session would be complete for 3 months. It would only be possible to calculate the indicator for follow-up visits for about 2 of the 3 months as most follow-up visits are scheduled to occur a month following a new method initiation.
Therefore an intervention needs to provide information and counseling so that (1) information is on-demand and accessible quickly and at extended hours for women, (2) information as well as counseling is available by trained and certified family planning providers, (3) the type of information and counseling available over the phone covers the same range of information available through in-person sessions with providers, including method adoption, side effects, and discontinuation decisions, (4) referral appointments with clinics can be scheduled, and (5) information is accessible to all family members, including husbands and mothers-in-law. With these aims in mind, an intervention of a free phone hotline with daytime and evening hours is recommended. It is crucial to note that the hotline is not meant to be a pure substitute for an in-person session with a provider, but rather to give a first round of information to clients prior to meeting in-person with a provider as well as provide triaging for questions and issues. It should be staffed by a variety of providers trained in family planning, including midwives, female doctors, and male doctors. A phone hotline instead of a video chat feature was preferred by clients for privacy and cultural reasons.

**Opportunity areas addressed**

- IF1: MCH clinics are open and public spaces that make intimate conversations about sensitive topics like family planning difficult.

- IP3: Providers do not always trust a client’s decision in part because they may not trust the client’s source of information.

- IC2: There is a mismatch between information sources currently provided to clients and women feeling informed.

- IC3: Information is not available for clients to access as needed, so clients turn to different sources of information at different points during the journey to adoption and continuation. The right information - especially regarding side effects - is not always available to them when they need it.

- IC5: Some clients are not preplanning for the counseling session with the provider and are not active participants during the sessions.

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(30) Ideally, women who call the hotline could be given preferential treatment at health facilities, for example they would be moved forward in the queue of waiting patients to incentivize calling the hotline.

(31) While the majority of women preferred to speak with a female doctor, male doctors could also be available, especially for husbands who may not feel comfortable talking with a female doctor.

(32) Part of the counseling could include informing clients that the hotline is not meant to replace in-person clinic visits and that an in-person visit would still be needed for new adopters or renewals.
• IC6: There is a cycle occurring in some sessions that is difficult for traditional counseling to break - clients are going into a busy clinic having already made a decision on a method, thus not necessarily wanting or feeling they need to ask questions, whereas time-scarce providers expect that a client has already made her decision and may not want to learn about other methods.

**Concepts included in prototype**

• G3- Better management of the MCH space available within health facilities to ensure more privacy; providing counseling in private spaces not within the public health facility, such as counseling with community counselors or via a free informational phone line.

• G14- Create online information for women to access, branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

• G18- Creates a free interactive informational phone line, WhatsApp group, or live online chat for women to access family planning counselors.

**Prototyping Feedback**

This prototype was discussed and iterated on during the two days of prototyping and co-design with clients and service providers. The elements described above are from what clients or providers requested or said they would want in the service, and feedback was overwhelmingly positive for this design idea.

<table>
<thead>
<tr>
<th>It’s a nice idea. It’s better than showing up with the doctor, it’s easier. When you have kids it’s hard especially without a car. I can call to discuss and if I need I can visit. It would save me time. [D1]</th>
</tr>
</thead>
<tbody>
<tr>
<td>It would be useful. For example with pills or if emergency with IUD. I could call and find out where to go and what to do. [D1]</td>
</tr>
<tr>
<td>Would be fine if I didn’t know the doctor on the call. [D1]</td>
</tr>
<tr>
<td>[Response to above comment] It wouldn’t be fine, I want to know the doctor. I may fear dealing with someone I don’t know. The doctor here knows me and I know how to talk with the doctor here. [D1]</td>
</tr>
<tr>
<td>It has to be effective and sustainable. It would close in 1 week from the volume of calls. [Laughs] [D1]</td>
</tr>
</tbody>
</table>
VI. Phase 3- Recommended Interventions

It would answer lots of questions. It would be good if [the hotline was] a reliable source [MD is reliable], better than asking friends or neighbors. [D2]

With hotline we could understand if it’s the method or just the individual [regarding side effects]. [D2]

If dedicated person, it would solve a lot of problems. … It would make our jobs easier, some questions would be answered without women coming in. [MW]

I would not want to do it [staffing the hotline]. I like seeing people. [MW]

**Piloting, Expected Outcomes and Key Performance Indicators**

To pilot this intervention, information about the hotline can be disseminated throughout health clinics and hospitals, not just in the MCH spaces but in all areas of the health facilities. Six health facilities can be selected for inclusion into a pilot study with duration of at least three months. It will be hard to control information spreading about the hotline and it should be accessible to everyone who calls, not only clients of a specific clinic. Therefore because it is not a physical intervention that can be controlled at specific clinics, it will not be possible to have control clinics.

**Expected Outcomes**

The hotline is expected to lead to the following medium-term outcomes:

1. Improve the knowledge of the client on the method and its side effects
2. Decrease the number of visits to health facilities

The hotline is expected to lead to the following long-term outcomes:

1. Increase in proportion of women adopting modern family planning methods
2. Decrease in proportion of women discontinuing methods within first year

**Process Indicators**

- Total number of calls per day
- Number of calls per day regarding general family planning inquiries
- Number of calls per day regarding specific family planning methods
- Number of calls per day regarding side effects
- Number of calls per day regarding discontinuation
**Outcome Indicators**

- Proportion of women who attend health facilities who called hotline in previous week [numerator: number of family planning sessions with hotline call in previous week / denominator: number of total family planning sessions]

- Proportion of women who attend health facilities who called hotline in previous four weeks [numerator: number of family planning sessions with hotline call in previous four weeks / denominator: number of total family planning sessions](33)

- Qualitative interviews with providers to understand if they feel the hotline has made it easier for them to counsel patients on methods

- Qualitative interviews with clients who have called the hotline to understand if they feel it has made it easier for them to access trusted information, ask questions and better understand methods and their side effects

**Monitoring plan**

A very simple chart, shown in Appendix A-IX, designed like a calendar for registration staff to put daily totals can be distributed to the selected clinics for the duration of the pilot study. During registration for family planning visits the client would be asked if they called the hotline in the past week or in the past month. The chart would include spots for the three raw data points: the number of women for family planning visits who called the hotline in the previous week, the number of women for family planning visits who called the hotline in the previous four weeks, and the total number of family planning visits.

A research staff member would need to visit each of the health facilities at least two to three times in the first few weeks of implementation to ensure that the charts are being completed daily and answer any questions the registration staff may have. At the end of the three-month period, the charts could be collected from each health facility and

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(33) Two indicators are included for time because of the nature of adoption. Some women may call the hotline to inquire about starting a method and be told that they will need to have their period before a method can be adopted, therefore they may delay a few weeks (or longer) before going to the clinic. The time-restriction on these two indicators may miss women who wait longer to attend the clinic.
key indicators would be calculated on a weekly basis by research staff. Qualitative interviews would also be conducted at endline with the service providers.

**Possible Challenges**

Challenges for this pilot include:

- Difficulty establishing a free phone system that allows for waiting (instead of a busy signal)
- Difficulty identifying and training qualified staff to conduct family planning counseling over the phone
- Inability to measure changes in clinic attendance because of issues addressed through discussion on hotline
- Financial constraints

**R3- On-demand Provider Trainings**

Service providers are experts in their field, yet they can benefit from training in client-centered counseling specifically related to rights-based counseling. Changing family planning methods and a lack of personal experience with some methods can make it difficult for service providers to adequately counsel clients on all methods and overcome some provider biases. Hands-on trainings, especially for FP method insertion for implanon, are crucial while refresher trainings can help reinforce knowledge and provide more confidence around the details of a method. Therefore, providers would learn about (1) rights-based counseling techniques that are client-centered (2) new methods or method changes when they do not feel comfortable with that method, including prior to a full hands-on training and (3) a method even if they are not qualified to insert it (for example with Implanon), (4) they can quiz themselves on

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(34) In a three-month pilot, the indicators around distribution and use of the cards during the initial counseling session would be complete for 3 months. It would only be possible to calculate the indicator for follow-up visits for about 2 of the 3 months as most follow-up visits are scheduled to occur a month following a new method.
knowledge and method selection, and (5) they can possibly receive non-monetary recognition for their additional knowledge and promote themselves as family planning champions. With these aims in mind, an intervention of online service provider training modules is recommended.

**Opportunity areas addressed**

- IP2: Some providers have their own personal favorites for methods and consciously (or subconsciously) may encourage those methods for clients.

**Concepts included in prototype**

- G11- Provides information in ways that they trust and can explain to their own clients, such as during trainings having individuals who use that method attend the training to share personal experiences.

- G12- Provides remote and on-demand training for providers, such as online tutorials and quizzes for providers to complete on a regular basis.

- G13- Provides interactive learning groups for providers with providers presenting and sharing recent case studies to other providers.

**Prototyping Feedback**

This prototype was not tested or iterated on during the prototyping and co-design sessions with providers because feedback from the limited number of providers the study team expected to interview would not have been sufficient to consider it a full prototyping activity. This intervention is recommended because it comes directly from comments from providers during the formative research, discussed in the Section IV.

**Piloting, Expected Outcomes and Key Performance Indicators**

To pilot the online training system, information about the system can be disseminated to service providers, either in just Amman or throughout Jordan. Data on use can be monitored for at least three months.

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(35) Any quizzes should be anonymous so that providers can take them without fear of failure affecting their job review or their supervisor seeing their scores. Quizzes should be on various modules/topics, such as knowledge of side effects or method selection with pre-existing conditions. Following a successful completion of a quiz, the service provider should be able to enter their name and have a certificate printed for that module, which they could then display on the wall of their counseling room if they choose.
Expected Outcomes

The revised provider trainings are expected to lead to the following short-term outcomes:

1. Improve the knowledge and comfort level of service providers on family planning methods

The revised provider trainings are expected to lead to the following medium-term outcomes:

1. Improve the counseling experience in MCH clinics for providers and clients
2. Increase in proportion of women adopting modern family planning methods
3. Decrease in proportion of women discontinuing methods within first year

Process Indicators

- Number of service providers logging into the training system
- Number of service providers starting specific modules
- Number of service providers completing specific modules

Outcome Indicators

- Changes in scores of knowledge of family planning methods and side effects
- Qualitative interviews with providers to understand if they feel the online trainings are easily accessible for them and if they have improved their knowledge or comfort level

Monitoring plan

A dashboard of key performance indicators could be built into the system for review by research staff. Qualitative interviews would also be conducted after three months with a random sample of service providers.

Possible Challenges

Challenges for this pilot include:
• A need to further refine the intervention idea, based on contextual feedback from providers

• Some service providers may not have high digital literacy and therefore may not be comfortable with an online learning platform

• Possible high costs of designing the system and training modules

R4- User Testimonials and Personas for BCC Materials

Women in Jordan highly value expertise and experience, but what they also value is information that is provided in a way that mirrors how they interact with and talk to their friends and family. Therefore revised BCC materials should (1) include actual user testimonials or user personas(36) that women can relate to, (2) tell stories that cover the experience women commonly have, including doubts and hesitations plus possible ways to deal with or overcome them(37), (3) be accessible for clients to read or watch on their own by finding them online, (4) be possible for providers to use in counseling sessions with clients, and (5) be branded by a trusted source such as the Ministry of Health. With these aims in mind, creating print and short video BCC materials that utilize user testimonials and/or user personas is recommended.

Opportunity areas addressed

• IP2: Some providers have their own personal favorites for methods and consciously (or subconsciously) may encourage those methods for clients.

• IP3: Providers do not always trust a woman’s decision in part because they may not trust the woman’s source of information.

• IC1: Women have varied mental models about what makes an information source valuable.

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(36) Within the global health world there are different usages of the terms “testimonials” and “user personas”. Here, a testimonial is a user telling her own story, with her name or face attached to her story. A user persona is an aggregation of multiple real stories, but told with a fake name or a video created using an actor representing a woman.

(37) For example, a user story that highlights a common hesitation and how to overcome it could be: “My doctor had told me that with injections it could take some months after stopping the injections to get pregnant, which was the case for me. My husband and I didn’t worry because we knew that could be a side effect. But to keep my mother-in-law from asking me every month why I wasn’t already pregnant and saying how worried she was about more grandchildren, we delayed telling her that I had stopped the injections.”
• IC2: There is a mismatch between information sources currently provided to women and women feeling informed.

• IC3: Information is not available for women to access as needed, so women turn to different sources of information at different points during the journey to adoption and continuation. The right information - especially regarding side effects - is not always available to them when they need it.

Concepts included in prototype

• G11- Provides information in ways that providers trust and can explain to their own clients, such as during trainings having individuals who use that method attend the training to share personal experiences.

• G14- Creates online information for women to access, branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

• G15- Provides information in a non-technical way in women’s own words, such as through testimonials from current users or positive deviants.

• G16- Provides information by creating personas of users - aggregations of real stories and experiences from clients that users would identify with - using examples that highlight clients’ own fears or misinformation and how to overcome them.

Prototyping Feedback

This prototype was discussed and iterated on during the second day of prototyping and co-design with clients and service providers with positive feedback. The elements described above are from what women or providers requested or said they would want in the service as well as from suggestions provided during the formative research. The recommendation for this intervention is broad because different women have different preferences for how they receive information - some want to read it and some want to see it in video form. Some women want it to be real stories and other would be happy learning about other anonymous women’s experiences. Therefore the BCC material should include multiple mediums and story tellers to be able to be as effective as possible for a broader range of women; but the key is that the stories (the information) are presented in a way that women identify with, using non-medical terms and also be branded by a trusted source.

Radio doesn’t exist in our lives. [D2]
I read. I prefer to read stories. [D2]

I might believe her [the woman in a video] because the symptoms I experience might be the same as hers. She could tell us what to do and how to manage the symptoms. [D2]

[I prefer] TV or videos. Part of [the video] could be a discussion with a provider [between woman and provider]. I want to hear about the experiences of many women. [D2]

I would hear about experiences based on this [video/story], I might consider adopting if so many method users talked about experiences, but still would need my doctor. [D2]

[Medium] should be Facebook or WhatsApp group. We don’t always watch TV. [D2]

Women will be influenced by videos. They’re contagious. It should be real experiences of women. … A conversation [shown in the video] would be old fashioned. Be creative. … Could be shown in waiting area of MCH clinic. [MW]

**Piloting, Expected Outcomes and Key Performance Indicators**

To pilot the revised BCC materials, the materials can be disseminated to six health centers and one or two hospitals within Amman\(^{(38)}\) selected for inclusion into a pilot study with duration of at least three months. If the materials are only print materials then control clinics could be selected, but a key insight addressed by the revised materials is that they be available to women whenever they need them, especially after leaving the clinics when they may be experiencing side effects. So on-demand resources available to all women would be preferred for a realistic pilot to only physical materials in the clinics.

**Expected Outcomes**

The revised materials incorporating personas or testimonials are expected to lead to the following short-term outcomes:

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\(^{(38)}\) Ideally the materials should be disseminated widely, including online. However for piloting they can be disseminated to health clinics and one to two hospitals that have high delivery rates and have the selected health clinics within their catchment area.
1. Increase the accessibility of knowledge for the client in moments when the client most needs it, i.e. when they are making decisions about family planning methods

2. Improve understanding of methods and side effects

The revised materials incorporating personas or testimonials are expected to lead to the following medium-term outcomes:

1. Increase in proportion of women adopting modern family planning methods

2. Decrease in proportion of women discontinuing methods within first year

**Process Indicators**

- Total number of materials created
- Total number of materials disseminated
- Proportion of women who attend health facilities who reported receiving the materials [numerator: number of family planning sessions with woman who received the materials or access to the materials at delivery / denominator: number of total family planning sessions]

**Outcome Indicators**

- Proportion of women who attend family planning session who reported reading the materials [numerator: number of family planning sessions with woman who reported reading the materials / denominator: number of family planning sessions with woman who received the materials or access to the materials at delivery]
- Qualitative interviews with providers to understand if they feel the BCC materials have made it easier for them to counsel patients on methods
- Qualitative interviews with clients to understand if they feel the BCC materials have increased their knowledge and comfort on methods and if they have shared the materials with friends or family members

**Monitoring plan**

A very simple chart, shown in Appendix A-IX, designed like a calendar for service providers to put daily totals can be distributed to the selected clinics for the duration of the pilot study. During counseling for family planning visits the client would be
asked if they received materials at delivery or accessed materials online and if so, if they read the materials. The chart would include spots for the three raw data points: the number of women for family planning visits who received the materials or access to the materials at delivery, the number of women for family planning visits who received the materials or access to the materials at delivery and read the materials, and the total number of family planning visits.

A research staff member would need to visit each of the health facilities at least two to three times in the first few weeks of implementation to ensure that the charts are being completed daily and answer any questions the service providers may have. At the end of the three-month period, the charts could be collected from each health facility and key indicators would be calculated on a weekly basis by research staff. Qualitative interviews should also be conducted at endline with the service providers. Additionally, qualitative interviews with a random selection of clients in the waiting room should also be conducted during monitoring and endline visits to the clinic to determine their views on the revised BCC materials.

**Possible Challenges**

Challenges for this pilot include:

- An online repository or smartphone-based app with user stories and additional information would be difficult to restrict to a specific clinic, therefore a control group of clinics may not be possible.

- Finding women who are willing to be interviewed and have their names or images used - either for print stories or a video - may be difficult.

- The stories of women should include a range of ages and demographic characteristics so that they are inclusive and show the diversity of the Jordanian population.

**Prototypes Not Recommended for Piloting**

Failure is an essential part of design thinking and should be an essential part of early program planning in all disciplines. Failing fast after early feedback from clients allows designers and policy makers to not create large-scale pilot projects which have little efficiency.

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(39) In a three-month pilot, the indicators around distribution and use of the materials may be incomplete because of delays in time from the date of delivery to the date of a first family planning visit.
chance of success. The two prototypes below did not fare well during feedback and are therefore not recommended as interventions for piloting.

**X1- Provider Rating System**

The study team presented a prototype of a provider rating system to clients, showing five tokens with 1 to 5 stars on them which could be anonymously put in a box after a clinic visit to rate the client’s visit with the provider. Not only did this link back to formative research from providers saying that they enjoyed it when clients thanked them, it was an attempt to harness the intrinsic motivation of providers, related to insight IP1.

**Opportunity areas addressed**

- IP1: Providers have intrinsic motivation and see themselves as champions of family planning; they enjoy providing information to women about available methods that maybe suitable to them…

**Concepts included in prototype**

- G9- Focuses on holistic measures of quality of care.

- G10- Creates opportunities for clients to rate or thank service providers for excellent service, such as thank you cards they can write and display in their office.

**Prototyping Feedback**

While there was positive feedback on this prototype, the reactions of women were mainly neutral. There was no strong interest from women in discussing how to refine this prototype, other than women stressing that it needed to be confidential, or in the type of feedback they would want to give. Women’s input on the type of feedback they would give would have been crucial to setting up a feedback loop for any provider improvement. The few providers did not see it as an intrinsic motivator and rather saw it as a monitoring mechanism, which is why the intervention is not currently recommended for piloting.

| Rating would let me be honest because I can’t say things verbally. [D1] |
| Yes, would want to see rating [if average rating from other clients posted in clinic] to see if she treats me the same as other patients. [D2] |
| Excellent idea. It is also important for someone to follow-up and monitor. [D2] |
But a person may not like me and give me a bad rating. … Details would help, not rating numbers. Maybe I'm tired that day and wasn't good but I would want details to help me improve. [MW]

Overall rating only, not specific criteria. Good idea to display overall rating. It would encourage people to work on areas to improve and those doing well would get credit. [MW]

Additional prototype testing around the idea of thank you cards could occur in the future, but there was not sufficient time for that during this stage of the activity.

**X2- Client Training Certifications**

The study team presented a prototype of a client training system to women, in which anyone could be certified in family planning methods and receive a “certificate” as being trained on methods. This prototype is related to family planning information being on-demand for the public, but instead of the information just being an information repository, individuals would be able to interact with the information and take quizzes, earning certificates for their knowledge.

**Opportunity areas addressed**

- **IP3:** Providers do not always trust a woman’s decision in part because they may not trust the woman’s source of information.

- **IC2:** There is a mismatch between information sources currently provided to women and women feeling informed.

- **IC3:** Information is not available for women to access as needed, so women turn to different sources of information at different points during the journey to adoption and continuation. The right information - especially regarding side effects - is not always available to them when they need it.

**Concepts included in prototype**

- **G14:** Creates online information for women to access, branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.

- **G20:** Creates an online learning system for women to teach themselves about family planning, such as online tutorials and quizzes with certificates for high achievers.
**Prototyping Feedback**

While there was positive feedback on this prototype, the reactions of women were mainly neutral. The difference between this intervention and providing revised BCC materials (Recommendation 4) is the ability for women to quiz themselves and become “experts” and that aspect was not embrace by the women above the ability to learn more.

<table>
<thead>
<tr>
<th>Might be nice. [D2]</th>
</tr>
</thead>
<tbody>
<tr>
<td>Some people might comment sarcastically about it saying ‘Oh, she’s a philosopher now’. [D2]</td>
</tr>
<tr>
<td>I don’t refuse anything that helps me, I can help sisters and relatives. [D2]</td>
</tr>
<tr>
<td>Used to do grassroots visits before, it helped 10 years ago. Now these stopped. They did them for MFP and breast cancer awareness. [D2]</td>
</tr>
<tr>
<td>I’m interested and it would help with general knowledge. I’m not sure if a certificate is helpful or if it’s for my benefit. [D2]</td>
</tr>
</tbody>
</table>
Appendices

A-I. Final Research Protocol

Behavioral economics operational research and investigation of behavioral determinants related to family planning service provision and decision-making in Jordan

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Research protocol and Literature Review

Summary
This research protocol outlines a two-phase project to identify and design solutions for behavioral bottlenecks that inhibit adoption and sustained use of modern family planning methods by Married Women of Reproductive Age (MWRA) in Jordan. The first phase will use behavioral science methods for formative research to discover and illuminate behavioral bottlenecks in the adoption and use of modern family planning methods. The results of the first phase of qualitative research will then inform the second stage: rapid prototyping and co-design with clients and providers of a set of recommended interventions to improve adoption or to sustain use of modern methods of family planning.

Background
Jordan’s population continues to grow despite the Government of Jordan’s target of a total fertility rate of 2.1 by 2030. Reported increases in family planning use over the past ten years are attributed to an increase in traditional methods of family planning instead of increases in more reliable modern methods (DHS 2012). Additionally, the total fertility rate in Jordan has stagnated following a decline from 5.6 in 1990 to 3.7 in 2002 (DHS 2012).
Abt Associates and its partners are implementing USAID’s Jordan Communication, Advocacy and Policy (JCAP) Activity. JCAP will use the results of this study to investigate the application of behavioral economics to improving adoption and sustained use of modern methods of family planning in Jordan.

Behavioral economics, a relatively recent addition to behavioral science, provides a novel perspective to allow us to understand human decision-making and behaviors. Behavioral economics is built around the fact that human decision-making and how we translate our intentions to actions is imperfect. For example, as humans we go to the grocery store to buy eggs yet forget to buy them, we intend to go to the doctor but don't actually make an appointment, or we make a “to do” list but keep putting off doing some of the items on it. These consistent patterns in our behavior are caused by imperfections in our thinking - referred to as cognitive and behavioral biases - which help us act efficiently at times but sabotage us at other times. Traditional behavior changes theories or Social and Behavioral Change Communication (SBCC) methodologies do not always consider this reality that humans are imperfect actors.

The broader field of behavioral science draws heavily from the fields of cognitive psychology, anthropology, sociology, behavioral economics, health communication and decision science. In partnership with behavioral science, human-centered design (also referred to as participatory design or co-design) is a process that builds empathy with clients to understand their needs and desired goals. Merging these methods of identifying why and how these biases are occurring and then co-designing programs allows us to improve behavioral outcomes for clients. In the context of Jordan, viewing family planning adoption and continuation through the lens of behavioral design has the potential to transform our understanding of the underlying causes of low uptake of modern family planning methods and to design novel ways to tackle it.

Behavioral economics is increasingly being applied to international development and global health as a way to design more effective programs and to bridge the gap between intention and action for clients. The Behavioral Economics in Reproductive Health Initiative of the Center for Effective Global Action at the University of California, Berkeley recently released a white paper proposing a rethink of reproductive health issues in the context of behavioral science, focusing on how the fact that humans are not rational actors affects reproductive health decisions (Action 2015). Additionally, recent USAID requests for proposals are requiring a behavioral economics component for project design, including the recent TRANSFORM and Breakthrough-ACTION activities.

To our knowledge, a behavioral design lens is only just now being applied to family planning programs in Jordan, and to date only to the population of refugees in
Determinants Related to Client/Provider Interaction for Family Planning

Northern Jordan. The purpose of this activity is to apply that lens to the urban area of East Amman to gain better insight into the behavioral bottlenecks that are causing low uptake of modern family planning and the 48% discontinuation rate of modern family planning methods within the 12 months of adoption (DHS 2012). Following an analysis of the behavioral insights from the formative research phase, HCD and co-design techniques will be used to prototype a set of interventions aimed at increasing informed choices of family planning options, including increasing modern family planning method adoption and continuation rates.

**Literature review**

The social norms around family size and family planning have been well documented in Jordan. On average, the current ideal family size is four children (JCAP 2015b, IRH 2016, JCAP 2015a, JCAP 2016a, JCAP 2016b, Pullum & Assaf 2016) and there is pressure to become pregnant directly following marriage (JCAP 2015b). Despite households having a traditional view of decision-making for finances, women do have a voice in decisions on family planning (JCAP 2016a, HSSII 2013, HSS 2014). Social norms are key influencers of behavior, but one thing that has not been sufficiently explored in family planning activities in Jordan is how providing information on what society is doing around family planning adoption and use could influence adoption and continuation.

It is a fact that human behavior is influenced by directly observing others’ behavior or by being given information on their behavior (Social proof; Cialdini et al. 1999). In the most simple example, when we see other people looking at the sky, we also look up. Or when we see other people going into a crowded restaurant compared to an empty one next to it, we follow that behavior since we assume that the people may know something about the great food there that we do not know. Applying that to Jordan, women in Jordan are getting information from their family and friends about using specific methods and continuing with specific methods, but that is not necessarily information on what women in society as a whole are doing. Additionally, the information from family and friends, particularly on the effectiveness or side effects of modern methods, could be false or misleading. Providing people with information on what others are doing has been effective at changing behavior in health care and other contexts. For example, providing service providers in Nepal information on how their behavior compared to similar clinics led to increases in appropriate counseling for post-abortion care (Lorenzano 2018) and in a different context, households being given information that allowed them to realign their perceptions on the energy use of their neighbors in the United States decreased energy usage (Alcott 2011).
Typically health promotion programs assume that humans are able to fully weigh complex information presented to them, but behavioral economics has shown that the timing of the information, as well as the context in which the information is provided, is important. Humans value the present more than the future and typically choose to experience pleasure now and defer pain or discomfort until the future (Present bias; O’Donoghue & Rabin 1999). Because of this, humans put off doing things that do not provide immediate pleasure until a later time (Procrastination). And when that thing makes us uncomfortable to think about—such as many health issues do— we even tend to put our heads in the sand and completely ignore the issue. Even if ignoring it means it could get worse, it makes us more comfortable to ignore it (Ostriching; Karlsson et al. 2009).

Behavioral economics has also shown that we should think of the brain like a muscle that has limited capacity and has to be replenished. When a muscle is under stress and feels overwhelmed, its performance is negatively affected. The brain is the same— we have limited ability (bandwidth) to make decisions throughout the day and when we are overwhelmed it becomes harder for us to process information and make decisions (Scarcity mindset; Shah et al. 2012). To apply this to a family planning context, even if a woman wants to prevent another pregnancy, if she is overwhelmed and focused on providing for her current family, she may not have the ability focus on anything other than her most pressing need like putting food on the table (Tunneling; Shah et al. 2012). So processing information and choosing a modern family planning method, despite a strong intention, may be very difficult for her in than situation. Therefore helping her select and start an appropriate modern method may not be about providing a woman with more information on methods or side effects, but rather about providing key information in a way that she can absorb and act on it.

Even when the desire to begin and continue a modern family planning method is strong, procrastination and difficulty making plans can exacerbates the gap between the intention to follow the necessary steps to continue a modern method and actually doing so on a routine basis. Having people make a specific plan prior to starting an action can increase the likelihood they do the specific action, as has been shown by increasing immunization rates in the United States (Implementation intentions; Milkman et al. 2011). In Jordan there is recent evidence on the importance of human follow-up to move an individual to action. The JCAP Community Outreach program included a telephone Careline that called participants who had received vouchers or referrals and “the follow-up phone calls were one of the key driving factors in moving women from contemplation to the action stage of behavior” (JCAP 2015a). However, the potential importance of behaviorally-informed tools such as reminders have not
been researched or used widely to bridge the intention-action gap in encouraging MWRA to continue using a modern method.

It is important to also recognize that also providers are humans and therefore do not always act perfectly. Providers’ own biases can hinder their ability to provide the highest quality of care and give informed recommendations on methods to their clients. Jordanian social norms of larger family sizes and the focus on a woman becoming pregnant directly following marriage influence providers just as they influence women. These biases have also been found to affect family planning providers in Ghana (Stanback & Twum-Baah 2001) and Uganda (Kiapi-Iwa & Hart 2004). Additionally, when someone is comfortable doing one thing for a long period of time it becomes hard to change and do something else (Status quo bias). So if a provider has been recommending one particular method for a long period of time, they may not easily change their recommendation, despite training, which may partially explain why recent training activities in Jordan (Kamhawi 2013 and SHOPS 2010) have met mixed success. This is not only true in Jordan; being uncomfortable with a specific method, despite training, led providers in the United States to be reluctant to insert IUDs (Rubin et al. 2011). Exacerbating the hesitancy to recommend new methods is the fact that providers are pressed for time with clients (IRH 2016) and the fact they may have other health issues to discuss with clients.

Just as clients are influenced by knowing what others like them are doing, providers may also be influenced by knowing the actions of their fellow providers (Social proof). Providers may not be able to observe the behavior of other family planning providers and they may not receive external feedback on their performance specifically related to family planning (Lorenzana 2018 and Ashraf 2014). Additionally, to save the brain energy and not wear out the “muscle” too quickly, providers may have “rules of thumb” they use to make decisions instead of considering each of the unique characteristics of a client (Heuristics; Gigerenzer & Gaissmaier 2011). For example, they may recommend to all women who are in their early 30s with at least three children that they consider an IUD without accounting for the unique desires of that woman. Lastly, providers may see themselves as champions of health in general but not specifically as champions of modern family planning as this is only one aspect of health (Identity biases). With these multiple cognitive and behavioral biases affecting a provider, following a traditional strategy, such as retraining, would only provide them with more information but not necessarily change their behavior or improve the quality of counseling for women. In order to improve the quality of the provider-client interaction during family planning counseling, the biases need to be investigated and interventions should design for those specific issues.
Central Hypothesis and Specific Aims

The goal of this research is to turn the lens of behavioral design on specific elements of the process a woman goes through when adopting a modern family planning method. The scope of this activity includes what happens after a woman forms the intention to adopt a method: how being at the health facility influences her adoption and how the interaction with the provider influences her adoption choice as well as her likelihood to continue on a method. The steps prior to arrive at the health facility: a woman forming an intention to start on family planning as well as forming an intention to go to a health facility are out of the scope of this research activity.

This research will increase the knowledge base in behavioral science and modern family planning methods in general. The insights will inform the design of a set of interventions that could be piloted in one region and then scaled-up throughout the country.

Limitations

Given the limited scope of this activity, one region will be selected for this formative research in partnership with Ministry of Health (MOH), to explore the feasibility of applying behavioral science to a specific problem in the context of family planning. Therefore given the unique context of the region and the health facilities chosen, findings of this research may not be generalizable to the larger context of family planning in Jordan. If applying the behavioral design lens to family planning is successful, it could also be applied to the broader context of family planning at the national level and to other health issues in Jordan.

Hypotheses

The key hypotheses, outlined here with more detail on each below are:

• Client Hypothesis 1: Despite the intention of speaking with the provider about family planning, the client may not ask specific questions or speak with the provider about other health issues instead of family planning.

• Client Hypothesis 2: Clients may be overwhelmed with information during the discussion with the provider and find it difficult to choose between multiple methods. Additionally clients’ emotional state and how they perceive themselves during the interaction with the provider could reduce the likelihood they start a method.
Client Hypothesis 3: Clients’ busy lives make it difficult to remember to continue on family planning methods and clients could also misinterpret any side effects or new health ailments to their family planning method, all of which would make it more likely they would discontinue use.

Provider Hypothesis 1: Providers may have preconceived notions around methods and the “types” of people who should be using those methods, which affect the way they counsel clients. Since they have numerous clients to see during a day they could also limit the information they give to clients or confuse clients with too much information.

Provider Hypothesis 2: Family planning is only one element of a provider’s job so they may not prioritize family planning activities when with clients or see themselves as champions of birth spacing/family planning and therefore may not provide high-quality services.

As shown above, there could be multiple reasons preventing a woman from following through on her intention to plan her pregnancies or preventing a provider from providing excellent care. Each of the key behavioral hypotheses is outlined in more detail below, with the cognitive and behavioral biases as well as the context in which the person is making the decision explained in detail.

Client Hypothesis 1: Despite the intention of speaking with the provider about family planning, the client may not ask specific questions or speak with the provider about other health issues instead of family planning.

Once a patient has overcome the hurdles of getting to the health facility, she still has to follow through on her intention to speak with the service provider about specific family planning options during the visit. Each of the following biases will be investigated to determine the extent to which they are affecting following through on the intention:

• How others treat us can change the way we feel about ourselves in that moment and affect our future actions. For example if a woman perceives that the service provider is treating her rudely, she could internalize that negativity and feel that she is not empowered enough to ask about family planning methods (Identity bias). This feeling could be exacerbated if she is a marginalized member of society, such as a refugee, about which society already has negative stereotypes (IRH 2016). She may worry that she is being seen as a burden on the health care system by taking up the provider’s time and chose not to ask questions (Stereotype threat).
• She may have specific questions about a method but then once with the provider she may forget to ask them, like going to the market to buy eggs and returning home with various bags of food but no eggs (Prospective memory failure). This could be because the provider dominates the conversation or because the woman is distracted by talking about other issues. Either way, she does not have the answers she wanted and therefore does not feel confident enough to start a specific method.

• Physical triggers are important in reminding us to do specific things so what a woman sees on the walls around her in a service delivery room are important. It is possible that the service delivery room does not have any visual reminders, such as posters, for the woman to ask about specific family planning methods (lack of Salience). Therefore she focuses on answering the questions the service provider asks her about other issues and does not bring up general or specific family planning options.

• Our emotions determine how we think and act in certain situations, as anyone who has gone to the market hungry and ended up with junk food or as anyone who has said something they regretted during a heated discussion knows (Hot-Cold empathy gap). The same holds true for talking about family planning, especially if a woman is in a heightened emotional state while with the provider, such as being hungry or very nervous, and she may not ask about specific family planning options.

Client Hypothesis 2: Clients may be overwhelmed with information during the discussion with the provider and find it difficult to choose between multiple methods. Additionally clients’ emotional state and how they perceive themselves during the interaction with the provider could reduce the likelihood they start a method.

In addition to a woman not asking a service provider about modern family planning when she has the intention to, she could also choose not to actually select or start a modern family planning method when she is with the provider during the visit. It could be due to a structural issue such as a lack of female providers and a strong preference for female providers for family planning (IRH 2016 & JCAP 2015a), or a behavioral bias could cause her to change her mind. Each of the following biases will be investigated in this research to determine the extent to which they are affecting following through on the intention to adopt family planning:

• Too many choices make it difficult for humans to make choices, especially when it is hard to see the difference between choices. If a woman is presented with too many options that each have complex side effects, she could postpone making a decision or not make a choice at all (Choice overload).
• Small annoyances, such as having to schedule a follow-up appointment or go to a pharmacy, could result in a woman changing her mind to begin family planning or postponing when she has more time. Even the expected hassle of having to have a method, such as an IUD or implant, removed could also negatively affect the perception of the method (Hassle factors).

• Just like with changing her mind regarding asking about family planning, if a woman is in a different emotional state from when she formed the intention to start on family planning options she may reverse her earlier intention to begin a modern family planning method (Hot-cold empathy gap).

• As could occur when asking about family planning, if a woman internalizes a negative interaction with a service provider, she could feel that she is not empowered enough or the “type” of person who uses a modern family planning method (Identity biases).

• Medical information can be confusing for the general public, and a rushed service provider may present the information in such a way that is unclear or confusing to the woman. Or the provider could reinforce existing negative information that the woman may have heard about side effects or difficulties associated with modern methods, leading to the woman reversing her intention to start family planning (Mental models).

**Client Hypothesis 3: Clients’ busy lives make it difficult to remember to continue on family planning methods and clients could also misinterpret any side effects or new health ailments to their family planning method, all of which would make it more likely they would discontinue use.**

In Jordan, the rate of discontinuation of a modern method within one year of starting it is 48% (DHS 2012). It is helpful to consider two types of discontinuation: active discontinuation and passive discontinuation. Active implies that the woman is consciously making a choice to discontinue or change methods, for example, if she is uncomfortable with side effects of a chosen method. Passive discontinuation occurs when a client misses important action steps such as obtaining a new supply of oral contraceptive pills and then she fails to restart the method or in going to a follow-up visit. Each of the following biases will be investigated to determine the extent to which they are affecting following through on the intention to continue using a modern method:

• If the side effects are confusing or ambiguous to a client, anytime she does not feel well she may blame it on the method, therefore increasing her dislike of the method
and her likelihood to discontinue it. Alternatively, if she becomes pregnant while using a modern method, she may blame the method for failure (i.e. becoming pregnant) when she was not using the method correctly (Mental models).

- Clients are busy people and have multiple activities in life that they need to attend to, not just remembering to think about family planning. Actively taking a method each day, for example, an oral contraceptive pill, and remembering to obtain more pills periodically can get lost in the many other activities a woman does (Tunneling).

- For a busy woman, the hassle or number of steps involved in having to repeatedly obtain new pills or to schedule and go to a follow-up visit for an IUD can prevent her from doing so (Hassle factors).

- Women may not talk to their family members or friends about their continued usage of family planning options or active choices to get pregnant. Therefore a woman may not know others are using family planning and cannot compare herself to them (Social proof).

There are also multiple behavioral biases on the side of the provider that create a situation in which the interaction between the client and the provider is not conducive to the client adopting the appropriate modern family planning method. Appropriate method adoption is a key factor in continuation. Each of the key behavioral hypotheses of provider behavior is outlined below, with the cognitive and behavioral biases as well as the context in which the provider is making the decision explained in detail.

**Provider Hypothesis 1:** Providers may have preconceived notions around methods and the “types” of people who should be using those methods, which affect the way they counsel clients. Since they have numerous clients to see during a day they could also limit the information they give to clients or confuse clients with too much information.

Providers themselves feel the pressure of social norms, and they may be influenced by the social norms that large family sizes with multiple sons are preferred in Jordan or that younger women should give birth early (HSS II 2013). Additionally, they have their own mental models of side effects and the repercussions of prescribing certain methods (HSSII 2013 & El-Khoury et al 2013). Behavioral biases may exacerbate these existing factors, weakening the intention to encourage family planning with all clients. Each of the following biases will be investigated in this research to determine the extent to which they are affecting following through on the intention to provide a modern method:
Providers have limited time to assess a client’s needs and therefore could use heuristics, also known as mental shortcuts or rules of thumb, to recommend a method to a client instead of recommending the method that may best suit her situation (*Heuristics*). For example, a provider may assume that a woman from a specific ethnic or social group may want to use a specific method because she has heard of other women in that group using it, therefore she may push that method without allowing for a full assessment of the individual client’s needs.

Providers may choose to not ask about family planning because of the lack of time and the fact that the provider is focusing on many other health issues with the client (*Inattention and time scarcity*).

Providers have a level of familiarity with methods they have recommended for a longer period of time, whereas earning about new methods and recommending them can feel uncomfortable and take mental effort. It is cognitively easier for a provider to continue to recommend the same method that they have been recommending in the past (*Status quo bias*).

**Provider Hypothesis 2: Family planning is only one element of a provider’s job so they many not prioritize family planning activities when with clients or see themselves as champions of birth spacing or family planning and provide high-quality services.**

Health providers may see themselves as champions of health in general but not specifically as champions of modern family planning methods or birth spacing since this is only one aspect of health. Additionally they have their own mental models of side effects and fears associated with prescribing certain methods that can lead them to consciously or unconsciously discourage certain methods (HSSII 2013 & El-Khoury et al 2013). Behavioral biases may discourage providers from being champions and providing quality care to clients. Each of the following biases will be investigated to determine the extent to which they are affecting providers:

- Providers may not be able to observe the behavior of their fellow providers who prescribe family planning at their own facility or nearby facilities. Therefore they may not be able to gauge their own progress and status as a good provider nor be influenced by the power of seeing that other providers are counseling clients on modern family planning methods and encouraging their adoption (*Social proof*).

- Many health care providers work in the health care field because of their intrinsic motivation as healers and their desire to improve society, but may see family
planning activities as an additional element of their job for which they are not receiving monetary or non-monetary compensation (*Motivation*).

- If an individual feels they are being treated unfairly by a system, for example, if a provider feels that they are overburdened with clients and not paid enough, they may attempt to get back at the system, which in the case of providers could mean providing lower quality services to clients (*Reciprocal fairness*).

**Experimental Design and Procedures**

The research will occur in two phases: (1) qualitative research to identify cognitive and behavioral biases that either support or negate the behavioral hypotheses listed above, and (2) a co-design phase to develop initial prototypes and concepts and elicit feedback on those concepts. A full schedule of the consultant’s days in Jordan and the activities on each day is shown in Appendix I: Detailed Schedule of Daily Activities and Clinics.

**Phase 1: Qualitative Research to identify behavioral biases in Amman**

The consultant and a female researcher hired by JCAP, both trained in qualitative methods, will conduct 60 interviews and 6 - 12 direct observations over the course of six days at six different clinics. The consultant will be accompanied by a translator (Arabic <> English) and the female researcher hired by JCAP will be fluent in both Arabic and English. All interviews are expected to occur in Arabic. Details are shown in Table 1 below. On each day 10 interviews will be conducted by the study team and 1 - 2 direct observations will be conducted, with both researchers visiting the same clinic.
Table 1. Interviews by day and by clinic

<table>
<thead>
<tr>
<th></th>
<th>Client Interviews</th>
<th>Service Providers</th>
<th>Direct Observations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group I: Visitation type: New; FP Counselling: Postponing pregnancy or birth spacing; Outcome: Did Not adopt a MFP method</td>
<td>Group II: Visitation type: New; FP Counselling: Postponing pregnancy or birth spacing; Outcome: did adopt a MFP method in the visit</td>
<td>Group III: Visitation type: recurrent; FP Counselling: Postponing pregnancy or birth spacing; and have used a MFP method in the past (will include switchers or discontinuers)</td>
</tr>
<tr>
<td></td>
<td>Service Providers</td>
<td>Direct Observations</td>
<td></td>
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</tr>
<tr>
<td>Clinic 1</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinic 2</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Clinic 3</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Clinic 4</td>
<td>4</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinic 5</td>
<td>2</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Clinic 6</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>16</strong></td>
<td><strong>16</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

Each clinic will be contacted 1-2 weeks prior to the scheduled date of interviews to confirm the research with the appropriate authorities and determine space availability for interviews and pre-schedule interview times with the family planning service providers.

Providers will be recruited based on their availability and interview times will be pre-scheduled with them to minimize disruption to their workload. Informed consent will be obtained at the beginning of the interview and the provider will be informed of the purpose of the interview as well as their right to leave during the interview. The interview will be recorded using an audio recorder and the researchers will take handwritten notes. The interview will last approximately an hour and will occur in a private room of the clinic without any supervisors present.

Patients will be recruited prior to the interviews and interviews will be scheduled for a specific date and block of time using various methods. The local researcher, trained in confidentiality protocols, will review patient registries and contact patients directly...
via the phone. Additional recruitment could occur by placing information about the formative research in the waiting areas of the health facility, including the fact that individuals will receive reimbursement as part of the interview. They will be encouraged to sign-up by saying that they have the chance to provide feedback on clinic services and issues around family planning adoption. The information will include a number for clients to contact and set up an appointment for an interview. While scheduling the interview the individual will be screened for if they have attended the clinic for at least 6 months and are currently using a modern method or not. Additionally, the woman will be screened for her age so that there is an even mix of individuals younger than and older than 30 years of age. Women younger than 18 or older than 49 will be excluded. Women who are trying to get pregnant and women who are not using a method because they have had trouble conceiving will be excluded from interviews. They will be told the interview will last approximately 1 hour and that they will receive a small snack and reimbursement for transport to the health facility or NGO office for talking with the researchers. If budget permits, JCAP will offer childcare for clients during interviews. JCAP is still determining whether this is feasible. If a woman fails to show up for the interview, patients will be approached in the clinic waiting room on the day of the interviews and asked if they would like to participate. Those women approached in the waiting room will receive the same reimbursement as pre-scheduled interviews.

The interviews will occur in a private room in each health facility in which the conversation cannot be overheard by others and providers will not be present. If there is no space available that meets these requirements, the interviews will occur at a local NGO. For late afternoon interviews, those that occur after the health facility has closed, the interviews will occur at a local NGO. Informed consent will be obtained at the beginning of the interview and the individual will be informed of the purpose of the interview as well as their right to leave during the interview. The interview will be recorded using an audio recorder and the researchers will take hand-written notes. The interview will last approximately an hour.

At each health facility, the research team will attempt to conduct 1 - 2 direct observations of a visit between a provider and a patient. Informed consent will occur for both the provider and the patient and the researcher will not ask questions, only sit and observe the interaction between the provider and the patient. If the patient is uncomfortable at any time the researcher will leave the room and discontinue the observation, including leaving the room when a physical exam is being completed.

Written notes from interviews will only contain numerical codes for each interview and will not record any identifiable information about respondents. Audio copies of
all interviews will also be kept on password-protected computers owned by JCAP and the consultant. The computers will be kept in locked offices or in the presence of the owner at all times. The audio recording will not contain the interviewee’s name or any identifying information. As researchers will be taking notes during the interviews the audio recording will serve as a reference for any missed information. The audio recordings will not be transcribed as part of this activity.

There are limitations to qualitative analysis. Clients may not show up to their scheduled interviews in which case the researchers will attempt to preschedule additional women and recruit additional women from the health facility. Also, as with all qualitative research, interviewees can provide false information. Therefore the analysis of results will include triangulation with other recent sources of data on family planning in Jordan, such as JCAP studies and facility reports.

**Phase 2: Co-design with Providers and Patients**

Qualitative analysis will be used to analyze the interviews. Interviews will be coded based on the pre-determined hypotheses as well as explored for any new themes that come out of the interviews. From the analysis the research team will identify key findings - referred to as insights - regarding each of the behavioral hypotheses.

Following generation of the insights, there will be a half-day brainstorming session with key stakeholders, including the study team, individuals from the Ministry of Health, JCAP, USAID Health Service Delivery, USAID, and potentially service providers. During this session, the insights will be discussed and transformed into opportunity statements. These opportunities will each be explored and three to four will be selected for brainstorming concepts. The group will discuss the generated concepts and map them along two key criteria - the feasibility of quickly and simply prototyping initial versions of them as well as their potential impact.

For example, if an insight is “Clients find it difficult to start the discussion about modern family planning options during the provider interaction”, then generating opportunity statements could expand the question to “How might we make it easier for clients to start the discussion about family planning with providers?” or “How might we allow clients to start the discussion when they feel comfortable, prior to interacting with the provider?”. Brainstorming sessions would generate a range of concepts, such as “Pre-completed questionnaire about topics to discuss with the provider” or “Empathy assistant to encourage women during all provider interactions”. The first concept appears more feasible to rapidly prototype and obtain feedback from clients on the design itself.
The research team will then return to two of the clinics previously visited for two days of additional co-design activities and feedback with providers and patients. The exact nature and number of individuals interviewed will depend upon the concepts selected. For example, there could be 4-5 co-design and feedback sessions with 1-5 people each, or it could be broken into individual sessions with 3-4 providers and 8-16 clients. As before, informed consent will be obtained from all individuals prior to speaking with them. Individuals will be approached in the waiting room by clinic staff and asked if they are willing to take part in a 30-45 minute co-design and feedback session around improving family planning service provision following their appointment. It is expected that the clients will not be individuals that were interviewed during Phase I whereas the providers will be re-interviewed. Both clients who are and are not using modern family planning methods will be interviewed but without target numbers for each type of individual. Sessions for providers and patients will be held separately.

The exact set of questions for these 30-45 minutes sessions will not be known until the prototype concepts are developed, but the sessions will follow standard co-design and participatory interview techniques. For example, participants will be asked to rank the different concepts by how likely they would be to help change their behavior and will be asked what they like and do not like about each prototype concept. They will be asked what they would design instead of the concepts they are shown and what they would change about those concepts. They may be asked to draw a picture of the key elements they would want an image as part of the concept to show. Audio of these interviews will not be recorded, instead, the researcher will take written notes of what the participant says and keep any drawings or notes written by the participant.

There are limitations to co-design and participatory feedback. Clients and providers may not be willing to engage in these activities. Researchers will attempt to recruit as close to the proposed target numbers as possible but will adjust the analysis of the feedback accordingly if the targets are not reachable. Additionally, as with all qualitative research, interviewees can provide false information or not provide a desired level of depth to their responses. In the event a participant is not providing depth to feedback on concepts, the researcher will thank the interviewee for their time, politely terminate the interview and look for an alternative individual to work with.

The insights, opportunity statements, concepts generated, and feedback on the concepts will then be compiled into a report and summary PowerPoint presentation that will include recommendations for a set of behavioral science interventions to improve family planning uptake.

JCAP will share findings and recommendations of the study and the set of interventions with the USAID Health Service Delivery team and with Women and Child Health
Directorate team at the MOH. JCAP will not implement recommended interventions from this study, but other stakeholders may choose to implement them if feasible and appropriate. It is anticipated that results from the study will inform USAID Health Service Delivery work to reduce supply side behavioral barriers such as provider bias against family planning. USAID Health Service Delivery will also provide feedback on the study draft report, particularly on the proposed list of behavioral economics interventions related to service delivery (i.e., the design and possible piloting), and on the targeted health centers.

**Data Security**

The data collected for this study will comply with all national, governorate, and applicable regulations regarding the safeguarding of data. The study team will develop a data security plan to describe how all data collected is secured, transported, and transmitted throughout all phases. Any data shared electronically will not be transmitted through email. Instead the team will use Huddle, Abt’s secure portal. Electronic data will be stored securely on password-protected computers at the JCAP office. Hard copy notes or other hard copy data will be stored securely in locked cabinets at the JCAP office.

**References**


• Health Systems Strengthening II. (2014). Attitudes Regarding Family Planning and Use of Services in Maan. Amman: Health Systems Strengthening II.


• The Johns Hopkins Bloomberg School of Public Health, Center for Communication Programs. 2013. Communication Impact: AWSO Expands Women’s Participation in Community and Family Life. Baltimore, Maryland: JHU CCP. Downloadable at:

• http://ccp.jhu.edu/documents/Communication Impact AWSO Jordan_final_0.pdf


Married Women of Reproductive Age in Selected Districts in Jordan. Amman: JCAP.


### Appendix I: Detailed Schedule of Daily Activities and Clinics

#### Overall Schedule

<table>
<thead>
<tr>
<th>Day Number</th>
<th>Date</th>
<th>Activity Summary</th>
<th>Preparation Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sun, 24 June</td>
<td>Intro to BE &amp; Research Review with JCAP Team</td>
<td>Invite JCAP team and selected others to presentation (2 hour session)</td>
</tr>
<tr>
<td>2</td>
<td>Mon, 25 June</td>
<td>Clinic Day 1</td>
<td>Schedule interviews at least 1 week prior to visit; should this occur during Ramadan or the week before the sessions?</td>
</tr>
<tr>
<td>3</td>
<td>Tues, 26 June</td>
<td>Research Synthesis</td>
<td>No preparation; a room will be needed in JCAP offices</td>
</tr>
<tr>
<td>4</td>
<td>Weds, 27 June</td>
<td>Clinic Day 2</td>
<td>see Clinic Day 1</td>
</tr>
<tr>
<td>5</td>
<td>Thurs, 28 June</td>
<td>Research Synthesis</td>
<td>No preparation; a room will be needed in JCAP offices</td>
</tr>
<tr>
<td></td>
<td>Fri, 29 June</td>
<td>Off</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Sat, 30 June</td>
<td>Clinic Day 3</td>
<td>see Clinic Day 1</td>
</tr>
<tr>
<td>7</td>
<td>Sun, 1 July</td>
<td>Clinic Day 4</td>
<td>see Clinic Day 1</td>
</tr>
<tr>
<td>8</td>
<td>Mon, 2 July</td>
<td>Research Synthesis</td>
<td>No preparation; a room will be needed in JCAP offices</td>
</tr>
<tr>
<td>9</td>
<td>Tues, 3 July</td>
<td>Clinic Day 5</td>
<td>see Clinic Day 1</td>
</tr>
<tr>
<td>10</td>
<td>Weds, 4 July</td>
<td>Clinic Day 6</td>
<td>see Clinic Day 1</td>
</tr>
<tr>
<td>11</td>
<td>Thurs, 5 July</td>
<td>Research Synthesis</td>
<td>No preparation; a room will be needed in JCAP offices</td>
</tr>
<tr>
<td></td>
<td>Fri, 6 July</td>
<td>Off</td>
<td></td>
</tr>
<tr>
<td>(15)</td>
<td>Sat, 7 July</td>
<td>Off (or Extra Synthesis Day, if needed)</td>
<td>No preparation; a room will be needed in JCAP offices</td>
</tr>
<tr>
<td>Day Number</td>
<td>Date</td>
<td>Activity Summary</td>
<td>Preparation Needed</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------</td>
<td>-----------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>12</td>
<td>Sun, 8 July</td>
<td>Insights Presentation &amp; Ideation</td>
<td>Invite JCAP team and selected others to presentation (2-3 hour session); prototyping (2-3 hour session)</td>
</tr>
<tr>
<td>13</td>
<td>Monday, 9 July</td>
<td>Co-Design/Prototyping Day 1</td>
<td>Need space in clinic; Women recruited in clinic on day</td>
</tr>
<tr>
<td>14</td>
<td>Tuesday, 10 July</td>
<td>Co-Design/Prototyping Day 2</td>
<td>Need space in clinic; Women recruited in clinic on day</td>
</tr>
<tr>
<td>(15)</td>
<td>Wednesday, 11 July</td>
<td>Off or Extra Co-Design/Prototyping Day 3</td>
<td>Need space in clinic; Women recruited in clinic on day</td>
</tr>
</tbody>
</table>

**Clinic Schedule for Research Phase**

Numbering code for each interview: TTTC-N

TTT: Type of interview

**NNE (New Not adopt Elder; Group 1 Elder):** Visitation type: New; FP Counseling: Postponing pregnancy or birth spacing; Outcome: Did Not adopt a MFP method, 30-45 years of age

**NNY (New Not adopt Youth; Group 1 Youth):** Visitation type: New; FP Counseling: Postponing pregnancy or birth spacing; Outcome: Did Not adopt a MFP method, 18-29 years of age

**NAE (New Adopt Elder; Group 2 Elder):** Visitation type: New; FP Counseling: Postponing pregnancy or birth spacing; Outcome: Did adopt a MFP method in the visit, 30-45 years of age

**NAY (New Adopt Youth; Group 2 Youth):** Visitation type: New; FP Counseling: Postponing pregnancy or birth spacing; Outcome: Did adopt a MFP method in the visit, 18-29 years of age
**RUE (Recurrent Using Elder; Group 3 Elder):** Visitation type: Recurrent; FP Counseling: Postponing pregnancy or birth spacing; and have used a MFP method in the past (will include switchers or discontinuers), 30-45 years of age

**RUY (Recurrent Using Youth; Group 3 Youth):** Visitation type: Recurrent; FP Counseling: Postponing pregnancy or birth spacing; and have used a MFP method in the past (will include switchers or discontinuers), 18-29 years of age

**SPR:** Service Provider

**DOB:** Direct Observations

**C:** Clinic Number

**N:** Interview number within that subgroup

**Flexibility in schedule:**

- Service providers should be pre-scheduled for times when they expect to have the lightest load.

- If a woman does not show up, her time slot can be substituted for direct observations. Additionally, women can be approached in the waiting room and asked if they would like to be involved.

- If there is only one service provider at that clinic, the second service provider slot can be scheduled for direct observation.

**Clinic Day 1:**

<table>
<thead>
<tr>
<th>Time</th>
<th>Researcher 1</th>
<th>Researcher 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15</td>
<td>Arrive Health Facility</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td>Clinic Opens</td>
<td></td>
</tr>
<tr>
<td>8:15 - 8:45</td>
<td>Introductions and viewing context of clinic</td>
<td></td>
</tr>
<tr>
<td>8:45 - 9:45</td>
<td>NNE1-1</td>
<td>NNY1-1</td>
</tr>
<tr>
<td>9:45 - 10:15</td>
<td>Transition to next interview</td>
<td></td>
</tr>
<tr>
<td>10:15 - 11:15</td>
<td>NAE1-1</td>
<td>NAY1-1</td>
</tr>
<tr>
<td>11:15 - 11:45</td>
<td>Transition to next interview</td>
<td></td>
</tr>
<tr>
<td>Time</td>
<td>Researcher 1</td>
<td>Researcher 2</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------</td>
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</tr>
<tr>
<td>11:45 - 12:45</td>
<td>RUE1-1</td>
<td>RUY1-1</td>
</tr>
<tr>
<td>12:45 - 13:30</td>
<td>Lunch</td>
<td></td>
</tr>
<tr>
<td>13:30 - 14:30</td>
<td>NNE1-2</td>
<td>NNY1-2</td>
</tr>
<tr>
<td>14:30 - 15:00</td>
<td>Transition to next interview</td>
<td></td>
</tr>
<tr>
<td>15:00 - 16:00</td>
<td>SPR1-1</td>
<td>SPR1-2 (or DOB)</td>
</tr>
<tr>
<td>16:00 - 16:30</td>
<td>Depart/Return to office</td>
<td></td>
</tr>
</tbody>
</table>

**Clinic Day 1 Totals:** NNE- 2; NNY- 2; NAE- 1; NAY- 1; RUE- 1; RUY- 1; SP- 2; DO- unknown

**Clinic Day 2:**

<table>
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**Clinic Day 3:**

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**Clinic Day 4:**

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**Clinic Day 4 Totals:** NNE- 2; NNY- 2; NAE- 1; NAY- 1; RUE- 1; RUY- 1; SP- 2; DO- unknown

**Clinic Day 5:**

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**Clinic Day 5 Totals:** NNE- 1; NNY- 1; NAE- 2; NAY- 2; RUE- 1; RUY- 1; SP- 2; DO- unknown

**Clinic Day 6:**

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**Clinic Day 6 Totals:** NNE- 1; NNY- 1; NAE- 1; NAY- 1; RUE- 2; RUY- 2; SP- 2; DO- unknown

**Total by clinic:**

- Clinic 1: 10 total; NNE- 2; NNY- 2; NAE- 1; NAY- 1; RUE- 1; RUY- 1; SP- 2
- Clinic 2: 10 total; NNE- 1; NNY- 1; NAE- 2; NAY- 2; RUE- 1; RUY- 1; SP- 2
- Clinic 3: 10 total; NNE- 1; NNY- 1; NAE- 1; NAY- 1; RUE- 2; RUY- 2; SP- 2
- Clinic 4: 10 total; NNE- 2; NNY- 2; NAE- 1; NAY- 1; RUE- 1; RUY- 1; SP- 2
- Clinic 5: 10 total; NNE- 1; NNY- 1; NAE- 2; NAY- 2; RUE- 1; RUY- 1; SP- 2
- Clinic 6: 10 total; NNE- 1; NNY- 1; NAE- 1; NAY- 1; RUE- 2; RUY- 2; SP- 2

**Total for 6 clinics:** NNE- 8; NNY- 8; NAE- 8; NAY- 8; RUE- 8; RUY- 8; SP- 12

(Group 1- 16, Group 2- 16, Group 3- 16), half each of each age group
A-II. Client Interview Guide

Patient Interview Guide

Hello. My name is … [say name here]… I am working with the Jordan Communication, Advocacy and Policy Activity and the USAID Health Service Delivery – both funded by the USAID. We are conducting qualitative research to better understand the attitudes and behaviors that women have around family planning, accessing family planning services, and going to a health facility.

You were randomly selected for an interview MCH registry book at the health facility. Thank you for having contacted us, and thank you for coming in today.

I would like to ask you some questions about your family and your thoughts and behaviors related to reproductive health and family planning. Questions normally take about 50 minutes but the total time for the interview, including this consent process, will be about an hour. As we discussed on the phone you will be provided with snacks during the interview and will be reimbursed for transportation costs.

All of the answers you give will be confidential. We are recording this discussion but we will not record your name. Your answers will be compiled along with the answers of many other women participating in the study from different health facilities before your answers are analyzed. In the analysis we will only refer to you as “participant”. The information we collect may help in the planning for future health interventions or programs on family planning.

You are not obligated to participate in this study, but we hope you agree to answer the questions, as your opinion is very important to us. If you ever feel uncomfortable answering a question you don't have to answer it. Just let me know and I will skip to the next question. You can also stop the interview at any time. In case you need more information about the study, you can contact the person listed on this card. [Hand participant card.]

Do you have any questions?

Could you please confirm your age with me?

- If patient is less than 18 years or older than 49 years, ask them to repeat their age. If they are outside of this range, thank them for their time and end the interview.

- If they are 18-49, then continue below.
Do you allow me to begin the interview now? If yes, please give a verbal yes. Then I will start the recorder.

• If the respondent accepts and agrees to be interviewed (1) --- continue to Part 0: Introduction

• If the respondent refuses to be interviewed (2) --- end the interview. Thank the respondent and show her out of the room.

[Start recorder]

Part 0: Introduction:

1. Could you tell me a little bit about yourself?
   a. How long have you been married?
   b. Do you currently have children?
   c. If you have children, how many do you have? What are their ages and gender?

2. How did you get to this clinic/health center today?
   a. How long did it take you to get here?
   b. How much did it cost to get here?

3. How many times in the past 6 months have you been to this clinic/health center?

4. Why did you decide to come to this clinic/health center over other health facilities in the area?

Part I: Family planning

First, I want to talk with you about family planning in general.

1. How does thinking or talking about family planning make you feel? I’m putting these cards in front of you in random order. Please pick 3-4 cards that describe how you feel thinking about family planning. There are also a few blank cards if you want to write your own word for how you feel.
   a. [uncomfortable, good wife, good mother, bad wife, bad mother, against my religious beliefs, compliant with my religious beliefs, empowered, happy, wise,
knowledgeable, unknowledgeable, confused, worried, angry, sad] Note: Write down order that client selects the cards.

b. Could you explain in one sentence each why you chose those 3 or 4 cards?

2. Have you ever talked about family planning with your husband?
   a. If yes, did you come to any type of agreement or decision on using a specific family planning method?
      i. What was the decision?
   b. If no,
      i. Do you want to talk with him about family planning?

3. Is there anyone else in your family, your husband’s family, friends or other people that you have talked with about using family planning?
   a. Who was it with?
   b. Describe the conversation.
   c. *If the woman does not mention a specific method, probe with:* Did you talk about a specific family planning method during the conversation? Which one?

4. Has anyone told you about their own use of modern family planning methods?
   a. Who? What did they say?

5. Have you ever heard of or seen information on modern family planning methods outside of this clinic?
   a. If yes, what have you heard or seen about them?

6. Have you ever heard of side effects of modern family planning methods other than from this clinic or its providers?
   a. Do you think those side effects are common and happen to most women who use that method?
   b. Is there anything that the woman could have done to prevent the side effect?
Part II: Prep for Facility

Now I want to talk with you about coming to the health facility.

1. Have you ever had a bad experience with a family planning provider at this health facility? Remember everything you say will be confidential and will not be linked back to you.
   a. If you haven’t had a bad experience with a family planning provider, have you had a bad experience with a non-family planning provider?
   b. Can you describe that experience?
   c. Do you think that experience could happen with a family planning provider?

2. Have you heard of other people having a bad experience with any family planning provider at this health facility?
   a. If you haven’t heard of other people having a bad experience with a family planning provider, have you heard of anyone having a bad experience with a non-family planning provider?
   b. Do you think that could happen with a family planning provider?

3. Is there any reason that you can think of why any provider at this health facility would not treat you or someone like you kindly?

4. Describe the physical space of the health facility to me. I’m going to put out random cards again, and just like before. If you could pick 1 or 2 cards that describe this clinic and if there’s a word you want to say that you don’t see, feel free to write it on the blank cards.
   a. [Welcoming, uncomfortable, sterile, bland, depressing, cheerful, comfortable, relaxing] Note: Write down order that client selects the cards.
   b. Could you explain in one sentence each why you chose those 1 or 2 cards?

5. Have you or someone you know had a bad experience with a family planning provider at a different facility?
   a. If yes, tell me about that experience.
Part III: Service provider at facility

Now I would like to ask you some questions about your experiences talking with a service provider about family planning methods.

1. Have you ever seen information on family planning at the health facility?
   
   a. If yes, where did you see the information- in the waiting room? In the doctor’s office? Any other location?

2. Have you heard friends, family or neighbors tell you about their experiences talking with a provider for modern family planning methods?

   a. If yes, what did they tell you their experiences were like?

3. Have you ever talked with a provider about family planning methods before?

   a. If yes, think back to that first time you talked to a provider about family planning methods. What lead you to decide that you were going to have the conversation about family planning with the provider?

      i. Did you talk with anyone else about the decision before you went to the provider?

      ii. Did you think about the conversation before you came and think about how you would start it or what you would say?

      iii. Had you written anything down or did you take any information you had on family planning to the provider?

      iv. When you started the conversation with the provider, did you have the intention of starting on family planning?

         1. If yes, did you have a specific method in mind?

         2. If no, then why did you start the conversation?

   a. If no, why do you think you have never talked with a provider about family planning before?

      i. What would make it easier for you to ask a provider about starting family planning?
Part IV: Deeper provider information

Since you spoke with the provider about family planning, I would like to ask you a few more questions on your interactions with the service provider.

1. When you talked with the provider, which methods did you discuss?
   
   a. Probe for if discussed multiple methods

2. How did thinking about selecting a family planning method make you feel? Just like before, if you could please pick 3 or 4 cards that I’m putting out.
   
   a. [uncomfortable, good wife, good mother, bad wife, bad mother, against my religious beliefs, compliant with my religious beliefs, empowered, happy, wise, knowledgeable, unknowledgeable, confused, worried, angry, sad] Note: Write down order that client selects the cards.

3. Did the provider ask you which specific method you preferred?

4. Did the provider make a recommendation?
   
   a. If the provider made a recommendation, do you feel that the recommendation took your concerns into account?

5. Did the provider talk with you about side effects of the different methods?
   
   a. What are the side effects of the different methods?

6. Did you start on a family planning method following the visit?
   
   a. If not, did you make an appointment or schedule another visit to either talk about or obtain family planning?

7. Think about the information on family planning that you have heard from the provider as well as from other sources. Which source do you value most when you are making the decision?
   
   a. Why?

8. Think of a friend or a family member who is also married and in a similar situation and has about the same number of children as you have. Would you recommend your friend or family member talk with this provider about family planning options?
Part V: Current method

Now I want to ask you a few questions about the current method, if any, you are using and if you have ever used a different method.

1. Which modern or traditional family planning method are you currently using?
   a. How long have you been using that method?
   b. What are the side effects of that method?
      i. Have you experienced those side effects yourself or are those the reported side effects?
      ii. Have you heard of friends or family or others having those side effects?
   c. Have you had a follow-up visit with a provider after you started that method?
   d. If condoms, how many condoms do you have left?
      i. How will you obtain new condoms?
      ii. What will you have to do to get more condoms?
   e. If pills, when will your current pack of pills run out?
      i. Have you ever missed taking a pill one day?
      ii. If yes, what did you do the last time you missed a pill?
      iii. How will you obtain a new pack of pills?
      iv. What will you have to do to get a new pack of pills?
   f. If IUD, when do you need to have the IUD replaced?
      i. How will you remember to get it replaced then?
   g. If Implanon, when do you need to have it replaced?
i. How will you remember to get it replaced then?

h. If Depo-Provera, when do you need to have a new injection?
   i. How will you remember to get the new injection?
   ii. What will you do if you are late to getting the new injection?

i. Was there a different method that you were using before this method?
   i. Why did you switch methods?
   ii. Tell me about the process you went through to switch the method.

2. If you are not currently using a modern family planning method, have you ever used one?
   a. If yes, which one?
   b. Why are you not currently using that method?
      i. Probe: did the method fail in your opinion
   c. What were the side effects of that method?
      i. Did you experience those side effects yourself or are those the reported side effects?
      ii. If you experienced those side effects, did you tell anyone or get more information about the side effects?
      iii. Have you heard of friends or family or others having those side effects?
      iv. When you’re not at the clinic, where do you get information on side effects?
   d. Tell me about the steps you went through to stop using that method.
      i. Probe: Who did you speak with, who made the decision, where did you go, what were the detailed steps you went through to stop this method
   e. Would you say that you actively planned to stop using that method or that you just forget to keep using it?
i. Could you explain your choice of why you said that?

Now I just have one last question.

If you could change the way that modern family planning methods are recommended and provided here in Jordan, how would you change it? Is there something that could make it easier for you to start or continue them? What would you want to make different?

Thank you for taking the time to speak with me today, I appreciate it very much. Do you have any questions that you would like to ask me now?

Have a great day.

**A-III. Provider Interview Guide**

Provider Interview Guide

Hello. My name is … [say name here]… I am working with the Jordan Communication, Advocacy and Policy Activity and the USAID Health Service Delivery both funded by the USAID. We are conducting qualitative research to better understand the attitudes and behaviors that women have around family planning and going to a health facility. The information we collect may help in the planning for future health programs.

You were selected for an interview because you work at a health facility where we are approaching women.

I would like to ask you some questions about your family, your thoughts and behaviors related to reproduction and family planning, and about providing family planning services to clients at this health facility. Questions normally take about 50 minutes but the total time for the interview, including this consent process, will be about an hour. You will not be reimbursed for your time talking with us today.

All of the answers you give will be confidential. We are recording this discussion but we will not record your name. Your answers will be compiled along with the answers of other providers from different health facilities before your answers are analyzed. In the analysis we will only refer to you as “provider”. You are not obligated to participate in this activity, but we hope you agree to answer the questions, as your opinion is very important to us. If you ever feel uncomfortable answering a question you don’t have to answer it. Just let me know and I will skip to the next question. You can also stop
the interview at any time. In case you need more information about the study, you can contact the person listed on this card. [Hand provider card.]

Do you have any questions?

Do you allow me to begin the interview now? If yes, please give a verbal yes. Then I will start the recorder.

- If the respondent accepts and agrees to be interviewed (1) --- continue to Part 0: Introduction

- If the respondent refuses to be interviewed (2) --- end the interview. Thank the respondent and leave the room.

[Start recorder]

Part 0: Introduction

1. Could you tell me a little bit about yourself?
   a. How old are you?
   b. Are you married, not married? Are you engaged?

2. Do you live in the neighborhood around this clinic?

3. What time do you typically arrive here and what time do you typically leave here?
   a. Are your hours the same every day or do they change day-to-day or week-to-week?

4. What transportation do you use to come to work?
   a. How long does it take you to get here?

5. What is your role here at the health facility?
   a. What other services do you provide other than family planning services?

6. How long have you worked here?
   a. Has your role changed since you started working here?
Part I: First, I want to talk with you about what happens when clients come in and what happens during that session.

1. When a female patient comes in, describe the visit with her.

2. Are there specific questions that you always ask first?
   a. If yes, what are they?

3. Are there key topics that you discuss with all female patients, regardless of the reason for her visit?
   a. If yes, what are they?
   b. If family planning is not always discussed: How often do you typically bring up family planning with a female patient?
      i. Why do you bring up family planning with a patient?

4. How long does it take for you to discuss family planning with a patient?

5. What is the average level of knowledge of family planning methods that your patients have before you talk with them about it?
   a. Which modern methods are they already familiar with?

6. Are there any visuals or tools that you use when you are discussing family planning methods with a patient?
   a. If possible, ask to be shown the visuals to you. Note how long it takes the provider to find them and where they are in the room. If possible, take pictures of the visuals without any identifiers of the provider or the space.

7. How long do you spend with each patient for the entire visit? Is there a maximum amount of time you will spend with a patient?

8. Do you have a target for how many patients you have to see in a day?

9. How frequently do husbands accompany their wives for a visit about family planning methods?
   a. What is different about the visit when the husband is there?

Part II: Now I want to talk with you about modern methods of family planning.
1. Describe the type or types of woman that should be using modern family planning. What characteristics do they have?
   a. **Probe:** age, number of children, education level

2. What is the ideal number of children that a family should have?

3. How would you describe a young, recently married woman who comes in and asks you to prescribe her a modern family planning method before she has her first child? I’m going to lay some cards out with words in front of you. If you could please pick 3 or 4 cards that describe the woman. If there are words you want to say that aren’t written, there are some blank cards and you can write your own words.
   a. [knowledgeable, unintelligent, poor, privileged, arrogant, rude, ungrateful, cruel, rebel, inconsiderate, caring, nurturing, bad wife, good wife, good mother, bad mother, wise] Note: Write down order that provider selects the cards.

   b. Could you explain in one sentence each why you chose those 3 or 4 cards?

4. Now, how would you describe a married woman with 3 children who comes in and asks you to prescribe her a modern family planning method? Just like before, if you could please select 3 or 4 cards or write your own.
   a. [knowledgeable, unintelligent, poor, privileged, arrogant, rude, ungrateful, cruel, rebel, inconsiderate, caring, nurturing, bad wife, good wife, good mother, bad mother, wise] Note: Write down order that provider selects the cards.

   b. Could you explain in one sentence each why you chose those 3 or 4 cards?

5. How do you feel when a client asks you about modern family planning? I’m putting new cards down for you, and if you could please select 3 or 4 or write your own.
   a. [excited, worried, annoyed, overwhelmed, tired, rushed, angry, happy, hopeful, eager, empowered, judged, useless] Note: Write down order that provider selects the cards.

   b. Could you explain in one sentence each why you chose those 3 or 4 cards?

6. Now, using the same cards, how do you feel when you are recommending modern family planning to a patient?
a. [excited, worried, annoyed, overwhelmed, tired, rushed, angry, happy, hopeful, eager, empowered, judged, useless] Note: Write down order that provider selects the cards.

b. Could you explain in one sentence each why you chose those 3 or 4 cards?

7. Now, how do you feel if a client disagrees with your recommendation for her for a family planning method?

a. [excited, worried, annoyed, overwhelmed, tired, rushed, angry, happy, hopeful, eager, empowered, judged, useless] Note: Write down order that provider selects the cards.

b. Could you explain in one sentence each why you chose those 3 or 4 cards?

8. When a client disagrees with you about your recommendation for a family planning method, what do you say to them?

a. What are the reasons that a client might give when she disagrees with you?

9. If a client tells you about incorrect side effects for a method, what do you say to them?

a. According to the client, what is the source of their information on incorrect side effects?

10. Are there any modern methods that make you uncomfortable to prescribe? For example, are there any that are hard for you yourself to start a patient on or for you to remove?

a. Have you heard of other providers discussing any methods that make them uncomfortable to prescribe? Have you heard of other providers discussing methods that are difficult for them to start or remove?

11. Do you have a target for how many clients you want to start on family planning?

a. How do you set that target?

b. Does anyone else know about that target?

c. How is the data tracked on providing family planning to clients?

12. When was the last time you were trained on modern family planning methods?
a. Were you trained on all methods or just a specific method?

13. As a health care provider in society, what is your role in ensuring society’s values are upheld?

Part III: And lastly, I want to talk with you about your job in general.

1. Is there a specific method that you typically prescribe to women?

2. Is this the method that you yourself recommend to patients or do they select it on their own?

3. If they select it, which method do you most frequently recommend to patients?

4. How frequently do your colleagues at this facility provide modern family planning methods?
   a. How do you know that?

5. How frequently do your colleagues at nearby health facilities provide modern family planning methods?
   a. How do you know that?

6. Are you (or your wife) using modern family planning methods? I won’t ask you why or which method, but it would be helpful to know just yes or no.

7. Have you ever told a patient that you (or your wife) are or are not using modern family planning?

8. Do you think that your supervisor cares about your rates of prescribing family planning methods?
   a. What are the things that your supervisor is most concerned with?

9. Has your supervisor ever talked to you about your rates for prescribing modern family planning?
   a. If yes, when was the last time? What did he or she say?

10. Have you ever received recognition for prescribing modern family planning? It could be monetary or another type of recognition.
11. Describe a good day here at the health facility. What makes a day at work a really good day for you?

12. What makes a day frustrating or not a great day at work?

13. Do you think that working conditions could be improved for providers like yourself?
   a. If yes, how?

14. Do you think that you are compensated fairly given the amount of work that you do?
   a. Why or why not?
   b. How could that be changed?

15. Do you see yourself as a champion of healthy and happy families?
   a. Why or why not?

16. Is part of being a champion of healthy and happy families encouraging family planning for women?
   a. Why or why not?

Now I just have one last question.

If you could change the way that modern family planning methods are prescribed, how would you change it? What would you do differently?

Thank you for taking the time to speak with me today, it is very much appreciated. Do you have any questions that you would like to ask me now?

Have a great day.

---

A-IV. Clinics Included in Research Study
<table>
<thead>
<tr>
<th>Date</th>
<th>None/Traditional</th>
<th>Pills</th>
<th>Condoms</th>
<th>Injectables</th>
<th>Implants</th>
<th>IUDs</th>
</tr>
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<tr>
<td>24 June: Wadi Seer</td>
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<td>2</td>
<td>3</td>
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<tr>
<td>25 June: Mogabalein</td>
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<td>1</td>
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<td>0</td>
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<td>2</td>
</tr>
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<td>27 June: Khreibet Souq</td>
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<td>2</td>
<td>2</td>
<td>1</td>
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<td>1</td>
</tr>
<tr>
<td>1 July: Sweileh</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2 July: Princess Basma</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>1</td>
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<tr>
<td>4 July: Abu-Nseir</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>5 July: Sweileh</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>20</strong></td>
<td><strong>10</strong></td>
<td><strong>8</strong></td>
<td><strong>3</strong></td>
<td><strong>6</strong></td>
<td><strong>10</strong></td>
</tr>
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</table>
# A-V. Matrix of Insights, Guidance and Recommendations

<table>
<thead>
<tr>
<th>Insight</th>
<th>Opportunity</th>
<th>Guidance</th>
<th>Prototypes (Both those recommended and not recommended)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF1: MCH clinics are open and public spaces that make intimate conversations about sensitive topics like family planning difficult.</td>
<td>OF1-1: Clinic spaces could better managed; to make the space more private so that a woman can sit privately with a provider knowing they will not be overheard or interrupted.</td>
<td>G1- Revising the current system of giving clients numbers to designate the order they will be seen so that clients or staff are not entering rooms during client sessions, for example by having numbers/charts put on the outside of doors.</td>
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<tr>
<td></td>
<td>OF1-1: Counseling sessions by trained staff could occur in a private space outside of the existing MCH clinic.</td>
<td>G2- Accounting for different levels of comfort with men in the facility by having both designated women-only days when men cannot attend the MCH clinic as well as days designated for men to attend.</td>
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<tr>
<td></td>
<td>OF2: Clients could be encouraged to be more active participants in counseling sessions.</td>
<td>G3- Better management of the MCH space available within health facilities to ensure more privacy; providing counseling in private spaces not within the public health facility, such as counseling with community counselors or via a free informational phone line.</td>
<td></td>
</tr>
<tr>
<td>IF2: Clients are not active participants during observed counseling sessions.</td>
<td>OF3: Clinic hours could be restructured to smooth the workload for providers and make it more efficient for women to attend clinics.</td>
<td>G4- Providing a pre-printed list of questions to clients for them to ask the provider.</td>
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<tr>
<td></td>
<td>OF3: Clinic hours could be restructured to smooth the workload for providers and make it more efficient for women to attend clinics.</td>
<td>G5- Providing an empathetic client advocate to accompany the client to the visit.</td>
<td>Discussion card</td>
</tr>
<tr>
<td>IF3: The structure and efficiency of clinics vary widely but a consistent element across clinics is that there is uneven client flow throughout the day.</td>
<td>OF3: Clinic hours could be restructured to smooth the workload for providers and make it more efficient for women to attend clinics.</td>
<td>G6- Blocking appointment times and clients are requested to show up in blocks, for example from 8-10, 10-12, or 12-1. Many appointments are not currently scheduled, but specific types of appointments such as follow-up family planning visits could be scheduled for blocked times to decrease the morning workload.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OF3: Clinic hours could be restructured to smooth the workload for providers and make it more efficient for women to attend clinics.</td>
<td>G7- Extending clinic hours one day per week could allow working women to more easily attend the clinic.</td>
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</tr>
<tr>
<td>Insight</td>
<td>Opportunity</td>
<td>Guidance</td>
<td>Prototypes (Both those recommended and not recommended)</td>
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<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
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<tr>
<td>IP1: Providers have intrinsic motivation and see themselves as champions of family planning; they enjoy providing information to women about available methods that maybe suitable to them.</td>
<td>OP1: Harness the intrinsic motivation of providers and their desire to be champions of family planning.</td>
<td>G8- Changing the dynamic of counseling sessions so that patients are actively seeking a provider's knowledge and expertise, instead of placing the burden solely on the service provider to provide counseling.</td>
<td>Discussion card Provider rating system</td>
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<td>G9- Focusing on holistic measures of quality of care.</td>
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<td>G10- Creating opportunities for clients to rate or thank service providers for excellent service, such as thank you cards they can write and display in their office.</td>
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<tr>
<td>IP2: Some providers have their own personal mental models (biases) around specific methods.</td>
<td>OP2: Providers could benefit from additional hands-on training on all available methods with continuing education on new methods.</td>
<td>G11- Providing information in ways that they trust and can explain to their own clients, such as during trainings having individuals who use that method attend the training to share personal experiences.</td>
<td>Provider trainings User testimonials</td>
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<tr>
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<td>G12- Providing remote and on-demand training for providers, such as online tutorials and quizzes for providers to complete on a regular basis.</td>
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<td></td>
<td>G13- Providing interactive learning groups for providers with providers presenting and sharing recent case studies to other providers.</td>
<td></td>
</tr>
<tr>
<td>Insight</td>
<td>Opportunity</td>
<td>Guidance</td>
<td>Prototypes (Both those recommended and not recommended)</td>
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<tr>
<td><strong>IP3</strong>: Providers sometimes worry about a woman’s method choice because they know false information about family planning is common and that some women may lack agency without their family.</td>
<td><strong>OP3</strong>: Give providers the ability to refer clients to information sources that they themselves have confidence in, so that they are more confident women have access to trusted information sources.</td>
<td><strong>G14</strong>: Creating online information for women to access, branded by a trusted health source such as the MOH, which both service providers and clients could reference and trust.</td>
<td>Hotline&lt;br&gt;User testimonials&lt;br&gt;Training for women</td>
</tr>
<tr>
<td><strong>IP4</strong>: Providers face a very uneven workload throughout each day.</td>
<td><strong>OP4</strong>: Clinic hours could be restructured to smooth the workload for providers so they are not rushing with some clients.</td>
<td><strong>G6</strong>: Blocking appointment times and clients are requested to show up in blocks, for example from 8-10, 10-12, or 12-1. Many appointments are not currently scheduled, but specific types of appointments such as follow-up family planning visits could be scheduled for blocked times to decrease the morning workload.</td>
<td></td>
</tr>
<tr>
<td><strong>IC1</strong>: Women have varied mental models about what makes an information source valuable.</td>
<td><strong>OC1</strong>: Provide information to clients in ways that mimic how they currently value and receive information.</td>
<td><strong>G15</strong>: Providing information in a non-technical way in women’s own words, such as through testimonials from current users or positive deviants.&lt;br&gt;&lt;br&gt;<strong>G16</strong>: Providing information by creating personas of users - aggregations of real stories and experiences from clients that users would identify with - using examples that highlight clients’ own fears or misinformation and how to overcome them.&lt;br&gt;&lt;br&gt;<strong>G17</strong>: Creating a “club” or group of women using modern methods, either via WhatsApp or a community group in which women can chat, including sharing side effect coping mechanisms</td>
<td>User testimonials</td>
</tr>
<tr>
<td>Insight</td>
<td>Opportunity</td>
<td>Guidance</td>
<td>Prototypes (Both those recommended and not recommended)</td>
</tr>
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</tbody>
</table>
| IC2: There is a mismatch between information sources currently provided to women and women feeling informed. | OC2: Provide information to clients in new ways or through new delivery channels. | G14- Creating online information (either through a website or an app) for women to access, branded by a trusted health source such as MOH.  
G15- Providing information in a non-technical way in women's own words, such as through testimonials from current users or positive deviants.  
G16- Providing information by creating personas of users - aggregations of real stories and experiences from clients that users would identify with - using examples that highlight clients' own fears or misinformation and how to overcome them.  
G17- Creating a “club” or group of women using modern methods, either via WhatsApp or a community group in which women can chat, including sharing side effect coping mechanisms  
G18- Creating a free interactive informational phone line, WhatsApp group, or live online chat for women to access family planning counselors.  
G19- Modifying language on side effects to highlight their normality or a woman's strength in dealing with them  
G20- Creating an online learning system for women to teach themselves about family planning, such as online tutorials and quizzes with certificates for high achievers.  
G21- Creating information and sharing stories about family planning use in other countries. | User testimonials  
Hotline  
Training for women  
Discussion card |
<table>
<thead>
<tr>
<th>Insight</th>
<th>Opportunity</th>
<th>Guidance</th>
<th>Prototypes (Both those recommended and not recommended)</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC3: Information is not always available for clients to access as needed, so women turn to different sources of information at different points during the journey to adoption and continuation. The correct information - especially regarding side effects - is not always available to them when they need it.</td>
<td>OC3: Provide information that women can access quickly whenever they need it, for example when they are making a decision with their family prior to going to the health facility or when they are at home and begin experiencing side effects.</td>
<td>G14- Creating online information (either through a website or an app) for women to access, branded by a trusted health source such as MOH. G17- Creating a “club” or group of women using modern methods, either via WhatsApp or a community group in which women can chat, including sharing side effect coping mechanisms. G18- Creating a free interactive informational phone line, WhatsApp group, or live online chat for women to access with family planning counselors. G22- Providing clients with a way to track or record common/typical side effects and signs they should come back to see a provider, possibly with a pain management metric. G23- Creating a side effects “toolkit” with information on side effects and items to provide comfort (such as heating pads) in the event of side effects. G24- Providing personal follow-up calls or messages to users concerning continuation and addressing any questions they may have.</td>
<td>User testimonials Hotline Training for women Discussion card</td>
</tr>
<tr>
<td>Insight</td>
<td>Opportunity</td>
<td>Guidance</td>
<td>Prototypes (Both those recommended and not recommended)</td>
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<tr>
<td>IC4: The majority of women who are going into the clinic to adopt a modern family planning method are going into the clinic with the intention to adopt a specific method.</td>
<td>OC4: Empower clients by guiding them with questions for the provider in a way that encourages them to think through their own future steps for continuation and what they would do if they experience side effects.</td>
<td>G4- Providing a pre-printed list of questions to clients for them to ask the provider. G22- Providing clients with a way to track or record common/typical side effects and signs they should come back to see a provider, possibly with a pain management metric.</td>
<td>Discussion card</td>
</tr>
<tr>
<td>IC5: Some clients are not preplanning for the counseling session with the provider and are not active participants during the sessions.</td>
<td>OC5: Empower clients prior to the discussion with the provider by providing them with details of when they should attend the clinic, what questions the provider will ask, and a guide of questions they should ask the provider.</td>
<td>G4- Providing a pre-printed list of questions to clients for them to ask the provider. G18- Creating a free interactive informational phone line, WhatsApp group, or live online chat for women to access with family planning counselors.</td>
<td>Discussion card Hotline</td>
</tr>
<tr>
<td>Insight</td>
<td>Opportunity</td>
<td>Guidance</td>
<td>Prototypes (Both those recommended and not recommended)</td>
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</tbody>
</table>
| IC6: There is a cycle occurring in some sessions that is difficult for traditional counseling to break - women are going into a busy clinic having already made a decision on a method, thus not necessarily wanting or feeling they need to ask questions, whereas time-scarce providers expect that a woman has already made her decision and may not want to learn about other methods. | OC6: Creating a moment during which clients and providers need to interact regarding the clients’ concerns and the clients’ future. (Current paperwork deals with information the provider needs, such as medical history, but not information the client needs.) | G4- Providing a pre-printed list of questions to clients for them to ask the provider.  
G5- Providing an empathetic client advocate to accompany the client to the visit.  
G8- Changing the dynamic of counseling sessions so that patients are actively seeking a provider’s knowledge and expertise, instead of placing the burden solely on the service provider to provide counseling. | Discussion card |
Determinants Related to Client/Provider Interaction for Family Planning

A-VI. Mapping of Insights, Guidance and Recommendations
Insights

- IF1: MCH clinics are not private spaces
- IF2: Providers are intrinsically motivated
- IF3: There is uneven clinic flow throughout the day
- IF4: Providers worry about women's info sources
- IF5: Providers face an uneven workload
- IF6: Different clients trust different information sources
- IC2: Women don't feel informed or knowledgeable
- IC3: Information is not available when needed
- IC4: Women decide on a method prior to the clinic
- IC5: Women do not prepare for the clinic visit
- IC6: The status quo for counseling is entrenched

Guidance

- G1: Revising clinic movements
- G2: Designated days for men
- G3: Counseling outside facility
- G4: Pre-printed questions for clients
- G5: Empathetic client advocate
- G6: Blocking appointment times
- G7: Extending clinic hours
- G8: Changing dynamic of counseling
- G9: Holistic quality of care indicators
- G10: Clients race or thank providers
- G11: Adding client stories to trainings
- G12: Remote & on-demand provider trainings
- G13: Provider learning groups
- G14: MCH branded online information
- G15: Real user stories/testimonials
- G16: Generated user stories/testimonials
- G17: Women's clubs for modern users
- G18: Info via phone/chat/WhatsApp
- G19: Modify language on side effects
- G20: Learning certification for women
- G21: Stories of users in other countries
- G22: Tracking diary for side effects
- G23: Side effects tool-kit for clients
- G24: Personal follow-up calls/messages

Prototypes

- X1: Provider rating system
- R2: Hotline
- R1: Discussion card
- X2: Training for women
- R4: User testimonials
- R3: Provider trainings

Note: Recommended prototypes and corresponding guidance and insights shaded.

A-VII. Impact versus Feasibility Map

Note: Shaded concepts were included in prototyping activities.
### A-VIII. Sample of Standard Prototyping Feedback Grid

**Feedback Capture Grid**

<table>
<thead>
<tr>
<th>+ What worked (things one likes or finds notable)</th>
<th>Δ What could be improved (constructive criticism)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>? Questions (questions that the experience raised)</th>
<th>! Ideas (ideas that the experience or presentation spurred)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>
A-IX. Sample Monitoring Forms for Pilots

Sample Monthly Log for Data Collection: Discussion Card

Facility Name: ___________________________ Month ___ of ___

Your Name: _______________________________________________________

Role at Facility:  □ Midwife    □ Doctor    □ Reception Desk Staff

Reception Desk Instructions: Please record the following key indicators for your clinic each day. If there is more than one staff member for the reception desk, please just write your own total on this form. Each staff member should have their own form. If you did not have stock of cards, please place an “X” in that day’s box.

<table>
<thead>
<tr>
<th>Week and Day</th>
<th>Indicator 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
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<td>Week 2</td>
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</table>

Number of cards you yourself handed out

<table>
<thead>
<tr>
<th>Week and Day</th>
<th>Indicator 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>1</th>
<th>2</th>
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</table>

Number of family planning referrals

Service Provider Instructions: Please record the following key indicator for your clinic each day. Please only record your own total for each day.

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<tr>
<th>Week and Day</th>
<th>Indicator 1</th>
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<td>Number of sessions in which cards completed by client</td>
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<td>Number of follow-up sessions in which client brought back previously filled card</td>
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<td>Number of follow-up sessions with women who had received card but did not bring it</td>
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</table>

Thank you very much for helping us with piloting the card! This chart will be collected at the end of each month by our monitoring staff.

If you have any comments or questions, please contact [Staff Name Here] at [Phone number here].
**Sample Monthly Log for Data Collection: Hotline**

Facility Name: ___________________________  Month ____ of ____

Your Name: _____________________________________________________________________

Role at Facility:  
- [ ] Midwife  
- [ ] Doctor  
- [ ] Reception Desk Staff

**Reception Desk Instructions:** Please record the following key indicators for your clinic each day. If there is more than one staff member for the reception desk, please just write your own total on this form. Each staff member should have their own form.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
<th>Week 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Number of family planning sessions</td>
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<td>Number of FP sessions for which women called the hotline in previous week</td>
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<tr>
<td>Number of FP sessions for which women called the hotline in previous 4 weeks</td>
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</tbody>
</table>

Thank you very much for helping us with piloting the hotline! This chart will be collected at the end of each month by our monitoring staff.

If you have any comments or questions, please contact [Staff Name Here] at [Phone number here].