Maternal Health Initiative

Final Report – A Summary of Our Work and Our Decision to Shut Down

March 2024

Introduction

Maternal Health Initiative (MHI) was founded out of Charity Entrepreneurship (AIM)'s 2022 Incubation Program and has since piloted two interventions integrating postpartum (post-birth) contraceptive counselling into routine care appointments in Ghana. We concluded this pilot work in December 2023.

From here, we conducted a thorough analysis of these pilot results alongside significant expert engagement and background research. A stronger understanding of the context and impact of postpartum family planning work, on the back of our pilot results, has led us to conclude that our intervention is not among the most cost-effective interventions available. We've therefore decided to shut down despite having the runway to continue operating. We believe that an organisational pivot is not the best use of the staff, funding, and other resources at MHI's disposal. As such, we have decided to shut down MHI.

This report summarises MHI's work, our assessment of the value of postpartum family planning programming, and our decision to shut down MHI as an organisation in light of our results. We also share some lessons learned.

We encourage you to skip to the sections that are of greatest interest using the 'Contents' below.

- For people interested in the practicalities of development work, we recommend 'MHI: An Overview of Our Work' and 'Pilot: Design'.
- For those interested in family planning programming, we recommend 'Pilot: Results', 'Why We No Longer Believe Postpartum Family Planning Is Likely Among The Most Cost-Effective Interventions', and 'Broader Thoughts on Family Planning'.
- Finally, for those interested in broader lessons around entrepreneurship and organisation-building, we recommend 'Choosing to Shut Down' and 'Reflection'.

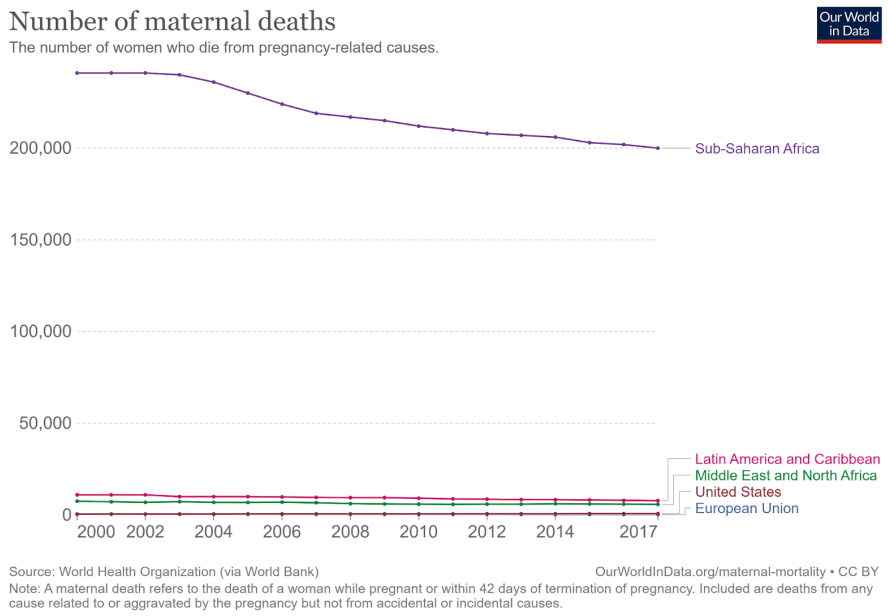
Contents

Why We Chose to Pursue Postpartum Family Planning

Why Family Planning?

Pregnancy-related health outcomes are a leading cause of preventable death among both mothers and children. In 2017, almost 300,000 women and girls died due to either pregnancy or childbirth (WHO, 2017). Cleland *et al.* (2006) estimate that comprehensive access to contraception could avert more than 30% of maternal deaths and 10% of child mortality globally.

Contraceptive access provides a wide range of other potential benefits. The most significant of these may be increasing reproductive autonomy for women who want to space or limit births and currently have limited options for doing so. Traditional practices of prolonged abstinence, breastfeeding, and social stigma around short-spaced births can provide significant pregnancy protection. However, modern contraception is generally both more reliable and effective - particularly in contexts where women may have incomplete autonomy over their reproductive and sexual decision-making (Mansour et al. 2010). Increasing women's reproductive autonomy has been linked to increased income, educational attainment, and subjective wellbeing (Canning and Schultz, 2012; Båge et al. 2023). More than this, increasing autonomy represents a worthy and important goal in and of itself (Senderowicz and Higgins, 2020).



Maternal deaths in Sub-Saharan Africa compared to other global regions (Our World in Data, 2024)

Why Postpartum (Post-Birth)?

Postpartum family planning (PPFP) – integrating family planning guidance into postnatal care and/or child immunisation appointments – has been identified as an effective way of increasing

contraceptive uptake and reducing unmet need (Wayessa et al. 2020; Saeed et al. 2008; Tran et al. 2020; Tran et al. 2019; Pearson et al. 2020; Dulli et al. 2016).

The maternal and infant mortality risks from short birth spacing make the postpartum period a potential point of particular value from increased contraceptive access (Conde-Adegulo et al. 2012; Islam et al. 2022; Wendt et al. 2012). Kozuki and Walker's (2013) analysis of DHS data across 47 countries suggests an 18% increase in neonatal mortality and a 21% increase in child mortality from short-spaced births. Changes in maternal mortality are harder to measure due to lower incidence but may be as significant as a 32% increase in mortality risk (Conde-Agudelo et al. 2007).

One potential barrier to higher rates of family planning is insufficiently good quality counselling (Rominski et al. 2017). While it is often an official policy that family planning counselling should be included in postnatal care (Ghana Health Service, 2014), the consistency and quality of family planning services in the postpartum period vary in practice (Morhe et al. 2017).

MHI: An Overview Of Our Work

Maternal Health Initiative (MHI) was founded in September 2022 out of the Charity Entrepreneurship (AIM) Incubation Program. From its beginning, MHI has had an explicit focus on postpartum family planning work based on research by John Hopkins University (High Impact Practices reports), Charity Entrepreneurship, and others suggesting it had the potential to be a highly cost-effective approach to improving women's health and autonomy.

We spent our first few months interviewing a few dozen experts, getting up to speed with research in the field, and selecting priority target countries. We took an initial field visit to Ghana in October 2022 to shadow the work of Family Empowerment Media (FEM) who were investigating scaling their programming to the country. Upon our return, we pursued a thorough geographic assessment process before selecting our country of operation.

Country Selection

Out of our modelling, the top countries we considered were Ghana, Sierra Leone, Liberia and Nigeria. We ruled out Liberia as the cost-effectiveness we modelled was a little lower than Sierra Leone with both countries presenting similar concerns around the feasibility of successful implementation due to weak post-Ebola healthcare systems and concerns around corruption. We ruled out Nigeria for security concerns in the run-up to the presidential election in February 2023.

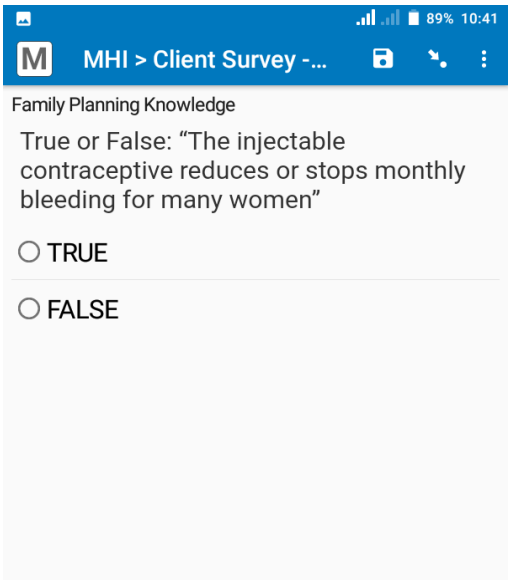
On this basis, we then undertook country visits to Sierra Leone and Ghana in January 2023. We struggled to find a viable partner organisation in Sierra Leone and our initial meeting with the

national government there suggested lower enthusiasm for the kind of work we were proposing. However, our visit to Ghana was more promising and we chose to launch pilot work in Northern Ghana with two local organisations - Norsaac and Savana Signatures.

Ghana appeared promising given the strength of its healthcare system, high unmet need, and low contraceptive uptake in its northern regions. The country overall has an unmet contraceptive need of 30%, meaning that many women would like to control the frequency and number of pregnancies but are not using contraception (Asah-Opoku et al. 2023).The partner organisations we selected - Norsaac and Savana Signatures - are based in the Northern Region of Ghana. In recent years, the family planning acceptor rate in the Northern Region has declined from 31.4% (2018) to 25.5% (2022).

Initial Surveying And Proof Of Concept Work

Once our partnerships were in place, we began conducting baseline surveys and interviews with both healthcare providers and recipients. We wanted to understand current levels of knowledge around family planning, the most prevalent reasons women were choosing not to use a modern method of contraception, and the current state of postpartum family planning at facilities in the region.



A screenshot from one of MHI's surveys on SurveyCTO - the platform we shifted to using after our initial issues with Google Forms

Building on this information, we ran initial proof of concept training sessions in April 2023 with around 25 nurses and midwives. There are a lot of small details that go into running a successful training. Running an initial two training sessions allowed us to identify easily fixable issues. In this way, our first sessions were imperfect - with insufficient practice time and major issues with the

use of Google Forms for data collection - but essential for hammering out the details of how to run highly effective training in future.

We conducted some follow-up surveying at the proof of concept facilities in May 2023. This data suggested that while providers had a strong knowledge of family planning, there was inconsistent implementation of counselling as designed.

Healthcare workers gathered after attending our first training session in April 2023

Building To The Pilot

This information led us to redesign our intervention approaches in the summer of 2023 in consultation with our local partners and the Ghana Health Service. We shifted from training providers on family planning knowledge and counselling best practices to training them in one of two specific, structured counselling models. These models are described in depth in the 'Our Pilot' section below. We also began exploring more rigorous forms of monitoring and incentivisation, identifying adherence as a key bottleneck to successful programming.

Through the second half of 2023, MHI's efforts focused on refining and then evaluating these two models. With Savana Signatures, we ran a larger proof of concept project at 6 hospitals across both the Northern and Savannah Regions with training sessions in August 2023. These sessions

showed us that larger provider attendance per training session did not compromise training quality and that providers were receptive to the specific approach and materials provided through the training. Further information about this work is available in the project report on our website.

Alongside these sessions, we conducted further client and provider surveying and secured ethical approval from the Navrongo Health Research Centre for a formal pilot project in partnership with Norsaac.

Our pilot took place from September to December 2023 across six hospitals in Ghana's Northern Region. Since its conclusion, MHI has focused on data analysis and investigation of the uncertainties around impact that have ultimately led us to the choice to shut down.

A map of Ghana's 16 regions, highlighting the Savannah and Northern Regions where MHI's programming took place

Pilot: Design

Guiding Choices

MHI's programming aimed to increase the quality and consistency of information given to women about contraception at routine appointments in the first year after birth (the postpartum period). In doing so, MHI expected to increase contraceptive uptake, thereby reducing rates of unintended pregnancy alongside the maternal and infant mortality borne from this.

In our program design, we placed a high emphasis on building a system of counselling that was truly client-centred. There are several different methods of contraception available through the Ghana Health Service. It was a point of emphasis in MHI's programming to ensure that women received information on multiple methods in an unbiased way. Increasing women's autonomy was a core part of MHI's mission and we believed that providing open, broad information on contraception was essential to providing genuine improvements in autonomy.

This meant that MHI's program design diverged to an extent from some of the prior studies with the strongest increases in uptake, which were often focused on long-acting reversible contraception (LARC) provision.

This decision was made for two reasons. First, LARC-centred programs are also an order of magnitude more costly to deliver. While counselling knowledge and materials can be delivered in

a single day's training, ensuring providers have the technical skills to safely deliver IUDs and implants tends to require 2-3 weeks' training, increasing costs by 10x. Second, we had significant reservations about the ethics of 'LARC-first' programming due to concerns about coercion and freedom of choice. These are discussed in greater depth in the later section 'Why We No Longer Believe Postpartum Family Planning Is Among The Most Cost-Effective Interventions'.

Our Models

As mentioned, MHI's pilot programme was based on two specific intervention models. These were the following:

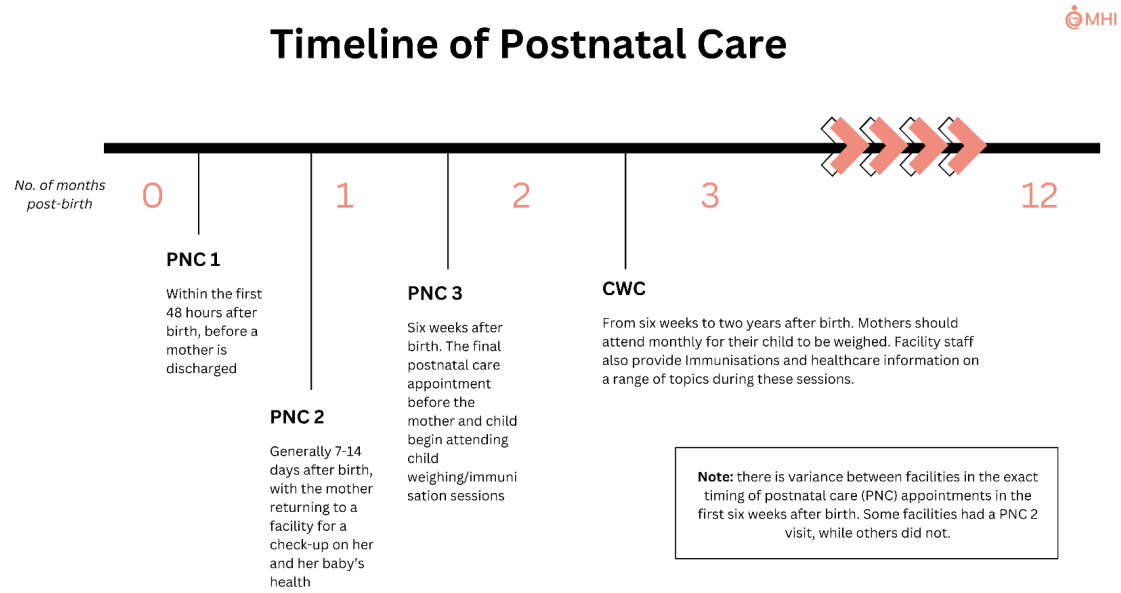
1. The provision of one-to-one family planning counselling during routine postnatal care (PNC) appointments
2. The implementation of short family planning messaging and a referral system as part of normal child welfare clinic (CWC) sessions.

These models were each selected to replicate a particularly promising RCT that we hoped would translate well to Northern Ghana. A study by Asah-Opoku et al (2023) in Accra concluded that one-to-one counselling as part of routine postnatal care sessions (PNC) was associated with a significantly greater uptake of contraception during the postpartum period. Meanwhile, Dulli et al (2016) found that incorporating family planning services into routine child welfare clinic sessions as part of immunisation provision resulted in a 15% shift in postpartum contraceptive use.

For each model, providers were invited to a one-day training session. Here, they received specific guidance on implementing the model alongside tailored counselling materials designed by MHI. The counselling materials for both models were designed with the aim of compiling best practices from a range of materials used in prior interventions delivered by other organisations. Providers practised using the counselling materials in line with the intervention model in the second half of the training. They then completed a post-training test to verify that they had a clear understanding of how counselling should be implemented. Downloadable copies of all of MHI's programming materials are available on our website.

Continuum of Care

The two models targeted different points on the continuum of care after birth, with mothers attending up to three postnatal care (PNC) sessions from 0-6 weeks post-birth, and then attending child welfare clinics (CWC) sessions monthly from 6 weeks onwards.



A timeline showing the timing of routine healthcare appointments in the post-birth period

There are benefits and costs to targeting either PNC or CWC. MHI's choice to test one intervention model focused on each was due to our uncertainty in how to weigh these pros and cons. PNC sessions as currently structured already involve significant one-to-one provider-client engagement, making these sessions well suited to providing in-depth family planning counselling. PNC1 is also the most consistently attended session since it takes place before mothers are discharged from the facility after giving birth. However, the timing of PNC sessions in the first six weeks after birth means that they take place at a time when the risk of pregnancy is exceptionally low for the vast majority of women, meaning many women have minimal interest in taking up a contraceptive method.

In contrast, CWC sessions occur later in the postpartum period. This means women are more likely to engage with family planning information and that contraceptive uptake is more impactful. However, CWC sessions are group-based and often very busy, with women waiting multiple hours for their child to be weighed and immunised. This places significant pressure and stress on providers and restricts the scope for one-to-one counselling.

Implementation Timeline

August-September 2023	**Phase 1 - Formative Research** We refined the program design through engagement with facility stakeholders and baseline data collection. We then completed baseline data collection through structured questionnaires conducted with postpartum women at facilities, following up with clients 14 days after the initial questionnaires via mobile phone to assess contraceptive uptake.
October - November 2023	**Phase 2 - Implementation of Intervention Packages** We delivered training sessions in October 2023, including an assessment of providers' contraceptive knowledge and attitudes towards contraceptive use. Implementation at the facilities began immediately post-training alongside ongoing monitoring work to ascertain the quality of implementation.
November 2023 - January 2024	**Phase 3 - Evaluation** We collected endline data at six weeks post-training through structured questionnaires with postpartum women at the intervention facilities. This was supplemented by mobile phone surveying 14 days later. The questions used for data analysis and structure of surveying were held constant between the baseline and endline surveying.

PNC Intervention Model

Our postnatal care intervention consisted of the following three key objectives:

1. Include family planning counselling as part of every 1:1 postnatal appointment they offer.
2. Use MHI's Counselling Guide as a framework for this discussion, with the Method Cards and Method Information Booklet used as key resources in this framework. The discussion should take around 20 minutes, depending on the number of questions from the client.
3. Offer a method directly, or a referral to the family planning unit, for women who express an interest in taking up a method of birth spacing at the end of the counselling discussion.

Each provider was given a copy of the three key counselling materials: the 'MHI Counselling Guide', 'Method Information Booklet', and 'Method Cards'.

MHI's core PNC counselling materials (in respective order)

The counselling guide provided an overall structure for the counselling session and acted as a job aid for remembering the training while delivering counselling.

The method cards were designed for client-centred counselling, providing a visual tool for clients to indicate their key preferences and which kinds of methods they were most interested in.

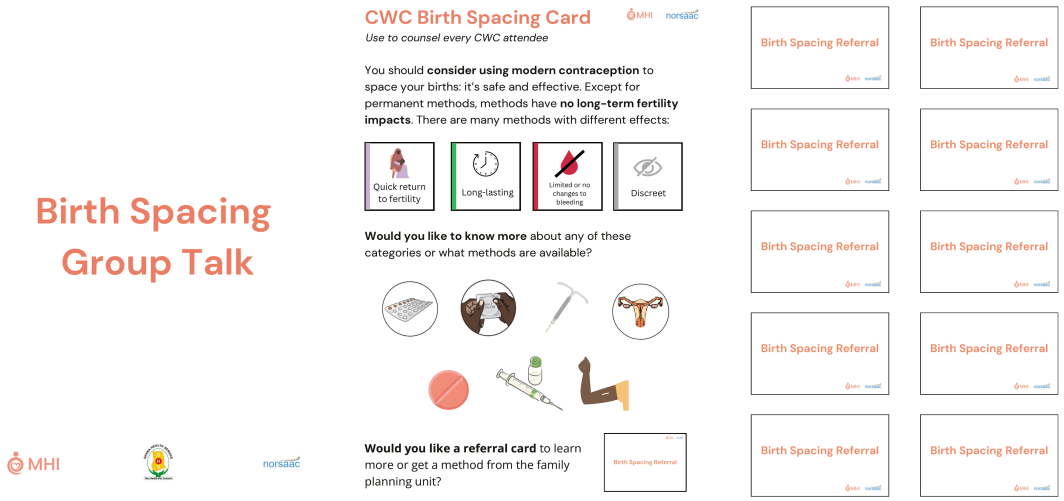
The 'Method Information Booklet' acted as a reference tool for providers to look up more complex or detailed information about different methods, including the following: side effect profiles; effectiveness; risk factors to screen for before method provision; and the mechanism for taking the method.

Finally, all facilities also received a large set of referral cards (as well as boxes for their storage and transfer). The referral cards were designed as a practical reminder and behavioural nudge to clients who expressed interest in a method that was not available for provision during the routine appointment, either due to stock shortages or the need for insertion by a trained specialist.

CWC Intervention Model

At the CWC session, providers were given a group talk flipchart, 1:1 counselling card, and referral cards for directing people to the Family Planning Unit. The child welfare clinic intervention was designed to consist of three key components - a group talk, one-to-one messaging, and a referral system:

1. Include family planning messaging in every group talk given while women wait for their child to be called up for weighing and immunisation, using MHI's streamlined 'Birth Spacing Group Talk' flipchart as a guide.
2. Providers giving immunisations have a very short 1:1 family planning discussion with each woman as her child is vaccinated using the 'Birth Spacing Card'.
3. Offer women the option of a streamlined referral for family planning at the end of this one-to-one engagement, using a system of referral cards to make it simple for women to receive a method that day should they choose to do so.



MHI's core CWC counselling materials (in respective order)

Providers were asked to offer a short family planning group talk using the flip chart at every child immunisation session. The 'Birth Spacing Group Talk' flipchart was designed so that the group talk would take no more than 10 minutes and be feasible to implement even at busy CWC sessions. The flipchart leads providers and clients through a discussion of the range of methods available to clients, how to safely take methods and manage their side effects, and the benefits of receiving family planning counselling while at the facility.

The 'Birth Spacing Card' was designed for use by providers directly administering immunisations to children after they have been weighed and their health records have been recorded. Providers were asked to counsel every woman whose child they immunised. The card was designed so that the engagement would last 1-2 minutes at a maximum to ensure feasible implementation. This model was chosen to mirror the approach of Dulli et al. (2016).

A referral card system was paired with the 'Birth Spacing Card'. All women who expressed interest in discussing family planning further received a referral card to take to the Family Planning Unit. These were

designed to be discreet to pass between provider and client to maintain confidentiality.

Referral cards acted as a physical reminder to the client to follow up on their family planning interest while indicating to providers at the Family Planning Unit of the hospital that the client had already received some family planning guidance and could receive a streamlined version of standard counselling.

Finally, all providers received a 'Method Information Booklet' as a reference tool to answer more complex questions about contraceptive method use and provision.

Monitoring and Incentivisation

Our proof of concept project had suffered from issues of provider adherence to the counselling model. In response, we implemented a number of monitoring and incentivisation strategies.

Program Champions
A 'Program Champion' was selected for each facility. Program Champions were current staff members at each facility whom we paid a small stipend[1] to carry out monitoring work on our behalf. They became responsible for ensuring the program was consistently implemented at their facility, and for highlighting any barriers to implementation promptly so that the project team could coordinate with the facility to address these.

Upon selection, each Program Champion was given a separate information booklet on the intervention and had to pass a knowledge test to be accepted into the role. This information booklet explained our expectations for them, the weekly activities they needed to complete, the systems they would use for these, and the compensation they would receive.

Whatsapp API
MHI also built a Whatsapp Application Programming Interface (API). This system was used to offer refresher training to every provider while engaging these providers in direct monitoring to maximise their adherence to the program. The API also allowed us to reach additional staff at the facilities who did not attend the in-person training, with the Program Champions collecting the phone numbers of any additional staff.

For the postnatal care program, we sent a weekly survey of around five questions. For the child immunisation program, we sent a fortnightly survey of around 10-15 questions with the provision of a small airtime incentive as compensation for the time this takes. Completion of the questionnaires was solid, particularly for those receiving the airtime incentive, suggesting that this is a viable strategy for direct provider engagement.

[1]Incentives were specifically tied to implementation rather than outcomes to avoid providers putting pressure on clients to accept a contraceptive method.

Other Strategies
MHI experimented with a variety of other monitoring strategies, finding mixed results. Spot checks from our partners and from District Public Health Nurses failed to produce significant meaningful insight into the quality of implementation. Similarly, working with Savana Signatures to connect clients to their SHE+ Helpline provided limited insight due to issues in limiting the sample to women who attended routine postnatal visits rather than those who visited the Family Planning Unit. Phone surveying of clients carried out by the Norsaac team at the midpoint of our pilot proved more valuable.

Finally, we had hoped to implement a system of client SMS feedback. However, we found that literacy levels were too low for this to be viable and encountered significant barriers in gaining regulatory approval to send SMS messages in Ghana.

A more detailed explanation and discussion of our pilot design is available in the project report on our website.

Pilot: Results

Sample Population

Our pilot surveyed women attending a PNC or CWC session at one of our target facilities. We surveyed 205 women pre-intervention, and 226 women six weeks after the training sessions.

The pre- and post-intervention groups were similar within the PNC and CWC intervention arms. Most respondents were Muslim, currently married, and had an average age of 27-28. The majority had previously used modern contraception and were currently abstinent, while almost all were currently breastfeeding.

Table: Background Characteristics of Pilot Participants

	PNC		CWC	
	Baseline (n= 100)	Endline (n=106)	Baseline (n= 105)	Endline (n=120)
Sexually active	4.00%	1.89%	32.4%	18.3%
Breastfeeding	100.0%	100.0%	100.0%	99.2%
Exclusively breastfeeding	86.0%	92.5%	42.8%	50.8%
Past use of modern contraception	68.0%	67.0%	67.6%	68.3%

Implementation

Family planning counselling should be included in every postpartum touchpoint according to Ghana Health Service policy. As such, we expected non-zero levels of baseline implementation. For counselling to be valuable, However, counselling must occur consistently in order to maximise its impact.

Our surveying results suggest that the implementation of family planning counselling increased significantly, with an increase of more than 20% seen across both interventions. However, this still fell short of the counselling consistency we had aimed for and likely diminished the pilot's impact. Variation between facilities suggests that substantially higher rates of counselling consistency are possible - such as the 81% implementation of 1:1 family planning counselling during PNC at Yendi. Challenges in achieving these levels consistently were unsurprising given implementation issues in previous facility-based family planning programs (Pearson et al. 2020; Vance et al. 2013).

Table: Implementation Consistency[2]

	PNC				CWC			
	Facility	Baseline (n= 100)	Endline (n=106)	Difference	Facility	Baseline (n= 105)	Endline (n=120)	Difference
1:1 Family Planning Counseling	*Bimbilla*	*2.27%*	*28.57%*	*26.30%*	*Karaga*	*20.00%*	*62.86%*	42.86%
	Gushegu	*28.57%*	*46.67%*	*18.10%*	*Kpandai*	*2.86%*	*68.57%*	65.71%
	Yendi	*31.43%*	*80.95%*	*49.52%*	*Zabzugu*	*2.86%*	*42.00%*	39.14%
	Overall	**18.0%**	**39.6%**	**21.60%**	Overall	**28.10%**	**55.80%**	**27.70%**
Group Talk on Family Planning					*Karaga*	*37.14%*	*68.57%*	*31.43%*
					Kpandai	*2.86%*	*77.14%*	*74.29%*
					Zabzugu	*5.71%*	*74.00%*	*68.29%*
				N/A	Overall	**15.20%**	**72.50%**	**57.30%**

Changes in Contraceptive Uptake

No statistically significant effects on actual or intended contraceptive use in either arm were observed at immediate surveying. Along with immediate surveying, we also conducted 2-week followup by phone at the recommendation of local stakeholders. We anticipated that a

[2] p-values were calculated using Pearson's chi-squared unless indicated otherwise
† = Fisher's exact test, used due to small sample size; * = p < .05; ** = p < .01

significant portion of any contraceptive uptake created by the program would occur after a short delay, as many women consult with their husbands or other family members before beginning a method.

Data from a 2-week phone follow-up survey suggests a 22% increase in contraceptive use ($p <$ .01) and a 25.3% increase in intended use ($p = .0187$) in the PNC arm and no statistically significant effects in the CWC arm. However, we have significant concerns about the robustness of this data given the reduced sample size and possible biases in this smaller sample.

Table: Changes in Contraceptive Use

	PNC				CWC			
	Baseline	Endline	Difference	*p* value	Baseline	Endline	Difference	*p* value
Immediate Surveying	n=100	n=106			n=105	n=120		
Use of modern contraception (all facilities)	2.00%	5.00%	3.00%	0.446ǂ	15.20%	14.20%	-1.00%	0.821
2-week phone follow-up	(n= 50)	(n=41)			(n= 52)	(n=59)		
Use of modern contraception (all facilities)	0%	22.00%	22.00%	0.000447ǂ **	15.40%	13.60%	-1.80%	0.794ǂ

Conclusions From Our Pilot Results

Based on a provisional cost-effectiveness analysis, we were aiming for a shift in contraceptive uptake of around 10% from our pilot program. Neither of MHI's pilot interventions approached this level based on the immediate surveying. The 2-week follow-up data for PNC suggests a much larger shift in contraceptive uptake. However, we have concerns about the reliability of this data. It is likely inaccurate, though to what degree is hard to say. Breaking down our results to the facility level, we see a 10% shift in contraceptive uptake for PNC at Yendi, where implementation quality was highest.

Put together, these results suggest a few conclusions. First, we can say with relative confidence that the CWC intervention did not work as hoped. Implementation was poorer but sufficient to expect reliable results, and we found no meaningful change in contraceptive uptake. Second, we can conclude that the effectiveness of the PNC intervention is hard to determine. We have conflicting surveying data, suggesting both a relative failure to produce change and potentially highly significant shifts in contraceptive uptake. Put together, this data suggests that the PNC

intervention likely produced a more meaningful shift in contraceptive uptake, possibly approaching or exceeding the 10% threshold we had set out when starting the pilot.

However, our pilot results also produced data on postpartum abstinence and breastfeeding practices that changed our understanding of the value of postpartum contraceptive uptake. We now believe that a 10% shift in postpartum contraceptive uptake is far less valuable and likely to still fall substantially below the cost-effectiveness threshold at which a program like this would be worth scaling. High rates of postpartum insusceptibility suggest that increasing postpartum contraceptive uptake has little impact on rates of pregnancy.

While we firmly believe in the value of family planning programming for increasing autonomy, we think that contraceptive uptake acts as a good proxy for this value. Information is useful to people to the extent that it shifts behaviour across a population; if family planning counselling does not change women's attitudes to contraception, the benefit to their autonomy is likely to be low.

Further information on our pilot results will be available in a forthcoming journal article.

Why We No Longer Believe Postpartum Family Planning Is Among The Most Cost-Effective Interventions

While the reasons listed in this section build on our pilot and implementation data, they are primarily based on substantial further research and engagement with the broader literature. As such, some of the discussion is comparatively technical.

Evidence of Limited Effects on Unintended Pregnancies

Family planning interventions are typically assessed based on their effects on contraceptive uptake, under the assumption that increases in uptake will necessarily translate into reduced unintended pregnancies. Postpartum family planning has been recognized as a "proven" high-impact practice in family planning – and hence received significant funding – on that basis (HIP Partnership, 2022). However, our experience working in this space has led us to believe that the connection between contraceptive uptake and unintended pregnancies is less clear-cut.

Measuring the effects of family planning interventions on unintended and short-spaced pregnancies has not been prioritised; hence, the evidence is limited. However, the evidence available is not promising for the efficacy of postpartum programming. Of the three studies we found that measure the effects of facility-based postpartum family planning programming on pregnancy rates, two found no effect (Rohr et al. 2024; Coulibaly et al. 2021), and one found only

a 0.7% decrease in short-spaced pregnancies (Guo et al. 2022). This suggests that facility-based programs may have limited to no effect on reducing unintended pregnancies despite increasing contraceptive uptake. More research investigating this area is needed to draw confident conclusions, but this is certainly concerning.

Increases in family planning uptake are primarily valuable insofar as they allow women to avert mistimed or unintended pregnancies. If modern contraceptive uptake does not change the likelihood of pregnancy, it will not have an impact on the rates of short-spaced pregnancies, maternal mortality, or other health outcomes. It will also do little to provide women with additional autonomy or control over their reproductive lives.

Surprisingly – or unsurprisingly, depending on your perspective – these studies do not appear to have generated much discussion regarding the usefulness of postpartum family planning programming itself. Even within the studies themselves, the results regarding pregnancy rates are not treated as particularly significant; in one study, for example, they are reported in a single line and receive no discussion (Coulibaly et al. 2021). However, we believe that they are very significant for evaluating the true impact of such programs and the lack of engagement speaks to the ease with which programs can focus on proxy rather than true endline measures of impact.

The Prevalence and Impact of Postpartum Insusceptibility

Postpartum insusceptibility describes the period after birth in which a mother is naturally at zero or extremely low risk of pregnancy. It results from the combination of two factors: sexual abstinence and amenorrhea due to breastfeeding.

Our study found very high rates of abstinence - 96% at baseline and 98.1% at endline in the PNC arm and 67.6% at baseline and 81.7% at endline in the CWC arm - coupled with near-universal breastfeeding practice. Data from Demographic Health Surveys (DHS) supports these results. In the Northern Region, the median duration of postpartum abstinence is 4.7 months and the median duration of breastfeeding is 20.5 months. Added together, these factors suggest postpartum insusceptibility continues throughout the first year after birth for the majority of women in the Northern Region.

Investigating this further, we found that these results generalise across much of Sub-Saharan Africa. DHS data suggests the mean duration of postpartum insusceptibility is 14.57 months across 39 countries with available data (see Table below).

Table: DHS Data Summarising Regional Rates Of Postpartum Insusceptibility, Abstinence, And Amenorrhea

Region	**Postpartum Insusceptibility** (Mean Duration)	**Postpartum Abstinence** (Mean Duration)	**Postpartum Amenorrhea** (Mean Duration)
Sub-Saharan Africa	**14.57**	**8.69**	**11.13**
Middle Africa	13.54	7.57	10.49
Western Africa	15.24	10.03	11.48
Eastern Africa	14.78	7.15	11.82
Southern Africa	14.73	10.03	10.75

Long-lasting postpartum insusceptibility significantly reduces the impact of family planning uptake in the first year postpartum. New users of contraception who are already protected by abstinence and/or breastfeeding will not incur additional benefits from modern forms of contraception.

Short-Spaced Pregnancies

One of the key arguments in favour of a postpartum-specific focus in family planning work is the risks of short-spaced births. Births that occur within 2 years of a previous pregnancy are correlated with a 32% higher rate of maternal mortality and a 21% higher rate of child mortality (Kozuki and Walker 2013; Conde-Agudelo et al. 2007).

We now believe that the impact of postpartum family planning programs in reducing short-spaced pregnancies is likely to be overstated - though again, more research into this would be beneficial.

First, the number of short-spaced pregnancies reached may be very low. We modelled the impact of MHI's work based on the average rates of short-spaced births in Ghana but now believe this is likely to overestimate the number of short-spaced births averted. Around 15-25% of births are short-spaced on average across Sub-Saharan Africa. It appears likely that those with an increased risk of short-spaced pregnancies are actually less likely to be among new contraceptive users, as short-spaced births are associated with lower levels of education and income (Rutstein 2011). Poorer and less educated women are typically less likely to obtain maternal and newborn care at health facilities and less likely to use contraception (Doctor et al. 2018; Ba et al. 2019).

Second, the prevalence of postpartum insusceptibility suggests that those short-spaced births that are successfully prevented by postpartum family planning programming may skew towards the second year post-birth. The risks of short-spaced births decrease as the time since the

previous pregnancy grows, with birth intervals from 15 months onwards showing no increase in maternal mortality compared to the average birth interval (DeVanzo et al. 2014). This suggests that the benefits accruing from any short-spaced births averted may be substantially lower than hoped.

Finally, there have been only minor reductions in the incidence of short-spaced births over the past several decades – in sub-Saharan Africa, 3.4 percentage points – despite a much larger increase in contraceptive uptake over that same period (Rutstein 2011; Tsui et al. 2011). Indeed, short-spaced pregnancies remain persistent in high-income countries, with 18.7% of births from 2015 to 2019 short-spaced in the United States (National Health Statistics Reports, 2023). These trends suggest that short-spaced births are not caused by a lack of contraceptive access and may remain at similar levels even if large increases in contraceptive uptake are achieved.

Discontinuation Rates

Some pregnancies are likely still averted due to shifts in attitude that lead to subsequent uptake or immediate contraceptive uptake that lasts beyond the period of postpartum insusceptibility. However, high rates of contraceptive discontinuation further diminish these already reduced effects.

There is a 36.6% average 1-year contraceptive discontinuation rate across 32 African countries with DHS data available. While the majority of women will continue to use beyond 1 year, this level of discontinuation undercuts the relative value of postpartum family planning compared to other approaches that are also likely to affect pregnancy rates in the first year of use.

Some evidence suggests that the use of short-term methods in the early postpartum period may even be counterproductive. An analysis of data from four African countries found that the use of injectable contraception was associated with short birth intervals (Ngianga-Bakwin et al. 2004). Additionally, a review of data from the Matlab program in Bangladesh found that postpartum acceptors of oral contraceptives became pregnant at a higher rate than non-users due to high rates of method discontinuation (Bhatia et al. 1987).

Why Not LARCs?

A possible solution to concerns around method discontinuation and the value of contraceptive uptake in the first year after birth would be to focus on the provision of long-acting reversible contraception (LARC) methods. LARCs - such as IUDs or implants - last for multiple years and have significantly lower rates of discontinuation. Indeed, some of the studies showing stronger increases in contraceptive uptake were focused on LARC provision (Pearson et al. 2020; Karra et al. 2018).

However, as mentioned briefly in the 'Pilot: Design' section, we developed significant reservations about the ethics of programs that emphasise the use of LARCs or counsel exclusively on their use (without discussion of other methods). There are several studies that have highlighted bias and coercion associated with some LARC-first counselling in high-income countries (Eeckhaut and Hara 2022; Biggs et al. 2020; Gomez et al. 2017; Brandi and Fuentes 2019). This can extend to the provision of incentives tied to LARC uptake (Boydell et al. 2023; Ma et al. 2020). Less work has been done in low and middle-income countries, but preliminary studies raise significant concerns, including providers offering misleading and inaccurate information concerning LARCs, or in some cases refusing to remove implants or IUDs, in opposition to women's preferences (Senderowicz 2019). Practices such as offering IUDs during labour without counselling on other methods are therefore antithetical to free and informed choice (Karra et al. 2018)

We firmly believe that contraceptive uptake, irrespective of its flow-through benefits, should never be the result of pressure or coercion. As such, we decided against pursuing any kind of LARC-focused program and remain committed to this decision.

Cultural Barriers

One reason we believed postpartum family planning may be particularly valuable was that it is an opportunity for women to take up contraception confidentially - or, in other words, without their husband's knowledge. By integrating counselling and method provision into routine services, women can attend healthcare centres and take up a contraceptive method without the stigma or controversy of visiting for the purpose of discussing family planning.

However, providers frequently reported that women were not interested in taking up family planning methods at postpartum appointments. Though these sessions were confidential, many women expressed a strong desire to speak to their husbands before making any decision. Debriefing with our partners in Ghana emphasised the importance of this cultural barrier. We heard several anecdotal stories from prior to our programming of men taking their wives back to healthcare facilities upon learning they had taken up a method of contraception and demanding that providers remove it on the spot. This suggests that women's lack of reproductive autonomy can become self-reinforcing. The value of confidential counselling is reduced when a substantial proportion of women decide not to make use of it for fear of possible consequences.

More broadly, cultural barriers to contraceptive uptake appeared more entrenched than we had anticipated. Clients' attitudes to family planning appeared too deep-seated to shift with short counselling, particularly given decision-making often lay with a partner or mother-in-law.

Meanwhile, providers appeared resistant to consistently providing counselling, undermining our belief that counselling will happen consistently on the long-term basis we modelled and anticipated. While formal surveying elicited nearly universally positive feedback, providers expressed frustration in informal conversations with the additional time required for consistent

1:1 counselling. While MHI had some success with monitoring and incentivisation strategies to improve implementation consistency, these substantially raised programming costs and did not fully solve the problem.

In light of this, approaches that aim for knowledge and behaviour change at a community level - such as mass media family planning messaging and Participatory Learning Action groups (PLAs) – seem likely to prove significantly more effective. Taking these counterfactuals seriously, postpartum family planning programming is likely drawing resources away from alternative family planning and maternal health interventions that can be significantly more impactful.

'Unmet Need' as a Misleading Metric

Unmet need is used to capture women who express a desire to space or limit their pregnancies but are not currently using modern contraception. One of the primary reasons we chose to work in Ghana was its high rate of unmet need relative to the strength of its healthcare system. The combination of these factors suggested that a facility-based postpartum family planning program could be implemented effectively and produce significant shifts in contraceptive uptake.

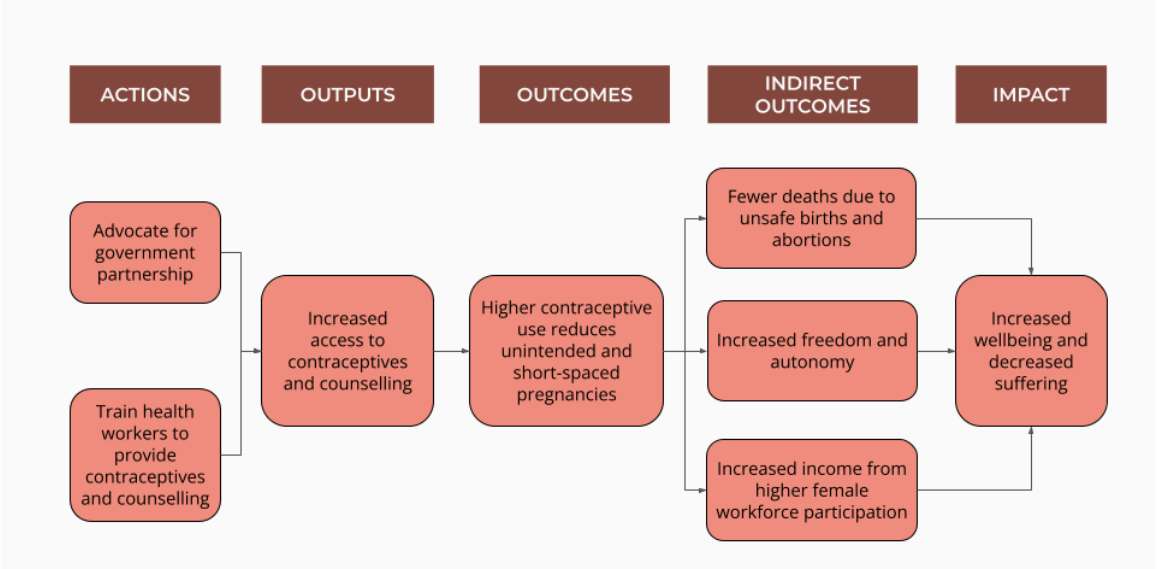
However, we now believe that conventional measures of unmet need are misleading, particularly when measuring the desire for contraceptive access in the postpartum period. The current DHS definition of unmet need is calculated based on the intendedness of a woman's most recent pregnancy, rather than their current behaviours or future plans for contraceptive use (Bradley et al 2012). As a result of this, many women are classified as having unmet need despite being insusceptible to pregnancy and expressing ambivalence about the timing of their births (Stateveig 2017).

Cleland (2015) proposes a "current status" measure of unmet need that takes postpartum insusceptibility into account. Comparing the two approaches, DHS estimates of unmet need among African countries are 2-7 times substantially higher than those using Cleland's "current status" definition. For example, DHS statistics from Ghana suggest that 50.6% of postpartum women have unmet need, while the current status approach indicates that 10.9% of postpartum women are at risk.

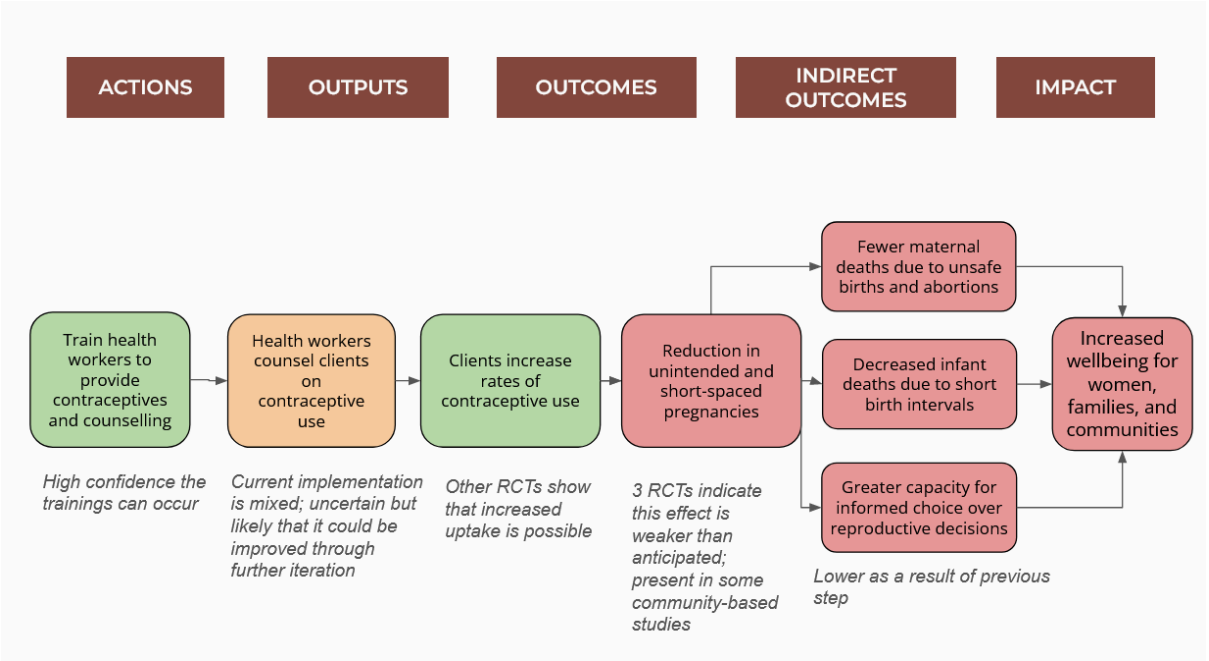
This is a substantial difference and validates MHI's programming data that suggests interest in postpartum contraceptive uptake is relatively low in Ghana.

Theory of Change

Many of the above points feed into a revised assessment of the theory of change for postpartum family planning. This change is shown in the figures below, depicting our original and revised models for family planning's theory of change.



Original theory of change (circa September 2022)



Updated theory of change (circa February 2024)

Broader Thoughts on Family Planning

The discussion above is focused on postpartum family planning programming specifically. However, there are both positive and negative conclusions on the value of family planning work more broadly that are worthy of discussion.

Concerns

Fertility Rate Change

This is an area of significant uncertainty but we believe more research is needed to demonstrate the robustness of the relationship between postpartum family planning uptake and fertility rate change. We expect that there is significant variation in the extent to which different types of family planning interventions drive reductions in unintended and short-spaced pregnancies. While our review of studies assessing facility-based postpartum family planning programs showed no strong effects on pregnancy rates (Rohr et al. 2024; Coulibaly et al. 2021; Guo et al. 2022), there is limited evidence of more promising results for other types of programs (Glennerster et al. 2022). Overall, there is a lack of robust evidence for such a crucial part of the theory of change for family planning work.

Additionally, there is tentative reason to believe that other factors may be as or more significant than improving family planning access in driving decreases in fertility rate. Some evidence suggests that reductions in child mortality and increases in formal schooling may cause more significant changes in fertility rates than family planning access (World Bank, 2010). This is likely due to their effect on women's desired family size. Indeed, the average desired family size in Sub-Saharan Africa exceeds the average fertility rates - suggesting that it is a lack of desire for smaller families, rather than a lack of access to family planning, that drives high fertility rates (Guttmacher, 2011). This is not to diminish the value of family planning work but rather suggests the drivers of family planning uptake are more complex. In cases where there is substantial existing access to contraceptive methods, other factors that influence the desire to have more or fewer kids may be more significant.

Side Effects

Robust and well-considered opposition to contraceptive use due to concerns around side effects is too frequently grouped together with wilder 'myths and misconceptions' as information barriers needing to be solved. Furthermore, arguments for family planning programming that heavily prioritise "modern" forms of contraception over other types minimise culturally specific concerns regarding contraception.

Side effects like inconsistent or excess bleeding may be seen as relatively manageable in Western countries with more accepting cultural norms and practices but can be far more significant in low-income countries (Kulhmann et al., 2017; Polis et al., 2018). Cultural practices

around inconsistent or excess bleeding can prevent women from participating in a range of regular activities, including prayer, sexual activities, and community engagement (Bradley et al., 2009; Mohammed et al., 2020). Meanwhile, amenorrhea from contraceptive use is frequently interpreted as a sign of pregnancy and therefore potential promiscuity (Mackenzie et al. 2020). Given these consequences, the choice of some women not to use hormonal contraception in order to avoid these consequences is worthy of respect and support.

Birth Spacing Promotion as a Vehicle for Flowthrough Effects

Some of the emphasis on family planning programming is driven by a focus on its large potential flowthrough effects. Project Drawdown, for instance, lists family planning as one of its top interventions for reducing CO2 emissions. Separately, family planning has been promoted for its potential as a highly cost-effective driver of animal welfare improvements. These effects stem from the impact of women having fewer children and the reduction in resource consumption that results from this.

In practice, many family planning programs act to persuade women of the benefits to their lives and their children's from contraceptive uptake, particularly through greater birth spacing - a practice that produces health benefits for both mother and child but will not change fertility rates if a woman's desired family size remains the same. Interpreted generously, this likely stems from a belief in the multiple benefits of family planning, and prioritisation of the most compelling benefits in different contexts - highlighting flowthrough effects to funders and immediate health benefits to program recipients. Indeed, our work with MHI has fallen into this trap at times.

From a harsh view, there is an element of deception here that disrespects the autonomy and freedom of choice of the women family planning programs serve. The choice of whether and when to have children is one of the most significant in any person's life. Treating this as an instrumental goal in order to reduce climate change emissions or animal suffering feels morally questionable, particularly given how this functions in outsourcing solving problems created in high-income countries to those in low-income countries. This is an area of particular uncertainty and reasonable disagreement between the MHI co-founders.

Reasons we still believe in the importance of family planning work

Despite the points above, we still believe that some family planning interventions can be hugely impactful.

The Need For Action

The issues that family planning programs work to address remain pressing. Maternal and infant mortality rates in Sub-Saharan Africa remain tragically high and family planning access has a significant role in addressing this.

Without aid investments in family planning, millions of women may be denied the opportunity to control whether and when to have children. National healthcare budgets are squeezed in many countries and contraceptive procurement often suffers from this. In both Ghana and Sierra Leone, informal conversations with major organisations like USAID and UNFPA suggested that external aid agencies were entirely responsible for the procurement of contraceptives for both countries. This was at a cost of around $8 million per year in Ghana.

Separately, cultural barriers to family planning uptake that mean many women lack control over their reproductive lives may make cost-effective programming difficult but are not an excuse for inaction. Instead, they suggest the need for different approaches that more directly address and engage these cultural barriers rather than seeking to circumvent them.

Promising Approaches

Certain approaches to family planning programming appear particularly promising, and significantly more impactful than postpartum family planning work. Mass media family planning interventions have the potential to reach millions of women at a greatly reduced cost compared to facility-based work. They also benefit from reaching the community as a whole, thereby addressing cultural barriers and encouraging discussion amongst couples that may lead to changes in desired family size.

We are also enthusiastic about more family planning interventions focused on supply rather than demand. Stockouts of contraceptive methods - when a facility has no supply of a commodity on a given day - were common at the facilities we worked at in Ghana. These problems extend across Sub-Saharan Africa and prevent women who already wish to use family planning from taking up a method. Supply chain management interventions show promise in reducing stockouts (Krug et al. 2020), albeit with a shallow basis of evidence.

Autonomy

Finally, and perhaps most importantly, family planning programming is worthwhile for its effects on women's autonomy. There are few decisions that are likely to be more significant in a person's life than whether and when to have children. Measuring improvements to autonomy is difficult, even more so when trying to compare potential interventions. With that said, we believe that providing family planning information and access to women with genuine unmet need is likely to be one of the most impactful ways of increasing autonomy. Given people will often sacrifice a significant degree of wealth, happiness, and health for a greater degree of freedom, increasing autonomy may be one of the most significant avenues for improving people's lives.

Choosing to Shut Down

There are uncertainties and caveats to all broader research conclusions. Our assessment of the value of postpartum family planning is far from immune to these. With that said, the analysis and

reasoning summarised above give us a strong sense that postpartum family planning is unlikely to be as cost-effective as other approaches to increasing family planning access, and other approaches in global health more broadly.

MHI was founded with an explicit goal of starting one of the most effective charities in the world. If a new organisation such as ours does not exceed the value of existing work, we are merely shifting impact rather than creating additional value. As such, our conclusions around the lowered value of postpartum family planning left us with a choice to either pivot or shut down.

Considering a Pivot

A pivot makes sense when an organisation has clear comparative advantages that it can leverage into a new area of work. For MHI, we believe our primary comparative advantages were significant experience and stakeholder relationships in delivering healthcare facility-based interventions in Ghana and substantial experience and knowledge in delivering family planning programming.

Ultimately, we decided that a pivot in either of these directions did not seem sufficiently compelling to be worth pursuing.

Why Not Pivot To A Different Area Of Work In Ghana?
We chose to work in Ghana because of its rates of unmet need, strong healthcare system, and relatively low contraceptive uptake. We now believe that the unmet need for family planning in Ghana is significantly overestimated - as discussed in the section "Unmet Need' as a Misleading Metric'. Perhaps more significantly, we knew when selecting Ghana that we were prioritising healthcare system strength and operating feasibility over countries with the greatest burdens of maternal and infant mortality. As such, we knew when selecting Ghana that it was unlikely to be as cost-effective as other countries for most other health interventions.

While we strongly considered working elsewhere - such as in Sierra Leone because of its high burden of mortality - we were concerned about our ability to successfully deliver and evaluate a pilot. Our implementation challenges in delivering the pilot potentially validate this decision, suggesting a pilot in Sierra Leone may have struggled far more significantly to function successfully.

Added to this, we believed that MHI's work may increase in cost-effectiveness at scale by leveraging the training, monitoring, and distribution systems the Ghana Health Service already operates. This long-term vision of government adoption meant that a more resilient and centrally-managed healthcare system such as Ghana's may prove more cost-effective than a country with higher baseline need. Our aim was to pilot a system of integrating contraceptive counselling into routine care that could be adopted by a national healthcare system. Given lower

levels of baseline need, we do not believe a similar approach would be sufficiently impactful for other interventions.

We believe that this was a worthwhile approach, albeit one that did not work out in hindsight. However, the choice to work in Ghana means that MHI built stakeholder relationships and operating expertise in a country with relatively better healthcare outcomes across most indicators compared to other countries in sub-Saharan Africa. Though Ghana's economy has suffered more recently, it has been classified as a "Lower-middle income country" since 2010.

We take the counterfactuals of our work seriously. We think that other work MHI could have pivoted to in Ghana was unlikely to be as cost-effective as a new project or other similar organisations working in different countries with higher burdens of disease and mortality. As such, we think an MHI pivot in Ghana was unlikely to be the best use of our resources.

Why Not Pivot To Another Family Planning Intervention?
We believe that there are other approaches to increasing contraceptive uptake that are likely to be effective in producing positive outcomes. There are several other family planning interventions we believe may be highly promising: mass media for social behaviour change, the direct provision of contraceptive methods, reductions in facility-level contraceptive stockouts, and policy shifts in who can offer methods and how methods are procured.

However, there is a wealth of organisations - such as Clinton Health Access Initiative (CHAI), Jhpiego, and MSI - that are already delivering family planning work at scale in many of these areas that appears to be producing significant impact. Separately, there are also highly promising organisations - such as Lafiya Nigeria and Family Empowerment Media - refining and beginning to scale more novel approaches to improving contraceptive knowledge and access. This reduces the counterfactual of pivoting MHI to another family planning approach.

More significantly, there is a difficult question of personal enthusiasm and belief in an area of work. For one of us, family planning is no longer an intervention area that we want to work in due to some of the critiques raised in the 'Broader concerns with family planning' section. Elements of these critiques are an area of respectful disagreement between co-founders. However, given neither co-founder wanted to pursue an MHI pivot on their own, it significantly undermines any case for MHI to pivot into a different area of family planning work.

Proceeding to Shut Down

In deciding against a pivot, we committed to exploring how shutting down could maximise the value of MHI's resources. We believe that the value of MHI at this stage in its development lies predominantly in the knowledge and skills of the people involved. While older organisations hold significant credibility and relationships based on their brand, for a smaller organisation such as

ours these aspects are likely tied more to the co-founders than the organisation. As such, we elected to focus on making the best use of our knowledge and experience.

By shutting down and potentially starting something new, our skills can be used on the most useful activities rather than what makes the most sense within the scope of MHI. Similarly, by shutting down we can redirect MHI's funding to other organisations with more promising signs of success. Founding is also demanding work - time away is likely to make us both more effective at whatever project we contribute to next.

The Process Of Shutting Down

Shutting down MHI has been an extended process that is now mostly, but not fully, complete. It has been the explicit focus of our work for the last two months, and an option under consideration since we received our pilot results in December 2023. Much of the data, analysis, and thinking that underpins the decision stretches further back through MHI's work. This timeline of decision-making is summarised below:

Timeline of shutdown-related decision-making

Founded MHI with a focus on PPFP *September 2022* Began working on MHI out of the Charity Entrepreneurship Incubation Programme.	**Considered, then dismissed initial reservations** *Autumn 2022* After our first country visit in October 2022, we had some concerns around PPFP's ability to target the biggest barriers to family planning uptake, and the counterfactual value of MHI working in Ghana. We spent time in November 2022 conducting a shallow review of possible pivot options but chose to stick with PPFP. This was a belief that there was a strong possibility that PPFP was indeed highly promising, deferral to the experts who recommended PPFP, and the lack of a compelling alternative.	**Designed, refined, and completed pilot** *Spring-Winter 2023* We committed to delivering our own pilot project to better understand MHI's potential value. Thorough interviewing and surveying work throughout this process helped us build a much stronger understanding of contraceptive decision-making in Ghana.	**Investigated concerns based on pilot results** *Winter 2023-Spring 2024* Our headline pilot results were weaker than hoped, while some of the underlying data around client and provider behaviour suggested more fundamental issues. We paused the development of new programming to focus on a deeper analysis of our pilot data, more thorough research into existing literature around key concerns (breastfeeding; abstinence; adherence), and further expert/advisor engagement.
Decided against continuing with PPFP *December 2023* We concluded that PPFP is unlikely to be as cost-effective as other family planning or global health programming approaches.	**Investigated pivot options** *December 2023 - February 2024* We considered a range of pivot options that coalesced around two themes: pursuing a different family planning intervention outside of Ghana; and pursuing a non-FP intervention in Ghana. We concluded that a pivot is unlikely to be as valuable as other projects using MHI's resources.	**Evaluated personal considerations** *December 2023 - January 2024* Each co-founder dug into their enthusiasm for several key considerations including: continuing to work in family planning, the counterfactual value of direct delivery organisations, the value of differnet pivot options, and potentially running MHI solo.	**Committed to shutting MHI down** *February 2024* Separately, we each decided whether we think it better to continue working on MHI or shut it down. Ultimately, we chose to shut down in the belief that PPFP is unlikely to be as cost-effective as other programming options, that a pivot is likely to be a poor counterfactual use of resources, and that we may have a higher chance of founding a field-leading organisation in future than in effectively re-founding MHI through a hard pivot.

A table summarising the process building up to MHI's shutdown

Throughout, we have tried to engage with this decision in a detailed, transparent and rational manner. We've spoken to a few dozen founders, development professionals, and family planning researchers to challenge and extent our understanding of the best available approaches. We have red-teamed our work, our conclusions on postpartum family planning, and our decision to

shut down. We have mapped out a 'best possible vision' of what MHI could look like in various possible scenarios. We have fleshed out the potential counterfactual uses of our time and funding and considered possible mergers with other organisations.

Reflection

Contextualising Our Results

What If The Pilot Had Worked Better?
As outlined above, the decision to shut down was prompted by our pilot results but is driven by broader concerns around the value of postpartum family planning borne out of wider research.

It is difficult to say whether we would have chosen to shut down after our pilot if the study had produced a larger shift in contraceptive uptake. Most likely, we would not have dug as deeply into concerns around postpartum insusceptibility and the impact of contraceptive uptake in the post-birth period. These would have instead rested as background concerns about impact that many organisations have to some extent about their work.

Stronger implementation through a tighter focus on monitoring and incentivisation strategies would likely have increased the pilot's impact on contraceptive uptake. With time, adjustments to the counselling models and materials may have helped them better address the specific barriers to greater family planning engagement in Northern Ghana. We also likely could have cut costs significantly, thereby increasing the cost-effectiveness of the work. Remote training and a shift to exclusive phone surveying might have reduced our costs by as much as two-thirds, though likely with some reduction in program quality alongside this.

These changes suggest that MHI could have delivered a significantly more cost-effective program with further iterations allowing us to refine our model. However, we do not believe that these changes are likely to be sufficient given our more fundamental concerns with the value of uptake in the postpartum period. Furthermore, the time and resources we could spend improving this program could instead be directed to programs that we believe do not have the same level of inherent flaws in impact.

Why Did Our Results Differ Significantly From The Rcts?
Multiple randomised controlled trials have produced shifts in postpartum contraceptive uptake greater than 10% (Saeed et al. 2008; Tran et al. 2019; Tran et al. 2020; Dulli et al. 2016). Why did MHI's pilot fail to produce similar results?

First, MHI aimed to test and evaluate a model of postpartum family planning that would be feasible for the Ghana Health Service to adopt nationally and integrate into standard procedure. As such, our models were significantly lighter-touch than some of the RCTs showing a more significant effect. These studies tend to adopt several changes to postpartum care

simultaneously. These include switching the availability of family planning services to 7 days a week and instigating home visits for follow-up engagements on women's interest in family planning services. We anticipate that these changes substantially reduce the cost-effectiveness of the models tested in these RCTs and make them infeasible for scale-up given the general shortage of healthcare providers and provider time across healthcare facilities in Sub-Saharan Africa. We wanted to test if we could capture most of the impact from these heavy-touch models through a comparatively lighter and more inexpensive approach.

Second, as discussed earlier in this report, MHI's model intentionally diverged from the "LARC-first" approach adopted by the majority of postpartum family planning rCTs. We made this choice based on ethical misgivings with LARC-focused programs, particularly those focused on the immediate postpartum period, as well as concerns with the cost-effectiveness of such programs given the substantially higher training costs.

Finally, a review of some of the main RCTs suggests that they tended to have stronger health facility buy-in. Saeed et al. (2008) was designed in direct partnership with the hospital at which it was delivered, while Karra et al. (2018) and Dulli et al. (2016) appeared to have substantially more government involvement than MHI's work. Our approach focused on testing our intervention at a small scale to iterate and then have evidence of its effectiveness to present to the government before pursuing a larger study aimed at laying the platform for government integration. In hindsight, this approach may have been misguided. Co-designing the intervention with the government from the beginning may have increased ownership at the facility level and thereby significantly improved implementation quality.

Lessons

While we think MHI's programming was ultimately undermined by the reduced value of postpartum family planning compared to other interventions, there are more than enough mistakes that we made that may have improved the quality of our intervention. In the hope that other organisations may benefit from these lessons, we have explored some of them below.

Insufficient Clarity Of Focus

As founders and directors of MHI, we were ambitious in what we set out to achieve. We pushed hard to establish a country of operation early, commence fieldwork swiftly, and gain a comprehensive understanding of family planning research that we could use to inform our work. We chose to design a counselling model from scratch in the belief that existing models were failing to deliver the kind of client-centred care we hoped to achieve.

While this was admirable, with hindsight it is clear that we attempted to deliver far too many things simultaneously. In choosing to do a lot of different things, we undermined our ability to do the few, most important things exceptionally well. There was a mismatch between our desire for speed and our willingness to streamline things. Choosing to test one intervention arm rather

than two in our pilot would have allowed us to focus far greater resources on refining its design and implementation. Too much time spent on organisation-building (communications; internal process improvements; funder relationships) detracted from the time available for improving our programming: the core driver of whether or not MHI would be successful. In zigzagging between a drive for speed, and a drive for certainty or comprehensiveness in our knowledge, MHI's clarity of focus as an organisation suffered.

Developing a program offers a seemingly infinite number of avenues of work that appear worthwhile. Many things seem likely to make your program better. However, the choice to pursue an additional research question, monitoring strategy, or surveying metric is almost never a choice to do one more thing. It is a choice to do one more *category* of things, and will likely produce many more questions and areas of work needing to be completed in the process of solving a singular question or issue. In this way, each additional avenue of work that you pursue increases the burden of work exponentially.

The solution to this is a clear vision of your organisation's priorities and perhaps a willingness to cut and discard more areas of work than seems reasonable. If you are only choosing not to do things that feel superfluous, you are likely not streamlining your work nearly enough.

Consistent Underconfidence As An Organisation

It is easy - and to some extent entirely justified - to feel imposter syndrome when founding an organisation in a field in which neither co-founder has prior experience. While this makes sense, MHI likely suffered from a collective underconfidence.

In our approach to working in Ghana, we positioned ourselves as a small actor with much to learn. In our first meetings with key stakeholders, we had a lot of open questions, lacked a clear vision of what kind of program we wanted to implement, and were reluctant to push for demanding requests or requirements. We wanted to learn from those with more experience and be humble in acknowledging the limits of our knowledge as Westerners arriving in Ghana with limited prior knowledge of doing development work in practice.

These were respectable aims and should not be discarded entirely. However, they speak to an excess level of underconfidence that undermined MHI's work. We were slow to engage the government at the national level for fear of misstepping when we could have acted more confidently in the knowledge that our resources and efforts offered significant value. Asking for more from the government and from our partners may have felt a little unreasonable given our lack of experience, but would have made elements of our work significantly easier.

More broadly, it is easy to worry too much about external signals of what a successful organisation should do or look like. Are we getting to the point of running a pilot swiftly enough? Is this the stage at which we should begin hiring staff? How much research do other organisations do before committing to a country of operation? These are the wrong type of

questions to ask. What matters is how these decisions make sense in the context of your organisation and your program. When do you need pilot results to be able to raise further funding before your seed funding runs out? What benefits would a new staff member bring relative to the costs of hiring and management time? What are the key questions we need to answer to know which country is most promising to start work in and how do we answer these?

While we likely believed at the time that our decisions were based on questions specific to our organisation, with hindsight some of these key decisions seem overly swayed by considerations about what people would expect an organisation like ours to be doing in this circumstance.

A client survey delivered by a member of the Norsaac implementation team

Data Collection Challenges

On reflection, we likely spent too much time trying to measure the impact of our work, and did this too soon, relative to measurement that increased our understanding of the intervention. A greater focus on understanding and improving the mechanisms driving impact, particularly in our Proof of Concept work, would likely have produced important programming and monitoring insights much sooner. This would have allowed us to then better address these issues and reduce their impact on the pilot.

With that said, this was challenging given our broader issues with quality data collection. Throughout our work, we grappled with the difficulty of acquiring reliable data about confidential counselling through a public healthcare system. We had hoped to use facility-level data to assess how MHI's programming affected the long-term trends in contraceptive uptake. Sadly, the quality and consistency of the data we received were poor. Facilities had frequent gaps in their records and some records appeared to be duplicates, leaving little scope to trust the reliability of this data as a whole.

The quality of the surveying delivered through our partner organisations was significantly higher. However, we struggled to find mechanisms for collecting data free from potential bias. Providers were wary that their results would be used to assess their performance, and as such appeared to inflate the consistency with which they were implementing counselling. Both clients and our partner organisations appeared to show significant deference to healthcare workers. This further undermined our efforts to understand the consistency and quality of implementation.

In one case, our client and provider surveying data suggested MHI's materials were in use for counselling during a CWC session that we attended in person, yet our own observation highlighted that they were not. Our best, though imperfect, solution to this was to triangulate data from multiple sources in order to determine the reliability of each source. The CWC session above is a good example of this in practice, with in-person observation allowing us to assess the reliability of observation from our partners, client surveying data, and provider surveying data.

Willingness to Spend

In part due to our data collection issues, we spent a significant amount of time debating and investigating uncertainties around our program through desk research. Staff time is costly - particularly in comparison to the costs of delivering work in lower-income countries. However, staff time does not feel like an active expenditure, unlike fieldwork budgets. Overall, MHI likely underspent on active programming costs relative to the monthly costs of paying our international team.

This is a simple enough error to understand but also one that is easy to insufficiently act upon. Knowing your organisation's weekly or monthly burn rate - the amount it costs just to keep the lights on each month - can help reframe programming expenses and encourage spending on the most useful things. Additional monitoring work may seem prohibitively expensive at a cost of $5,000, but it pays for itself if it saves more than two weeks of work for an organisation with 2+ staff by resolving the causes of implementation issues.

Conclusions

Shutting down MHI was not the outcome we wished for when we founded the organisation in the summer of 2022. While our pilot likely failed to deliver the impact we had hoped, we believe with further iteration and improved implementation the impact on contraceptive uptake likely would have increased. Ultimately, this decision is based on concerns around the endline impact of our programming: changes in maternal and child health, and maternal autonomy. Rates of postpartum insusceptibility and method discontinuation, reduced impact on short-spaced pregnancies, incorrect estimates of unmet need, weak data connecting uptake to pregnancy rate shifts, and the importance of cultural barriers to uptake combine to suggest that postpartum family planning is unlikely to be as cost-effective as other family planning and global health interventions.

Upon drawing these conclusions, we considered pivots to other facility-based interventions in Ghana or other areas of family planning work in other countries. However, we believe that a pivot in these directions is unlikely to be the best use of MHI's resources relative to redirecting the talent and funding to other new or existing organisations. This left us with the decision to shut down MHI's operations.

It is essential that organisations are willing to hold themselves to high standards and shut down if they do not believe their work is effective. The value of new development charities - such as those set up by Charity Entrepreneurship (AIM) - is largely dependent on finding avenues for additional impact relative to existing organisations pursuing similar work. We set out with the aim of creating one of the most cost-effective charities in the world. In acknowledging our likely failure to reach this standard, we hope to encourage other organisations to engage deeply with the impact and counterfactuals of their own work with a willingness to shut down if this appears appropriate.

Thank you for taking the time to engage with this report on MHI's work and decision to shut down. There is a lot of information here, and we hope that different aspects will prove particularly useful to different actors. There are countless lessons to learn from projects that do not succeed, perhaps as many or more as the lessons available from large successes. If you would like to learn more about our work or discuss the conclusions we have drawn from it, please visit our website or reach out to us directly through the contact details at the end of this report.

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Sarah Eustis-Guthrie
Director of Research and Strategy
Maternal Health Initiative
Email: sarah@maternalhealthinitiative.org

Ben Williamson
Director of Partnerships and Field Operations
Maternal Health Initiative
Email: ben@maternalhealthinitiative.org