Learning Report of the Using Participatory Approaches for Health Systems Strengthening Project

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Learning Report of the Using Participatory Approaches for Health Systems Strengthening Project

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COURTNEY TOLMIE
WONDERLIGHT
# CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>EXECUTIVE SUMMARY</td>
<td>6</td>
</tr>
<tr>
<td>1. VISION AND INTERVENTION</td>
<td>7</td>
</tr>
<tr>
<td>1.1. The Problem</td>
<td>7</td>
</tr>
<tr>
<td>1.2. Global Integrity's theory of change to address system-wise challenges</td>
<td>7</td>
</tr>
<tr>
<td>1.3. Principles of participatory systems thinking</td>
<td>9</td>
</tr>
<tr>
<td>The value and experience of participatory framing in systems thinking</td>
<td>10</td>
</tr>
<tr>
<td>1.4. Developing the PSTA</td>
<td>11</td>
</tr>
<tr>
<td>The four core steps of our approach</td>
<td>11</td>
</tr>
<tr>
<td>Adapting the PSTA to projects with limited resources, time and capacity</td>
<td>13</td>
</tr>
<tr>
<td>Our partners</td>
<td>13</td>
</tr>
<tr>
<td>2. EVALUATION METHODOLOGY</td>
<td>15</td>
</tr>
<tr>
<td>2.1. Purpose</td>
<td>15</td>
</tr>
<tr>
<td>2.2. Evaluation goals and boundaries</td>
<td>15</td>
</tr>
<tr>
<td>2.3. Evaluation approach</td>
<td>15</td>
</tr>
<tr>
<td>2.4. Methodology</td>
<td>16</td>
</tr>
<tr>
<td>Data collection</td>
<td>16</td>
</tr>
<tr>
<td>Data analysis</td>
<td>18</td>
</tr>
<tr>
<td>2.4. Evaluation limitations</td>
<td>18</td>
</tr>
<tr>
<td>3. OUR EXPERIENCE IMPLEMENTING THE PSTA</td>
<td>20</td>
</tr>
<tr>
<td>3.1. Co-developing of the PSTA with health system expert and CSO project partners (Step 1)</td>
<td>20</td>
</tr>
<tr>
<td>3.2. Mapping the problem and planning actions (Steps 2 and 3)</td>
<td>21</td>
</tr>
<tr>
<td>3.3. Actions to address the problem (Step 4)</td>
<td>21</td>
</tr>
<tr>
<td>3.4. Action learning cycle iteration (revisiting steps 2, 3, and 4)</td>
<td>22</td>
</tr>
<tr>
<td>4. RESULTS AND LEARNINGS</td>
<td>23</td>
</tr>
<tr>
<td>4.1. PSTA Outcomes: To what extent are actors more able to operate in more adaptive-learning centered ways changing, and what other expected and unexpected outcomes are appearing? (KLQ 1)</td>
<td>23</td>
</tr>
<tr>
<td>Outcomes observed within partners and within project activities</td>
<td>23</td>
</tr>
<tr>
<td>Outcomes observed beyond partners and project activities (ripple effects)</td>
<td>27</td>
</tr>
<tr>
<td>4.2 PSTA Factors: What are the enabling factors and barriers associated with the implementation of the PSTA? (KLQ 2)</td>
<td>30</td>
</tr>
</tbody>
</table>
Enabling factors ................................................................. 30
   People-related enabling factors in the workshops ................ 30
   Process-related enabling factors in the workshops .............. 31
   Process-related enabling factors outside of the workshops .... 33
Barriers .............................................................. 33
   People-related barriers in the workshop .......................... 33
   People-related barriers outside of the workshops ............... 35
   Process-related barriers in the workshops ....................... 35
   Process-related barriers outside of the workshops ............. 36
4.3. PSTA Components: What project components played a meaningful role in supporting PSTA outcomes? (KLQ 3) ...................................................... 37
   Co-creating and co-designing the PSTA workshops ............. 37
   Debrief sessions ......................................................... 37
   Multistakeholder convening ........................................... 38
   Mapping root causes and stakeholders .............................. 39
   Action learning cycle .................................................. 40
   Participatory and interactive facilitation methods ............. 41

5. OUR PROPOSED WAY FORWARD ....................................... 41
   5.1. Recommendations for those seeking to undertake this work ... 41
   5.2. Remaining questions we have .................................. 45
Problems within the health systems that lead to poor outcomes are complex, multifaceted, and differ across contexts, countries, and even communities. Systems thinking approaches have great potential to address these deeply embedded challenges and the technical, political, economic, and social causes that underlie them. However, systems thinking has traditionally been designed and tested with academic partners and with significant resources, without adaptation to engage with civil society and grassroots organizations.

In this report, we share findings from a developmental evaluation that analyzed a participatory systems thinking approach that differs from traditional approaches in three core ways: (1) it is led by domestic civil society organization partners rather than academics or international partners, (2) it is time-constrained to under twelve months, and (3) it does not include outside resources for partners to undertake actions designed as part of the systems thinking process.

Working with partners in Malawi and Kenya, we found that a systems thinking approach can be adapted to be more participatory and to achieve several critical outcomes, including increasing stakeholder understanding of root causes, supporting more diverse and stronger alliances among stakeholders, increasing collaboration on collective action, and increasing adaptation of actions. While the project and evaluation timeline does not allow us to observe changes in the health system, the evaluation did provide evidence that the within-partner changes related to systems thinking and multi-stakeholder collaboration have continued to expand beyond partners to their constituents and stakeholders, including youth and government leaders.

The evaluation also provides important evidence regarding the factors that helped and hindered the effectiveness of the participatory systems thinking approach, including characteristics of people and partners involved in the work and elements of the approach both within learning workshops and outside of the workshop settings.

Finally, the report highlights actionable recommendations derived from the experience of piloting the participatory systems thinking approach and open questions. These recommendations and questions can serve as guidance for those seeking to support or undertake similar initiatives in the future and reveal adaptations to the model that we believe are worth testing in subsequent iterations of the model.
1. VISION AND INTERVENTION

1.1. The problem

In many countries around the world, people are not able to access quality health services, which contributes to poor health outcomes. This system breakdown has dire implications for individuals, families, communities, and the ability of countries to meet their commitments to ensure healthy lives and promote well-being. These problems persist for a variety of reasons, including environmental and contextual factors, gaps in technical capacities, financial resources, and decisions and actions taken by policymakers, service providers and communities.

While the specific challenges vary by country and even community, health outcomes and the patterns of service delivery that contribute to those outcomes are shaped by the interplay between multiple actors in complex systems. These actors include patients, medical staff, hospital administrators, pharmaceutical companies, politicians, regulatory authorities, finance ministries, development partners, and civil society watchdogs. Because root causes of health system breakdowns emerge through the inter-relationships amongst these actors and other social, economic, and political factors, they demand solutions that are more complex and take into account system relationships.

The degree to which these actors are able to work together to address common challenges plays a major role in contributing to the quality of and access to health service delivery and ultimately health outcomes. Effective solutions to complex challenges are likely to emerge through locally-led cycles of action and learning that enable collaboration and action to shift the dynamics of systems (and their underlying political economy aspects).

1.2. Global Integrity’s theory of change to address system-wide challenges

The Health Systems Strengthening project, funded by the Bill and Melinda Gates Foundation, was designed to address diverse and widespread health system challenges by supporting organizations to address the interrelated technical and political economy problems that limit the performance of those systems and their ability to deliver health services effectively.

Global Integrity’s approach to supporting change is based on our understanding of the dynamics of such systems:

- The dynamics of such systems are shaped by a variety of factors which range from the more technical (rules, regulations and the availability of resources) to those that relate more closely to the political economy aspects of the system (power, capabilities, incentives and relationships).
While common principles may apply across different systems and contexts, effective approaches to addressing complex, systemic and context-dependent challenges that stand in the way of better health outcomes in particular places emerge through cycles of action and learning that are led by actors within the system.

This project supported the efforts of our partner organizations to address health service delivery challenges by designing and testing a participatory system thinking approach (PSTA) that leverages the dynamics described above. Our approach involves providing tailored support and facilitation for participatory systems thinking and associated cycles of collaborative action and learning. This builds on a growing consensus about the contribution that problem-driven cycles of action and learning can make to addressing complex and systemic challenges that have both political economy and technical aspects (including issues related to accountability), and to improve the governance and functioning of such systems.

Our theory of change is that, by participating in this process, health systems actors will enhance their capacity to improve the dynamics of those systems, by operating in more collaborative, learning-centered, and adaptive ways (Figure 1). For instance, they will develop their abilities to understand the systemic nature of the challenges they face; strengthen their relationships with other actors in the system; enhance the flow of information and feedback in the system; collaborate more effectively; and, co-design, implement and test ways of strengthening the system of which they are part.

**FIGURE 1: Project theory of change**

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>PARTNERS</th>
<th>SYSTEM</th>
<th>PEOPLE’S LIVES</th>
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<tr>
<td>Health system actors participate in a collaborative, learning-centered systems thinking practice</td>
<td>Health system actors operate in more collaborative, learning-centered and adaptive ways</td>
<td>Health system dynamics are improved, fostering more innovative and adaptive solutions</td>
<td>Health services are delivered more effectively, in ways that meet people’s needs</td>
</tr>
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By operating in more collaborative, learning-centered, and adaptive ways, we hypothesize that health system actors will, in turn, strengthen the capacity of those systems and their constituent actors to innovate, learn and adapt their way toward addressing the challenges that stand in the way of the effective delivery of essential health services. We hypothesize that this, in turn, will contribute to health services being delivered more effectively, in ways that better meet people’s needs.
1.3 Principles of Participatory System Thinking

The participatory systems thinking Approach has its foundation in traditional systems thinking. Systems thinking is a by-product of many different disciplines, and the term therefore does not have a single widely accepted definition. There are common concurrent themes and fundamental principles that coalesce around a way of viewing, understanding and making sense of the complexity that exists within the world. Systems thinking is an approach that can be applied to complex problems which are multifaceted consisting of both visible and hidden facets, constantly evolving, unpredictable, without a single and obvious cause and solution involve many people, and take time to resolve.

<table>
<thead>
<tr>
<th>SYSTEMS THINKING PRINCIPLES</th>
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<tr>
<td>1 Seeing and understanding the bigger context surrounding the problem</td>
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<tr>
<td>2 Viewing the problem from multiple perspectives</td>
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<tr>
<td>3 Understanding the problem to have multiple causes and multiple effects</td>
</tr>
<tr>
<td>4 Thinking critically about the problems’ root causes and how they are interconnected</td>
</tr>
<tr>
<td>5 Identifying multiple leverage points and pathways to change</td>
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<tr>
<td>6 Considering short-term and long-term consequences of any action or intervention including their unintended consequences</td>
</tr>
<tr>
<td>7 Innovating and adapting interventions in response to changes, feedback and experience</td>
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</table>

Systems thinking as an approach is more than just tools and methods: it is a way of thinking, being, and doing. Systems thinking is useful for making us aware/sensitizing us to unobservable and yet powerful structural and contextual factors that influence our reality as well as the structural factors that underpin and drive complex problems such as power imbalances, patterns of behavior, mental models and perceptions.1

Systems thinking is an approach that helps stakeholders to uncover structural factors underpinning a problem, to arrive at workable solutions by empowering them with knowledge to better understand the problem and the structures that are holding those problems in place, and to identify multiple causes for a problem as well as multiple possible interventions or solutions.

Systems thinking in health policy, research and practice is seen as better equipping stakeholders to address health challenges that are complex by nature.2 It is considered a very useful and empowering approach because it helps health system actors to frame and solve a problem in new and different ways. This is because the health sector is made up of a diverse number of actors, institutions, policies, relationships, and other interacting elements at multiple bureaucratic levels. The sector also has a large number

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of diverse outcomes. The connections and interdependence of various health systems components impact and affect public service outcomes in many different ways. Health system components are dynamic, constantly changing. This means the interactions and relationships between system components often influence and impact each other in unexpected ways with outcomes which are hard to predict (Mansoor and Williams, 2018).

The value and experience of participatory framing in systems thinking
Systems thinking is also a valuable lens to use to address public sector challenges because it facilitates and incorporates multiple perspectives through inclusive participation of a diverse range of actors operating in the system in the design, evaluation and implementation of policies. As such, key participatory methods can be integrated with systems approaches as they are often suitable and complementary. A combination of participatory methods and systems thinking methods creates a flexible and intuitive approach that can be adaptable to different health system contexts and stakeholder groups.

Systems thinking requires the participation of multiple stakeholders as a key principle. As such it:

- Builds stakeholder capacity to articulate and listen to different viewpoints and critically analyze challenges and solutions, including how to reach consensus and action plan collectively.
- Develops teamwork and solidarity among participants.
- Empowers diverse stakeholders to provide input (including in the design of interventions) that affects their lives, thereby reinforcing participants’ sense of understanding and ownership to sustain interventions.
- Understands that interventions are more likely to succeed because they are culturally appropriate and practical to direct experience/realities.

Although many recognize the advantages and value of applying participatory systems thinking approaches, they have not been widely applied among local health system actors in low- and middle-income countries. Studies have identified a myriad of challenges that have limited participatory systems thinking uptake (which include but is not limited to):

- The length of time, effort and resources required to engage in mapping the dynamics and root causes underlying problems which includes recurring, iterative work and analysis to generate insights.
- The many insights generated by the approach can be overwhelming - preventing local actors from taking first steps to conceptualize action, implement, test & adapt, particularly without proper guidance.
- It can appear as being too ‘abstract’, making it hard for actors to relate to the conceptual discussions regarding hidden structural dynamics, preferring instead to use approaches that help local actors to identify and grapple with concrete and discrete problems experienced on a daily basis.

3 Mansoor, Z and Williams, J. 2018. Systems Approaches to Public Service Delivery: Lessons from Health, Education, and Infrastructure (Background paper)
1.4. Developing the PSTA

This project – and the design of the PSTA – seeks to leverage the promise of systems thinking for local health challenges while overcoming the barriers presented above to make this approach truly participatory. Our goal was to support local change agents to more effectively address health service delivery challenges. We sought to achieve this goal by co-designing, piloting, and testing a participatory systems thinking approach aimed at strengthening change agents’ capacity to design and implement complex interventions that recognize and take into account that service delivery challenges are a product of the technical, social and political realities of the sectoral systems and the broader governance context in which they are embedded.

The four core steps of our approach

Our approach to participatory systems thinking involves four core steps, undertaken in a series of learning and adaptation cycles. Putting this approach into practice will involve working through the following four core steps which includes cycles of action and learning: (1) Preparation, (2) Mapping the problem, (3) Planning how to address the problem, and (4) Acting to address the problem. With the exception of the first step, these components are undertaken in an ongoing action learning cycle. (see Figure 1 below)

FIGURE 2. The 4 steps of the PSTA

- **STEP 1 SET-UP/PREP**
  Defining the overarching health system problem in the context in which it exists, including identifying stakeholders who should play a role in mapping, planning, and acting on ways to address the problem.

- **STEP 2/MAPPING THE PROBLEM**
  Collaboratively working to identify the underlying causes of the health system problem, the technical and political economy factors that contribute to it, and the roles and characteristics of stakeholders that influence how the system functions.

- **STEP 3/PLANNING**
  Designing actions to address the problems and stakeholder behavior changes identified in the Mapping step.

- **STEP 4/ACTIONS TO ADDRESS THE PROBLEM**
  Implementing the complex actions designed and prioritized to improve health system functions.
STEP 1 includes a set of preparation and set-up activities to review and adapt the design of the overall approach to the problem and the context in which it will be implemented. During this step, Global Integrity identified CSO partners and worked with selected partners and health systems thinking experts to (1) develop a problem statement, (2) adapt and finalize the detailed plan for the subsequent steps and learning cycles, and (3) develop lists of stakeholders that should be involved in the process based on the context and health system issue. This first step in the approach incorporated and established a participatory and multi-stakeholder component by securing a level of buy-in and commitment from a diverse range of local key system actors at an earlier stage. In addition, the process of developing a problem statement with local partners ensured that those who participated in implementing the entire approach had an initial agreement as to the problem they would address and also shared a common interest in resolving the problem.

During STEPS 2 AND 3, Global Integrity and health systems thinking experts supported partners through the process of mapping the problem (including validating a problem statement, defining and bounding the problem, and identifying and understanding relevant actors and their roles and positions with regard to the problem) followed by discussions to plan actions to address the problem (including determining entry points, ideating and prioritizing specific actions/interventions). The participatory aspect of these steps involved facilitating system actors and change agents to broaden their understanding of the problem by getting actors to share with each other as well as listen to how other actors perceive the problem and its causes. This was an important process in the step of defining the problem because it reveals multiple reasons for a problem as well as multiple possible interventions/solutions.

These steps also supported stakeholders to understand the problem through facilitating the analysis of the systemic root causes of the health delivery challenges from the perspective of other actors, providing opportunities to explore hard and soft elements of the problem (including technical, contextual and political economy factors underlying health service delivery challenges). Furthermore, the mapping and planning steps of the PSTA were designed to support stronger inclusive engagement between different stakeholders by facilitating dialogue between diverse system actors. Ultimately, the mapping and planning discussions sought to empower health system stakeholders to use their deeper understanding of the system structure and the multiple perspectives of system actors to identify different root causes, entry points, and solutions to the problems they sought to address.

Step 4 of the PSTA entailed the project’s CSO partners and other local health system stakeholders working to implement the actions that they designed and prioritized in previous steps with the objective of improving how the health system functions. The culmination of Step 4 was a reflection and learning discussion between stakeholders and project partners to reflect on the data collected and the experiences of partners regarding problem identification, action planning, and implementation during the previous cycle. Based on these discussions, project partners and health system stakeholders revisited Steps 2 and 3 to adapt their understanding of the problems and potential actions, resulting in a revised action plan to be implemented in the subsequent learning and implementation cycle and follow-up evidence generation and learning/adaptation discussions.
Ongoing learning and adaptation (Action Learning cycle) provided the thread that runs through the cycles of mapping, planning and acting, supporting the efforts of participating actors to progressively hone in on the problems they are tackling and sharpen the approaches they are taking to address those problems. The learning component of the cycle was designed to help the process of adaptation, preparing CSO partners and their local health system stakeholders to face the system complexities that were not initially identified in steps 2 and 3 including decision-maker incentives, unexpected root causes, and unintended consequences of actions.

Adapting the PSTA for projects with limited resources

Many efforts to test traditional systems thinking approaches have required resources and longer timelines for partners, not taking into account the limitations of many civil society organizations. As a result, local organizations have not been able to integrate systems thinking into their works. We designed the PSTA to reflect both systems thinking and participatory principles and also to take into account some of the resource, capacity, and time limitations of practically applying systems thinking approaches to health in local contexts.

First, we selected project partners that met the following criteria:

- Had the time, capacity and interest to jointly map problems as well as co-design and test possible solutions over a six month period (rather than a longer duration often used in systems thinking approaches);
- Intended to apply the PSTA to an existing funded health systems program, project or initiative that would be a good fit for the approach (rather than providing new funding for a new program);
- Was currently involved in, or supporting, efforts to ensure the efficient and equitable delivery of health services, with other local health system stakeholders; and,
- Had some level of knowledge and/or strong interest in learning about and integrating systems thinking into their work.

The action learning component of the PSTA was adapted to provide light-touch virtual peer learning meetings and check-in meetings to assess how actions were progressing to inform rapid iterations as well as to design the agenda for an in-person reflection, learning and adaptation workshop. Due to the limited availability of GI and CSO resources, the action learning cycle was adapted to limit the cycle of testing and adapting to a single round.

Our partners

The Center for the Study of Adolescence (CSA). Based in Kenya, CSA is a leading national organization committed to the promotion of the health and development of young people through research, technical assistance, advocacy, and capacity building to expand choices and improve access to safe, affordable and sustainable health services. CSA selected the Right Here, Right Now (RHRN) II project, for which they serve as the lead partner, as the focus for testing the participatory systems thinking project. CSA’s RHRN project aims to allow young people (including vulnerable groups, LGBTI+ and youth
community) to improve their access to comprehensive sex education and youth-friendly sexual reproductive health rights.

**Ipas-Malawi.** Ipas is an international NGO that supports government and civil society to make Malawi’s health and human rights commitments a reality for women and girls. Since 2005, Ipas Malawi has engaged with government officials, religious leaders, and community actors to highlight the dangers of unsafe abortion and build support for abortion law reform. Ipas Malawi works with partners to build sustainable abortion ecosystems. Ipas Malawi selected to test the PSTA approach on their comprehensive ecosystems approach which they apply across institutions and communities and recognizes there are multiple factors that influence a person’s ability to access abortion—including individual knowledge and power, community and political support, trained and equipped health systems, and laws and policies that uphold the human rights to health and to bodily autonomy. Ipas is testing the PSTA in Malawi to improve treatment for abortion-related complications at public health facilities and to build an advocacy movement that includes broad-based support for improved access to safe abortion care.

**The African Health Innovation Center (AHIC).** AHIC is an organization based in Ghana focused on strengthening Africa’s burgeoning health innovation ecosystem and has strong facilitation experience and skills with a diverse range of health system stakeholders in a range of African country contexts. AHIC spun off from Impact Hub Accra in 2019 and is the first organization in Ghana dedicated to improving health outcomes through innovation and entrepreneurship. AHIC works throughout West, East, and Southern Africa.
2. EVALUATION METHODOLOGY

2.1 Purpose

The purpose of the evaluation of the PSTA was to generate actionable insights about: (1) key elements of the implementation of the approach that worked, (2) expected and unexpected outcomes that this intervention generated, and (3) contextual factors that acted as enablers and barriers. Ultimately, we sought to triangulate what we learned during our research and what we have learned during the testing exercise to inform improvements of the PSTA model and future adaptations to new contexts and new people that could be shared with the broader field.

2.2 Evaluation goals and boundaries

To identify our key learning questions, the team reflected critically on our project’s theory of change which served as a strategic learning tool for developing solutions to complex social problems.

This led to the identification of three key learning questions (KLQ):

- **KLQ#1**: To what extent is actors’ capacity to operate in more adaptive-learning centered ways changing, and what other expected and unexpected outcomes are appearing?
- **KLQ#2**: What are the enabling factors and barriers associated with the implementation of the PSTA?
- **KLQ #3**: What program components are playing a more meaningful role in achieving the expected outcomes?

We did not evaluate the work or effectiveness of the individual actions implemented by our partners. Rather, our efforts focused on the PSTA model implementation, and adoption of learning and adaptive centered skills by our partners. We did not expect to see significant changes in the long-term outcomes of improving the health service delivery services in Kenya and Malawi during this project implementation period. Rather, we sought to explore our core assumptions on how this model could contribute to more effective systems dynamics.

2.3 Evaluation approach

Given the innovative and developmental nature of our questions, we undertook a Developmental Evaluation (DE) approach. DE is a well-established approach that supports social innovation (in our case, developing and testing a new model) by providing real-time actionable data to inform ongoing decision-making and adaptations. The core of this approach is to:
1. Embrace what is emerging in the complex context where the evaluation is taking place.
2. Prioritize adaptation and flexibility over fidelity-focused methodologies.
3. Generate real-time data that enable rapid responsiveness.

DE provided us the opportunity to generate data and learnings throughout the project, facilitate sensemaking, and offered actionable insights about (1) existing and emergent dynamics to inform how we might shift the PSTA and learning cycles to better meet our partner’s needs and contexts and (2) our ToC and our hypothesis of how the change occurs.

2.4 Methodology

To guide the process the GI team developed an evaluation and learning framework in September 2021. As part of this framework, the GI team designed, implemented, and analyzed the following qualitative and quantitative data collection efforts.

Data collection

**Ongoing systematization of PSTA adaptations:** During a project, actors are usually so busy engaging in the day-to-day implementation, they are less able to systematically capture the reasons why they decided to choose one path over another. To avoid this risk and effectively capture the adaptations made in our PSTA, the GI team developed a change log tool to document changes, the decision-made process, and the implications of these changes. This tool allowed us to establish a comparative analysis of how the approach evolved. All this information was summarized later in a “development book” that answers the learning questions and captures the dynamics and contextual factors that make the situation complex and unique, reflects the decisions made in the face of that complexity, and highlights the implications, reflections, and lessons learned.

**In-the-moment evaluation methods:** To strengthen our capacity to obtain rich feedback, a set of data collection efforts was designed and implemented with the intention to engage with PSTA participants in the moment. The following methodologies were implemented during the in-person PSTA workshops.

- **Mini Interviews:** A total of 38 interviews were conducted with workshop participants across the two case studies (19 each in Kenya and Malawi). These short interviews allowed us to dig deeper with individual stakeholders to understand their lived experiences participating in the workshops, their main takeaways, and the “why” and “how” of these takeaways.

- **Observational tool:** Observation provided the opportunity to monitor the process and document evidence of what was seen and heard. Seeing actions and behaviors within a natural context provides insights and understanding of the event, activity, or situation being evaluated. The observations during the first set of workshops in each case study were systematized into a tool that we used to record specific occurrences such as comments on outcomes and factors. This approach was adapted during the second round of workshops to integrate observations directly in the debriefing activity.

- **Quick feedback surveys:** A total of 209 survey responses from workshop participants were collected across the two case studies (109 in Kenya and 100
in Malawi). These surveys allowed us to get real-time quantitative information to better understand participants’ perceptions about the workshop, collect suggestions to improve it, gauge main takeaways, and assess the extent to which the goals for that day have been achieved.

Debriefing sessions. A total of 14 debriefing sessions were implemented across the two case studies (seven each in Kenya and Malawi). Each session was done at the end of each workshop day. During these sessions, the GI team met with the partners - CSA, Ipas, and AHIC - to reflect on what went well during the session, what was emerging, what adaptations were being made, and what implications these could have for future workshops and the overall model.

End of the project evaluation activities. During the final in-person workshop conducted in Ghana, the GI team facilitated a set of evaluation activities focused on strengthening the quality of our data by triangulating it with project partners. Activities included:

- **Action evolution wall:** a participatory activity focused on identifying what adaptations partners made to their actions over the course of the PSTA project and what motivated these adaptations, including the PSTA and other factors.

- **Most Significant Change mapping:** an activity inspired by the Most Significant Change (MSC) method, which is a participatory method that involves generating and analyzing personal accounts of change and deciding which of these accounts is the most significant. This activity allowed us to identify the most significant change(s) (positive and negative) that partners believe the project contributed to, how the project helped/hindered that change, and the factors outside of the project that contributed to the change.

Peer learning exchange. At the end of the implementation of each learning cycle, the GI team facilitated a group conversation between our partners - CSA and Ipas - to exchange experiences, recommendations, and expectations. A total of two facilitated opportunities were implemented, and they allowed CSA and Ipas to identify similarities and differences in their lived experiences participating in the project, further highlighting contextual factors and developing new relationships between them.

Post-learning cycle team reflection checkpoints. After the implementation of each learning cycle, and after triangulating all the data available until that point, the GI team facilitated learning discussions and reflection exercises to identify the next steps based on what elements worked well, what did not, the contextual factors associated with these elements, and how this information should inform our TOC. These discussions were an opportunity to combine evaluation data with intuitive and experiential learning. As such, the discussions were informed by the input collected during the workshops through the in-the-moment methodologies, the post-workshop reports generated by AHIC, other outputs generated such as the systems maps and action plans, and the lived experiences of each actor as implementers.

The following table (Table 2) summarizes how the mix-methods approach allowed us to answer each KLQ and provides a snapshot of the different data sources that have been triangulated to answer each question.
TABLE 2: Data triangulation

<table>
<thead>
<tr>
<th>KLQ#1: To what extent is actors’ capacity to operate in more adaptive-learning centered ways changing? What other expected and unexpected outcomes are appearing?</th>
<th>ONGOING SYSTEMATIZATION OF PSTA ADAPTATIONS</th>
<th>IN-THE-MOMENT EVALUATION METHODS</th>
<th>DEBRIEFING SESSIONS</th>
<th>END OF THE PROJECT EVALUATION ACTIVITIES</th>
<th>PEER LEARNING EXCHANGE</th>
<th>POST-LEARNING CYCLE TEAM REFLECTION CHECKPOINTS</th>
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<tr>
<th>KLQ#2: What are the enabling factors and barriers associated with the implementation of the PSTA?</th>
<th>ONGOING SYSTEMATIZATION OF PSTA ADAPTATIONS</th>
<th>IN-THE-MOMENT EVALUATION METHODS</th>
<th>DEBRIEFING SESSIONS</th>
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<th>KLQ#3: What program components are playing a more meaningful role in achieving the expected outcomes?</th>
<th>ONGOING SYSTEMATIZATION OF PSTA ADAPTATIONS</th>
<th>IN-THE-MOMENT EVALUATION METHODS</th>
<th>DEBRIEFING SESSIONS</th>
<th>END OF THE PROJECT EVALUATION ACTIVITIES</th>
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Data analysis

To triangulate the evidence collected and assess the quality of the data, the GI team developed and implemented a data triangulation tool and met regularly to ensure that learning and synthesis were happening across all the data sources. During these triangulation meetings, the team looked for similarities, differences and trends across data sources, identifying areas with strong evidence or gaps in the data. This synthesis across sources strengthened the quality of data collected, deepened the learning cultivated during the evaluation, and informed the next evaluation and learning efforts.

2.4 Evaluation limitations

The evaluation’s limitations are primarily related to the facts that:

- Most of the data obtained came from self-reporting on changes in perceptions and intentions of behavioral change or the adoption of new approaches or activities. Attempts were made to triangulate even self-reported data.
- Throughout the project, there was some rotation in key actors in our partner organizations (Ipas and CSA) which diminished our capacity to track trends and patterns in the data.
- Confirmation bias is hard to mitigate. The team implemented some measures to address this risk such as asking participants to identify examples and using those as the starting point to explore their views on how and why the PSTA and
associated learning cycle might have led to changes or asking indirectly about main takeaways, likes, or dislikes instead of asking closed-ended questions.

- Two out of our three evaluation team members were not from the African region where the project was implemented. This involved some language, culture, and power dynamics considerations that were very present during our work. To help us mitigate some risks the team relied heavily on partners AHIC, Ipas, and CSA to help us interpret the data and contextualize the findings.

4 The respondent agreeing with the evaluator's theory or giving encouraging responses to evaluators for the sake of politeness or ensuring their favor. In these cases, it may be difficult to get not biased evidence
3. OUR EXPERIENCE IMPLEMENTING THE PSTA

In this section, we provide additional detail on the actual implementation of the PSTA, including relevant information on adaptations and learnings that provide helpful context for interpreting evaluation findings (Section 4).

3.1. Co-developing of the PSTA with health system expert and CSO project partners (Step 1)

A competitive Expression of Interest (EoI) process was used to identify CSO partners. Using EoI submissions and partnership selection criteria, a total of 15 organizations submitted EoIs, and a subset were shortlisted. Interviews were conducted with shortlisted candidates, and, in August 2021, Global Integrity chose to test, adapt and learn from the implementation of the PSTA with the Center for the Study of Adolescence and Ipas Malawi.

While the model did not require that partners work on the same health system problem, CSA and Ipas identified complementary problems to work on within their respective countries and work programs:

- **Ipas Malawi’s problem statement**: Many women in Malawi want/need access to safe abortion services and post-abortion care, and currently the resources and policies along with the enabling environment do not allow women to have access to safe abortion services and postabortion care.

- **CSA Kenya’s problem statement**: In Nairobi County, adolescents and young people (especially young women, sexual and gender minorities, and people living with disabilities) have limited and/or insufficient access to quality sexual and reproductive health commodities, services, and information including comprehensive sexuality education that they need in order to live healthy lives.

In addition to identifying complementary problem statements, both partners have critical pre-existing relationships with diverse actors in the system and have significant experience and knowledge working with the country’s health systems.

Following the selection of the project CSO partners, Global Integrity identified a health system expert that would provide GI and the project partners with technical hands-on support to tailor and implement the PSTA. GI elected to partner with The African Health Innovation Center (AHIC). AHIC’s role in the PSTA was to work with GI to design the mapping and planning workshops with CSO partners and to facilitate these workshops. GI provided support between workshops, co-designed workshop sessions to align with the goals and principles of the PSTA model, and led the evaluation and learning component of the project. CSA and Ipas were the lead CSOs in the target countries participating in the mapping and planning workshops, identifying stakeholders to include in the workshop, and facilitating the testing of actions developed or adapted during the workshops.

For several weeks after the selection of partners between August and October 2021, GI and AHIC facilitated the PSTA co-designing and adaptation process by meeting in...
advance with a core team from Ipas & Malawi on a weekly basis prior to the actual implementation of the PSTA workshops, with the goals of:

- Gathering background information on the health system context, key actors, and activities designed to address the health system challenge;
- Setting the PSTA workshop goals and problem statement to ensure expectations are clear and agreed upon;
- Jointly identifying suitable workshop participants who could help to map the problem and generate solutions which could be tested; and,
- Drafting the PSTA workshop agenda and getting feedback on the workshop materials and activities suitable for the issue, context, and workshop participants.

3.2. Mapping the Problem and Planning Actions (Steps 2 and 3)

The first PSTA workshop for Kenya was conducted in Nairobi over a three day period (24 -26 September 2021) with the local partner CSA and a total of 24 local health system actors (including civil society and community-based organizations, policymakers and administrators, healthcare workers, representatives of young people and gender and sexual minorities, and parents). For Malawi, the first PSTA workshop was conducted in Blantyre over a three day period (2-4 November 2021) with the local partner Ipas Malawi and a total of 20 diverse local health system actors (including civil society and community-based organizations, policymakers and administrators, healthcare workers, representatives of young people, and religious leaders).

The workshop objectives were to ensure that workshop participants:

- Shared information to connect elements of the system and multiple technical and contextual factors to the problem to reveal root causes of the health system problem;
- Created a shared understanding about the problem and causal factors;
- Viewed the problem from the perspective of other actors; and
- Framed problems in ways that encourage and make room for new and deeper collaboration to address the target problem.

In order to achieve the workshop objectives, each day of the workshop focused on a specific set of activities. The first workshop day was focused on identifying, understanding, and deep diving on the dynamics of the problem. The second day focused on identifying, understanding, and deep diving on key actors and the roles various stakeholders play in supporting or preventing addressing the dynamics of the problem. On the final day, workshop participants ideated potential solutions to the problem statement. Detailed reports of the PSTA workshops in Malawi and Kenya are available here and here.

3.3. Actions to address the problem (Step 4)

Upon completion of the mapping and planning workshops, project partners and other local health system stakeholders designed actions to address root causes and improve health system dynamics. In practice, this step progressed differently in Kenya and Malawi.
In Kenya, CSA undertook action ideation as part of the third day of the workshop; however, they expressed that they were not in a position to make decisions regarding action adaptation for a project in which they were not the only partner. They needed to take the time to independently review and discuss the workshop data and recommendations with all the consortium partners at a separate learning and reflection meeting.

In Malawi, AHIC adapted the solution ideation component of the workshop design based on learnings from the Kenya workshop. Ipas received guidance from AHIC on the final day of the workshop to filter and select from a long list of possible solutions/actions they wanted to test during the action learning cycle and were facilitated through a process of targeting actions that were feasible as part of their work.

Because the project did not provide CSO partners with a budget for testing and iterating new actions designed at the first PSTA workshop, the actions taken forward from the workshop by CSO partners were not brand new actions. There were largely adaptations to actions that were currently being implemented, with small but significant differences informed by the mapping and planning exercises undertaken during the workshop. Some of these actions were being jointly tested with other workshop stakeholders. A list of actions tested by Ipas and CSA between the two rounds of PSTA workshops in 2021 and early 2022 is available in these workshop reports here and here.

Between workshops, both CSA and Ipas engaged in biweekly check-in meetings to provide reports and updates on the progress of the actions they were testing. However, with the exception of monthly check-in calls, no additional support was provided to partners between workshops.

### 3.4. Action Learning Cycle Iteration (revisiting Steps 2, 3, and 4)

Six months after the first PSTA workshops, partners and select local health system stakeholders reconvened for a second PSTA learning and reflection workshop. The second PSTA workshop was designed to achieve three objectives. First, participants reflected on actions they were testing, identifying obstacles hindering actions as well as the contextual issues affecting them. Second, participants revisited and updated system maps to reflect new insights gained from the testing of their actions. Finally, workshop participants further adapted their actions for the next cycle of testing. While many workshop participants remained consistent across the two workshops, partners did identify some participants to add and remove from the workshop invitation list. Detailed reports of the PSTA workshops in Malawi and Kenya, including the agendas of the workshops, are available here and here.

A final workshop was held in Ghana in June 2022 in which CSO partners, AHIC, and GI came together to reflect on the PSTA model, learnings, challenges, and adaptations. While this workshop was originally designed to be a third iteration of the action learning cycle in the target countries (following a similar approach to the second workshops), all partners decided that it would be valuable to have the final workshop instead focus on peer learning, sharing experiences and evidence, and discussing “what next” for the PSTA.
4. RESULTS AND LEARNINGS

4.1 PSTA Outcomes: To what extent are actors more able to operate in more adaptive-learning centered ways changing, and what other expected and unexpected outcomes are appearing? (KLQ 1)

Even within the relatively short timeframe of the PSTA pilot, we identified evidence of changes that partners made within the context of the project and their own organizations. These changes in approach and mindset align with results we anticipated as part of the PSTA theory of change and, in many cases, may have extended reach beyond partners and audiences immediately engaged in the project.

Outcomes observed within partners and within project activities

The changes that we observed in partners broadly follow the components of the action learning cycle, with partners experiencing improvements in their awareness of root causes, stronger and more diverse alliances among stakeholders, and more collaboration in the development and implementation of their work, ultimately leading to great adaptation within the project actions.

Increased understanding of the systemic root causes of the problem. Beginning during the first workshop with partners and stakeholders, the PSTA includes an explicit focus on facilitating participants as they reconsider components of health sector topics with which they may feel very familiar. Workshop sessions included a review of root causes of health sector issues and a mapping of stakeholders, including power and interest as they relate to issues like increased access to safe abortion care and supporting sexual and reproductive health rights for traditionally marginalized groups.

Workshop participants confirmed that they gained significant knowledge about the problem statement as well as the many causal factors including different perspectives and how they were interconnected; further, workshop participants reported discovering new actors in the system and/or learning something new about actors they already knew about. Participants also reported that because of their participation in the workshop they now can identify new underlying causes behind the limited access to quality sexual and reproductive health services to young women, sexual and gender minorities, and people living with disabilities. On the issues of system stakeholders, participants reported that they learned how to identify and explore stakeholder interests and incentives using participatory systems mapping.
“What I learned today, changed my perception about the youth. In the facility where I am working (as a care provider) we have a youth-friendly center, so how we deal with them (youth) in that center will be different.” - 1st workshop participant, Kenya

“In projects, we fail because we don’t take much time to systematically analyze who are the stakeholders, what is their conflict, their interest... this methodology has brought that new thinking to me.” - 1st workshop participant, Malawi

“We learned today that there are many gaps in interest in power. The government has the power but it is not interested and the CSO have the interest but don’t have the power. We have to close this gap.” - 1st workshop participant, Malawi

While participant perceptions are an important data point, workshop outputs such as the systems maps created confirmed that participants were able to better reflect root causes (including technical causes and those related to political, economic, and relational factors), the interconnections of these factors, the key actors connected to the problem, and where these root causes fall within stakeholders’ power and interest.

During the final reflection workshop, both CSA and Ipas confirmed that they are continuing to use PSTA tools in their work. Both partners highlighted how the PSTA allowed them to better understand root causes underlying the health system problems on which they were working. In the case of Kenya for example, CSA noted that the root cause mapping helped them to identify the SRH information needs for adolescents and young people which the organization and partners then used to redesign community sexuality information outreach activities. Beyond the root cause mapping itself, both partners also highlighted how other components of the PSTA including stakeholder mapping and the action learning cycle helped them to work collectively with their partners to reflect on relevant health system breakdowns.

Finally, partners cited that this increased understanding is something that they have not only used during the PSTA project, but also outside of the project scope. This increased capacity is important because CSA and Ipas both operate in dynamic systems where the set of stakeholders are constantly changing and evolving; the PSTA helped them to generate the skills, new tools, new methods, and knowledge of the process of how to reflect and talk about the problem that they can continue to apply to their work.

Built more diverse relationships and stronger alliances with key actors in their systems. While understanding root causes and stakeholder lenses is critical to systems thinking, the purpose of this analysis is to help partners better identify and engage with stakeholders that may not be “the usual suspects” for their work, such as religious leaders or political figures that are traditionally seen as opposing partners’ views. We observed a clear evolution in how partners engaged with diverse stakeholders over the course of the project.

In the first workshop, participants reported that because of their participation in the workshop they met new people and/or got closer and reconnected with people that they already knew. When asked about the main takeaway from their engagement in the workshop, 38% in Kenya and 35% in Malawi cited knowing the actors and the importance of generating relationships, collaboration, and coordination amongst different actors in the system to create change.
“I told to myself how could I have never noticed that religious leaders, (.) are more influential than other leaders, that came as a shock. (.) they need to be convinced because they have the power to change the mind of the people.” - 1st workshop participant, Malawi

The second workshop built on these lessons and in fact helped participants increase their engagement with different stakeholders. In addition to reporting that they met new people and/or strengthened engagement with people that they already knew, participants also engaged in concrete consultations and discussions with implementation partners in order to make decisions regarding new solutions and/or current project work plans. These micro-political processes - requiring buy-in, consensus, consultation, and ownership amongst Ipas, CSA, and their consortium of local implementation partners - were navigated using PSTA tools to support sense-making and collective decision-making.

“So in the end action learning is about more than just the results. For us, it’s about creating good relationships and creating a safe space for our partners to be able to freely discuss things, to speak about sensitive topics in a way that helps us to get to a different level of depth and openness in our conversations with partners” - CSA, 3rd workshop, project reflection

Finally, while reflecting on the PSTA process at the end of the project, both CSA and Ipas confirmed that both the workshops and components of the PSTA helped them to work with a wider range of stakeholders and to strengthen their relationships with these actors. In the case of CSA, mapping exercises helped them to design new intergenerational dialogues in their work and to engage more deliberately and actively with gender minorities in their work. Beyond diversifying the stakeholders with whom partners engaged, CSA and Ipas also cited that the PSTA helped to strengthen relationships, stating:

“So in the end action learning is about more than just the results. For us, it’s about creating good relationships and creating a safe space for our partners to be able to freely discuss things, to speak about sensitive topics in a way that helps us to get to a different level of depth and openness in our conversations with partners.” - CSA

In the final workshop, Ipas highlighted one reason why the PSTA tools may have helped achieve this outcome - by helping the partners broaden their understanding of different actors. The Ipas team noted that the workshops and PSTA tools, especially the ability to have multi sectoral engagement during the workshops, helped them to gain new insights into actors’ motivations and beliefs that they had not understood before, providing them greater information to help with strategic planning and advocacy:

“When we separate stakeholders in our workshops and meetings it does not help us to fully understand why certain stakeholders act they way they do or why they took that particular position but a participatory way of convening multiple stakeholders such as faith leaders, health workers, young person, policy director it helps us to understand why a particular person has taken that position and to understand from their perspective their decisions and appreciate the role they play. Once we understand each other it paves the way for a common solution to be found. That is why for us engaging faith leaders is becoming easier because we simply ask them to explain their positions and decisions to us. So we are starting to see some milestones because of the multi stakeholder participation.” - Ipas
Supported greater collaboration with other actors in designing collective solutions more frequently. The workshops were designed to provide space for participants to propose new solutions which were adopted or adapted into current work based on the feedback and exchange of ideas with their peers. Stakeholders gave their feedback on proposed actions and even came up with new ideas about how they can work together on activities to improve law reform and community engagement with SRH issues. As a result, these collaboratively-developed solutions were developed into tangible actions that partners took forward after the workshops.

Both CSA and Ipas also expressed how PSTA led to a shift in how the organizations collaborated with partners and beneficiaries - specifically adapting their practices to ensure that the people they were seeking to benefit and influence have more say in the work. As one of the most significant changes that they experienced from the PSTA work, CSA highlighted that PSTA tools ensured that they have more focus on participant response and feelings towards interventions (including young people, policymakers, parents, teachers, and allies). This has allowed them to give preference to the voices of their beneficiaries and partners who are at the core of implementation. Similarly, Ipas highlighted a major change in the development of how they engage stakeholders (including legislators, CSOs, media houses, and traditional leaders), stating:

"Before we told them what we wanted them to do, but now we are more collaborative and focus more on underlying problems and ensuring greater ownership." - Ipas

Adaptation of actions to improve work. Ultimately, the PSTA seeks to ensure that the approach, including the root cause analysis, stakeholder mapping, and more collaborative problem solving with diverse actors, leads to greater learning and adaptation in the work that partners undertake. Reflections with partners at the end of the project and a review of action adaptations suggest that this outcome was achieved.

During the third workshop, partners also had the opportunity to reflect on two completed action learning cycles, which provided new evidence regarding whether partners adapted their actions in response to learning that occurred throughout the project lifecycle. Ipas and CSA shared myriad concrete examples of this outcome being achieved, including:

- Adapting outreach materials for CSE to provide offline viewing options to ensure that marginalized communities have access to them (CSA);
- Working with their own partners to undertake root cause analysis and stakeholder mapping to adapt project workplans (CSA);
- Diversifying SRHR services in Ministry of Health facilities and increasing thematic areas of work based on learnings from PSTA (Ipas); and,
- Adapting engagement strategies with youth-focused CSOs and CBOs to improve work with these beneficiaries (Ipas).

One example from Ipas showcases how PSTA directly supported the adaptation of one set of actions related to their advocacy in response to religious leaders' work on the Termination of Pregnancy (ToP) Bill:

"When the Bishops statement came out, we decided not to just be counter reactive but rather to apply a new stakeholder analysis strategy and try to uncover why the
religious leaders felt the way the did and try to engage them on those issues instead by getting them to clarify their stance and the reasons for the position that that they had taken and try and arrive at a place of common understanding.” - Ipas

Outcomes observed beyond partners and project activities (ripple effects)

The changes in organizational understanding and their approach to collaboration and adaptation discussed above demonstrate the results that can be observed even during a relatively short timeframe with limited resources. However, projects like this one raise questions about the sustainability of outcomes and the degree to which results extend outside of project timelines and stakeholders. The evaluation of the PSTA signals that the changes observed within partners and within project activities have begun to expand outside of these boundaries.

Adoption of PSTA methods into partners’ broader organizational work. While we have strong evidence that our partners used PSTA tools such as root cause analysis and stakeholder mapping as part of the project, we also observed that partners have adopted these tools in work outside of the project scope. Interviews conducted during the first workshop suggested early interest in adoption, with 7 out of 15 participants identifying elements related to the value of learning a new methodology that they plan to implement in their future.

Evidence of this adoption was even clearer in discussions with partners held at the end of the project. Both CSA and Ipas shared concrete plans that they have begun to implement root cause analysis, stakeholder mapping, and power and interest mapping into their work. In addition to the use of technical PSTA components, both partners also cited how they are using what they learned related to facilitation methods and coordination to strengthen collaboration with their partners.

“We are seeing a mindset change of organization officers, previously they would say no to engage multiple partners preferring to engage one partner at a time but now we are encouraging them to say if you are working in Blantyre don’t just work with one partner, work with all the other partners in Blantyre. We also encourage them to listen and follow what the partners are saying, we cannot be rigid.” - Ipas

“The methods we learned during the PSTA workshops we are using to help us jointly explore and identify problems with young people and members of the community. So for sexuality information, we bring young people and community members together and we ask them what are the issues you are experiencing with accessing sexuality information, we ask them what are the topical issues and needs in their community areas...we then allow them to develop some action plans and what we do now is just provide them with the resources after we co-design community activities.” - CSA

Beyond adopting these methods internally, the partners also highlighted how they are bringing tools such as stakeholder mapping and root cause analysis to their own partners, further expanding the adoption of systems thinking techniques outside of immediate project partners:

“Some of the young people we work with who attended the PSTA have challenged us to use some of the methods that were used to address problems that young people
were facing when they attended other meetings and workshops with adults and vice versa.” - CSA

Early signs of adaptive ways of learning within partners. While the adoption of PSTA methods is an important outcome of this project, it is perhaps even more valuable to observe signs of a shift in partners toward a more adaptive and responsive means of working. Partners shared ways in which they have experienced changes in how they think and operate to better assess systems changes and quickly respond to these in the design and implementation of their work. While this shift originated with the implementation of the PSTA tools, partners have expressed how they see the bigger picture of being adaptive in their work:

“We were able to understand how action learning is a continuous loop of measuring whether our actions were a success or not, the continuity of the process was exciting for us” - CSA

“When you train and just leave, there is a risk of having a false impression that progress is happening because there is no way of checking and verifying things... but if you know that there is a point where you need to check in you are much more vigilant.” - Ipas

Partners undertaking a more participatory and inclusive approach to their work, with the potential to improve power imbalances. Both CSA and Ipas have demonstrated how they are giving more opportunities, power and resources to local stakeholders as part of co-designing & adapting local solutions. CSA has revised its engagement approaches with young people and community members and has adopted the participatory and co-design components of the PSTA to ensure there is an equal level of representation, influence, and voice across partners and beneficiaries in identifying project goals and stakeholders, co-designing solutions, planning and implementation. Ipas has noted how they are now taking a more participatory and inclusive approach with everyone with whom they work:

“The deep dive designing has increased because it is the partners who come out with the challenges and the solutions. It is them who now suggest to us that this intervention can be planned in this way and as Ipas all we say now is how we can support compared to what we used to do in the past. We used to go to the community and say ‘we have come as Ipas and these are the activities we want to implement’ whether they liked it or not, they just did what we said. Now we bring them together and ask them to share their ideas and co-design a strategic work plan which fits each and every stakeholder.” - Ipas

Relationally, partners cited how this approach and the process of engaging in a more inclusive and participatory way has helped them to overcome assumptions that they held about their partners and beneficiaries:

“The idea has always been there to have young people at the apex, but we have also had assumptions about how young people behave, how they work and if they are reliable professionally - and likewise young people have assumptions about how adults treat them and perceive them, so the PSTA helped to clear some of these negative assumptions and stereotypes. The PSTA has been used to try and break that by having young people and adults sitting in the same room discussing issues and finding
solutions together, strengthening the involvement and voices of the youth in the program.” - CSA

In addition, both CSA and Ipas alluded to learning how to apply the participatory elements (co-design process & facilitation methods) of the PSTA to neutralize power asymmetries to create an enabling and safe space for active participation for collaborative action with different types of stakeholders.

“We learned how to get quieter people to speak up and to get involved... we also learned how to get the same people to come back and participate again actively. We learned how to keep people engaged by making things relevant...” - Ipas

“We also learned about the importance of how to set up a room, how to set up an environment as a way of making people feel comfortable and confident to participate actively.” - Ipas

“For us it’s also not just about having multiple stakeholders and meeting multiple times - it is about creating the right environment. We are also learning that it is about softening hearts, creating an environment in which the partner is not looking at us like we are ‘perfecting’ them.” - CSA

**Increasing collaboration, engagement, and multi-sectoral dialogue outside of partners.** A final ripple effect that we observed was the extension of the uptake of collaborative and participatory practices beyond the partners themselves. Based on their mapping of stakeholders, CSA adapted their actions to directly include young people, parents and faith leaders in meetings that they held with the Ministry of Health and Ministry of Education. After hearing directly from these constituents, the government stakeholders themselves decided to continue to engage directly with these representatives and invite them to future meetings for feedback, an action they had not previously undertaken.

This outcome stems from the spaces that the PSTA helped create for different stakeholders who had not previously engaged with each other to collaborate and better understand each others’ perspectives. Partners noted early signals that this multi-sectoral engagement may extend beyond the life of the project itself:

“We have seen an increase in an awareness and understanding in our partners for the need to have diverse voices being included when organizing meetings and workshops, we are no longer seeing just policy makers being invited or powerful and influential stakeholders. They are now inviting young people and different types of people to attend meetings with the policy makers.” - CSA

“The MPs were shocked to see youth champions who attended the workshops presenting so well and so confidently who were not afraid to demand things and say take this issue forward on behalf of us as youth champions and present them at the August House of Parliament.” - Ipas
4.2. PSTA Factors: What are the enabling factors and barriers associated with the implementation of the PSTA? (KLQ 2)

In addition to collecting evidence on outcomes achieved as part of the PSTA, we also sought to understand what factors enabled the PSTA to work well and what factors acted as barriers. For the purposes of our analysis, we identified two dimensions of factors: (1) those related to workshops (the main activity of the PSTA) and those outside of workshops, and (2) those associated with people (including partners and stakeholders) and those associated with the approach itself. Both enabling and hindering factors emerged in each of these four categories, which we explore in more detail below.

Enabling factors

People-related enabling factors in the workshops

**Pre-existing relationships.** We found that existing relationships among the workshop participants contributed to creating a suitable environment that supported the overall objectives of the PSTA workshops. Diverse workshop participants felt comfortable engaging in mapping and planning discussions because most of the workshop participants that had been selected to attend the workshop had some level of prior engagement with the other participants. This helped to mitigate the effect of unequal power relationships. In addition, participatory facilitation techniques were applied by the workshop facilitators that helped to create a somewhat level playing field by granting every workshop participant an opportunity to actively contribute. Fewer power asymmetries were observed and were less salient during the second PSTA workshop because of the stronger pre-existing, collaborative working relationships among participants who participated in the workshop as colleagues and implementation partners.

In those cases where pre-existing relationships did not exist, workshop facilitators used participatory facilitation techniques and created opportunities for relationships to form during the workshop through the use of small group discussions and activities. Facilitators designed activities to get attendees comfortable with each other by warming up the conversation among participants and getting them to comfortably interact with each other. Participants reported that the PSTA workshop approach was participatory, that all voices were heard, listened and respected, and that they felt like they had all contributed to designing solutions.

**Partner and stakeholder characteristics.** The project data highlighted that project partners and local health system stakeholders attending the workshops exhibited the following characteristics that played a pivotal role in the successful implementation of the PSTA workshops (in no particular order of importance):

- **Content expertise:** The high level of content expertise among project partners and workshop stakeholders was identified as one of the more important enablers for successfully implementing and achieving the objectives of PSTA workshops. One implication of this expertise was that exercises to map the system did not
generate much new insight for the main project partners CSA and Ipas; however, mapping did provide new insights to other workshop participants.

- **Openness to collaborate with diverse stakeholders:** Partners and selected workshop participants demonstrated a willingness to listen to and work with other health systems actors including those who could be categorized as being in opposition or not sharing the same values or ideology. However, this attitude towards willingness and openness to collaborate with different types of stakeholders was easier to obtain because both the project partners and the majority of workshop participants had some pre-existing levels of trust or collaborative relationships with each other and/or other similar key actors in their system.

- **Learning and curious mindsets:** Although project partners and workshop participants had a high level of knowledge and content expertise on certain aspects of the problem and context, they did not let their expertise get in the way of being open to receiving relevant information concerning the problem, context, and system dynamics from other health system stakeholders. They maintained an interest to share as well as listen to other perspectives on a problem and the broader health system context. They were also willing and interested in thinking outside of the box and trying new approaches.

**Internal buy-in and commitment.** Prior to the implementation of the PSTA, many assumptions were made around the characteristics of a partner organization that would be ideal for successfully implementing the PSTA. Our engagement in this project has highlighted that it is important that the project partners have internal organizational support, especially high levels of commitment and buy-in from senior management to engage. Implementing the PSTA demands a considerable level of resources and commitment; it is critical that a partner not only recognizes the value of the approach but is also willing to put in or invest the necessary time, resources and effort to properly plan and execute the entire PSTA cycle. Without this internal support and dedicated resources, this would not have been possible.

“The co-creation process of PSTA approach is quite intensive and it would have not worked if we had not been willing to make the big and small sacrifices which in the end paid off... thanks also to the CSA [senior management] who gave us the ability and latitude to make decisions about how we use their time and resources on this project” - CSA, 3rd workshop, project life cycle reflection

**Process-related enabling factors in the workshops**

**Fun, participatory and active workshop design.** PSTA workshops were facilitated over a three day period, exploring difficult conversations and requiring workshop participants to engage in highly demanding exercises such as mapping multiple hidden system dynamics with a large group of people who held diverse understandings and viewpoints on a problem. The process was made even more challenging by the sensitive nature of the health system challenges being discussed, specifically abortion rights and access and sexual and reproductive health rights for gender and sexual minorities.

To overcome this challenge, the workshops were designed and facilitated in a fun and engaging way which made participating in sensitive topics of discussion easier. Workshop participants were motivated by the participatory methods and activities, incentivized...
by the workshop goals, and overall found the workshop to be an enjoyable and not a burdensome experience. In post-workshop evaluations, 100% of participants stated that they would encourage others to attend similar PSTA workshops in the future because of how participatory and inclusive the methodology is and how the process helps people to develop skills such as critical thinking and acquire new knowledge. Workshop participants consistently rated the different elements of the workshop (the facilitation, the activities, the agenda, other participants, informal time to connect with others, and the venue) as good or excellent.

“It is super interactive, you get to learn more of others’ experiences and ideas. It has also been very fun, so that definitely a plus for the workshop” - workshop participant, second PSTA workshop

“I would recommend others to attend because, through it you get to interact with people from different backgrounds and organizations and get to share ideas therefore expanding your knowledge and thoughts.”

During the second PSTA (learning and adaptation) workshops, workshop facilitators relied on the use of interactive games to keep workshop participants engaged and motivated. The games were also useful tools for facilitating learning and reflection. Adaptations were made to interactive learning games to better support peer learning around complex and abstract governance concepts such as power and accountability. Through the interactive games, workshop participants were able to learn and influence each other and facilitate critical thinking about the nature of the health system, the nature of a problem, and how to address a problem.

**Flexibility, tailoring, and constant adaptation.** The PSTA was designed in such a way that the methodology could constantly be adapted to meet the needs and the context of the health system issue and local health system stakeholders, and some of the small adaptations made appeared to have a big impact. These included changes to how action ideation was conducted based on learning from the first Kenya workshop (including helping Ipas to focus on actions that are within the scope of their current work), updated methods for facilitating discussion about accountability-related root causes, and ensuring parts of the workshop were reserved for participation by subsets of stakeholders who were better able to engage on certain actions.

**Use of scenarios and non-technical language to guide conversations on abstract and complex concepts.** A key finding to emerge from the first PSTA workshop was that discussions about accountability happened very subtly. During the first workshop, participants focused on discussing and mapping root causes to sexual and reproductive health rights (SRHR) challenges and touched briefly on some of the accountability gaps and concerns in the health system; accountability discussions did not organically emerge. As such the agenda of the second PSTA workshop was adapted to incorporate more deliberate workshop activities for exploring and facilitating conversations concerning accountability. Specifically, workshop facilitators adapted the language of the reflection questions and prompts they were using to facilitate group discussion about accountability in the local health care system and provided scenarios and examples of service delivery failures representing accountability issues instead of asking abstract questions. Workshop participants discussed the scenarios in small groups, identifying the role and responsibility of different stakeholders vis a vis the service delivery failure. Each
scenario of a service delivery failure due to a breakdown in accountability was put on a post-it to create an “accountability wall.” As workshop facilitators, AHIC also utilized interactive games to support more discussion. Participants were better able to interlink activities to accountability gaps which enriched their understanding of the impact of various contextual factors and they were able to see how multiple political economy and technical factors impact to create accountability gaps/issues in the system.

**Process-related enabling factors outside of the workshops**

**Unstructured peer learning opportunities.** Project partners Ipas and CSA noted the value of having the opportunity to connect with one another and reflect on their experiences, context, and progress. Many lessons were exchanged between the CSO partners who appreciated similarities in their context challenges and some of the solutions they were testing. The peer learning discussions highlighted which context barriers are the most challenging and helped to set the agenda for additional reflections and iterations at the next two rounds of PSTA workshops in March and June 2022.

**Barriers**

**People-related barriers in the workshops**

**Power dynamics and differences between multiple stakeholders.** During the PSTA workshop, the religious and cultural beliefs held by some of the workshop participants played a role in stifling some workshop activities, including how the nature of the problem was mapped, discussed and prioritized. This combined with the unequal power dynamics among the different stakeholders meant that the values and beliefs of the more vocal and influential workshop participants dominated and influenced the mapping and planning discussions.

During the Malawi workshop, dominant workshop stakeholders influenced what root cause challenges were mapped, how they were mapped and discussed, as well as which ones were prioritized. Some of the workshop participants who wanted to map and discuss challenges associated with vulnerable groups, such as LGBTQ individuals and sex workers, were shut down by religious leaders and other more conservative workshop participants. In Kenya, project partner CSA made the strategic choice to deliberately exclude religious leaders from participating in the mapping and planning workshop because they were aware that their beliefs would interfere with other workshop participants who could freely discuss SRHR service challenges being faced by the LGBTQ youth community.

“The attitudes, power dynamics and the capacities of the stakeholders have a strong influence over whether and how root causes are discussed, mapped and addressed.” - CSA, 3rd workshop, project reflection

“Bringing together multiple stakeholders was challenging because you had to manage different interests and ideologies...” - Ipas, 3rd workshop, project reflection

Workshop facilitators adapted their approach to ensure every workshop participant was able to freely contribute and map challenges; however, because of the diverse positions and beliefs that participants held, not all workshop participants were able to help others to recognize that these challenges exist despite their own personal values and beliefs.
While this did prove to be a barrier, it is also worth noting the importance of convening workshop participants who may not necessarily agree on all aspects of the problem or solution but have a certain level of openness and willingness to explore the issue fully, listen and engage with other actors in the system.

**Varying levels of skills, expertise and capacity amongst workshop participants.** Participants who attended the PSTA mapping and planning workshops had different levels of expertise and skills which did present some challenges. First, differing capacities made it difficult for some participants to engage in small group discussions or mapping activities, due to a lack of knowledge about some parts of the system. Second, differences in the level of skills, expertise, decision-making authority, and resources amongst workshop stakeholders created additional barriers for joint planning because not all participants had the capacity or resources to support all of the designed actions. GI and AHIC made adaptations to address this barrier in the second workshop, and the facilitators and partners were more intentional about leveraging our understanding of the workshop participants’ level of expertise, and resource capacities to pre-assign workshop participants to small groups that would work best for them. This shift played an important role in helping partners and workshop participants have more meaningful small group sessions and to better adapt work plans for the second round of testing.

**Political buy-in (“small organizational politics”).** One specific barrier that emerged in Kenya was the difficulty in planning actions due to the need for buy-in by a large group of consortium members. CSA was applying the PSTA to an SRHR issue that was being addressed by CSA within the context of a consortium project; as such, any changes to actions that emerged from the PSTA workshop had to be approved by relevant organizations in a consortium of seven partners, some of whom were not involved in the workshop. As such, the action plans developed in the workshop needed to be reconciled with the program work plan and consortium partners who were not all present at the PSTA workshop. CSA sought to address this challenge by presenting relevant mapping data and findings as well as the actions designed at a separate learning and reflection meeting with consortium partners. This barrier highlights the need for project partners to review and revise actions with other key decision makers in their own organizations or networks of implementing partners.

**Revisiting and updating mapping outputs with new participants.** To facilitate learning and adaptation, the second round of PSTA workshops was designed for stakeholders to revisit the outputs from the mapping and planning step of the PSTA and reflect on changes that need to be made, including updating root causes, technical and political economy factors, and stakeholder interests and incentives. However, not all the workshop participants from the first mapping and planning PSTA workshop were invited to participate in the second round of workshops. As such, AHIC had to adapt the second workshop to recap and explain the objectives and outcomes of the first PSTA workshop because the objectives and activities of the first and second PSTA workshops were closely aligned. Despite this adaptation, it was observed that some of the new participants debated, questioned and challenged the accuracy and logic of the original mapping outputs, which some workshop participants then set out to correct rather than update. While some debate is helpful for mapping, some new participants rehashed issues and questions that the previous workshop’s participants had already discussed and resolved.
People-related barriers outside of the workshops

**Turnovers with the core implementation team.** During the implementation of the PSTA, both partners went through staffing changes, including core staff assigned at the project’s launch. Overall, there is no evidence that the staff turnover negatively impacted project outcomes; but the staffing changes did create challenges with implementation, resulting in some delays and complications which had to be navigated and accommodated.

Process-related barriers in the workshops

**Overly-ambitious workshop agendas.** Because so much time during the PSTA workshop agenda was dedicated to mapping, planning and reviewing activities, there was limited time available for critical feedback, reflection and peer learning and knowledge exchange. Facilitators sought to adapt to sessions running long; however, adaptations often required cutting back on the amount of time and opportunities for participant interactions and peer exchanges during the workshop.

**The use of jargon/technical terms (systems rhetoric).** Participants found some concepts such as power dynamics or incentives unfamiliar and complicated. Even with intentional efforts on the part of the facilitators to explain the terms, conversations about power and accountability were hard to guide despite effort to adapt the language and reflection questions.

**Limitations of root cause analysis method.** During the mapping and planning PSTA workshops, some partners and workshop participants struggled with participating in root cause analysis discussions which were aimed at uncovering the multiple causes creating the SRHR service delivery challenges using the different perspectives of multiple stakeholders. While this analysis did help participants to uncover the multifaceted nature of SRHR challenges in each health system context, it also led to discussions that could be long, unclear, and tangential to the problem being mapped. Project partners also reported having challenges with following all of the many root causes being mapped, some of which were not always supported by strong evidence or experts in the room that could provide useful additional information. Despite these challenges, CSA and Ipas both cited the value of root cause analysis in their own organizational work. As such, it may be useful to adapt either the method or the participants in future PSTA work to ensure that they are better matched.

“The 5 whys is an interesting root cause analysis tool but it requires a bit of direction and mentorship because it is easy to get lost and to just deviate from one problem to another and you can lose focus that way. You also run the risk of coming up with a list of problems that are too outside of the expertise that is in the room. So it can’t just be a loose conversation, it needs to be well managed and more closely facilitated” - CSA, 3rd workshop, project reflection

**Location and in-person format of PSTA workshops.** Workshops were limited to a maximum number of participants and to those who reside in the locations where PSTA workshops were being implemented (Nairobi and Blantyre), potentially leaving out other key stakeholders who would have been valuable to include in discussions.
“Convening multiple stakeholders located in different districts/localities was a challenge because the workshop was convening in one district” - Ipas, 3rd methodology, project reflection

Process-related barriers outside of the workshops

**Insufficient time and resources to support testing of actions.** The PSTA did not provide additional funding for testing workshop actions. Despite the PSTA model facilitating the design of multiple pathways for change, partners used a set of criteria for deciding which of the actions they could test during the action learning phase of the PSTA which did not lend itself to pursuing those multiple pathways:

- Actions/ that align with and/or can be easily integrated into pre-existing project work plans;
- Actions that are high impact and low cost;
- Actions that will require collaborating other workshop stakeholders and/or other health system stakeholders; and,
- Actions that can be easily adopted/taken up as well as that can be reasonably tested within a short time frame (approximately three months) before the next round of PSTA workshops.

In the end, the lack of additional funding for testing actions prevented partners from pursuing several interesting actions that were discussed, such as conferences for sexual and gender minorities and policy advocacy actions that require significant resources. In addition, CSO partners shared that their teams had to balance competing priorities. Testing and adaptation of actions required a certain level of time and effort, and while senior management within the organizations was generally supportive of their engagement in the PSTA, they were not always able to redeploy staff or resources for new purposes such as testing and adapting actions discussed and designed during the PSTA workshops.

**Legal, cultural, and religious sensitivity of the SRHR topics.** The sensitivity of the SRHR topics at the center of the PSTA in Kenya and Malawi created additional challenging dynamics that made the accountability discussions and the design of accountability interventions difficult. Many options for promoting accountability that would be available for legal health rights were not options in the case of abortion access, LGBTQ rights, and other issues that are not protected by laws in the focus countries. In combination with the challenges of discussing these sensitive issues with diverse stakeholders, these twin issues of illegality and cultural and religious sensitivity removed many pathways that partners would have otherwise been able to consider to address these health system challenges.
4.3. PSTA Components: What project components played a meaningful role in supporting PSTA outcomes? (KLQ 3)

The PSTA was designed and tested with the expectation of producing the following behavioral outcomes in partners:

- Partners operate in more adaptive learning-centered ways including by incorporating testing and adaptation into their practice; and,
- Partners work to improve public service delivery by:
  - Collaborating with other actors in the health system;
  - Co-designing collective solutions more frequently;
  - Initiating more diverse relationships
  - Building stronger alliances with key actors in their systems;
  - Seeking more feedback about the systemic root causes of the health challenges that they face, including data and resources;
  - Focusing on shifting power dynamics in the system; and,
  - Adopting key components of participatory and system thinking approaches.

During the final PSTA workshop in Ghana, GI, AHIC, CSA, and Ipas provided data on each partner’s experiences regarding specific PSTA components that played a meaningful role in achieving the project’s desired behavioral outcomes. Ultimately, several elements of the PSTA emerged as critical to the model’s success according to multiple partners.

Co-creating/Co-designing the PSTA workshops.

The PSTA includes a very deliberate preparation step in which partners themselves help to adapt the design of the approach and especially the first workshop to fit their context and needs. Since the workshop co-creation process, CSA and Ipas cited that they have been more inclusive of their own partners in thinking about how to critically design collaborative actions that would be feasible and possible within the project time frames and budget.

“We learned by observing how you prepared and planned the PSTA workshops that you can have a basket full of activities but if you don’t coordinate and communicate and organize them with different stakeholders it won’t succeed.” - Ipas, 3rd workshop, project reflection

“There is a learning event that is coming up next month and CSA is part of the planning committee...we are proposing for the PSTA to be utilized for some of the sessions which will include facilitating reflection and learning discussions with different types of conference participants about what it is they have done in the past year. As part of preparing for that learning, we sent out a survey to conference participants asking about what they want to learn as well as their skills, expertise to see how they can contribute.” - CSA, 3rd workshop, project reflection
Debrief sessions.
The co-creation workshop process also included components of adaptive delivery. During the implementation of the PSTA workshops, partners would meet at the end of the day to review and reflect on the workshop proceedings, participants, and activities and would be involved in making rapid iterations to the workshop agenda, facilitation methods, and activities. This was done to make sure that PSTA workshops stayed on track to achieve set goals and objectives. CSA and Ipas shared that their participation and involvement in the adaptation of the PSTA workshop sessions during regular debriefs made them fully aware and receptive to the usefulness and importance of adaptive management. Both partners noted that they found the debriefs to be a simple, yet powerful tool that enabled them and project stakeholders to reflect on what happened with key project activities and outcomes and why it happened, and both have since adopted this approach in their own internal and external events and meetings.

“We are more consultative and willing to engage with different structures and staff and partners within Ipas and do more debriefing and task reflection activities internally and with other stakeholders.” - Ipas, 3rd workshop, participant growth reflection

“Now after every major event and activity we are making sure we are debriefing even if that meeting has ended late because debriefing plays a very important role in whether or not tomorrow's event is a success by adapting either the activities or objectives of each day and that is something that we did not do, that was not a part of our culture as an organization, it's something new and we are finding it to be very helpful.” - CSA, 3rd workshop, participant growth reflection

Multistakeholder convening.
Central and critical to the PSTA is the multistakeholder component of the mapping and planning workshops. At the start of the approach, CSA and Ipas helped AHIC to jointly identify different categories of stakeholders that would be suitable workshop participants that would be both willing and available to help to map the problem and generate suitable solutions which can be tested. Both CSO partners reported that attending, participating in, and observing the multistakeholder workshops has increased their desire to diversify their relationships and partnerships as well as to collaborate with other actors in the health system. Ipas specifically noted that their capability and motivation to work with other CSOs and community-based youth organizations had been enhanced, increasing their collective action and working with multiple stakeholders at once rather than with one stakeholder at a time based on the issues and solutions identified by the stakeholders.

“We have increased working with multiple stakeholders and the types of services we offer but mainly with the Ministry of Health stakeholders; they appreciated the new ideas, strategies and proposed actions developed during the PSTA workshops...this way of work seems to be replicating itself in the different localities that these stakeholders operate.” - Ipas, 3rd workshop, participant growth reflection

Both CSA and Ipas described how they are now much more open-minded and willing to develop multiple strategies with multiple stakeholders as well as ideating solutions and project strategies with a diverse set of stakeholders.
“We are seeing a mindset change of organization officers. Previously they would say no to engaging multiple partners, preferring to engage one partner at a time, but now we are encouraging them to say - if you are working in Blantyre, don’t just work with one partner, work with all the other partners in Blantyre. We also encourage them to listen and follow what the partners are saying, we cannot be rigid.” - Ipas, 3rd workshop, participant growth reflection

“We are eager to start inviting multiple stakeholders with different levels of power and not just engaging highly influential policy actors separately.” - CSA, 3rd workshop, participant growth reflection

Since experiencing PSTA multi stakeholder workshops, both CSA and Ipas have reported increasing how regularly they convene stakeholders to co-create or iterate project strategies and activities. The partners highlighted that they have adapted their community engagement approach to be more inclusive, particularly with regard to how frequently they are jointly ideating solutions with multiple stakeholders and especially their youth partners. CSA stated they are now more comfortable and open to receiving feedback and ideas and inviting feedback and suggestions from their youth partners and stakeholders so that they make further changes and improvements to their work. This has especially improved and helped to clear any misconceptions and stereotypes they have about young people’s ability to make strong contributions and partnerships.

“We now allow participants to influence us and we allow ourselves to get feedback from them to do further adaptation ...” CSA, 3rd workshop, project reflection

Mapping root causes and stakeholders.

For Ipas and CSA, the most significant contribution from mapping the problem and the stakeholders was not that new content was generated; instead, the partners noted the effectiveness of engaging in a joint mapping process with diverse stakeholders. Ipas and CSA stated that the mapping activities helped workshop participants to shift and filter the many root causes and to select the top factors, and ultimately paved the way to building solutions based on mutual agreement and aligned interests amongst diverse stakeholders. Both partners noted that it was the first time that they discussed problems and solutions with such a diverse set of stakeholders and the first time that they mapped key health system stakeholders against a power/interest grid. These participatory/joint mapping tools have created a better understanding of how they can engage other health system stakeholders around their perspectives on the nature of the problem and possible solutions that take into account power, interests and incentives.

“We have seen that workshop participants have been able to evaluate other stakeholders including themselves that these are the strongest areas of interest, this is how much power each stakeholder has. They are able to assess how each stakeholder is unique ...they now try to bring together those stakeholders they have identified as being the weakest with those stakeholders they have identified as having power so that they can work together.” - Ipas, 3rd workshop, participant growth reflection

“We have seen that multi stakeholder participation and collaboration towards the same goal has increased ...I will give you an example of Ipas’s digital application platform - we have doctors, youth champions lawyers, nurses, police officers, people with disabilities all these diff stakeholders are working together to achieve the same goal.” - Ipas, 3rd workshop, growth reflection
For example, Ipas and CSA observed that jointly mapping challenges and solutions built the confidence of their youth partners who attended the PSTA workshop. Since the workshop, youth champions no longer seem intimidated by the idea of working with other powerful actors in the system and were boldly offering unique and relevant solutions.

“The idea has always been there to have young people at the apex, but we have also had assumptions about how young people behave, how they work, and if they are reliable professionally; and likewise young people have assumptions about how adults treat them and perceive them. So the PSTA helped to clear some of these negative assumptions and stereotypes. The PSTA has been used to try and break that by having young people and adults sitting in the same room discussing issues and finding solutions together, strengthening the involvement and voices of the youth in the program.” - CSA, 3rd workshop, participant growth reflection

Action Learning Cycle.

Ipas and CSA noted that the checkpoints and pause and reflection sessions that were part of the action learning cycle were useful tools that they have begun applying to their interactions and engagements with their own implementation partners as a mechanism for engaging in ongoing project monitoring and learning about the effectiveness of their strategies and assumptions. Both CSA and Ipas acknowledged the important role of engaging in a continuous loop of testing, learning and ideating as essential for improving the design and success of their interventions.

“We were able to understand how action learning is a continuous loop of measuring whether our actions were a success or not, the continuity of the process was exciting for us.” -CSA, 3rd workshop, project reflection

“Recently, as Ipas, we have taken the decision to issue small grants to a few community and youth organizations. We will take what we have learned here and apply it with them. Probably this June we are planning on meeting with these grantees to review together what they have done, what have been the challenges. It is also an opportunity to test the things that we have learned from the workshop if that is indeed what they are also experiencing on the ground.” - Ipas, 3rd workshop, project life cycle reflection

Participatory and interactive facilitation methods.

CSA and Ipas reported adopting the participatory methods they learnt during the PSTA workshops, including those used for solution ideation and co-designing actions with different stakeholders. CSA has revised their engagement approaches with young people and community members and has adopted the participatory and co-design components of the PSTA to ensure there is greater inclusion and an equal level of local partner representation, influence, and voice over decision making in identifying project goals and stakeholders, co-designing solutions, planning and implementation. CSA also indicated that adopting co-creation and participatory elements in co-designing their larger project theory of change and workplans has been a way to improve their relationship with consortium members by correcting the power imbalances and misconceptions of the roles of different partners. Finally, CSA shared how they have adopted participatory facilitation methods from the PSTA as a tool for supporting collective harvesting of outcomes, having open conversations, and strengthening relationships of trust with project partners.
5. OUR PROPOSED WAY FORWARD

5.1 Recommendations for those seeking to undertake this work

The design, implementation, and evaluation of the PSTA with partners in Kenya and Malawi was designed to be a learning project and in many ways a pilot. As described above, this approach builds on the well-developed theory and practice of systems thinking and systems approaches; however, the PSTA was deliberately adapted to apply this theory and practice to contexts in which they are not traditionally used. We sought to make systems thinking work with local partners working on a constrained timeline and with no additional financial resources to undertake actions that they might adapt using systems thinking tools. As with any learning project, we undertook this pilot with the recognition that the PSTA might not produce the outcomes we hoped to observe.

As described in Section 4, the PSTA did in fact show evidence of contributing to several positive outcomes, including increasing understanding by partners of root causes, building more diverse relationships and alliances with key actors, and encouraging more collaborative and participatory solutions to health system problems. This emerging evidence, while not proof of impact, does suggest that organizations can use and adapt the PSTA as a way to support organizations to use systems thinking for more collaborative multistakeholder actions to address at least some root causes of health system problems.

Beyond this finding, we have identified several actionable recommendations for stakeholders and organizations that want to build participatory systems thinking into their own work or the work of their partners.

**Identifying the right partners.** A first step of the PSTA is to identify partners with which to undertake this work. Our selection of partners for this project revealed a checklist of helpful criteria that we recommend using to select CSO partners for similar work:

- **Motivation** – while CSOs do not need experience with systems thinking to undertake the PSTA, potential partners should demonstrate a strong interest in developing their skills in this area, including using and testing methods that may be unfamiliar to them and to their stakeholders.

- **Local stakeholder network** – one outcome that we observed from the implementation of the PSTA was an increase in the breadth and diversity of stakeholders with whom partners engaged. However, we found that it was valuable to have partners with a strong country presence and ability to convene an initial set of stakeholders interested in the focus of problems with the health systems on which they could build these relationships.

- **Strong knowledge and experience in the target health system problem** – we initially anticipated needing more time to conduct background research on the
health problem before launching the PSTA learning cycles, but having partners who already had much of this critical knowledge made it easier to launch the PSTA.

- **Interest in accountability and governance aspects of health system challenges** – while the PSTA was not designed to only focus on root causes related to governance and accountability, it is still true that many root causes do stem from these issues. It is critical to have partners who want to engage on not just technical health solutions but those related to political, economic, social, and relational changes.

**Adapting the preparation stage to partner needs.** One lesson from the PSTA pilot in Malawi and Kenya is that an intensive preparation phase for the approach may not be necessary, but this should be adapted to the needs and characteristics of partners. In the case of this project, we planned for a series of activities such as background research on the health system problem, key informant interviews, and lengthy discussions with partners about crafting a key problem statement to act as the foundation of the PSTA in each country. Our partners started the PSTA as experts in the health systems problems on which they wanted to focus, and even the key problem statements were largely determined by work they were already conducting. As such, we were able to reduce the intensity of this phase and focus on logistical preparations (such as identifying stakeholders to invite to the kick-off workshop). PSTA implementers and supporters may need to reintroduce background research and other preparation steps into this phase if partners do not start with this level of expertise.

**Inclusion of participatory mapping tools to support root cause and stakeholder analysis.** While there is no single set of tools or facilitation designs that are necessary for the PSTA, we did find several elements of mapping that proved useful to partners in the PSTA and characteristics that made these elements more participatory and action-oriented:

- **Inclusion of root cause mapping and stakeholder analysis.** Our facilitation partners, AHIC, designed and used several tools to support workshop participants in Kenya and Malawi to identify root causes as well as critical stakeholders for the target health system problem. While different tools worked better for different contexts and groups, the inclusion of both of these elements (root cause mapping and stakeholder mapping) in the PSTA was cited by partners as being critical to their work as part of this project and in the future.

- **Tools should be adapted to the people in the room.** Identifying issues like power and influence and even root causes can be sensitive to discuss, depending on the people in the room. For example, it may not be productive or safe for a CSO representative to share their perspectives about government incentives to support sexual and reproductive health rights when a representative from that government is sitting across the table. As such, the use of root cause analysis and stakeholder mapping tools needs to be adjusted to the knowledge, incentives, and constraints of those participating in the discussion. In some cases, this may mean restricting some parts of a PSTA workshop to only include allies of the partner so that some discussions can be held more openly.

- **Tools should be simple enough to be adopted by partners after the workshop.** One challenge with traditional systems thinking approaches is that they can include complicated and heavily facilitated tools. For the PSTA, we found that simpler tools like power and influence matrices were useful to partners not
just in facilitated workshop sessions, but also in their own offices. Both Ipas and CSA shared with us that they brought tools like this back to their teams and consortium partners outside of the project and were able to leverage them to bring systems thinking into their work beyond the workshop setting.

**Recognizing the challenge of identifying and addressing accountability gaps.**

One component of the PSTA that we believe still deserves further exploration is supporting discussions on accountability. While the PSTA was not designed to only address accountability root causes, considering these challenging issues is something that we hoped the approach would allow partners and stakeholders to do. In reality, this was more difficult than planned for several reasons including the people in the room and the inherent obstacles in addressing accountability-related problems. We first sought to introduce accountability into PSTA discussions subtly, through the use of the PESTEL (Political, Economic, Social, Technological, Environmental or Ethical, and Legal) framework to uncover accountability issues that fall into these categories; however, without explicitly tackling accountability, these issues often did not rise to the surface in conversations and were not prioritized when they did come up. In subsequent workshops, AHIC adapted accountability sessions to gamify these discussions, bringing up the issues explicitly but doing so in a way that put participants at ease. We did observe more discussion of accountability as a result of these changes; however, it is not clear whether these discussions also led to more consistent accountability-focused solution ideation.

Those seeking to implement the PSTA with their partners should take into consideration these challenges and adapt the model if addressing accountability challenges is a single or primary goal of their work. One option to consider is to revisit the structure of workshops to directly match accountability challenges to possible actions or solutions. These sessions could include discussions and reflection on the issues and processes for addressing the issues and in-depth scenario planning.

**Designing action planning to focus on actions that partners can actually change and implement.** The PSTA pilot was designed deliberately to test participatory systems thinking for partners who would not receive additional financial resources from the project to change and implement actions; in other words, any solutions or actions that root cause analysis and stakeholder mapping led partners to change had to be solutions or actions that they could take forward without new funding (at least from the project). While we made this constraint clear to partners at the start of the project, it became clear that we did not initially design the “action planning” component of the PSTA in line with these constraints. For example, partners in Kenya implemented the PSTA as part of a larger consortium-driven project, but not all consortium members were able to join the first workshop. As a result, the PSTA tools helped our partners identify new ideas and changes to their larger project workplan that they could not implement because the consortium members leading those actions were not involved in the discussions. We changed this approach in subsequent workshops, but designing this component to address such constraints from the beginning would have provided more time for partners to design and implement actions over which they had authority. For people who are interested in implementing or supporting the PSTA, we recommend designing the action planning component to focus on those actions that can be feasibly integrated into the workplan of the partners in the room and/or implemented with pre-existing project scope of funds and capacities.
Consider testing the funding of new and adapted actions. As noted above, the design of action planning should be adapted to the constraints and sphere of influence that partners have to design and test new actions. Alternatively, future iterations of the PSTA could seek to increase the scope of potential actions by providing additional financial resources to test new actions. Even when the action planning was designed to help partners identify multiple solutions or pathways for change targeting root causes, a major determinant of what type of actions ended up being designed and tested was the lack of funding for testing actions at the time. Because the model did not provide additional funding for testing workshop actions, partners elected to move forward with the most feasible actions rather than those that may have been more impactful but would have required additional resources. Future iterations of the PSTA could test whether providing even minimal supplemental funding to partners would change the types of actions they choose to undertake and open up new pathways for change outside of those available without additional resources.

More cycles likely allow for better adaptation and outcomes. The PSTA is designed to be a cycle of mapping, planning, undertaking actions, and then repeating the cycle based on revised experiences and knowledge about root causes, stakeholders, and actions that do and do not work. There is not a predefined limit or recommendation for the number of learning cycles; in fact, we hypothesize that there is new information that can emerge after each cycle and improve the work of partners to address the health system problem. In the case of the PSTA pilot in Malawi and Kenya, we were only able to complete two full learning cycles, which had limits on the amount of adaptation and learning that partners could do. Looking at the evidence that we have on outcomes, there is a clear maturity of outcomes as time went on, with more changes observed in later action and learning cycles. This is a signal that the PSTA over time can continue to strengthen both expected and unexpected outcomes and that those undertaking the PSTA should seek to build in more adaptation and learning cycles to realize these outcomes.

Consider providing support between workshops. For the pilot, the primary support provided to partners was facilitating mapping and planning discussions during the three workshops. We provided support to partners between workshops which served as learn and reflect moments. While this model still showed evidence of several important outcomes (as described in Section 4), it is possible that additional support between these moments would have allowed for faster progress of actions or other changes. Support between workshops could include different options, including technical support on specific actions and/or virtual discussions with subsets of stakeholders to address learnings from action implementation.

PSTA is not “health problem agnostic.” Our partners identified the problems in the health system that were most important to their work and their organizations’ missions, which included a lack of access to safe abortion care and sexual and reproductive health rights for marginalized populations including LGBTQIA+ individuals and people living with disabilities. As we piloted the PSTA, we learned that many of the activities related to accountability were uniquely challenging to undertake with these problems. For components of health care that may not be legal or socially accepted in the countries or communities where partners work, many of the formal accountability routes (such as the judicial system and policy approaches) may not be options to address breakdowns in care and outcomes, limiting the actions that partners can undertake to improve the health system. While we still found that the approach was able to achieve important outcomes
while addressing these complex issues, it is important that PSTA implementers adapt the model to the realities of the health system problem they seek to address, especially if it is one for which rights are not protected in the country’s legal system.

Managing expectations about the speed of changes in health systems. We would encourage any implementers to be realistic about how changes occur in health systems and the fact that changes to health outcomes themselves will generally take more time than a typical project lifecycle. We observed that the PSTA supported changes in how partners who are committed to long-term changes in health systems operate, and there are signs that these changes will make organizations more participatory, collaborative, and engaged in systems thinking over the longer term. While these outcomes may not be the ultimate changes that we hope to see in issues like access to safe abortion care and sexual and reproductive health, they do have the potential to have ripple effects that could influence these bigger changes.

5.2 Remaining questions

In addition to the lessons learned and shared above regarding how best to implement the PSTA model, the pilot of this approach in Malawi and Kenya revealed several questions that are worth further exploration to continue to make the PSTA work better for partners worldwide.

Which enabling factors are necessary to ensure the successful implementation of the PSTA? In section 4.1 we shared evidence of factors related to the people and process of the PSTA that helped make it a more effective model; however, without a counterfactual, it is difficult to assess whether these factors are necessary or merely helpful. Factors such as a baseline of openness and trust to engage with project stakeholders are likely necessary to ensure that partners stay engaged and motivated in the implementation of the PSTA. Alternatively, pre-existing relationships between health systems stakeholders in the workshops and pre-existing knowledge of systems thinking made implementation easier but may not be necessary to ensure that the PSTA contributes to the desired outcomes of partners.

How can the PSTA be adapted to best leverage enabling factors and mitigate barriers? For those factors that are not necessary to have (or avoid), there are further questions about the best ways to design elements of the PSTA to leverage or mitigate them. We did undertake some iteration during this project and thus have some signals regarding ways to work with these factors, but there is much more that could be explored regarding how to mitigate and leverage factors.

Are the organizational changes that were observed (such as increased collaboration and participation) pre-conditions to systems changes? As noted in our final recommendation in section 5.1, systems change requires more time than what was available during the lifetime of this project. We hypothesize that the outcomes that were observed in how partner organizations operate are a necessary precursor to partners improving health systems. Without a longer timeframe, we cannot say for sure if this is the case. It may be that these organizational changes have other value but are not needed to influence systems change. This question is worth exploring in more detail in the future.
Can the PSTA better address power imbalances for stakeholders on both ends of the power spectrum? While our evaluation did not explicitly assess changes in power dynamics among stakeholders, we did observe changes in how workshop participants engaged with each other during and between workshops that suggest that participants were able to amplify their voices and ability to engage with those in positions of power. However, workshop participants were generally centered closer to the middle of the power spectrum, including government officials and religious leaders (but not those with the greatest power) and civil society organizations and their beneficiaries (but not the most marginalized). It remains untested whether representatives of the most marginalized populations could be integrated into the PSTA to amplify their own voices and whether those at the highest level of power could be facilitated to cede some of their power (or at least voice) to more marginalized communities.

How would outcomes have been different if we relaxed the constraint of “no additional financial resources” for partners to undertake actions? As described in Section 5.1, we hypothesize that our model of not providing additional resources for actions may have led partners to test actions that were less ambitious and potentially impactful because these were the ones that fit within their scopes and existing resource pools. We did however observe discussions during the workshop in which stakeholders

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**Recommendations for adapting the PSTA to respond to enabling factors and barriers**

- **Turnover** – recognizing that the turnover of partner staff can hinder the approach, we recommend working with a core team of individuals from project partners (rather than one point person) so that there is some level of consistency and continuity with the partner’s core team if staff members leave.

- **Diversity in stakeholders** – this emerged as both a barrier and an enabler in the PSTA, with diverse stakeholders helping partners to identify unique root causes and actions that they might not otherwise while also leading to some tense discussions between actors who have very different perspectives on the health systems problem. To leverage the positive components of diversity while mitigating challenges, we recommend having facilitators who know how to manage power dynamics and interests and have participatory and inclusive facilitation skills. We also recommend working with partners to identify potentially challenging power dynamics in advance and developing approaches, such as small group work or rotating session leadership, to offset the potential that one strong personality overtakes the discussion.

- **Decision-making structures within partner organizations and networks** – actions designed and adapted during the PSTA workshops often rely on collaboration and joint-decision making with actors outside of workshop participants. This highlights the need as well as the importance of project partners to independently sift through ideas with other key decision makers in their own organizations and/or network of co-implementing partners using their own internal planning processes, a component that could be built formally into the PSTA.
brainstormed bigger, longer-term, and more resource-intensive actions that were then not undertaken. This leaves two important questions. First, would partners have chosen different actions if there were resources available through the project? Second, if they chose different actions, would these have led to bigger changes? These are both issues worth exploring in future iterations of the PSTA.