

JOURNEY MAPPING 2.0

Andrew Secor, Senior Research
Advisor, PSI

Hilary Kinka, Technical Advisor,
Private Sector Engagement, PSI

JANUARY 21, 2025



BACKGROUND & OBJECTIVES



1. Consumers' journeys through the health system are complex; understanding their touchpoints and relationships with the health system is key to making health systems stronger and more responsive.
2. Current methods (e.g., household surveys, journey mapping) have limitations (time- and resource-intensive, focus on a particular product or service, fail to capture the complexity of and changes in the user's experience over time) making it difficult for policymakers to improve clients' experience of care and health outcomes.
3. With funding from the Endless Foundation, PSI designed and tested a methodology to continuously and remotely track consumers' journeys, starting with the pregnancy journeys of women in rural and urban settings of Uganda.
4. Long-term vision for the methodology is to (i) apply it to Primary Health Care (PHC) more broadly, (ii) institutionalize it for more routine use at scale, and (iii) replicate it in /adapted it to other geographies.

Research Objectives:

1. Investigate how remote engagement mechanisms can be used to collect consumer insights more frequently (relative to traditional journey mapping)
2. Assess real-time innovative journey mapping techniques to describe care-seeking pathway of pregnant women in urban and rural settings of Uganda.

METHODS



Setting:

- Two districts in Uganda
 - Wakiso (urban)
 - Mukono (rural)

Data collection approaches:

- IDs & Avatar: In-person and retrospective (combined ANC & delivery experience)
- IVR & WhatsApp: Remote and longitudinal (after monthly ANC visits & once after delivery)

Participants:

- Sampling: Convenience sample using community-based recruitment
- IDs & Avatar: Women who have had a live birth in the past 6 months.
- IVR and WhatsApp: Women who are currently pregnant in their second or third trimester
 - Endline phone survey: Subset of IVR and WhatsApp sample

Data collection tools

Traditional Journey Mapping

Remote Journey Mapping

In Depth Interviews
(*n=30*)

Interactive Voice Response (IVR)
(*n=107*)

Digital Avatar Survey
(*n=17*)

WhatsApp Survey
(*n=100*)

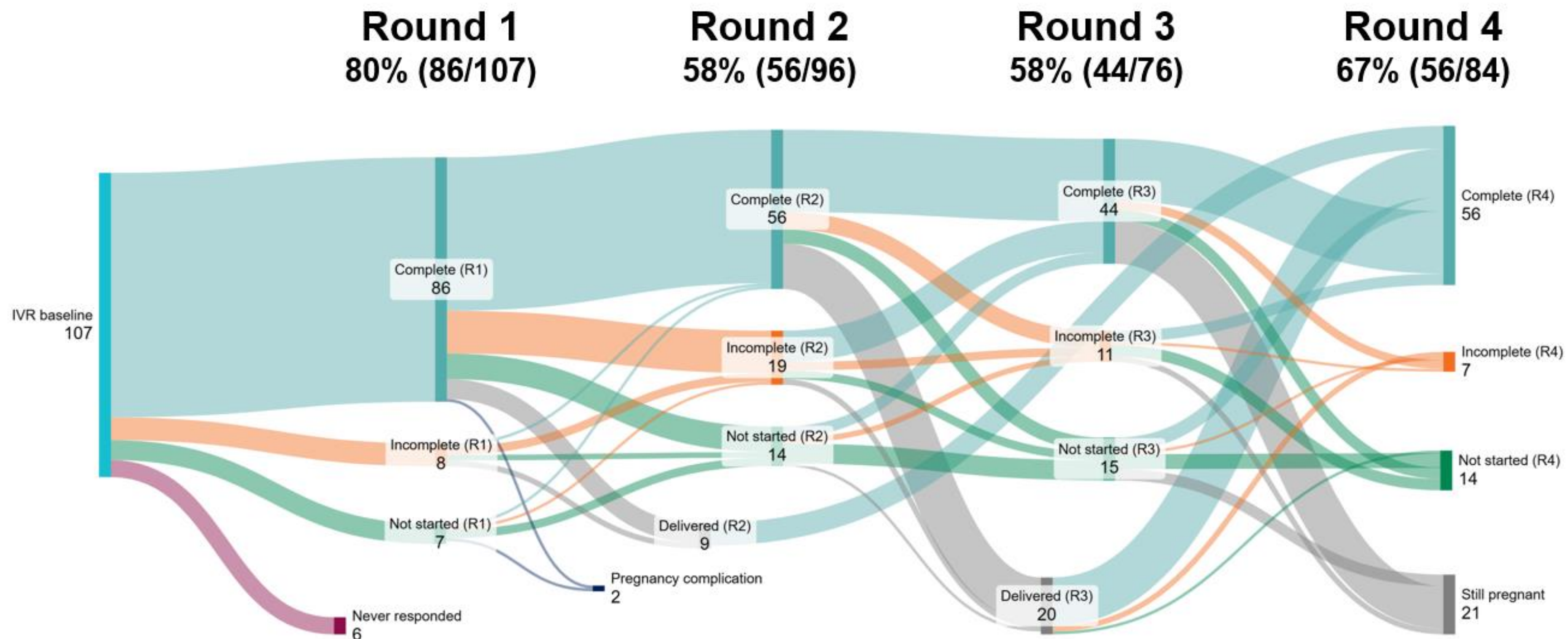
IVR RESPONSE RATES

89%

of IVR participants completed at least one survey

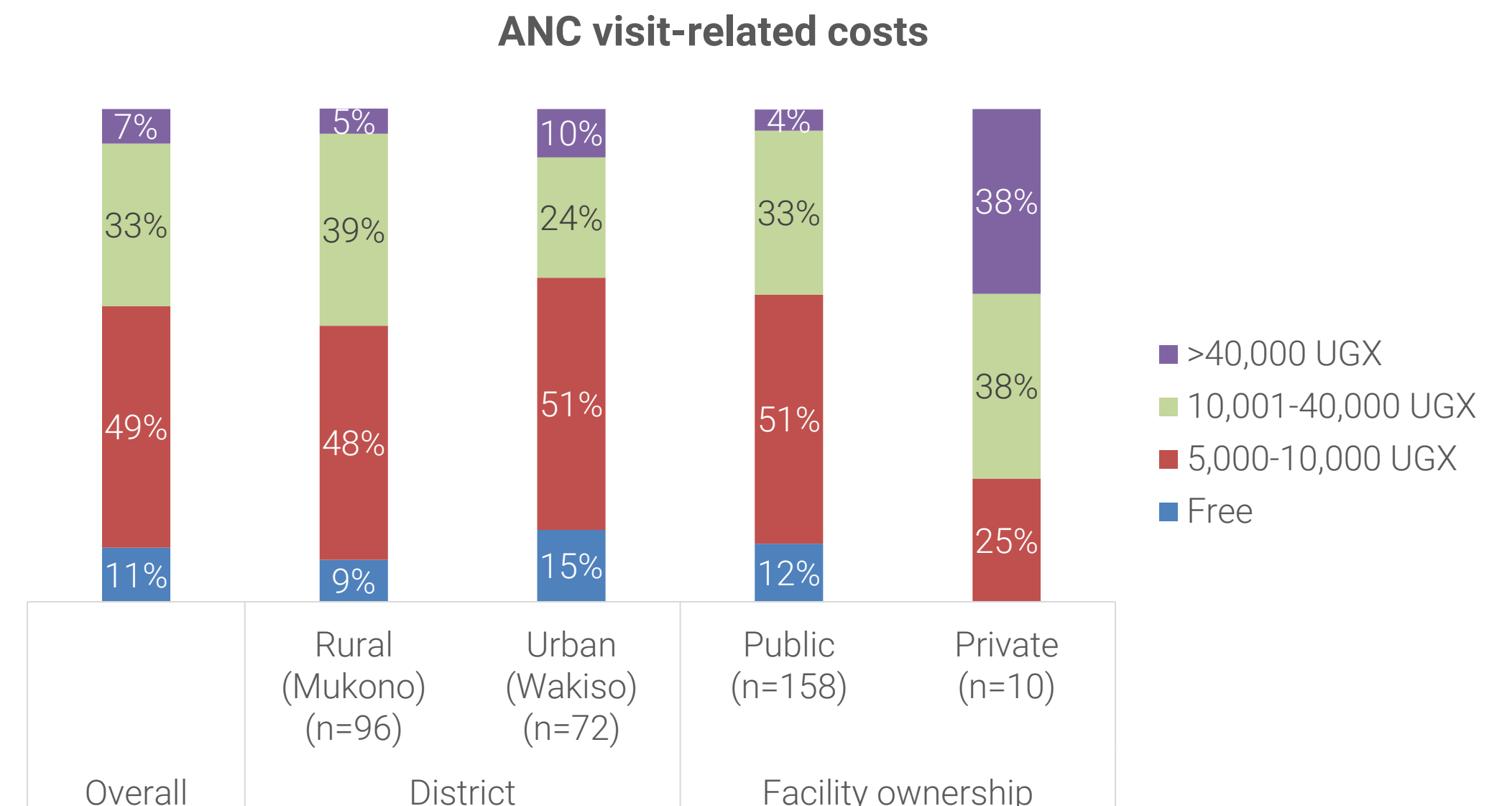
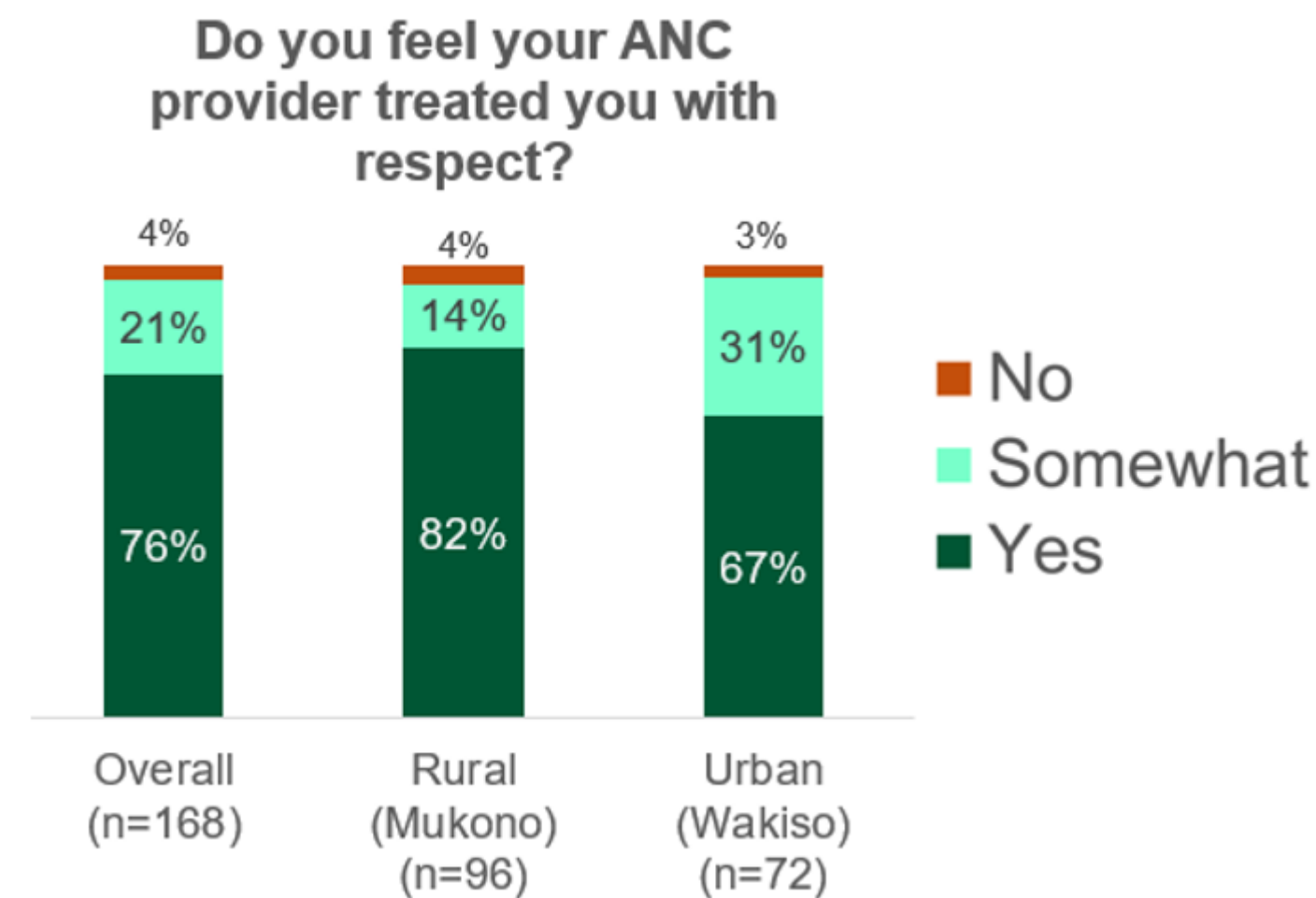
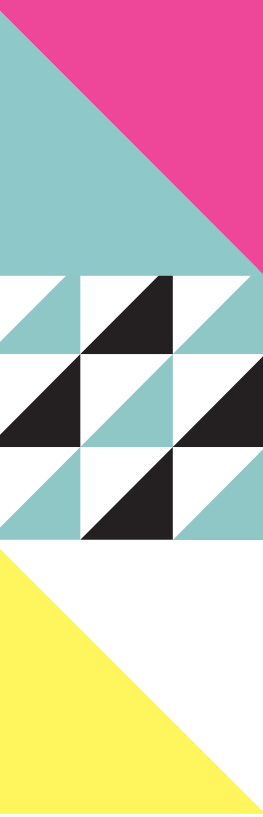
66%

Average completion rate for eligible IVR participants across survey rounds



QUALITY AND COST OF CARE*

- Explored both quality and cost of care through IVR survey
- Despite format limitations (closed response questions w/ limited choices), still able to collect informative data on quality of care (e.g., respect during interactions with providers) and costs associated with care



*Costs include medical services (e.g., scans, medications, etc.) as well as transportation; 1 USD = 3717 UGX

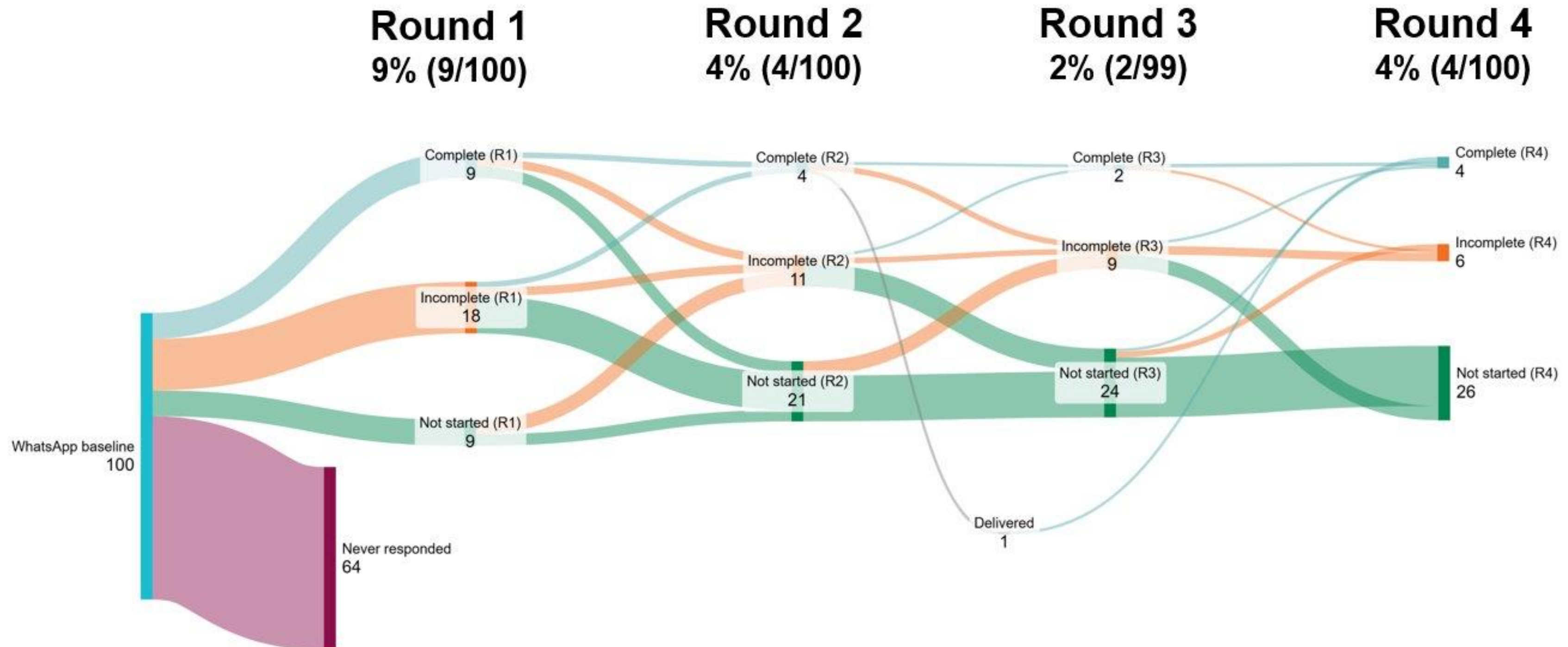
WHATSAPP RESPONSE RATES

11%

of WhatsApp participants completed at least one survey

64%

of WhatsApp participants did not start any surveys



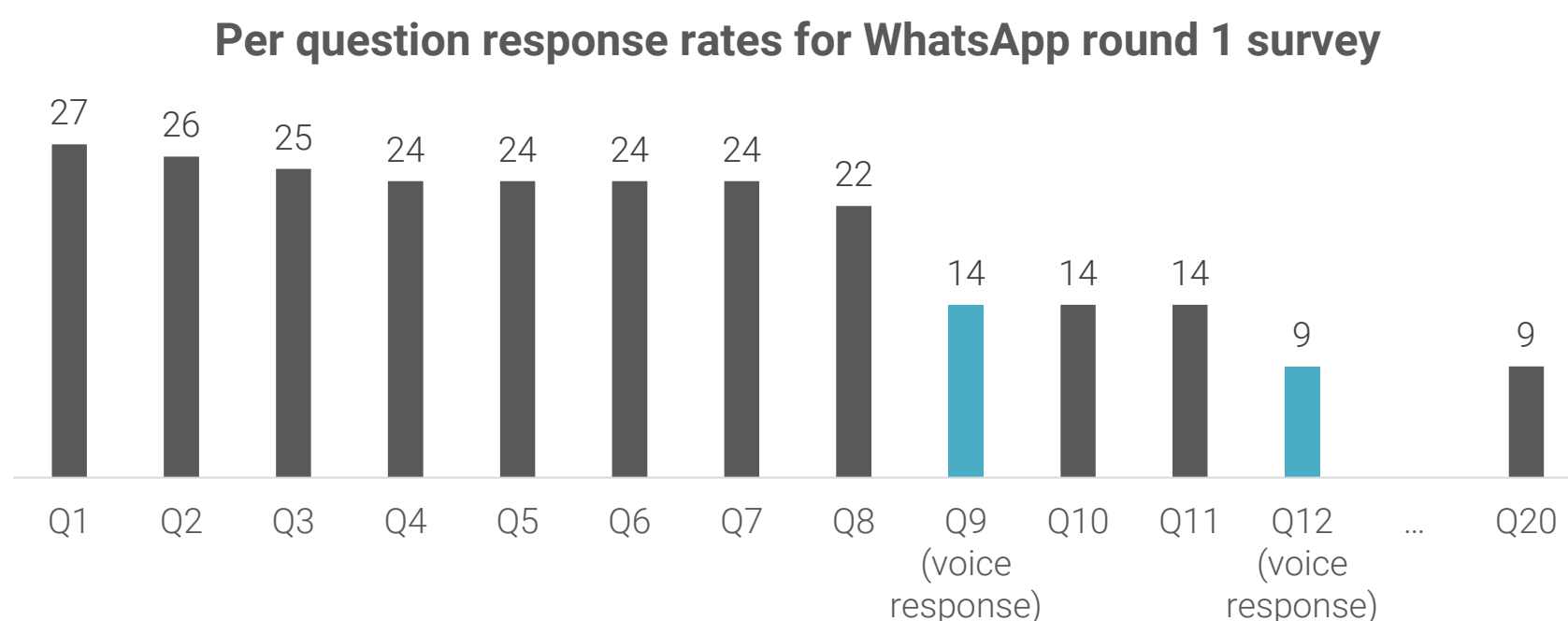


WHATSAPP INSIGHTS

OPEN VS. CLOSED RESPONSE QUESTION TYPES

- Challenges with navigating voice response may have contributed to low response rates
 - Marked decrease in response rates after two voice response questions in survey round 1 (bottom figure)
- Open voice response questions revealed much more about ANC motivations, quality of care received, and ANC challenges as compared to the closed response options of IVR

Comparison of IVR and WhatsApp data richness



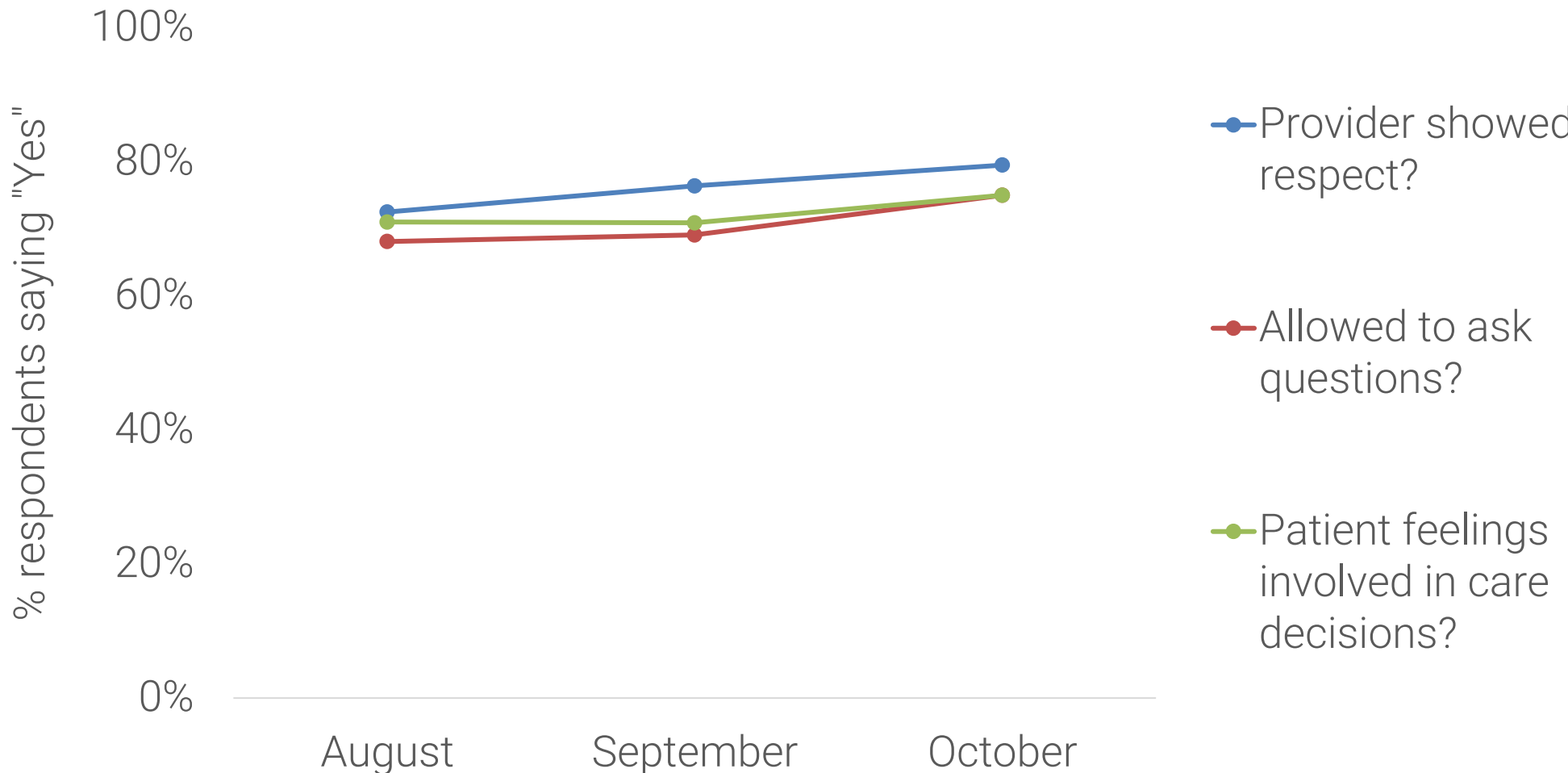
Q. Did your provider treat you with respect?	
IVR (closed choice responses)	WhatsApp (voice response)
<p>76% 21% 4%</p> <p>Yes Somewhat No</p>	<p>“The respect...they try. It’s only the shouting problem that is still there. They don’t disrespect people. For me they respected me very well.”</p> <p>“All those who worked on me respected me because I was with my husband. Every woman if they move with their partners are always respected”</p>



TRADITIONAL VS. REMOTE JM: REAL-TIME LONGITUDINAL DATA

- Routine longitudinal surveys offer the ability to monitor trends in quality of care, including informing targeted quality improvement efforts (e.g., intensified supportive supervision activities at a facility showing low or decreasing provider respect over time)
- Such data would not be feasible to collect routinely through traditional journey mapping due to the intensive resources required, and client-reported outcomes are generally not available through routine data sources such as an HMIS

Changes in quality of care indicators over time (IVR data)



DIGITAL AVATAR SURVEY



Response rate

- When supported by a Research Assistant to provide technical assistance, survey completion was high (88%, n=15); no engagement via WhatsApp

Response content

- High level of detail in survey responses
- Lack of in-person interviewer to provide clarification or probe may have reduced data richness

Comfort sharing health information with avatar

- Most reported feeling comfortable sharing health information with the avatar, although a few did not. All said they'd be willing to participate in future avatar surveys.

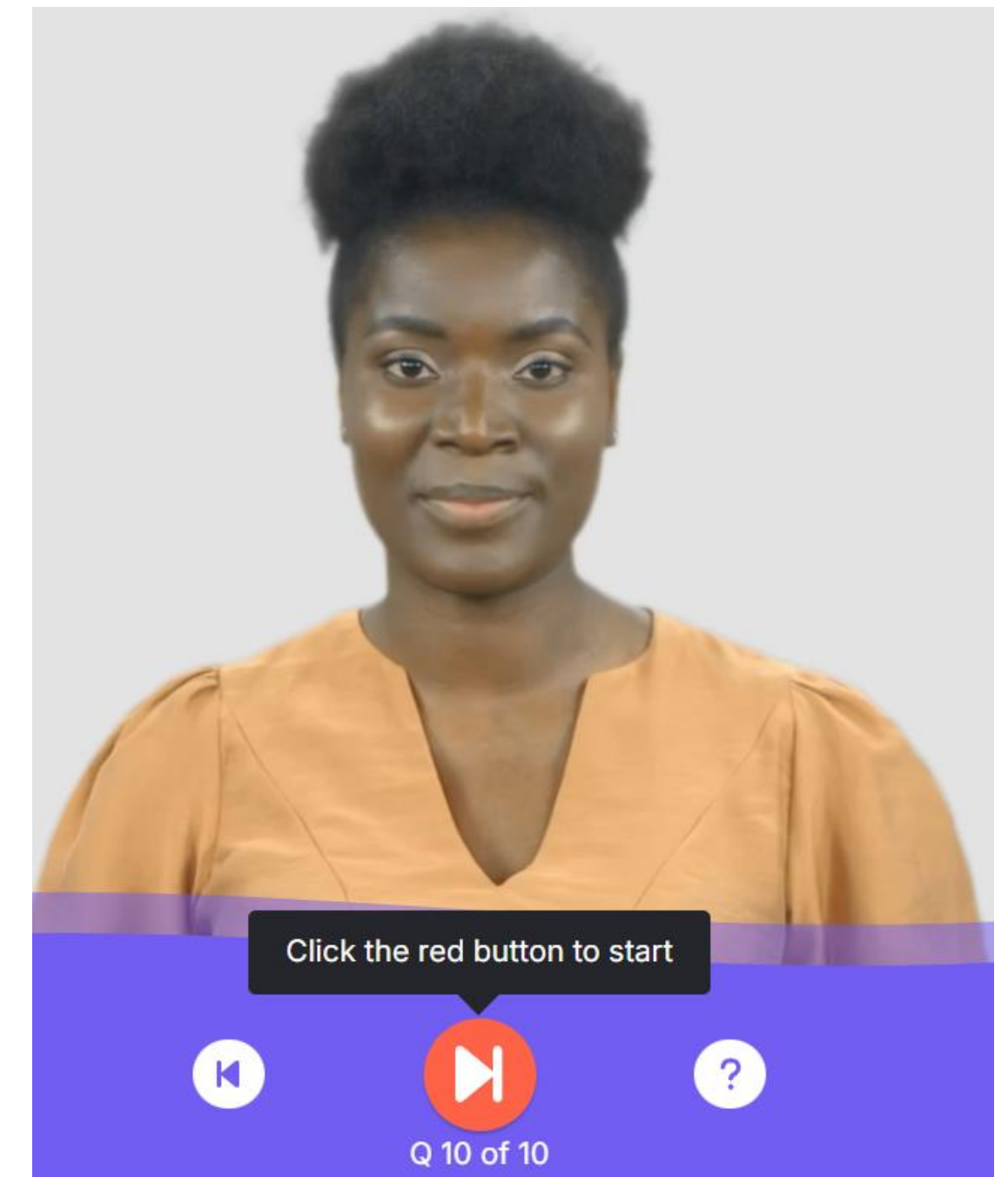
Data quality

- Some data quality issues, including nonsensical responses, which may have resulted from user issues or issues with the automated transcription process

Language

- Local language (Luganda) Avatar preferred over English

AI-generated digital avatar survey appearance



ENDLINE PHONE SURVEY



Sample

- Subset of participants completed endline phone survey (n = 18; IVR = 13, WhatsApp = 5)

Survey content

- All but one respondent (94%, n=17) reported being happy with the content of the surveys
- All respondents said that the number of questions and survey length (approximately 15-20 minutes) were appropriate

Survey frequency

- Half of respondents found monthly surveys not to be frequent enough; a third said that they would prefer bi-weekly surveys
 - However, 88% said they found the four surveys to be sufficient

Trust in digital data collection

- All felt comfortable sharing health information through the digital surveys; all but one felt confident in data privacy (potentially due to community-based recruitment)

Benefits of participation

- Contribution toward the improvement of maternal health service delivery
- Companionship during the pregnancy journey
- Information and education from the questions themselves
- Financial support (via the post-survey incentive)

Future use

- All willing to share their future pregnancy journeys through the digital tools
 - However, only one-third felt that other women would be likely to participate in future digitally based surveys, with 17% saying that data privacy concerns might prevent women from sharing health information
- All interested in using digital tools to share other health information (e.g., child immunization, malaria, family planning)
- A few interested in receiving information for family planning, childcare after delivery, etc.

IVR VS. WHATSAPP



	IVR	WhatsApp
Data format	<ul style="list-style-type: none">Limited to closed questions w/ pre-set response choices<ul style="list-style-type: none">Easier to analyze (quant)	<ul style="list-style-type: none">Pre-set response choices or open voice/text questions
Sampling bias	<ul style="list-style-type: none">Can be completed on any kind of phone	<ul style="list-style-type: none">Sample restricted to participants with access to a smartphone
Participant costs	<ul style="list-style-type: none">Free	<ul style="list-style-type: none">Requires (limited) data to complete surveys
Response rates	<ul style="list-style-type: none">Higher than WhatsApp in our sampleVariable engagement across survey rounds<ul style="list-style-type: none">Some very engaged participants, others only completed 1 or 2 surveys	<ul style="list-style-type: none">Preferred option per our digital preferences survey, but low response rate in practiceResponse rates could be improved by provision of data bundles and excluding voice response questions or better training on completion of that question type.
Start-up costs	<ul style="list-style-type: none">Higher start-up costs; changes to survey (e.g., adding questions, changing response options) also have costsPer survey costs once implemented is more reasonable	<ul style="list-style-type: none">Lower start-up cost compared to IVRCan be more feasibly designed/implemented internally (depending on technical capacity of organization)

NEXT PHASE LEARNING AGENDA



1. To what extent can supporting participants with data bundles at the time of survey receipt contribute to increased WhatsApp response rates?
2. To what extent can training for respondents on how to answer open-ended questions on WhatsApp lead to richer and more robust data?
3. How can AI voice calls be leveraged to introduce Avatar survey links and drive-up response rates when the Avatar is deployed through remote engagement mechanisms?
4. How can multiple remote engagement mechanisms be combined to longitudinally track a nationally representative sample over a period of time?
5. How can remote engagement mechanisms offering close-ended questions be used to understand general trends, complemented by channels offering open-ended questions to further probe for additional detail?
6. With larger sample sizes, how can we use longitudinal tracking to understand consumer experiences before, during, and after interventions promoting more responsive health systems?
7. How can AI be used to quickly analyze data collected across remote engagement mechanisms to reduce human costs associated with transcription and qualitative analysis? (building on what we tested with IDI and avatar analyses)
8. How can governments implement these data collection strategies at scale, including building systems for data-driven decision-making?
9. What is the benefit to governments of reviewing systems level data (service delivery, coverage, human resources performance, etc.) in conjunction with consumer level data to pinpoint health systems challenges and swiftly address them?



NEXT STEPS

1. Validate results with Ugandan MOH (Feb. 2025)
2. Assess whether the remote approach can be institutionalized and scaled by the government
3. Conduct additional research to test expansion to PHC
4. Adjust WhatsApp and Avatar approach to increase response rates (e.g. airtime bundles, AI voice calls, etc.)
5. Integrate surveys into health promotion campaigns (including national health hotlines) to assess how consumer journeys differ with and without interventions

CLIENT EXPERIENCE OF CARE (CEC) MEASUREMENT



Project / focus areas	Goal	Location of data collection	Status
Cross-cutting client experience of care (CEC) metric	<p>A cross-cutting metric/toolkit for measuring client experience across health areas, service provision sectors and channels, and geographies.</p> <ul style="list-style-type: none"> Builds on a literature review of the current client experience metric landscape conducted in 2023 & expert advisory group convening and KIIs among key stakeholders to develop conceptual model / use cases 	TBD	Conceptual framework/metric development
Women's experience of care	<p>Gates Grand Challenge's award to test novel metric development methods via digital data collection to develop metric to measure women's experience of care</p>	India, Kenya, Nigeria, Guatemala	<p>Metric development</p> <ul style="list-style-type: none"> Data collection expected to launch in Q1 2025
Family planning/ANC/PNC toolkit & metric	<p>Novel indicator of client experience of care that is relevant to all family planning, ANC, maternity, and PNC clients</p> <ul style="list-style-type: none"> Composite tool pulling from existing validated PCC/CEC metrics 	Benin (as part of MOMENTUM project)	Final analysis
Self-care metric	<p>Novel metric of self-care experience, reach, and equity among contraceptive self-injectable users</p> <ul style="list-style-type: none"> Respond to key evidence gaps and provide critical insights for self-care program and policy design, implementation, and scale-up 	Malawi	Final analysis



THANK YOU