Evaluating Adolescent and Youth Sexual and Reproductive Health (AYSRH) programs embedding the Human-Centered Design Process: Thoughts from a Monitoring, Evaluation, and Learning Expert.

Interview by Peter Nasokho, Monitoring, Evaluation and Learning Lead, HCDExchange

About Bram Brooks, DrPH

Dr. Mohamad Ibrahim (Bram) Brooks is a public health professional with over 15 years of experience managing, implementing, and evaluating health and development projects in low- and middle-income countries. Bram works as a Senior Manager for the Global Monitoring, Evaluation, and Learning (MEL) team at Pathfinder International designing performance monitoring systems, implementing applied research studies, and disseminating evidence-based results and program learning within the global health community. Before joining Pathfinder, he worked as a researcher at Boston University's Center for Global Health and Development and as a consultant with international development organizations such as the World Health Organization (WHO), the Bill and Melinda Gates Foundation (BMGF), and the United States Agency for International Development (USAID) in technical areas including sexual and reproductive health, maternal and child health, and health systems strengthening. Bram has a Master and Doctorate in Public Health from Boston University School of Public Health.

Could you please tell us your personal journey working in AYSRH as an evaluator?

Bram's reflections

Yeah, sure. So, my path is somewhat circuitous. I've been doing M&E in global health for about 17 or 18 years. I'm a mixed methods researcher by training, I have my master's and doctorate in public health. And when I started my public health career, many moons ago, I mostly focused a lot on infectious disease work. So I trained as an epidemiologist, I did a lot of evaluations of infectious disease projects. When I was doing my doctorate, a lot of my dissertation focused on work related to maternal health. And, from there, when I joined Pathfinder International almost a decade ago, I walked into the sphere of family planning and reproductive health. So, as we think of the RMNCH spectrum of all those different health topics, starting from infectious diseases, to maternal health to family planning, it's then that I became more exposed to a lot of the Adolescent and Youth programming. A lot of what Pathfinder activities focus on is AYSRH programming. So that's kind of like the journey through the different technical domains - kind of like a curving river as I worked on other technical domains, but eventually then moved into the Adolescent and Youth sphere. As a researcher, I started my career in academia, in Boston University School of Public Health, where a lot of the emphasis as a researcher is to answer research questions, to try to get things published, either at international conferences, journals or manuscripts. But then when I left academia, I moved on to doing consultancy work with WHO, USAID, the Gates Foundation, mostly looking at process evaluations. And then when I worked at Pathfinder, it's a lot of emphasis on the monitoring element of M&E. I started as a researcher, and then moved to the realm of monitoring, where I understood some of the techniques and strategies to figure out whether projects are working or not. Sometimes, you don't need a complicated research design, there are other tools and tricks of the trade that allow you to figure out whether those programs are working. It's from there that I have a better appreciation of the world of M&E, but also a better appreciation of working in the realm of AYSRH, so that's kind of my quick journey being an AYSRH evaluator.

I would like to look deeper now into evaluation specific to HCD in AYSRH, I know you did this in the Beyond Bias project. Can you tell us a little bit about your personal experience working on evaluation specific to HCD+AYSRH?

Bram's reflections

So, one of my assignments at Pathfinder, a few years ago, was to be the MEL Lead on the Beyond Bias project, which is a project that uses HCD approaches on AYSRH programming. And in this particular case, Beyond Bias was trying to develop new interventions, new modalities to address the issue of provider bias - health providers, doctors, and nurses not wanting to give adolescents family planning methods to use, because they were too young, they didn't have any kids yet, or they weren't even married. So, there are a lot of issues of social norms wrapped into this project. As the MEL Lead, I was in charge of the MEL plan and the MEL approach. This was a Gates funded project so there was a requirement by the donor to do a rigorous evaluation. So, with that, we were partnering with the RAND Corporation, who are our external evaluators. We wanted to make sure that there was objectivity between the implementers (Pathfinder International) who were working with partners such as YLabs and other colleagues developing the intervention, versus, the external evaluators whose main task was to find out if the intervention was effective.

Bram's Reflections

That was my first exposure to working on an HCD project. As a researcher and an evaluator, you think about study options and methods to evaluate whether the program was implemented as designed or if the intervention is working. But in an HCD project, you sometimes don't even know what that intervention is going to be. So, it was challenging to figure out what I'm monitoring and evaluating because the intervention hasn't been designed yet. As we use HCD approaches, you're getting a lot of end user feedback and a lot of client experiences to help develop the right intervention. We had to figure out what's the best way, what M&E systems and tools can I use to figure out if this is the right intervention. So anyways, the way we tackled our M&E approach was in two phases: an initial phase of thinking about M&E systems to figure out whether we are designing the right intervention and then a second phase where you're actually evaluating the intervention. As you know, RAND Corporation took the lead with that second phase. I felt like the external evaluator's job was relatively easy - they ran a randomized control trial to answer a simple research question. For me, it was very challenging in the first phase to figure out the appropriate monitoring and evaluation systems for an intervention that kept changing over time. It was a crash course for me to figure out how to evaluate an HCD intervention – but it was a good experience nonetheless.

So, for the RAND Corporation, did they use the randomized control approach for the evaluation?

Bram's Reflections

They did. So, I said earlier that RAND had an easy job, but that is not entirely true. Anytime you run a randomized control trial (RCT), there's a lot of challenges to consider – both logistically and technically. You know, it wasn't easy for us to figure out how to measure provider bias. Because it's a new intervention to address the topic of provider bias, we wanted to have a rigorous methodology to provide the necessary evidence to show to the global community that this intervention that we developed was effective in changing the key outcomes of interest. So yes, we used an RCT for the evaluation phase of the project.

Any challenges they faced during the evaluation?

Bram's Reflections

I feel like the whole Beyond Bias project was an exercise in patience and an exercise in problem solving. All we did was to try to figure out how to solve different problems every month. A few things that were challenging, I think, from an evaluators' perspective, is trying to figure out the outcomes that we wanted to measure. We were trying to address the issue of provider bias. And at the end of the day, you know, the program is an intervention targeted to health providers. So it's a supply-side facility based intervention to train the provider so that they have more positive attitudes and behaviors when it comes to FP counseling and FP service provision for youth. So, the intervention is targeted at the providers. So, it's important to figure out some of the outcomes there. But you're also trying to measure the outcomes at the client level. So are the clients seeing improvements in quality of care and better patient centered care? Are we seeing changes in method mix? It was difficult to figure out what the right measurements were. And when looking at the client level are you trying to focus outcomes at increasing FP uptake, changing method mix amongst youth, or are you looking more at the quality of care? It's also tricky to assess judgmental care – whether you were scolded or judged by the provider. A lot of the quality of care focuses on questions like the method information index, you know, whether providers talked about side effects, alternative methods, etc. Here we're looking at judgmental care. And it's tricky to figure out the right questions, like do you feel judged? Do you feel scolded? You can also use questions like, would you recommend the provider to your friend? In addition, each culture has a different way of whether they felt judged by a provider during that FP counseling session. It took a while for the evaluation team to figure out the right set of outcomes. In the end, we decided to measure everything, we're going to look at outcomes at the provider level to track changes in their attitudes and behaviors, we're going to track changes in terms of quality of care, and whether they as the patient are seeing better FP services. We're also going to measure the perceptions of care. Do you feel that you had good care? Did you feel like you were being judged? So, at the end, we were tracking over 20 outcomes across those different levels. It was challenging trying to make sure we were measuring the right metrics and the right outcomes of interest.

Did you experience healthcare provider attitude problems? Did you have a context of outcomes based on different age categories of the providers?

Bram's Reflections

We looked at different types of providers either based on their age, the type of CADREs - whether they're nurses or doctors, the type of experience, we looked at the different profiles and characteristics of the provider, because you're right, you know, those who are older might be more set in their ways. So we did try to measure some of those elements. I don't know if we saw any drastic changes. But I think as you're talking about a health facility intervention, I think it's a reminder to us that the provider is living in a context of how he or she, as the provider, interacts. And I think it was interesting, because originally, when we tested the evaluation, the evaluation was primarily focused on quantitative results. When you do an RCT, you look at key outcomes of interest, and you get to see significant changes (or not). But I think we were able to successfully convince the donor, in this case, the Gates Foundation, that we should consider doing a mixed methods study design. That might be my bias as a mixed methods researcher, but it is sometimes important to understand the context such as the challenges in the health systems and the background issues that we need to be aware of. I think that it was strategic to conduct a mixed-methods study to better understand why we weren't seeing any changes in key outcomes of interest, is that because we were doing a poor job implementing the intervention? Or are there other contextual issues that are at play? For example, in settings like in Burkina Faso, there's a lot of health system issues. I mean, we're at the point where there was attrition and turnover of 20-30% of health providers. If you had about 100 providers that you started and trained at the beginning, towards the end, you only ended up with 70. So, you know, there were elements of the health system that were important to factor in. In addition, Burkina had coups and other political issues, for example, there were points during our project where the providers weren't being paid their salary. If providers aren't being paid, it's tough to make sure they are incentivized to provide quality care. So, it was very important for us to keep tabs and pay attention to the contextual issues, which, we were able to capture from the qualitative interviews and approaches.

Getting some of the data that you might need from their health HIS might be a challenge. So even just looking at if the uptake of FP as an indicator changed, you're not very sure.

Bram's reflections

We talked about the importance of the contexts that providers are working in, whether they're getting paid, the high level of attrition, etc. There are also elements of the health facility to look into. For example, do they have health providers that are trained in providing LARCs? Do they have a supply of LARCs?? Do they have the implants and IUDs in-stock if a user wants those methods, so all these things are connected? In the Beyond Bias project, we tried to address those issues by implementing this pilot, the RCT study, in sites that had prior support. We had platform projects that were doing supply side strengthening making sure that facilities had the necessary FP commodities, and providers were trained to try to better isolate the effects of the Beyond Bias intervention in changing provider attitudes- and improving the quality of FP care to youth.

Did you get to a point where you got the results, the outcomes had changed, but then you could not measure the causal effect of that change?

Bram's reflections

Yeah, so it's interesting. I think we had a tough time when it comes to how you interpret the results, especially when you have so many outcomes. So, I think we felt pretty good. We have strong evidence that the intervention changed the providers' attitudes - so that's good. And then when you move down the theory of change, looking at the client level outcomes, for the most part, we saw pretty good changes in terms of quality of care. And then when you look at perceptions of care, like how the client felt they were being treated, you also saw pretty good improvements. What we didn't see was positive changes in FP uptake. There are several potential reasons for this - it's a short timeframe, we only implemented it in one year and it can be hard to see behavior change such as FP uptake take place in a short period of time. Because it was a supply-side intervention, facility-based provider training, there was no demand generation. So, we weren't bringing in new youths to the facilities that could have benefited from new clients that could have taken an FP method. As a result, we didn't see any changes in MCPR and FP uptake. And then the final thing is, because we're implementing the RCT on platform projects, project sites that are in pretty good shape, i.e., they have health system strengthening, they have FP commodities - it means that your FP performance on those sites are quite high. And when it's quite high, your ability to move the needle on measures such as FP uptake is limited.

Bram's Reflections

So anyway, we had to figure out how to interpret our results. It's always good, as you know, to have your theory of change to help figure it out. You know, does this make sense and does it logically connect as you triangulate your qualitative data to provide some context? Nothing's more frustrating when you see no significant results and you can't find the reason behind this. Hopefully, the qualitative data will give you some potential answers and will provide you the context that you need.

Talking about the theory of change, how did the planning process for the evaluation go for this HCD project? What changed during the course of the project?

Bram's Reflections

Yeah, I feel like whenever you're working on an HCD project, things will automatically change. The intervention will change your theory of change. So, in the beginning, we had a loose theory of change, just trying to figure out, alright, we're trying to deal with the problem of unmet need among youth. We're trying to increase FP uptake amongst youth, what are our potential interventions? So, we had a very loose and generic theory of change that we had to refine once we had a better sense of what those interventions would look like. Once we were getting ready for the evaluation stage, we had to tighten and provide more detail into our theory of change. It was helpful for the M&E team and the research evaluators to figure out, what are the outcomes that we want to look for? What are the outcomes at the provider level and at the client level? What are potential outcomes on the health system? It's nice to have a framework to ground your outcomes. And just to make sure, like, if this is supposed to change that, is that going to contribute to that? And if that doesn't happen, what are the other options? So, it's nice to have a framework for folks to align their thinking and align the measurement goals. I felt that we tinkered with our theory of change multiple times. And the thing is, as you know, working in a multi- disciplinary team with different expertise – for example, our evaluators were health economists, we have HCD experts, we also have SBC and FP professionals, etc. All this different expertise means that sometimes you are speaking in different language. And it was nice to have a theory of change, where we were able to see eye-to-eye because there's some language in HCD that I couldn't quite understand or had limited familiarity with. For example, the health economists only wanted to measure things quantitatively, while SBC folks wanted to see the nuances. In any case, the theory of change is a nice grounding framework for the different stakeholders to work together to see common goals and understand the different connecting points.

Are there any factors that you considered in the process of this evaluation that was specified during the planning for the evaluation?

Bram's Reflections

Yeah, we tried to capture as many factors as we can. There's a framework called the CFIR – Consolidated Framework For Implementation research that gives you a nice categorization of key factors that you should be thinking about when looking at key implementation factors. That can be helpful when you think about how you structure your qualitative interviews. There's also the Expand NET Framework, which is thinking about how to scale up interventions and address issues of institutionalization. These frameworks are helpful because there's so many factors out there, and you need some sort of guiding principle to make sense of things. And as you could probably tell, I'm someone that likes framework, the world is messy, things are confusing. If I can visualize it into simple graphics, it helps. So, we tried to do our best using existing frameworks such as CFIR and Expand NET to make sure we were asking the right questions when it came to the qualitative components. There are also other important elements to consider, such as team dynamics and cultural factors to consider when you're working with many stakeholders. Just to make sure everyone's on the same page, because you know, these are people with different experiences and different backgrounds, and sometimes different languages too. For example, it was confusing at times to understand the difference between prototype type versus intervention versus piloting when you're working with HCD Experts. In addition, it's also important to have a culture of curiosity and mutual respect as you are working towards the same goal. As an element of team building, building spaces to understand and work effectively together is an important element of project management that often, most people with technical skills and background, just sometimes forget, As they say, you have to be able to play nicely in the sandbox.

The multi-centered approach teaches me that whatever interventions, and when you're trying to do the scale, what works in Kenya might not work in Tanzania?

Bram's Reflections

Precisely, and that was very challenging. And again, anyone who's worked in the realm of HCD, when those interventions keep changing, especially when you have three countries, this approach might work in Pakistan, but it might be very different in another country. So, there are a lot of discussions that we had as a team – for example, can we have one standard intervention modality that can apply to all three countries? Because you're trying to customize it to the local context, it's an interesting experience for sure.

I'm looking at the experiences from the key learnings on evaluation for HCD AYSRH. What were the key learnings that were learnt in the process evaluation? I will let you respond to the process evaluation first, and then maybe we go to the program evaluation.

Bram's reflections

Yeah, I think the process evaluation is tricky when you're trying to figure out whether an intervention is promising and whether or not it's working, I think you have to feel okay relaxing some of the rigor and methodological approaches. And a lot of research evaluators want to use the most robust research methodologies out there. But when you're trying to figure out whether an unproven or newly developed prototype works, you have to relax those expectations of rigor and think about quick ways to figure out if this is working or not. It may only be a bunch of focus group discussions with youths or end users like health providers to give you a sense of whether or not it's working. You might use a simplified version of qualitative approaches and interviews, especially as we are trying to figure out the right intervention modality. It's also helpful to manage those expectations accordingly. What are ways to quickly figure out whether interventions are working or not, or whether your prototypes are working or not. Can we use qualitative interviews and focus group discussions? Can we do quick surveys with the providers to see if some of those intermediate outcomes of interests are changing? You have to be quite agile and fast because an intervention may fail so you don't want to invest too much of your M&E resources as you figure out whether this is working or not. And if your protype works, you have to pivot or think about another strategy. For process evaluation approaches for HCD projects, it might be helpful to relax your expectation on the methodological rigor and work with the team to figure out what are the data sources that make sense, to quickly figure out whether your prototype is working or not.

By testing prototypes, you're not sure if they will work or not and you have to change them. If you use the traditional approaches it will be a little bit difficult to get to the result, maybe you can get results, but they're not conclusive.

Bram's reflections

Yeah, and how do you phase your M&E approach for prototyping when you're not certain that a prototype is going to work out? And then when you have a more refined prototype, can you test for a longer period of time? Can you strengthen your data sources to give you more confidence that it works? There are these newer complexity-aware monitoring approaches, such as most significant change, outcome harvesting, etc. – but these can be challenging to implement correctly. Again, you have to move quickly in an HCD project and sometimes you've got to decide in a week whether the prototype is working or not. And you've got to go fast. You know, the traditional researcher is like, Ah, I'm going to figure out my interview guide, develop my research protocol, hire my enumerators, etc. At that point, the team has already worked on a different intervention. So, you've got to move quickly to produce the right data that allows you to make the right decision at that time.

Indeed. Maybe you can go into the program evaluation?

Bram's reflections

Yeah, the program evaluation was more straightforward for us because it was a mandate by the donor, the Gates Foundation, to do an external evaluation, using robust, rigorous methods. So, we used an RCT study design. As I had earlier mentioned, we had some challenges making sure we had the right framework and that the theory of change made sense, but to me, I think that it was relatively straightforward. The program evaluation, the RCT, the impact evaluation, because now that you're implementing a more traditional research evaluation approach, it wasn't that bad. Again, we had some challenges in interpretation - making sure that we were able to interpret our findings correctly, challenges on making sure we had the right metrics, making sure we had both quantitative and qualitative approaches. But to me, the program evaluation was more straightforward, more standard, because you had your intervention package, you had your final solution set and you're just evaluating for a year with a traditional RCT.

What areas of learning or innovations need to be explored when it comes to integrated designs in health programs or integrating design in programs?

Bram's Reflections

A potential learning area for innovation is how to do the HCD performance monitoring in a more standard manner. I'm talking about rapid learning and rapid M&E systems. And to me it's difficult to do that when the prototypes and interventions continue to evolve and change as you find the final solution set. And I don't know if there are some guiding principles that M&E professionals working on HCD should consider. So, to me, one of the learnings is that we have to simplify our data collection approach and we have to move quickly. And when you simplify and try to move quickly, you're sacrificing rigor - it's not really about the sample size, and whether you can get p values, you're just trying to make sense whether this prototype is a solution worth pursuing. And at this point, you are thinking about qualitative approaches. So I think for the process evaluation, in your assessment of whether prototypes are working, having a mixed methods approach, having an adaptive M&E performance monitoring system, where you can do a quick checklist and quick and simple data sources, talk to the relevant key stakeholders and end users, so that you can get data quickly and then pivot as needed. So, to me, there's a lot of learning that I have experienced from this, making sure to use mixed methods approaches, simple data collection, data analysis strategies, and being able to pivot. But there might be opportunities to better standardize, and you might have a better sense as you talk to implementers and evaluators and in the HCD field to see if there are any common themes that you're observing at the higher level as you interface with all these folks.

We might need to come up with standards that guide the evaluation process for programs that have embedded HCD. I think we need to have experts come together to talk about it and document that, just as a way to guide anyone who wants to develop tools to capture quick results.

Bram's reflections

It might be very challenging to come up with standards, especially when your domain jumps from Health, Education, climate rights, etc. I don't know, if it might be a losing battle to come up with those standards, maybe it's more of guidelines and checklists, for example, basic theories of change that implementers and evaluators can agree upon, you know, what are we working towards and what are some quick, adaptive, and continuous monitoring systems that allow you to get data more quickly and efficiently. I think the other piece is also building in pause-and-reflect sessions. Sometimes the HCD teams are going so fast that it can be difficult to understand how you are interpreting results and findings as a group so we can all move together to the next chapter and gain consensus. There are a lot of key components about HCD that means developing standard guiding principles or checklists might be helpful for this community. And maybe that's where the global movement is going towards.

If you are given another chance, what will you do differently?

Bram's reflections

I think I would do a few things differently. I think there's an important element of team management and team culture. All too often, you know, in these big projects with multiple consortium partners, there are HCD designers, external evaluators, technical advisors, etc., I think we need to be careful and make sure that there's a strong team culture so we're all working on the same page. I think more emphasis on linking and making connections between implementers and evaluators will be helpful. It's a lot of time and investment, especially since these donors want to see results in a short timeframe. I think we need to emphasize upfront the importance of project management, team dynamic, and fostering a learning culture. As you can see, I'm moving outside the realm of like, M&E to general project management. I think it's important for us to note and find ways to pause and reflect. Yes, it takes time. But I think it's worth it in the end to make sure that we're all moving together. So, I think there are elements of project management that we need to consider carefully, in addition to the important elements of theory of change and measurement. Another piece is also being open to novel or simple performance monitoring approaches. As an evaluator, I like to make sure I have carefully developed interview guides, have the appropriate sample sizes, etc. - I think we need to be flexible on the types of data sources that we can use for rapid feedback. For example, maybe we can have quick conversations with implementers and designers to see if we want to pivot or abandon a prototype and move on. I think those are some of the elements that I would do differently.

What is your advice on what evaluators and designers should do to work well together given different tasks?

Bram's Reflections

There's something important about team dynamics that will make your project run more efficiently and your team to work in a unified manner - I think it's an important practice. In addition, it can be strategic to build in pause-and-reflect sessions. You've probably worked on enough USAID projects to learn about CLA and making time to make sure you understand what's happening throughout different time points of a project. I think I'd like to also emphasize the importance of a strong theory of change that will lay out the causal pathway and help you identify your primary, intermediate and output level outcomes that will be useful to get everyone on the same page. And again, I think it's best practice to have a culture of curiosity and respect so you can get different partners and stakeholders to work effectively. And for evaluators, maybe we can be more flexible on novel or new monitoring, data capture approaches. For example, maybe we can use our meeting notes as part of our data sources to figure out whether these prototypes should be pivoted or abandoned? Can we use simple checklists with key stakeholders to make these informed decisions? In any case, a few points to consider.

Sure, I think, I agree on the simple data capture approaches, because sometimes people don't think that if you have a meeting, that those discussions from that meeting can serve as a data source as decisions from the meeting affect the direct implementation of the project. The meeting notes will be used to validate for any changes.

Bram's reflections

I think that documentation is important because those key decisions are based on implementation experience, or some sort of data that allows that decision maker to make informed decisions. For example, meeting notes I think are good data sources for us to consider. And then you mentioned the important element of team dynamics. Right? It seems like the evaluation team wasn't fully appraised of some of the earlier pivots or adaptations to the model. And then the point on theories of change, right? Like we can't quite agree what we're trying to do and how this intervention is affecting those key drivers or key factors that we had envisioned. So again, there's something to be said about that, the importance of better team dynamics, better culture of respect and curiosity, and just better ways of helping each other out. At the end of the day we're one team, we succeed or fail together.

Would you share any favorite moments or an inspiring story from the evaluation?

Bram's reflections

I feel like my favorite moment - just like a marathon runner – is that we crossed the finish line and that we were able to successfully end the project amidst all the challenges between partnerships, designing prototypes, implementing a complex evaluation, etc. For me it was nice to see this project all the way to the end. Alright, here's our final report, Gates Foundation, we've crossed the finish line achieving most of the outputs, outcomes, and deliverables that we had intended to do. Again, it was a challenging project tackling a complicated AYSRH issue, with challenges from the measurement perspective, but also managing the different stakeholders. It was a sense of accomplishment that I was able to see the whole process from beginning to end and experience the good, the bad, and the ugly and the enrichment for my own learning. It was a rewarding and satisfying experience. I felt like I learned a lot from this experience, got new strategies, you know, made new friends along the way. So, it felt nice and rewarding to cross the finish line.

But you won of course, because you got the outcomes?

Bram's reflections

Of course, we crossed the finish line. We didn't change the primary outcome of interests which was to increase FP uptake amongst youth in all our 3 countries, but I think we had reasonable interpretations for why we didn't see this result – which had to do with health system issues, the short implementation timeframe, etc., I felt proud that we crossed the finish line. I think at the end there's a lot of excitement, in particular with Beyond Bias and on how to scale it up. So now my task at Pathfinder is working with colleagues around the world to figure out how to scale it up? If we know that we've got strong evidence and that this is a promising intervention, how do we scale it up? And as we scale it up, we realize that we have to make further adaptations and further changes. So, these elements of pivoting, thinking about the data sources that we want to use to make a determination, will be important as the scale-up version of Beyond Bias may look very different to the original intervention. And to me, it's exciting to learn from this experience and figure all this out.

Looking at this, is there any final advice to evaluators evaluating design in health programming?

Bram's Reflections

Yeah, I think we have to remind ourselves why we're doing this – which is trying to improve the lives of vulnerable populations, such as adolescents and youth. When there are challenges with timelines, I think trying to be calm and trying to see the bigger picture is important. Life is short, you know, we're trying to make differences to tackle some of the inequities that we see in the world, and we're trying to provide better services and higher quality care for communities in need. I think having that north star or guiding principle for the whole team will be helpful, both for you and the whole team. So, I think that's one piece of advice to consider. It's more of a reminder of why we're doing this.

Do you have any plans to continue working on HCD in AYSRH as an evaluator and in global health programming?

Bram's reflections

So yes, as an evaluator, I want to know whether things are working and whether we're seeing the outcomes that we intend to see. So yes, I would like to be an evaluator for HCD in AYSRH. But I also want to think carefully about monitoring the process evaluation systems, some of the simpler, more straightforward data capture systems on the front end of the prototyping. So definitely, as an M&E professional, it's exciting to figure out whether things are working or not. So definitely HCD in AYSRH, but since M&E is cross-cutting, I'm also doing a lot of work in terms of climate change, climate resiliency. So those are elements where I hope to use some of my learnings, approaches and strategies to figure out how to apply HCD in climate change and other programs. It's fun for me to learn how to measure and evaluate different things, because at the end of the day, we're professional bean counters and we can count and measure anything. So happy to apply these skills in different contexts.

Organizational website: https://www.pathfinder.org/

Beyond Bias evaluation report: https://www.pathfinder.org/wp-content/uploads/2022/03/Beyond-Bias-Project-Evaluation-Brief-English.pdf

Find Bram on LinkedIn: linkedin.com/in/bram-brooks-b893935