



Catalysing the adoption and scale-up of innovative maternal and newborn health interventions within the health system of Uttar Pradesh, India: findings from a qualitative study

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Improving health worldwide

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IDEAS overview

- *Informed Decisions for Actions in maternal and newborn health* is grant by the *Bill & Melinda Gates Foundation* to the *London School of Hygiene & Tropical Medicine* 2010 to 2015
- Aim: improve evidence for maternal and newborn health (MNH) programmes in northeast Nigeria, Uttar Pradesh in India and Ethiopia
 - Evaluating BMGF's MNH strategy – programmes and investments
 - Offering lessons for policy and practice



Estimated 6% of the world's population, 10% of global births and 16% of global maternal & newborn deaths



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Our objectives

1. To build capacity for measurement, learning and evaluation
2. To characterise innovations
3. To measure efforts to enhance interactions between families and frontline workers and increase the coverage of critical interventions
4. To explore scale-up of maternal and newborn health innovations
5. To investigate the impact on coverage and survival of maternal and newborn health innovations implemented at scale
6. To promote best practice for policy



Credit: Bill & Melinda Gates Foundation



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Qualitative study of scale-up overview

Aims

- *To understand how to catalyse scale-up of externally funded MNH innovations and identify factors enabling or inhibiting their scale-up*

Definition

- **‘Scale-up’**: *increasing the geographical reach of externally funded MNH innovations to benefit a greater number of people beyond grantee programme districts*
- **‘Innovations’**: *new interventions introduced by grantees to enhance interactions between frontline workers and households*

Methods

- 150 in-depth interviews in 3 geographies in 2012; follow-up in 2014
- Stakeholders in the field of MNH: government; development agencies; civil society; MNH grantees; professional associations; academics/researchers/experts



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Examples of 'innovations'

- Tools to enhance **frontline worker performance** - communications materials, quality assurance measures
- Strengthening **healthcare referral** - emergency transport schemes and call centres
- Strengthening **community structures** e.g. **Village Health and Sanitation Committees** to promote awareness, behaviour change, data collection, mobilisation



Msakhi – ‘mobile friend’

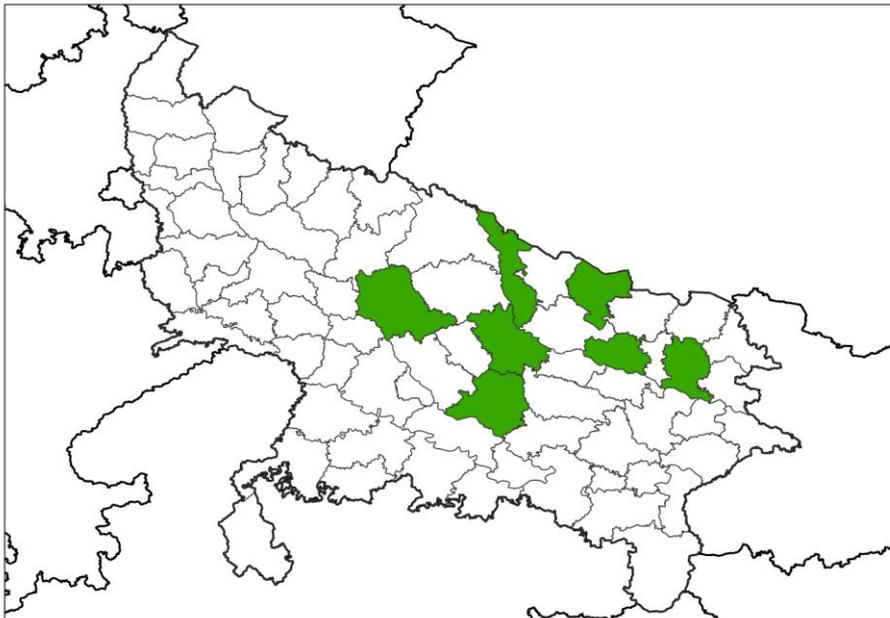


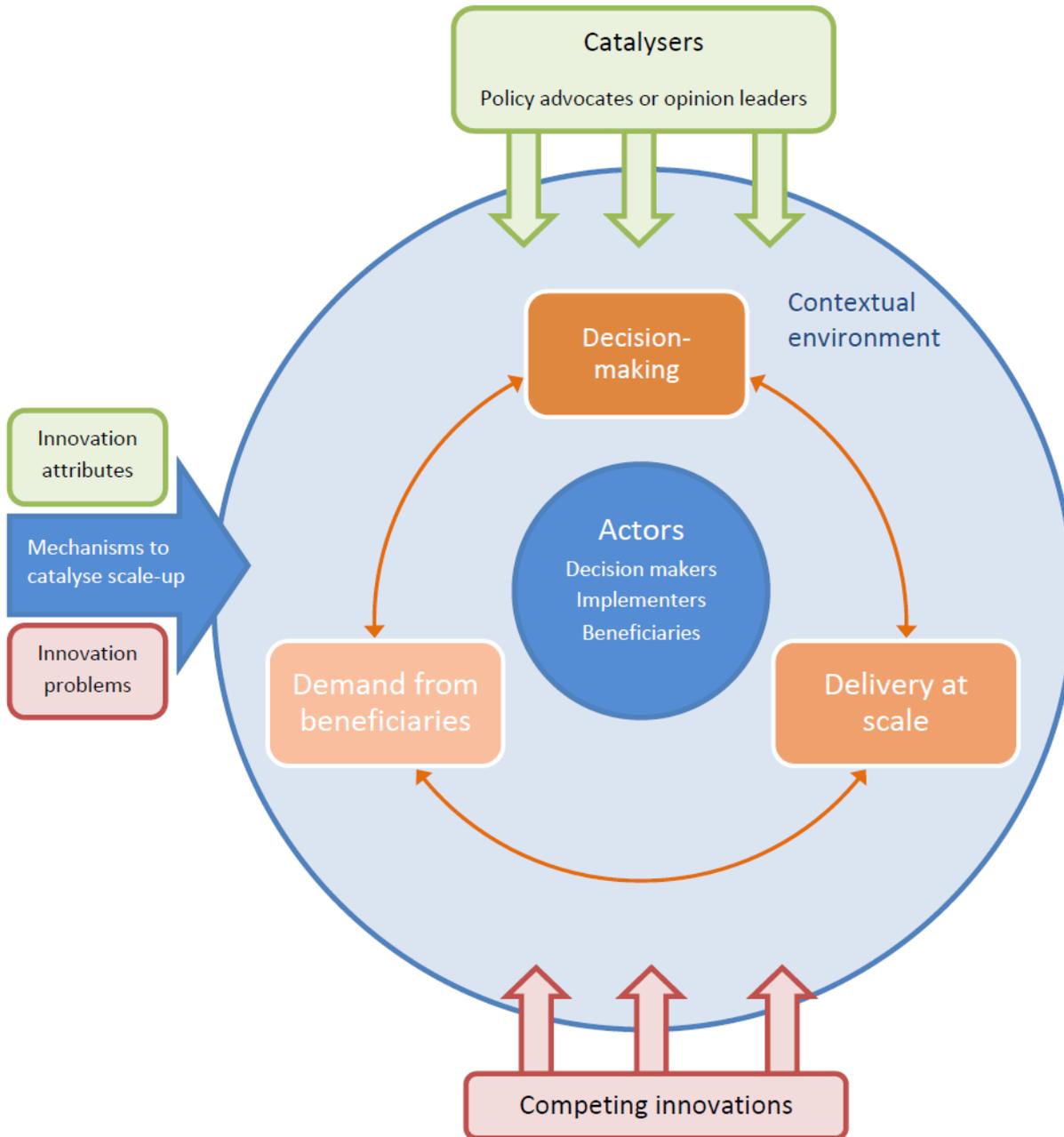
- Pictorial communication messages
- Patient registration system
- Text message prompts



Why study scale-up?

- Grantees (CSOs) funded for 2-4 years to develop innovations in pilot districts
- Can grantees catalyse innovation 'scale-up' beyond pilot districts to meet needs of whole populations longer term?
- Usually means government accepting, adopting and financing innovations at scale





WHICH ACTORS INFLUENCE SCALE-UP?

- **Decision makers:** government, development agencies, private companies, professional associations, community/religious leaders
- **Implementers:** government, private sector, NGO service providers
- **Beneficiaries:** individuals, households, communities

DECISION MAKING: *what influences decisions to accept or reject different innovations?*

DELIVERY AT SCALE: *the capabilities of implementers to deliver at scale and the barriers to implementation*

DEMAND FROM BENEFICIARIES: *what factors shape innovation demand & uptake by beneficiaries?*

MECHANISMS TO CATALYSE SCALE-UP: *how are grantees catalysing innovation scale-up?*

PROBLEM CHARACTERISTICS: *is MNH framed as important (or not) compared to other health problems?*

ATTRIBUTES OF INNOVATION: *is the innovation amenable to adoption?*

CONTEXTUAL ENVIRONMENT: *does the country context enable or undermine scale-up?*

CATALYSERS: *are policy advocates or opinion leaders championing innovations leading to scale-up?*

COMPETING INNOVATIONS: *are alternative innovations competing for decision makers' attention?*

Key findings from Uttar Pradesh, India

- *Is Uttar Pradesh an enabling environment for scaling MNH innovations?*
- *How can externally funded implementers persuade government accept, adopt and finance their innovations at scale?*



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Is Uttar Pradesh an enabling environment for scaling MNH innovations?

1. Governance and decision making context
2. Health systems context
3. Sociocultural context



1. Governance and decision making context

Optimism about current political leadership

- Responsive to new ideas and partnership working with development partners
‘The [political] environment currently seems upbeat with officials - the Chief Secretary level, the National Rural Health Mission - wanting to push forward...’
‘It is important for institutions to capitalise on this mood’

National Rural Health Mission (NRHM) policy framework

- Increased the priority of rural healthcare/MNH
- New funding - Uttar Pradesh NRHM annual budget over \$50M
- Introduced new structures
 - ‘Accredited Social Health Activists’ (ASHA) - strengthen links communities and health system / health messages
 - ‘Janani Suraksha Yojana’ (JSY) - cash incentives to mothers for facility deliveries

Shadow of BSP administration

- Misuse of funds, heavy corruption, NRHM scandal - funds siphoned, assassinations
- Created suspicion, fear, paralyses officials to act: *‘One and half years after the NRHM scam and nothing is moving - still people are cautious ...’*



‘Politics as usual’

- Weak accountability, lack of transparency, limited use of evidence *‘...Policies aren’t always based on evidence - sometimes huge decisions are made in an hour!’* *‘This is India - work happens over tea, coffee and dinners...’*
- High turnaround of government officials: *‘...how many Mission Directors changed in Uttar Pradesh, how many district directors? What does government buy-in imply?’*
- Competition/lack of coordination among development partners, CSOs: *‘The more fragmented we are the less successful we will be...we have individual organisations’ mandates and competing products and services...’*



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2. Health systems context

Service delivery

- Poor infrastructure, equipment/commodity supply
- Scaling innovations through rural clinics challenging: *'In smaller health clinics conditions are so bad this project may not work very well...'*



Health workers' capacity to deliver MNH innovations

- Shortages, poor training: *'... the whole system is a shambles – how do you scale-up without people?'*
- Multiple government/donor programmes run through key health workers - high workloads/turnover
- Health workers recruited from higher castes: *'...the attitude of workers isn't positive... [it's about] contamination of their caste system virtues, mixing with other castes'*



Health systems governance

- Weak supervision/accountability/information systems: *'UP is so overwhelming, so complicated, corruption's a huge problem...'*
- Heavy regulation/bureaucracy: *'...from the directorate to the planning commission there's a tedious process to get approvals, once approvals are made there are bureaucratic delays...'*

Some resistance to task shifting (especially dispensing drugs) to lower cadre workers: *'[Medical associations] have knowledge, power, they think they know what to do... relinquishing power is a major problem for them'*



3. Sociocultural context

Hegemonic gender relations

- Innovations empowering women resisted by men
- Women's seclusion – problems with uptake of MNH facility-based services: *'...women are treated as disposable commodities at home...'*



Poor, marginalised communities

- Low expectations, low service uptake: *'People are extremely poor. People don't expect much, don't expect better...'*
- Limited community mobilisation and demands on government: *'...we are talking of women who come from marginalised society...we fool ourselves, we're romanticising, when we think those women will come out and ask for accountability'*



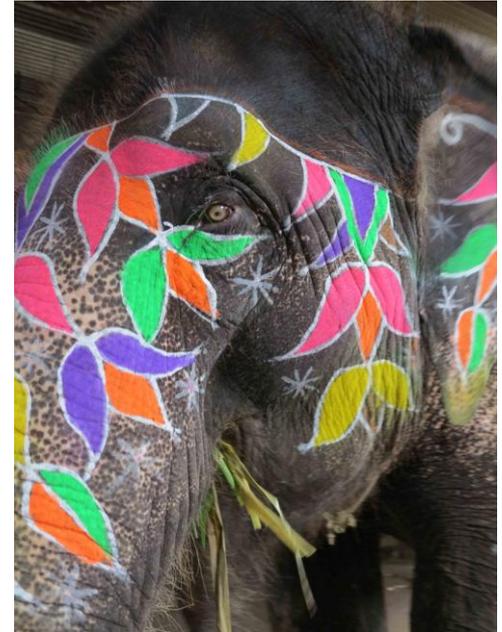
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What can externally funded implementers do to catalyse scale-up of their innovations?

1. Partnership working
2. Investing time and money
3. Designing innovations to be scalable
4. Power of evidence



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1. Partnership working

Harmonising donor programmes

Donors/grantees engaging UP's coordination mechanism *Partners'*

Forum:

- External partners' voices unified when advocating/presenting evidence to government: *'...it's our moral and ethical duty to work together...we have to go beyond our little thing and ask for common asks based on evidence...'*
- External partners sharing expertise and learning to strengthen innovations: *'People in India are not combining their expertise...instead of wasting time reinventing the wheel we need to come together...'*

Partnership working better than working in isolation

- Invoking media, TV shows to support innovations and raise consciousness: *'Media is the fastest and most powerful'*
- Working with technical partners e.g. M&E partners, advocacy partners



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Policy alignment

State government is main potential owner/financer of scale-up: *'In India scale-up is only possible through government whether you like it or not: government has maximum reach, money, resources and systems...'*

Innovations closely aligned with government policies/targets

- NRHM / state Programme Implementation Plan ('PIP'): *'What matters is government's priority area - if your idea's not there, no matter how much you push, scale-up is almost impossible'*

Government involvement essential - planning and throughout project

- Innovations better aligned with policy: *'...government from the beginning has been involved in all phases of design, testing, monitoring and evaluation...'*

Framing innovations as having 'political mileage' - being politically attractive: *'...government's vote bank is very important and so long as it contributes to their vote bank they would be receptive to good innovations'*



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2. Investing time and money

Building in time for planning – assessing policy priorities, institutional blockages, stakeholder analysis, community needs/norms, developing advocacy plans: *‘...engagement and thorough analysis of the policy environment and players is critical in pushing your agenda forward’*

Donors/grantees investing resources to catalyse scale-up

- Human resources: staff with advocacy skills and dedicated time
- Financial resources to support/incentivise grantees for scale-up: *‘...donors should set aside funding and tell grantees that 30% you’ll invest in scaling-up avenues...But you have to tell them because without that they’ll look for their next grant’*

Longer grants = greater chance of scalability

‘You need to work on it for five to seven years before you get it instituted into the system’

‘So many times the idea is just at its tipping point of becoming scaled-up when donors pull out’

3. Designing innovations to be scalable

1. **Relevant to needs and priorities** – communities and health workers
2. **Impacts positive and observable:** *‘If impact is felt there will be demand’*
3. **Desirable:** *‘If people didn’t want an iPod it would have been a failure...’*
4. **Comparative advantage over other innovations**
5. **Simple to implement and use**
6. **Low cost/human resource inputs**
7. **Benefit/not burden health workers:** *‘This tool doesn’t add anything to FLWs’ existing workload - this is the selling point...’*
8. **Culturally acceptable** – sociocultural norms, religion, language, health beliefs and practices
9. **Adaptable to different geographical contexts**
10. **Aligned with government policies/targets**



Tensions

Effective/high quality ‘boutique projects’ or simple, low cost innovations?

*‘...to look good we invest many resources... but after the project ends it’s the end of everything. You cannot have a programme that’s so ***** resource intensive!’*

Work within health system for better alignment or outside for rapid results? ‘...we try to scale up things through a broken system. It’s difficult to succeed in that context’



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4. Power of evidence

Evidence critical to persuading government to scale-up: *‘Evidence is the backbone of advocacy’*

Need for strong, relevant evidence

- Robust methodology, rigorously conducted
- Independent, unbiased: *‘...implementers doing self-evaluation and giving a positive picture get taken with a pinch of salt...’*
- Evidence aligned with government targets and indicators

Generating multiple types of evidence more powerful than single types:

- Quantitative data demonstrating innovation impacts
- Qualitative process data – implementation lessons
- Cost data, estimated costs of scaling: *‘When it’s actually required to take it to scale government first asks what’s the cost...’*
- Firsthand experience of innovations: *‘Taking decision makers on demonstration visits is a sure-shot way to make evidence more impactful!’*

Effective communication of evidence

- Appropriate presentation: *'...well written, well presented information makes a humungous impact on decision making!'*
- Targeting audience with power to act: *'The dissemination meeting wasn't attended by people able to take this forward...not by high level people...'*
- Continual advocacy: presenting evidence early and throughout life of programme
- Timing communication: around decision making cycles; when government's attention is on an issue



Country comparisons

Ethiopia

- Political commitment to rapid scale-up
- Strong government coordination of development partners – strategic deployment of programmes geographically
- CSO grantees - limited say in decision making

Northeast Nigeria

- *International Health Partnership* - better donor coordination
- Security situation in northeast – barrier to implementing health programmes
- Resistance from some traditional/religious leaders



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Summary

Country contexts – opportunities and challenges of scale-up

- Governance and decision making context
- Health systems context
- Sociocultural context

Catalysing scale-up involves multiple approaches - no 'magic bullet':

- Partnership and coordination
- Investing time and money
- Developing scalable innovations
- Strong evidence
- Luck!

Technical soundness of grantees/innovations +

Awareness of, responsiveness to politics and policy: *'Scaling-up is a craft rather than a science - political rather than technical'*



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