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## 'Scaling-up is a craft not a science': Catalysing scale-up of health innovations in Ethiopia, India and Nigeria



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### ABSTRACT

Donors and other development partners commonly introduce innovative practices and technologies to improve health in low and middle income countries. Yet many innovations that are effective in improving health and survival are slow to be translated into policy and implemented at scale. Understanding the factors influencing scale-up is important. We conducted a qualitative study involving 150 semi-structured interviews with government, development partners, civil society organisations and externally funded implementers, professional associations and academic institutions in 2012/13 to explore scale-up of innovative interventions targeting mothers and newborns in Ethiopia, the Indian state of Uttar Pradesh and the six states of northeast Nigeria, which are settings with high burdens of maternal and neonatal mortality. Interviews were analysed using a common analytic framework developed for cross-country comparison and themes were coded using Nvivo. We found that programme implementers across the three settings require multiple steps to catalyse scale-up. Advocating for government to adopt and finance health innovations requires: designing scalable innovations; embedding scale-up in programme design and allocating time and resources; building implementer capacity to catalyse scale-up; adopting effective approaches to advocacy; presenting strong evidence to support government decision making; involving government in programme design; invoking policy champions and networks; strengthening harmonisation among external programmes; aligning innovations with health systems and priorities. Other steps include: supporting government to develop policies and programmes and strengthening health systems and staff; promoting community uptake by involving media, community leaders, mobilisation teams and role models. We conclude that scale-up has no magic bullet solution – implementers must embrace multiple activities, and require substantial support from donors and governments in doing so.

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### 1. Introduction

There is growing attention on how to build on the achievements of the Millennium Development Goals after 2015. In the field of health this means continuing to improve the effectiveness of health policies and programmes and to extend their reach to the maximum number of beneficiaries. Donors and other development partners commonly introduce innovative practices and technologies to improve health in low and middle income countries. Yet many effective innovations are slow to be translated into policy and implemented at scale. Understanding the factors influencing scale-

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up is clearly important (Paina and Peters, 2011; Yamey, 2012; Sgaier et al., 2013; Gawande, 2013).

There are multiple meanings of 'scale-up' including increasing financial, human or capital programme inputs and increasing programme reach to benefit greater numbers of people over wider geographical areas (Mangham and Hanson, 2010). We define scale-up as: '... an increase in the coverage of health interventions that have been tested in pilot and experimental projects in order to benefit more people ...' (Mangham and Hanson, 2010:2 after Simmons et al., 2007). There is an extensive literature on the factors influencing lack of or limited adoption and scale-up of innovations in health and other sectors. Factors include the features of an innovation such as its simplicity, comparative advantage and whether benefits can be observed (Fajans et al., 2006; WHO and ExpandNet, 2009, 2010, 2011; Simmons et al., 2010). The characteristics, needs and attitudes of potential adopters – the 'receiving environment' – influence their willingness or ability to accept new practices or technologies, and 'change agents' such as policy champions and community opinion leaders can influence government adoption, and community acceptance of an innovation (Ryan and Gross, 1943; Rogers, 1962; Greenhalgh et al., 2004; Fajans et al., 2006; Cooley and Kohl, 2006; Dearing, 2008; WHO and ExpandNet, 2009, 2010, 2011; Linn et al., 2010; Simmons et al., 2010; Yamey, 2011; Bradley et al., 2012). The political, economic and social contexts within which innovations are introduced are important. Decision makers' values, ideas and ideologies often shape health priorities and which policies and programmes are adopted or rejected, and decisions are inevitably constrained by financial resources and influenced by prevailing social attitudes (Cooley and Kohl, 2006; Shiffman, 2010; Linn et al., 2010; WHO and ExpandNet, 2009, 2010, 2011). Different actors have different levels of power to influence policy decisions, including the power of civil society advocates to make demands of governments (Sabatier and Jenkins-Smith, 1993; Walt and Gilson, 1994; Cooley and Kohl, 2006; Shiffman, 2010; Harmer et al., 2013). There are aspects of health systems that enable or constrain the delivery of innovations at scale including health workers' training and attitudes, and the strength of supply chains and supervision systems (Hanson et al., 2003; Fajans et al., 2006; Simmons et al., 2007; Mangham and Hanson, 2010; WHO and ExpandNet, 2010; Simmons et al., 2010). Community uptake of an innovation may be influenced by sociocultural values and norms, health beliefs and practices, while access may be constrained by economic, geographical and bureaucratic barriers (Cooley and Kohl, 2006; Fajans et al., 2006; Gilson and Schneider, 2007).

While there is a rich conceptual literature, few empirical studies of the adoption, scale-up and diffusion of innovative practices and technologies have focussed on low- and middle-income countries. We conducted a qualitative study to explore scale-up of innovative maternal and newborn health (MNH) interventions targeting mothers and newborns within poor, vulnerable populations in Ethiopia, the Indian state of Uttar Pradesh and the six states of northeast Nigeria, which are settings with some of the highest burdens of maternal and neonatal mortality in the world. Our aim was to identify the key activities that implementers of externally funded MNH and other health programmes can adopt to catalyse scale-up of their innovations beyond their intervention districts.

## 2. Methods

Informed by the above literature our study aimed to capture the key activities we expected externally funded implementers to adopt in an effort to catalyse scale-up as follows:

- Designing scalable innovations;
- Planning scale-up;

- Persuading government to accept, adopt and finance innovations at scale;
- Supporting and enabling government to implement innovations at scale;
- Promoting community acceptance and uptake of innovations.

Based on these activities we developed a topic guide that was piloted in Addis Ababa by researchers from Ethiopia, India, Nigeria and the UK, and minor adaptations were made to reflect country contexts. Between July 2012 and April 2013 we conducted fifty semi-structured interviews in each of the three settings with purposively selected stakeholders representing government, development partner agencies, civil society organisations including externally funded MNH implementers, professional associations and academic institutions. All interviewees had a role in the field of MNH or in-depth knowledge of issues surrounding the scaling-up of MNH innovations. Interviewees included: directors and managers, programme officers and coordinators, technical advisors, and research and evaluation officers.

Our interviews focussed on ways externally funded implementers – civil society and academic organisations funded by bilateral and philanthropic donors including the Bill & Melinda Gates Foundation – develop, deliver, evaluate and position for scale-up relatively small scale MNH-related 'innovations', which we define as approaches that are new in a particular programme context with the aim of improving MNH. Some of these innovations promote community behaviour change such as demand for new products, services or approaches, while others aim to enhance coverage, quality, efficiency and equitable delivery of existing government MNH services in rural settings. Illustrative examples are given in Box 1.

The interviews were conducted by NS, RD, DB, AW and FF and other researchers trained in qualitative methods using the topic guides. Respondents gave informed consent before interviews which took place in private spaces to maintain confidentiality. Sound recordings were used to capture interview data. Expanded field notes (Halcombe and Davidson, 2006) were written soon after each interview consisting of detailed notes organised under analytic themes including quotes to illustrate interviewees' voices. Data capture and analysis occurred concurrently, with interviewers noting interpretations and emerging hypotheses for further exploration in subsequent interviews.

The analysis involved multiple stages: 1) NS, DW, FW, RD and DB attended an analysis workshop in London in December 2012 where emerging findings were reviewed and jointly agreed, and a

### Box 1

Examples of innovative technologies and practices.

- Increasing capacity, broadening roles and incentivising frontline workers including community health workers and traditional birth attendants
- Introducing tools to enhance frontline worker performance including communications materials, mobile phone technologies and quality assurance measures
- Strengthening healthcare referral systems to increase facility deliveries through introducing emergency transport schemes, an MNH call centre and strengthening the role of community health workers and traditional birth attendants in making referrals
- Strengthening community structures to raise awareness, promote behaviour change and make decisions locally

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