

**A Strategic Management Approach
to Scaling Up:
*The Case of SEARCH's
Home Based Neo-Natal Care***

Dr. Richard Kohl

Presentation to the

Public Health Institute

Oakland, CA 29 July 2010

Background

- Scaling up historically taken for granted:
 - Key was the intervention itself, build it and they will come, spontaneous
 - Conscious activities limited to Dissemination, RIP, National Strategy
- Now recognized as a major challenge domestically and internationally: USAID/GH; WHO; White House Social Innovation Fund; Grantmakers for Effective Organizations
- Little understanding of what it takes or formal process technology; mostly tips, principles, things to look out for
- MSI develops scaling up strategic management framework
- Process technology with concrete steps and tasks

Experience in Scaling Up in ECD and Public Health

- **Nigeria:** Community-Based Approach to Health Education (Community Life Project)
- **Mexico:** Public-Private Partnership of Improved Adolescent Sexual Education Curriculum (INSAD)
- **India (MacArthur and Packard Foundations):**
 - Home based neo-natal care (SEARCH)
 - Reproductive Health of Married Adolescent girls (IHMP)
 - Community-base Health Insurance (SEWA)
 - NGO Management of Public PHCs (Karuna Trust)
- **Wolfensohn Center for Development**
 - Scaling Up Early Childhood Development in Developing Countries
 - Scaling Up Innovations for Rural Poverty -- IFAD

Seven Phases of Scaling Up

1. Intervention: that is effective and efficient
2. Evidence: demonstrating effectiveness, compatibility, robustness and relevance
3. Creating a Strategy: What, Where, How and Who has
 1. Capacity and capability to legitimate, fund, and implement at scale
 2. Resources and capabilities to go to scale
4. Advocacy: convincing institutions to adopt, fund and implement the intervention at large scale
5. Modifying and Strengthening Organizations: creating the capacity and/or capabilities to implement at scale
6. Implementation at Scale: coordination among multiple stakeholders AND monitoring and feedback for fidelity and adaptation
7. Sustainability: political, financial and institutional

Definitions and Types of Scaling Up

1. Scaling an intervention -- supply, delivery, demand -- to greater reach (scale)
 - Raw Numbers
 - Demographics
 - Geographic
 - % Coverage
2. Scaling up method: Expansion, Replication, Collaboration
3. Other forms of large scale change: advocacy, institution building, system strengthening, enabling environment
4. Scaling up the intervention itself (model): breadth/depth
5. Scaling up the Organization
6. Same or different issue (e.g. task shifting)
7. Doing More...

A 3 Step, 12 Task Scaling Up Management Framework

Step 1: Preparing the Model & Developing a Strategy

Task 1: Identifying the Intervention, Capabilities and Context

Task 2: Setting Goals and Choosing a Method

Task 3: Assessing Scalability & Filling In the Gaps

Task 4: Reconciling Model, Vision, Method and Capability Building

Task 5: Mapping the Political Terrain and Creating an Advocacy Plan

Task 6: Translating the Strategy into an Action Plan

A Three Step, Twelve Task Scaling Up Management Framework

Step 2: Creating the Preconditions

Task 7: Advocacy for the Issue, Adoption, Funding and Implementation

Task 8: Modifying and Strengthening Organizations

Task 9: Creating Coordination Mechanisms

Step 3: Implementation At Scale

Task 10: Rolling Out the Model

Task 11: Monitoring for Quality, Fidelity, & Flexibility

Task 12: Ensuring Political, Financial and Institutional Sustainability

Task 1. Identifying the Model

What is Being Scaled-Up?

- Identify the model's key components
 - Preconditions: what has to be in place to implement, esp. HR
 - Technical: drugs, equipment, training content, BCC
 - Process: how technical components are implemented
 - Values: Empowerment, Rights-based, Gender, etc.
 - Follow-up: Supervision, Monitoring, Accountability, Incentives
- Social, Cultural Economic Environment
- Institutional Context
- Need to pay attention to invisible components and factors that are essential for impact
 - Creating ownership, buy-in and permission
 - Tacit, intangibles: how things are done

Task 1. Components of HBNC

- Technical Training of Village Women
 - Antenatal care and assessment of high risk pregnancies
 - Diagnosis/treatment of 7 leading causes of infant mortality/morbidity
 - Attendance at birth and regular follow-ups
 - Provision of injectable antibiotics (genamycin) for sepsis
 - 6 month competency-based training; 1 week classroom, 3 weeks experiential field work, written exams and practical tests
 - Emphasis on women's empowerment, respect
- VHWs Selection: strict criteria based on testing
- Incentives: performance-based pay & fixed stipend
- Strict regular supervision and monitoring of performance
- Community Sensitization and Outreach, esp. TBAs





Task 1. Social and Institutional Context

- Tribal (indigenous) villages in rural Maharashtra
- Public PHCs difficult to reach, understaffed and under-equipped, intimidating for tribals
- Private sector largely RMPs or “quacks”
- SEARCH: Rural Community Health Research Ashram
 - Based on Gandhian principles: talk to the people, listen to the people, care for the people’s needs
 - Charismatic leadership by world-class MD/MPHs
 - Small, dedicated, mission-driven team (low-paid)
 - Close relationship of trust with local community

Task 2. Setting Goals and Defining Successful Scaling Up (RISE)

- Reach: the scale to be attained, number of people, locations, demographic, % coverage
- Impact: impact on key outputs and outcomes
- Sustainability: political, financial and institutional
- Equity: reaching the hardest to reach: the underserved, unserved, poor indigenous, women, minorities, rural areas

Scaling Up Goals and Vision

- To 500,000 villages in India and other underdeveloped countries
- Replicate community-based approach using VHWs, value-driven emphasis on RBA, gender equity, empowerment, respect.
- Impact: same level of efficacy, 60-75% drop in NMR/IMR (& improved MMR); reach MDGs
- Equity – Reach marginalized communities of SCs/STs and more generally in areas where institutional care not available; ultimately universal.

Task 3. Scalability Assessment

- Credible and Observable: hard evidence, legitimacy, emotional appeal, visible link to results, robust and generalizable
- Relevant: objective issues, policy priority, important to beneficiaries
- Relative Advantage: over existing practices, competing alternatives, cost-effective,
- Easily Implementable: compatible with potential large scale organizations
- Affordable: cost savings, internal funding source, economies of scale, fits in existing fiscal space

Task 3: Assessing Scalability

- Is it desirable to scale up the model?
- Is it feasible to scale-up the model? If not, what can be done to improve its scalability?
- Are there other new models or innovations which need to be taken into account?

Going to Scale is particularly difficult when...

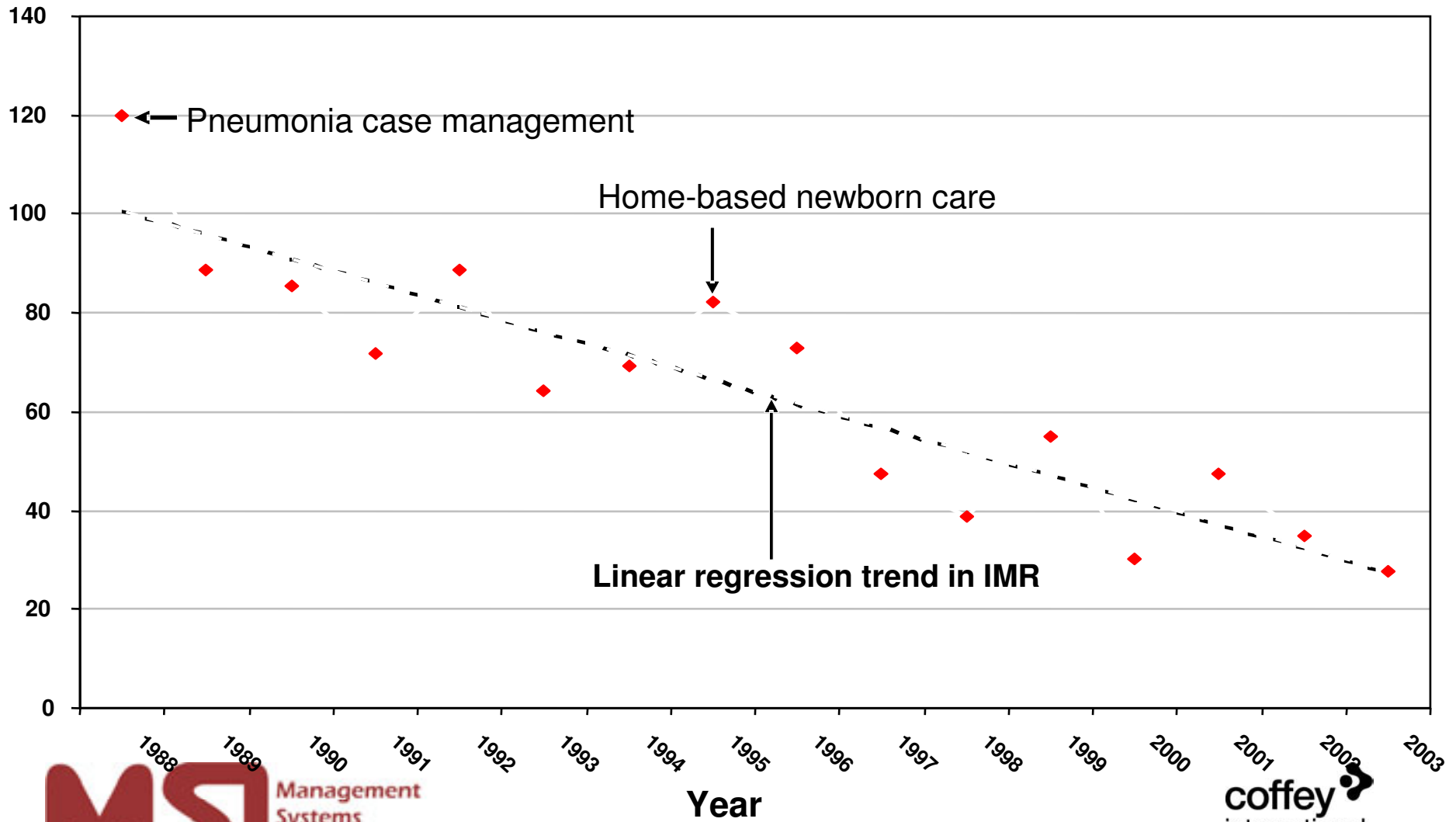
- models lack credible evidence of impact, intuitive or logical, and emotional appeal
- do not include a technological innovation
- are process intensive and community-based
- are complex, comprehensive or both
- are replacements/substitutes for missing govt. services rather than innovations in service delivery
- are not easily grafted onto existing services
- do not have a dedicated funding source or some other means of generating revenue internally

Scalability of HBNC

- Credible, Observable
 - Solid evidence – published in Lancet
 - reputation of Bangs/SEARCH
 - appeal of newborns/VHWs
 - Gandhian, intuitive
 - A few prominent individuals with legitimacy
- Relevant: Objectively high IMR, important domestic priority due to MDGs, India's rising status (UNSC).
Not important to beneficiaries.
- Alternatives: No proven alternative, very cost-effective, only IMCI

IMR in Gadchiroli Pilot(1988 – 2003)

39 intervention villages



Scalability of HBNC

■ Implementable:

- Too complicated? High quality? Supervision-intensive?
- Too process, community-based?
- Could this work without Bangs/SEARCH qualities?
- Work in government context? Grafted onto the system?

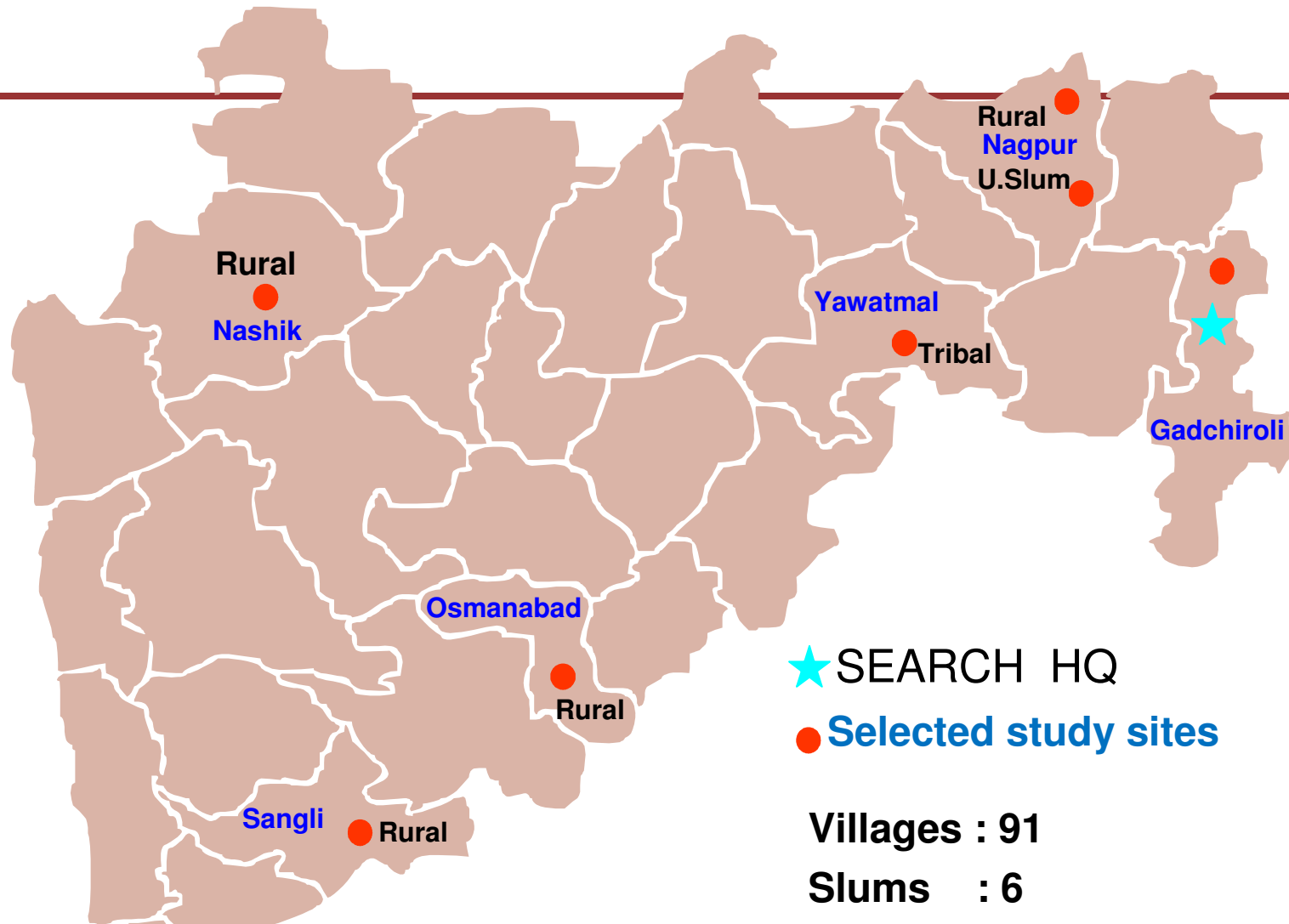
■ Affordable and within Fiscal Constraints:

- No internal funding source, but much cheaper than competition
- major GOI commitment to rural health (NRHM), money not being spent by states

Actions to Improve Scalability

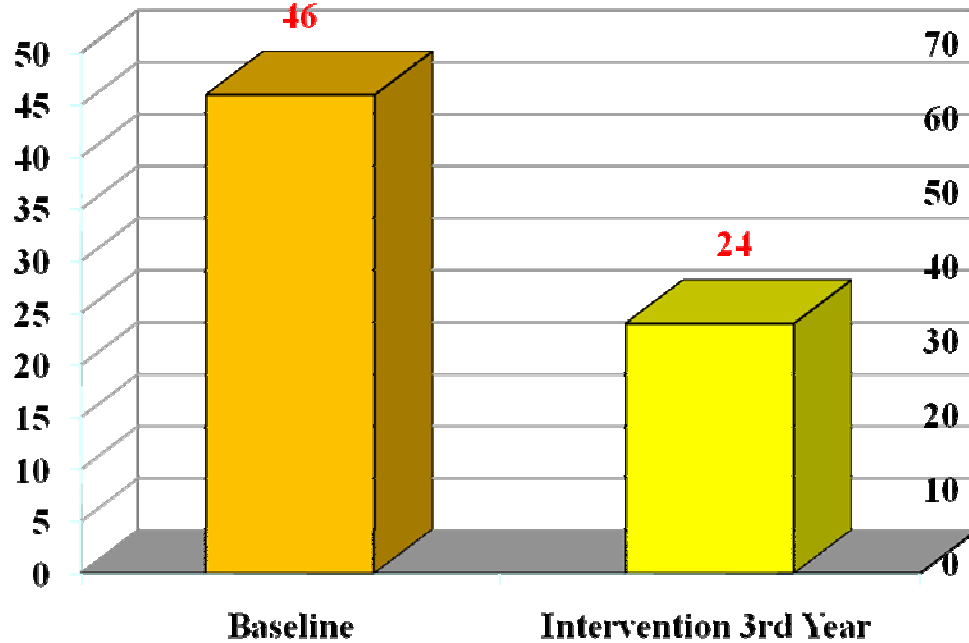
- Consider simplifying the model; shorter training, less supervision
- Document the processes and tacit components of the model
- Test in other NGOs (Ankur Project)
- Test in the context of the government system
- sponsored by Indian Center for Medical Research (govt. seal of approval)

ANKUR Project

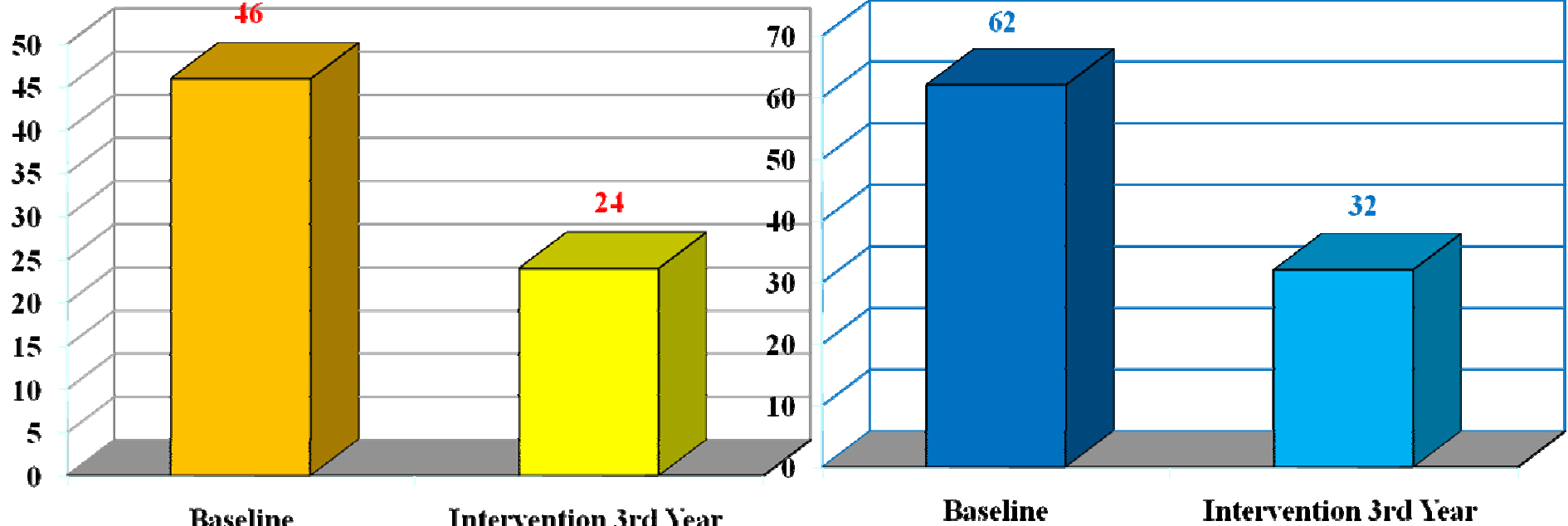


Results of the ANKUR Project

NMR



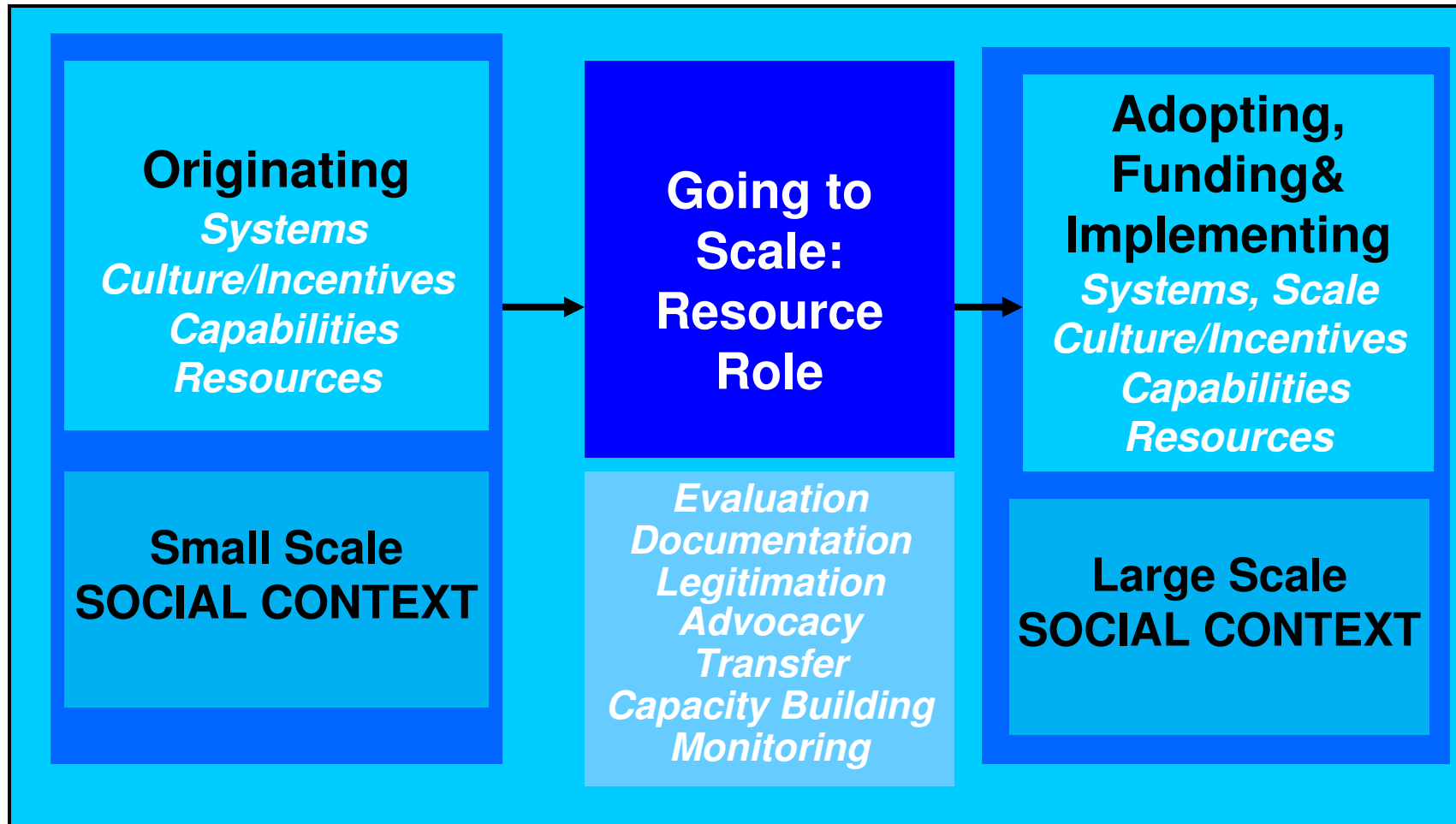
IMR



Task 4. Creating A Scaling Up Strategy: How and Who?

- Methods distinguished by the degree to which the organization that managed the initial pilot – the Originating Organization – continues to control implementation as the model goes to scale.
 - **Expansion**: the Originating Org. retains control of adoption (and usually implementation)
 - **Replication**: the Originating Organization transfers control of adoption to another organization(s)
 - **Collaboration**: the Originating Organization shares adoption/implementation with other organizations or roles are split across several organizations

Task 4. Roles in Scaling Up



Task 4. Criteria for Who

- Capability to Implement the Intervention with desired impact
- Capacity to deliver at the desired scale or reach
- Funding to provided the needed resources
- Legitimacy to allow for acceptance

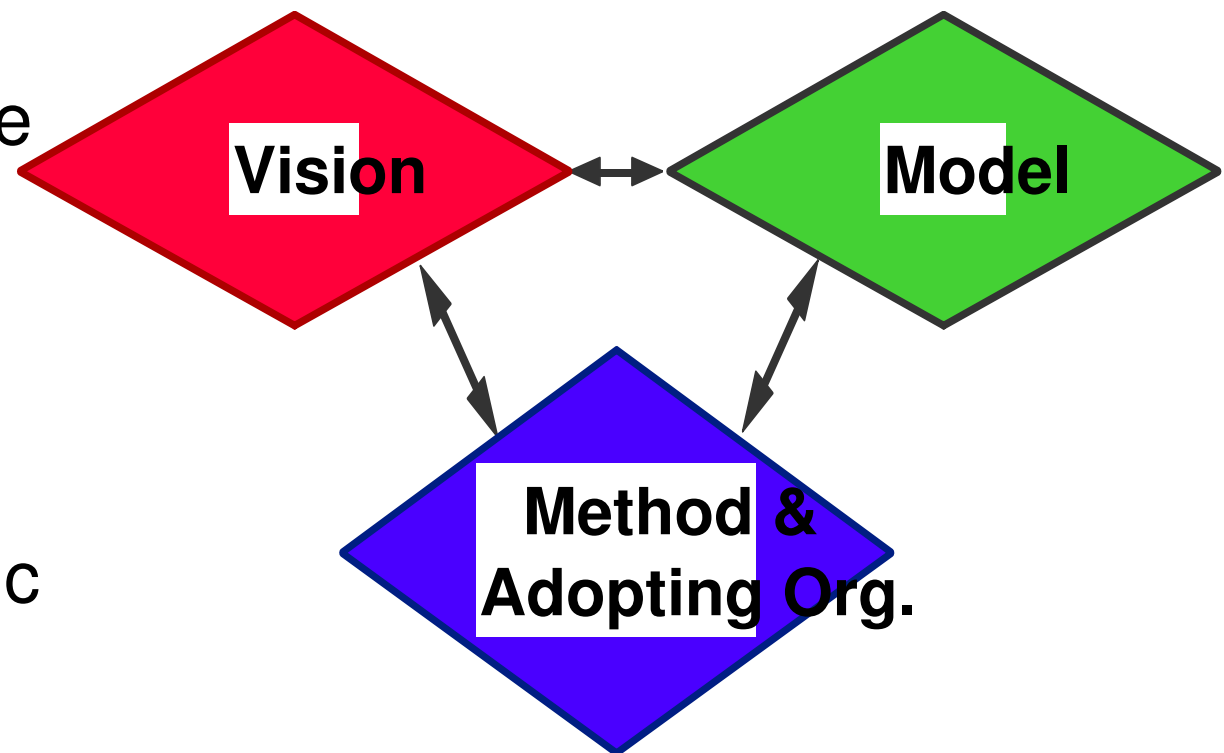
Task 4. Strategic Choice of How/Who

- Expansion and Collaboration not options; SEARCH a research center, not a large scale implementer or hub of a network

- Replication the method, question of Who:
 - Public Sector: capacity but no capability
 - NGOs: capability but no capacity
 - Private sector: possibly both, but would they have incentives to retain values and equity?
 - Knowledge diffusion: would it work with tacit knowledge?

Task 5. Reconciling the Vision, Model and Method

- Are the vision, model and method aligned?
- Can the model be simplified?
- If not, what else needs to be changed?
- Iterative, Dynamic Feedback



HBNC Vision, Model and Method Not Aligned

- Public sector couldn't implement with desired impact
- NGOs couldn't implement at scale
- Private sector unknown
- Choice between 70% of country at 50% effectiveness vs. 5-10% of country at 100% effectiveness
- Refused to simplify the model; accept dilution and deterioration of quality

Task 5. Mapping the Political Terrain and Creating an Advocacy Plan

- Policy mapping showed that multiple decision makers at national and state levels, heavily influence by professional medical associations (IMA, FOGSI) and UN agencies (WHO, UNICEF, UNFPA)
- Stakeholder mapping indicated potential opposition from both sources of influence
 - Medical professionals threatened by task shifting
 - UNICEF had a competing model

Task 5. Advocacy Strategy

- Emphasize the need and inability to achieve MDGs without high impact intervention
- Strong evidence base in multiple sites and locations – robust and generalizable – vs. IM(N)CI
- Power of site visits to Gadchiroli ashram
- Divide IMA with our own favorable experts
- Build coalition: PFI, NGO partnership,
- Leverage neutral and powerful govt. stakeholders; Planning Commission, NHSRC

New Delhi Convention

- Planning Commission
- 11th Five Year Plan
- National Rural Health Mission
- ASHA
- State Governments
- South Asia
- Africa



Task 6. Translating the Strategy into an Action Plan

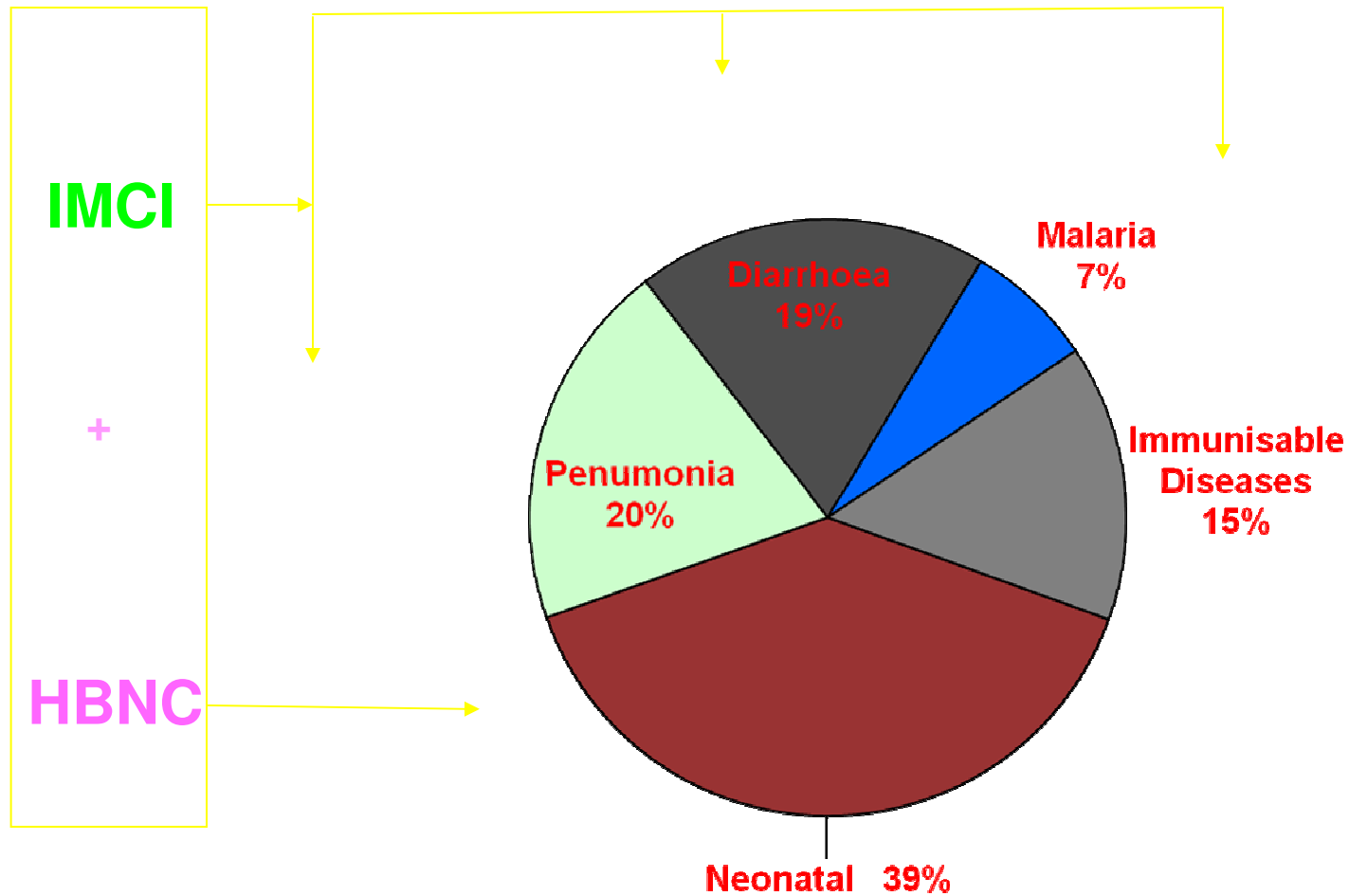
- Dissemination workshop and coalition building at national level
- Pursue state level advocacy with SEARCH in the lead supported by NGO coalition and PFI
- BUT...
 - lack of resources for state level advocacy
 - SEARCH lacking capacity and desire to manage scaling up effort
 - MSI/PFI lacked resources, capacity respectively

Task 7. Advocacy for Adoption, Funding, and Implementation

- Substantial Opposition emerged
 - Institutional delivery advocates see community delivery has diverting political will, resources and second class status
 - UNICEF pushes their model of IM(N)CI
 - Medical mindset, threats to medical prerogatives and livelihoods (injectables by non-professionals)
- Dissemination able to Convince Planning Commission quickly into 11th Five Year Plan
- MOHFW equivocates, complicated by turnover in Sec'y
- Pressure to drop injectables, dilute training
- Results in compromise of no initial injectables and pilots at scale in 5 states

A combined package for children 0-5 years age: Home-Based Newborn and Child Care (HBNCC)

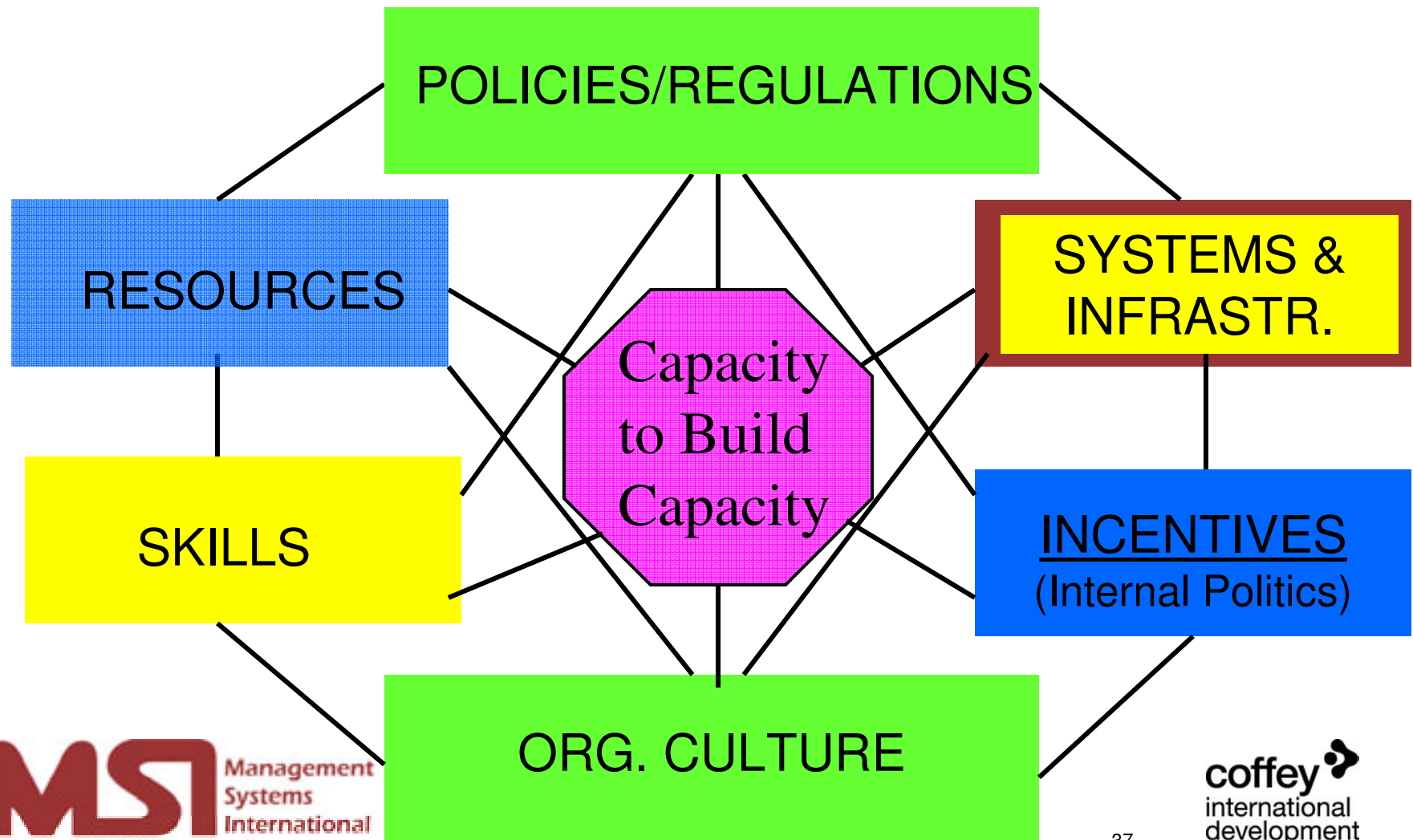
Causes of death
1 month – 5 year



Key Lessons

- Legitimation not necessary in context of favorable policy window
- NGO Coalition too weak to overcome bureaucratic opposition and medical professions
- Key advocacy at state level not done!
- Lessons:
 - Hard to overcome personalized politics and vested interest groups without time, commitment, resources
 - process of scaling up has to be adequately resourced financially and organizationally

Task 8. Mobilizing and Strengthening Organizations



Task 8. Hard to Get Training Done

- GOI and individual states have no training infrastructure in place, mobilize CARE etc.
- Hiring of ASHAs initially captured by political process, delays in basic training
- Use of NIPi money and institutions a delay
- Cascade training risks loss of quality
- Scaling up through GOI delayed, forced to pursue other implementers
- **Lesson: Hard to control the implementation process at scale**

Accomplishments to Date

- Integrated into 11th Five Year Plan
- Govt. of Karnataka state in 7 districts
- Integration into SHGs in AP, 20 districts
- Training of National Trainers for 16 states
- Adoption in Bangladesh, Pakistan, Nepal
- Partnership with UNICEF in Africa; 4 pilot countries; 11 countries trained
- Global policy shift supporting home based care where referrals are not possible

HBNCC Replication sites

**Total 49
Sites**


Africa
4 countries

- ★ SEARCH, Gadchiroli
- ANKUR Project in Mahatashtra
- ICMR Study: Government of India, five states.
- Other NGOs
- ▲ Other States
- Other Countries

Lessons

- Evidence (and reputation) necessary but far from sufficient in face of vested interests
- Need to compromise on goals, impact and method to achieve scale with impact
- Going to scale takes time: HBNC planned in 1990, still implementing at national scale in 2010
- Hard to scale community-based, values driven program into bureaucratic, medicalized system
- Going to scale itself takes financial and organizational resources usually not provided
- Ownership – whose model is it?

Acknowledgement and Recognition

***Thanks to the generous support of the
John D. and Catherine T. MacArthur Foundation
& the David and Lucille Packard Foundation***

In collaboration with...

- Dr. Abhay and Rani Bang and SEARCH, Gadchiroli, Maharashtra, India
- Population Foundation of India, New Delhi

