MEETING REPORT ON EMPTY SCALE-UP, WITH FOLLOW-UP ACTIONS
MAY 10, 2016
SPONSORED BY SAVING NEWBORN LIVES PROGRAM, SAVE THE CHILDREN
LOCATION: WASHINGTON, D.C.

Table of Contents

EXECUTIVE SUMMARY 1

MEETING OBJECTIVES 2

PROBLEM CHARACTERIZATION & DRIVERS OF EMPTY SCALE-UP 2

ACTIONS TO IMPROVE LEARNING AND ADAPTATION 5

ENVIRONMENTAL OPPORTUNITIES AND OBSTACLES 8

NEXT STEPS 10

GOING FORWARD: SCALING UP SUBSTANCE 10

APPENDIX: PARTICIPANT LIST FOR MAY 10TH MEETING 13

Note that this document and the discussion paper that served as the jumping off point for this working meeting are posted on a community-of-practice website. To access the site, you will need to provide some basic identifying information to become a member of the HNN web community at: www.healthynewbornnetwork.org/join-the-network

The link for the community of practice we have just set up is:
http://www.healthynewbornnetwork.org/working-group/scaling-up-substance/

By all means, steer any interested colleagues to this site. We expect to be posting other resources there, over time. This will include useful web-links, related upcoming events, and other resources. We also expect to develop it for use as a discussion forum.

Executive Summary

While there have been enormous gains made globally in health and well-being over the past generation, due in part to specific health program efforts such as immunization, the field of global health has nevertheless largely been in denial over the extent to which many large-scale program efforts operating at scale, for long periods of time, draw considerable resources but are not achieving their intended impact – what we are calling "empty scale-up." Instead of learning and adapting, such ineffective program efforts persist.

Our initial inquiry into this phenomenon can serve as a starting point for further investigation, reflection and—ultimately—concerted action. Our work has entailed in-depth interviews with 22 global health leaders and a comprehensive literature review. This research served as the basis for the first meeting on empty scale-up (see the SNL Working Paper by Hodgins & Quissell). For the meeting documented in this report, 19 additional global health practitioners were brought together for a consultative discussion. The goals of this meeting were to: develop a better characterization of the problem and the factors and processes driving it, identify solutions and feasible actions to fix these underlying drivers, and galvanize a community of committed global health leaders to follow through on these actions.

As a group we reached agreement on many of the underlying factors and processes driving empty scale-up, as well as potential solutions. The list of problems developed was long and detailed, but the primary issues identified include: the lack of recognition that empty scale-up is taking place in global health which allows the problem to continue; the current processes employed in designing, measuring, and implementing programs make learning and adjustment difficult; and prevailing program cultures or norms prohibit failure, further impairing learning and adaptation.

In order to address these problems, participants believed a good place to start was by bringing attention to the problem of empty scale-up through targeted advocacy and communications strategies. Next, there was consensus around the importance of making changes to the culture of global health programs and how these programs are designed, measured, and implemented in order to make them more amenable to learning and adaptation by: clearly articulating program assumptions and the theory of change, developing a learning system in the program design, changing how we do measurement to include indicators necessary for learning and adjustment, extending program timeframes, and better syncing programs with country processes.

Meeting Objectives

1) Reach a shared understanding on the problem of "empty scale-up" and its principal remediable drivers
2) Identify and prioritize needed actions
3) Begin to mobilize as a group to take action

Problem Characterization & Drivers of Empty Scale-up

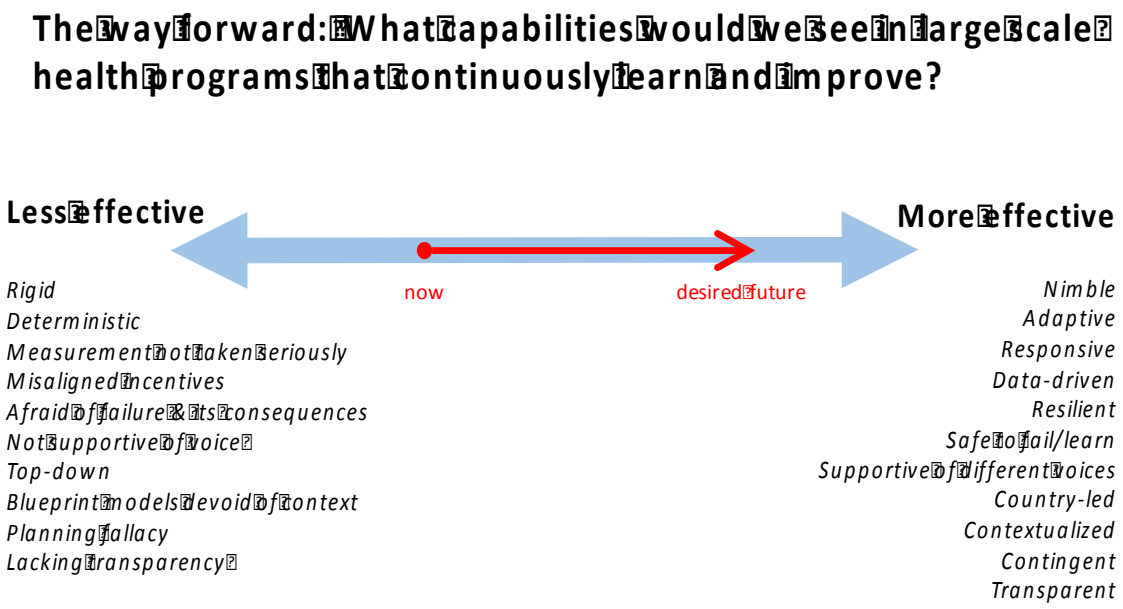
There is agreement that while there have been enormous gains made globally in health and well-being over the past generation, due in part to specific health program efforts such as immunization, the field of global health has largely been in a state of denial over the extent to which large-scale program efforts operating at scale, for long periods of time, have continued to draw considerable resources despite not achieving their intended impact. In this document we have been referring to this challenge as "empty scale-up." Instead of learning and adapting, these ineffective program efforts persist. This dysfunctional phenomenon is certainly not exclusive to global health. There is increasing documentation of this pattern in other development sectors as well as in U.S. domestic programs (e.g. the DARE anti-drug program in the US, which has been ongoing for over 30 years, costing billions of dollars, despite rigorous evidence that it has not been working).

Potential drivers of continued commitment to failed endeavors have been studied in disciplines such as management and psychology, and include the influence of sunk costs on decision-making, cognitive biases discounting negative information, and management structures discouraging speaking up about problems. However, the problem of empty scale-up has been little discussed in global health. So the factors and processes driving this problem continue unabated. There are also dynamics more specific to global health and development assistance that may be influencing this phenomenon that have received little attention to date. In particular, large-scale global health programs tend to include a variety of organizations with different levels of resources and power over decision-making, making inter-organizational dynamics an important factor to examine.

Initial research on empty scale-up in global health has developed a foundation of knowledge on this topic. Drawn from in-depth interviews with 22 global health leaders and a comprehensive literature review, this research served as the basis for this first meeting on empty scale-up (see the SNL Working Paper by Hodgins & Quissell). For this meeting, 19 additional global health practitioners were brought together for a consultative discussion.

The first step in problem characterization was to reach consensus on the attributes of current global health program efforts interfering with learning and adaptation. The second step was to develop a vision of the desired future, where global health programs have qualities and capabilities facilitating learning and adaptation when there is evidence initial efforts are not achieving the intended impacts. These characteristics are summarized in Figure 1 (below), and they can largely be grouped under the categories of program design, measurement, implementation, and culture/norms.

Figure 1: Summary of program characteristics



On the negative side of the spectrum, one of the program characteristics interfering with learning and adaptation is the *lack of transparency,* in the sense both of the visibility of decision-making and implementation processes and also the underlying program theory, assumptions, and explicit and implicit program goals. Many of the global health programs failing to adapt in meaningful ways *lack an explicit, credible theory* spelling out how the effort is expected to produce the intended population health effect. These programs are also more likely to focus on measuring inputs and outputs, assuming these components will lead to impact. Measurement of outcomes and how different components of the causal chain contribute to these outcomes is lacking, and without these measures programs do not have the data needed to identify problems and make meaningful changes. *Measurement is not taken as seriously as needed* and it does not measure the most important factors. Additionally, many programs operate with other *implicit goals or side-bets* alongside the explicit population health goals. In some instances, key stakeholders will have implicit goals that are, in fact, more important to them than the explicit goals of an initiative. Some of the implicit goals discussed include: keeping money flowing, developing and maintaining relationships, and maintaining the appearance of success. Implicit goals cannot be entirely avoided. However, when they are not fully consonant with the explicit goals of the program they can constitute a challenge to effectiveness. For example, there is a commonly found motivation to keep one's job or to keep a positive relationship between a donor and a host government. These underlying desires can contribute to an unwillingness to acknowledge or act upon problems in program implementation because failures are perceived as risky for jobs and relationships.

Next, we discussed the "*planning fallacy*" that bedevils much program work. We systematically underestimate how long it will take, what money and other resources will be required and the degree of uncertainty or unpredictability we will face. Instead, we have inordinate confidence

that with enough up-front planning, we will necessarily have a smooth, uneventful process and a successful outcome. With such a stance, we are not well primed to identify and act on problems if they arise over the course of implementation. Our program efforts are likely to be *rigid* and *over-determined*, instead of nimble, adaptive, and responsive.

Related to this planning mentality, many large-scale global health programs are centered on what are seen as universal solutions, or *blueprint models*, of best-practice. While implementation requires some degree of standardization, and while we may have knowledge of particular interventions and processes working well in other contexts, this knowledge does not necessarily translate directly when brought to different regions or countries. With these blueprint models often comes a misplaced confidence that programs will work as planned, which can work to undermine careful monitoring and evaluation. With these blueprints we also tend to assume things are simpler than they really are, and we do not adequately take into account context and systems. This blueprint-driven approach further compromises responsiveness and adaptability.

Top-down program design and implementation is another obstacle to learning and adaptation. Important contextual information fails to be used. Without sufficient opportunity for community/country participation and input in the design and implementation of programs, programs are more likely to be ineffective and to have structural obstacles to the acknowledgment of problems and to the ability to act on them. *Lack of local/country ownership* can also undermine investment in what is happening. When programs are planned, funded, and implemented from the top-down, *inappropriate timelines* are frequently imposed. In global health, program timelines set by donors often run from three to five years – which is generally too short a time period to have sufficient knowledge of impact. It also creates a system where programs have to move quickly and constantly apply for continued funding. This system creates *misaligned incentives* encouraging ignoring problems and projecting the appearance of success (even if effectiveness is in doubt) in order to keep the money coming in – contributing to empty scale-up.

Lastly, many global health programs have a *culture or a set of norms* in place prohibiting failure. When failure is unacceptable, people are more likely to be punished for perceived failures, lower-level employees are less likely to speak up about problems to higher-level employees, and opportunities for learning and adaptation are impaired. Being *afraid of failure* can *restrict the voice* of front-line staff, clients, and implementing organizations, which is problematic as voice is a necessary component of problem acknowledgement. Without the ability to acknowledge problems, learning and adaptation cannot take place. Without learning and adaptation, ineffective program efforts can continue. As the commitment of time and resources advances it can become more and more difficult to make changes. The bigger the program gets and the more momentum builds, the more difficult it is to change course – leading to the *escalation of commitment to a failed course of action* and empty scale-up. There are many barriers and complexities to redirecting large program efforts.

The overall vision of the future agreed upon at the meeting conceives of programs with contrasting characteristics. Instead of rigid, deterministic, top-down, blueprint programs, there

would be *nimble, adaptive, responsive, country-led, and contextualized* ones. These programs would also be *data-driven, transparent, participatory*, and have *cultures and norms supportive* of *speaking up* about problems, *learning* from failure, and *taking corrective action*.

Actions to Improve Learning and Adaptation

In order to bring us closer to this shared vision, we broke into small groups to brainstorm potential remedial actions. In these small groups, and then together as a large group, we worked to identify and prioritize actions needed to move large scale programs to those that learn, adapt, and achieve impact. Across the small groups there was significant overlap in terms of priority action categories, with a variety of ideas for concrete steps to be taken. These are summarized in Table 1. In general, participants believed a good place to start was with bringing attention to the problem of empty scale-up through targeted advocacy and communications strategies. As one participant mentioned, "the first step is admitting we have a problem, there is no motivation to solve a non-problem." Specifically targeting donors, contract officers, program implementers, and ministries of health. Next, there was consensus around the importance of making changes to the culture of global health programs and how these programs are designed, measured, and implemented in order to make them more amenable to learning and adaptation. Ideas for how to make these changes are in the table below. Lastly, the dynamics between the different organizational partners (ministries of health, nongovernmental organizations, donors, evaluators) need to be altered by longer program timelines, giving more ownership to country-level actors, and syncing these programs better with country processes.

Actions identified by meeting participants are outline in table 1, below…

Table 1: Summary of Actions

Problems addressed	Actions to Take	Possible Next Steps
	1. Advocacy and communication to bring attention to the problem of empty scale-up by:	
1) Lack of recognition of empty scale-up in global health	a. Clearly articulating the problem (diagnostic framing) and the solution (prognostic framing) to implementers and broader health community b. Bringing this issue to the SDG discussion of accountability c. Creating something like a Lancet series documenting cases of empty scale-up as well as positive deviants (or another method of disseminating positive and negative cases) d. Holding a summit of failures to destigmatize the problem (we've all failed, so how are we going to learn from it?).	• Create a simple, advocacy statement for the 'challenge' development audience • Create a visual model that highlights vision

	e. Getting donors and NGOs onboard with learning-based programs, no more empty implementation	
	2. Clearly articulate program assumptions and theory of change by:	
Lack of transparency **Lack of an explicit theory** **Planning fallacy** **Implicit goals** **Misaligned incentives**	a. Assuming that mistakes will be made and programs will have to change b. Addressing differences between implicit and explicit goals through critical assumptions testing (are we talking about the same thing?) c. Making assumptions visible so they can be assessed along the way and changed d. Developing hypotheses for testing and not assuming we have the answer e. Clearly relating hypotheses and program goals to context and population (fit) f. Laying out a potential sequence of steps in implementation, including clearly outlined roles and responsibilities for partners that are connected to the causal chain	
	3. Develop a learning system/responsive program designs by:	
Lack of transparency **Planning fallacy** **Implicit goals** **Blueprint designs** **Top-down design and implementation** **Culture of fear surrounding failure** **Restricting voice** **Rigid, deterministic programs** **Misaligned incentives** **Lack of country ownership**	a. Including knowledge from the frontlines in framing problems, designing programs, and implementing adaptive learning systems b. Seeing the program as a process rather than a fixed endeavor c. Making learning by doing an explicit objective of scale-up efforts d. Including an inception phase in programs to identify early failures and to make adjustments e. Celebrating and incentivizing learning from what isn't working f. Allowing for discretion and flexibility g. Creating intra/inter-country exchanges and learning opportunities	
	4. Change how we do measurement by:	
Lack of transparency **Top-down design and implementation** **Measurement not taken seriously**	a. Developing learning indicators to assess feedback loops of data into adaptation b. Developing process indicators for implementation strength and effective coverage and include in routine monitoring systems	

Measuring the wrong things **Misaligned incentives** **Lack of country ownership**	c. Having interim measures that follow the causal pathway articulated in the theory of change d. Collecting data on the perceived quality of programs from service recipients e. Prioritizing what gets measured with preference for what is most useful on the frontline of implementation f. Meaningfully reporting data 'down' to clients, 'out' to colleagues, and 'up' to government/funders/counterparts	
	5. Extend timeframes for programs by:	
Top-down design and implementation **Rigid, deterministic programs** **Misaligned incentives** **Inappropriate timelines** **Lack of country ownership**	a. Dialoguing with donors about pace of change, reasonable expectations, and the consequences of faulty timelines b. Recognizing that donors need results, so we need to give them the theory of change, a proposed timeline, and interim results c. Not proposing outcomes in 1-2 years in the proposals we write d. Creating an opportunity for countries to determine timelines, or to give significant feedback on timelines e. Changing the incentives from speed to quality f. Convincing contract officers to support learning grants	
	6. Sync programs with country processes by:	
Top-down design and implementation **Blueprint designs** **Rigid, deterministic programs** **Misaligned incentives** **Lack of country ownership**	a. Co-designing with country MOH and other key stakeholders, no predetermined plans b. Making sub-national leadership and capacity central to implementation c. Requiring joint planning and joint resources where possible d. Documenting examples of where syncing has worked well to use in making the case to donors	

Environmental Opportunities and Obstacles

In a detailed discussion of the policy environment, the group elaborated opportunities and obstacles to program learning and adaptation posed by current developments in global health, including: the transition from the era of the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs), new funding mechanisms such as the Global Financing Facility (GFF), and the new emphasis on country-ownership and universal health coverage. Although they present uncertainties and some potential obstacles, the overall view was optimistic – particularly if we could introduce the problems and solutions from our meeting into these larger discussions. For example, the transition from the closed process of deciding the narrow list of MDGs to the open process of creating the broader list of SDGs has mobilized people from around the world to unite, talk openly, and move forward on a variety of issues, many of them neglected in the MDGs. As the accountability and measurement frameworks for the SDGs are still being developed, this could present an opportunity for us to influence these processes. However, if we are unable to do so, and if these frameworks continue to prioritize the needs/goals of the global level and not the country level/citizens, there may be a global norm surrounding SDG program design and implementation put in place that would undermine a movement toward more adaptive learning programs.

Participant contributions to the discussion are summarized in table 2, below…

Table 2: Summary of environmental opportunities and obstacles

	Uncertainties	Opportunities	Obstacles
The SDGs	• Will funding for global health get diluted? • Will the needs of global organizations/ funders be prioritized or the needs of countries/ citizens?	• Window for influencing frameworks with a learning agenda • Open discussions already taking place at global level and in countries around ownership, sustainability, transparency, and implementation issues • Global motivation to unite and move forward	• With so many goals ensuring accountability will be difficult • The goals are not contextualized, so this could lead to empty scale-up • Fragmentation due to the large number of goals, could lead to unfocused scale-up
The GFF	• How will funding happen? • What level of the country will be engaged? • What will be done regarding implementation systems? • Will country adaptation be possible?	• Strong focus on ownership and results • Window for public health conversations to happen in a political space (with ministries of finance) • Creating longer-term development plans	• Set up based on the planning fallacy • Unreasonable theories about what can be achieved in a given amount of time
Ownership rhetoric		• More joint priority setting and program design is taking place • Discussions have begun around timelines • Our conversation fits well with these conversations already taking place	• Power has not really shifted to the country-level, in many respects it is still at the global-level
UHC		• Creates a space for countries to examine health systems, fill in gaps, address disparities • Greater accountability to citizens • Communities value UHC • We could introduce our concepts to this conversation	• UHC can be considered an example of empty scale-up • Dominated by health finance, not about delivering services • UHC is being pushed too fast and in places where it does not fit

Next Steps

1) Hold a satellite session at an upcoming meeting to gather input, ideas, and information from the country-level, specifically representatives from ministries of health
2) Hold a different session with donors
3) Create an advocacy document/statement of principles for key stakeholders to sign onto
4) Turn working paper into a journal article

Going Forward: Scaling Up Substance

The following section is based on further reflections on discussions during the May 10 meeting

I. Building a language

- Contextualized, embraced
- Continuous learning
- Safe to fail – every defect is a treasure
- Adaptive, changing
- Nimble, flexible
- Responsive, proactive
- Data and information driven
- Resilient, reliant
- Transparent, shared
- Country-led, community-led, shared ownership
- Rhythm of change
- Complexity – like parenting rather than a recipe

II. Frame the challenge and the promise of a better way

- Needs simple, understandable language that translates well global to country to community (and vice versa) – right now it's too complicated
- Frame as a *challenge* rather than a *problem* (has to be possible to change – not Sisyphus)
- Make sure the framing does the following:
    - Creates a vision
    - Creates a sense of urgency for change (change is difficult, why do it?)
    - Paints a clear picture of an actionable alternative from what is being done now (has to be actionable in the minds of those who will have to do it)
- Probably needs visualization (not only words) to communicate and invite input

III. Create and be guided by a high level 'pathway' or theory of change that is evolved as we learn (simultaneous with II – core, guiding group that is thinking about the future)

- Will help put opportunities/next steps into a bigger 'strategy' so they can be built upon, linked, and 'tested'
- Principles (see Kotter's updated framework below – this refers to organizational or strategic network change and may be useful to think about what is needed to change within an organization [i.e. donor] or what the network needs to consider for co-creating change; D. Gustafson's models for predicting project success is also useful (Gustafson 2003, Health Services Research 38:2)

From John Kotter, 2014 XLR8

- Walk the talk (and evaluate/course correct ourselves)
- As specific work streams or groups of activities are done - make clear what skills and knowledge the people who are doing the work need (there are likely to be gaps)
- Remember that social support is needed for people making changes – usually within organizations, but may be within a context like a country (not just about embracing failure)
- Engage, build leadership from the beginning (short term, long term, appropriate to 'space')
- Who are the leaders and who are the volunteer army?
- Might be put on a website for input, run through relevant SC meetings for input

IV. Communicate the framing and advocate for change

- More specifically define and segment the audiences (they are likely to be reached differently)
    - Country leaders, country practitioners (need to be careful to give voice to people in the system)
    - Donors, technical agencies that act like donors/foundations
    - Development partners (TA – possibly segment further into NGOs/public health agencies like CDC/bilateral projects/multilateral country offices, universities, etc.)
    - Congress (eventually … but need to have others, like USAID, in line first)
    - Look at global partnerships/alliances and possible engagement – ie GAVI, GF, GFF, PMNCH
- Target framing communication to key audiences individually (what are the progressive aims for this communication)
- Side meetings at conferences that are relevant
    - Accountability meetings? (EWEC, WB related, etc)
    - Regional technical meetings
    - Organizational annual meetings (for big organizations)

V. Possible Near Term Specific Actions

- HSS meeting in Vancouver:
    - Hold a satellite session to pressure test a next step framing with country leaders – get input, ideas, and information (want open session – out of the box ideas, frank questioning – probably needs to be by invitation, Chatham house rules, don't try to get too much out of them – target the framing and learn what grabs them – 2 hours?)
    - Hold a satellite session with donors, those shaping strategy for HSS – test framing but focus on their behavior going forward, possible quick wins (2 hours)
    - Look for potential leaders, comrades and invite them into a longer term process individually (see below for process)
- Journal article(s)
    - Technical 'advisory' group for articles – will have to decide about authorship but can be supportive or more fully engaged depending on article
    - Background may be useful as a starting point but need to move into commentary
- Piggy back on technical areas that may offer opportunities to do things differently
    - New IMCI?
    - Reaching the unreached under GAVI?
    - Within SNL – newborn?
    - Ethiopia new bilateral health project development process
- Interest BMGF in incorporating framing into new funding – they can take the biggest risk with their funding although it would also have to fit with their partners in a country – Under country PHC in Integrated Delivery? (Ethiopia, India) or new funding for child health that bridges MNCH with disease specific people (CONIC).

Appendix: Participant List for May 10th Meeting

- Lynn Freedman, Columbia University
- Jeremy Shiffman, American University
- Michael Woolcock, the World Bank and Harvard University
- James Shelton, Johns Hopkins University, GH:S&P
- Pierre Barker, Institute for Healthcare Improvement
- Anne Peniston, USAID
- Anita Gibson, Save the Children, MCSP
- Kathleen Hill, JHPIEGO, MCSP
- Jim Ricca, JHPIEGO, MCSP
- Eric Sarriot, ICF International, MCSP
- Sharon Arscott-Mills, ICF International
- Nosa Orobaton, JSI R&T
- Stefan Peterson, Unicef
- David Hipgrave, Unicef
- Luwei Pearson, Unicef
- Robert Clay, Save the Children
- David Oot, Save the Children
- Joy Riggs-Perla, Save the Children, SNL
- Lara Vaz, Save the Children, SNL
- Steve Wall, Save the Children, SNL
- Greta Wetzel, Save the Children, SNL (logistical support, note-taking)
- Chadd Wish, Save the Children (logistical support, note-taking)
- Katy Quissell, Boston University (meeting facilitation)
- Mary Taylor, consultant (meeting facilitation)
- Steve Hodgins, Save the Children, SNL (meeting facilitation)