RESEARCH BRIEF
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IDEAS
Evidence to improve maternal & newborn health

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

How to catalyse scale-up of maternal and newborn innovations in north-eastern Nigeria

Key messages

How to catalyse scale-up

- Design programmes that are scalable in the local political, policy making, economic and social context
- Work closely with government at all stages and align innovations with government policies and programmes
- Harmonise activities with other externally funded programmes
- Advocate for policy decisions by using evidence effectively and seeking support from policy networks and champions
- Work with influential community groups and leaders and stimulate the diffusion of ideas among communities

Challenges

- Limited government prioritisation for health, including maternal and newborn health, and a challenging political and policymaking context
- Fragmentation among externally funded health programmes
- Weak health systems including problems of infrastructure, human resources, commodity supply, governance and financing
- A deteriorating security situation
- Sociocultural, geographical and economic barriers to the uptake of maternal and newborn health innovations

*Definitions

Externally funded programmes: health programmes funded by donors outside of the federal or state government of Nigeria, including the Bill & Melinda Gates Foundation and governments of high income countries.

Innovations: new ways of working, introduced within Nigeria by externally funded programmes, to enhance interactions between frontline workers and households. Examples include training frontline workers, a call centre for maternal and newborn health and an emergency transport scheme to enable facility deliveries.

Scale up: increasing the reach of a maternal and newborn health innovation to benefit a greater number of people over a wider geographical area.

About the study

A study of scale-up focussing on the north-eastern Nigerian states of Gombe, Bauchi, Yobe, Borno, Adamawa and Taraba forming part of the IDEAS project at the London School of Hygiene & Tropical Medicine.

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Prepared by **Dr Neil Spicer** on behalf of the IDEAS team.

Study Aim

To understand what enables or inhibits scale-up of maternal and newborn health innovations.

Methods

Fifty in-depth, key-informant interviews conducted in 2012 with federal and state government staff, development agencies, programme implementers and other civil society organisations, academics, researchers, experts and professional medical associations.

Scope

This summary presents evidence from the study. We focus on what interviewees report as the most important ways externally funded* maternal and newborn health programmes can catalyse scale-up* of their innovations*, and the major challenges to achieving this. We include illustrative quotations from interviewees in italics.

Target Audience

Government, development agencies and implementers in the field of maternal and newborn health.

How to catalyse scale-up

Design programmes for scale

Plan for scale-up: *"you need to know who you want to advocate to"*

Embedding scale-up plans within programme design is critical, including recruiting dedicated staff experienced in advocacy. Assessing policymaking systems and institutions helps plan for scale-up and anticipate opportunities and blockages: *"Politics, perceptions and power... we don't want to run afoul knowingly of these things".* Stakeholder analyses are valuable in identifying allies who can support scaling an innovation or others who may resist: *"...it beholds you as an external person to do a little stakeholder mapping – know who your allies are – preach to them, empower them, make them understand, see the evidence, share your vision..."* It is critical to assess community needs, sociocultural norms and health beliefs and practices in designing scalable innovations.

Designing scalable innovations: *"it should be a bottom up approach"*

Innovations must be designed to be scalable. In the north-eastern Nigerian context, the following attributes make an innovation amenable to scale-up:

- Demonstrated as effective with evidence
- Simple to implement and use
- Cost effective: *"...don't just go for the cheapest intervention, but the one that will be most effective in bringing the expected results"*
- Require limited external resource inputs, such as those with local income generation: *"Once communities are convinced of the benefits of programme they can contribute their own resources and they'll drive the process beyond the life of the project"*
- Build on existing structures and services: *"...don't introduce something that is new – rather you build on something that exists in practice..."*
- Meet community needs and priorities
- Delivered by culturally acceptable community actors: *"The FOMWAN group is already there in the community... they are well known, they have clout..."*
- Adaptable to diverse cultural contexts, health seeking behaviour and healthcare needs: *"The fact that [the innovation] worked in state 'a' doesn't necessarily mean it will work in state 'b' if we don't adapt some things...'*

Harmonisation and alignment

Work with government: *"they must be part of it"*

Government is likely to be the main owner of innovations at scale as no single donor can mobilise sufficient resources for sustainable scale-up: *"There is no donor that can provide funding to scale-up any intervention. It beholds the government to do so...".* Working closely with government – such as involving government in programme design and monitoring and evaluation plans – is essential in engendering ownership of and support for an innovation.

Building trust and relationships in government is important, while memoranda of understanding can effectively formalise government cooperation: *"Once government officials are supportive they will be enabling..."*

Offering technical assistance and capacity building can convince government of an implementer's credibility, as can supporting government to develop and implement maternal and newborn health policies at scale.

> "Donor coordination is key to any scale-up otherwise you will have duplication and waste of resources..."

Policy alignment: *"innovations with political mileage"*

Aligning innovations with government priorities, targets and policy frameworks is critical to fostering government buy in. Framing innovations as serving political ideas and interests can attract government attention: *"...the ministry wants to see the results – how the innovation can contribute to the ministry and the health sector...".* Working within and building on government systems rather than in parallel can also enhance ownership.

Harmonisation of externally funded programmes: *"everyone is working together"*

Engaging in partner coordination mechanisms can foster government oversight and ownership of external programmes and help government to strategically deploy externally funded innovations at scale. Such mechanisms can promote lesson sharing and provide effective advocacy platforms. Donor mapping, pooling financial resources and embracing joint working can improve coverage of externally funded innovations at scale: "Donor coordination is key to any scale-up otherwise you will have duplication and waste of resources..."

Policy advocacy

Effective advocacy: *'it's a lot of discussion isn't it?'*

Policy advocacy is usually needed at multiple levels of government. Substantial time, effort and determination are required including ongoing advocacy at all stages of a project and repeating advocacy efforts as governments and their officials change: *"It requires spending a lot of time with the relevant people, sitting down and exposure and discussion..."*

Evidence to catalyse scale-up: *"different stakeholders, different evidence, different packaging..."*

It is important to communicate robust evidence effectively. Presenting multiple types of evidence is often required including: quantitative outcomes and impacts data; estimates of costs of scale-up; qualitative process data and implementation lessons; site visits for demonstrating projects firsthand; mapping and needs assessments; benchmarking international best practices.
To influence decisions on scale-up evidence needs to be perceived as trustworthy – it must have a robust methodology, be rigorously conducted and should be unbiased by interests: *"If evidence is derived through due process and is reliable it influences policy positively".*

Effectively communicating evidence is essential including: tailoring a communication method to the audience; presenting simple, powerful messages rather than complex ones; suggesting concrete actions for decision makers; timing communication based on policy cycles; communicating evidence to multiple audiences including federal, state and local government, policy champions, civil society organisations and communities: *"The thing is to know your audience... if I am presenting to commissioners for health I better have my statistics, my pie charts, my bar diagrams...".*

Policy networks and champions: *"if we put our voices together our voice is stronger"*

Invoking policy champions can strengthen advocacy for innovation scale-up and raise the profile of maternal and newborn health issues. A visit by Bill Gates solidified state governors' commitments and fostered support from traditional rulers. Champions include those within federal, state or local government, first ladies, traditional authority and religious leaders: *"The former Commissioner for Health is still our champion... We have some religious leaders [as champions] as well...".*

Networking and alliance building with development agencies, civil society organisations, professional medical associations and the mass media can also leverage broad support for an innovation or increase political attention on maternal and newborn health issues.

Community uptake and demand

Mobilise community groups and actors: *"community people who can open doors"*

Working with influential community groups and traditional and religious leaders can facilitate innovation uptake beyond districts where grantees work: *"Working with traditional rulers and religious groups is very important – these are the groups that make it work at community level...".* Establishing community mobilisation teams as advocates can improve relationships between communities and health professionals and help leverage services and resources.

Stimulate community uptake and demand: *"they look at it as their own thing"*

Stimulating the diffusion of ideas among communities through mass and local media and by word of mouth can be effective in changing health practices and increasing community demand thereby catalysing scale-up within and beyond pilot areas: *"Teach the communities the basics, and how to carry the message and spread the knowledge... using the strategy of "each one teaching one"".*

The ways an innovation is introduced influences its uptake – community participation approaches can help sustain innovations after a project is complete, while top-down programmes may undermine its acceptance. Inclusion of men is needed to ensure an innovation's acceptance within communities of north-eastern Nigeria. ■

Left: Meeting with local leaders to discuss family health, Gombe State, Nigeria. © Society for Family Health

Challenges to scaling innovations

Government decision making

Issue prioritisation: ***"politicking and jostling for a piece of the cake"***

Health has not been a political priority. Moreover, in the field of health, malaria and HIV compete with maternal and newborn health for policy attention due to high levels of external funding, particularly for HIV. Resources for rural primary healthcare are also limited compared to tertiary and secondary level services. It has therefore been challenging for the federal and state governments to support and commit resources for scaling maternal and newborn health innovations: *"The main challenge is to make maternal and child health programmes politically [attractive] for policymakers to push it up the priority list in their campaigns for budgetary allocations..."*.

The government has responded to emerging evidence robustly presented by civil society advocates, and the mass media in recent years have increased coverage of maternal mortality-related stories prompted by an initiative to train journalists on these issues. Nigeria has responded to global agendas such as the Millennium Development Goals and pressure from other African countries. This has increased attention on maternal and to some extent newborn and child health, increasing government support for scaling maternal and newborn health innovations.

Policymaking context: ***"policy change is difficult"***

Complex sociocultural, tribal, religious and ethnic realities and problems of accountability and government bureaucracy combine to make policy decisions and their implementation challenging. Nigerian states have discretion to allocate funds to different sectors, and state governors have considerable say on health budgets and programmes. Evidence informed decision making varies between states and often depends on experience of individual decision makers. In this context government commitment to and financing of maternal and newborn health and other health innovations at scale has been variable.

Nevertheless interviewees were optimistic that democratic institutions and processes are becoming stronger enabling people to make demands of government and obliging leaders to respond: *"As democracy becomes entrenched people are beginning to make demands and as people make demands, government wants to show results..."*

> "Traditional authority is a very important champion in the context of [northern] Nigeria..."

Photo: Hospital beds © Dr Bilal Avan

Actors influencing maternal and newborn health policy: ***"most things are driven by NGOs and donors"***

Development agencies, civil society, traditional authority and professional associations all have an influence on government decisions – understanding their influence can help plan for scale-up.

Federal government and many north-eastern Nigerian states are receptive to development agency programmes – although the expectation that donors will fund health programmes, and hence donors' substantial influence on health policies, limits government ownership and oversight: *"...everything is seen as [if] it has to be donor funded"*.

Government increasingly accepts the contribution of civil society organisations to policymaking and as implementation partners. Pressure from **civil society organisations** has influenced recent policy decisions and the allocation of resources for maternal and newborn health and other health programmes.

Traditional and religious leaders can influence state government decisions despite not having a formal role: *"Traditional authority is a very important champion in the context of [northern] Nigeria..."*. Some traditional leaders have publically supported health programmes including polio vaccinations, although resistance to 'western' health programmes is growing in some northern states.

Health policies and programmes are influenced by **professional medical associations**, although rivalry makes consensus building problematic. Professional associations have resisted innovations based on task shifting, such as traditional birth attendants administering misoprostol: *"[Professional medical associations] have knowledge, power, they think they know what to do... so relinquishing power is a major problem for them"*.

Coordination of externally funded health programmes

Donor fragmentation: *"the issue of competition is crazy!"*

Poor harmonisation among donors and other development agencies and implementers and weak alignment of donor programmes with nationally defined policies, strategies and targets are important challenges: *"Donor coordination is weak – there's a disconnect between programmes and needs, but it's the responsibility of the government to coordinate donor activities..."*

Reasons include competing interests, priorities and mandates, pressure to attribute outcomes to programmatic efforts and federal and state ministries' limited capacity for leadership over development agencies, as an interviewee suggested: *"...the Federal Government should be in the driving seat to coordinate all development work, but... cannot say 'no' to funding..."* Further, health programme implementers compete for donor funds and are under pressure to deliver results to ambitious time frames limiting their capacity to coordinate with and learn from other programmes.

In this environment it is difficult for government to strategically deploy externally funded innovations, and for externally funded implementers to advocate collectively for innovation scale-up since they are competing for government attention.

Towards aid effectiveness: *"donors have a forum where they meet regularly"*

In 2011 the Nigerian government and major health partners responded to the International Health Partnership by signing a Compact on Health signalling a shared commitment to aligning programmes under the Nigerian National Strategic Health plan. This has reportedly started to improve donor information sharing, programmatic coordination and engagement in partner coordination mechanisms: *"... integration among donors has improved over the years... but there's still a lot to be done..."*

> "...integration among donors has improved over the years... but there's still a lot to be done"

Challenges to delivering innovations at scale

Health systems constraints: *"health systems are very, very weak"*

Introducing and scaling innovations linked to government rural primary healthcare is problematic due to chronic health systems weaknesses in north-eastern Nigeria:

- Low coverage and inequitable distribution of rural primary healthcare services and poor infrastructure
- Rural-urban migration of health workers and high attrition of trained doctors into public office. There are particular shortages of women healthcare workers, and the capacity of traditional birth attendants is an acknowledged problem
- Health workers are overstretched, not least community workers implementing multiple health programmes. Low motivation and poor attitudes to rural communities are other common problems
- Governance at all levels of the health system is weak including supportive supervision and accountability linked to poorly functioning monitoring and evaluation systems
- Lack of drugs, vaccines and equipment, and poor distribution systems result in frequent stock outs;
- Delays and blockages in releasing finances and 'leakage' of finances as they are disbursed through the system commonly result in the non-payment of healthcare workers' salaries
- Years of neglect and decay have left communities discouraged from using rural health services: *"...you have people who are disillusioned, people who feel betrayed and are not willing to access the system anymore'.*

Security in north-eastern Nigeria: *"they are afraid of getting killed or injured'"*

Security is a particular challenge in north-eastern Nigeria. Services are frequently disrupted or closed. It is difficult to recruit and retain health workers, who fear for their safety. Donors are becoming less willing to support programmes, and their staff cannot travel to the region Community healthcare seeking is highly disrupted making health facility based innovations difficult to deliver and take to scale: "Women can't go to the facilities and when you refer them they're afraid of getting killed or getting injured"

Community uptake of innovations

People are spending more than half of what they earn on health. That's not fair – that's a big barrier"

Geographical barriers: ***"it's very difficult to access some of the communities"***

Low population density across a wide geographic area and nomadic pastoralist production makes delivery at scale challenging. The geographic terrain during the rainy season coupled with poor road and public transport exacerbates problems, although current investment in the road network is reported as improving the situation: *"During the rainy season it's very difficult to access some communities – it's very dangerous, especially where there are no bridges"*

Economic barriers: ***"poverty, poverty, poverty..."***

North-eastern Nigeria has low average income per capita - poverty among rural farming communities remains a challenge to scaling innovations. Family income is largely seasonal and those with limited financial resources do not prioritise healthcare seeking during some parts of the year. Informal out-of-pocket payments are a common barrier to accessing services: *"[People] are spending more than half of what they earn on health. That's not fair - that's a big barrier'"*

Sociocultural factors: ***"men dictate virtually every aspect of women's life"***

'Traditional' health beliefs and practices linked to prevailing religious doctrine and hegemonic gender relations inhibit scaling innovations among some communities in north-eastern Nigeria including reluctance to accept technologies and 'modern' healthcare, preference for homebirths, male dominance over decision making, and harmful health practices such as not breastfeeding for the first three days of a baby's life and female genital mutilation. Current social pressure to embrace these values makes the prospect of introducing innovations increasingly challenging. ■

IDEAS project

IDEAS (Informed Decisions for Actions) aims to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, North-Eastern Nigeria and the state of Uttar Pradesh in India, IDEAS uses measurement, learning and evaluation to find out what works, why, and how in maternal and newborn health programmes.

IDEAS is funded between 2010 and 2015 by a grant from the Bill & Melinda Gates Foundation to the London School of Hygiene & Tropical Medicine.

This investigation of scale-up is one component of IDEAS. A follow up investigation of scale-up is planned for 2014 during which we will study additional themes, such as potential roles for the private sector and community demand in catalysing scale-up of maternal and newborn innovations.

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