DEPARTMENT OF GLOBAL HEALTH

UNIVERSITY of WASHINGTON

Spreading IDEAs: The Integrated District Evidence-to-Action Program to Improve Maternal, Newborn and Child Health

Kenneth Sherr

ksherr@uw.edu

Quinhas Fernandes

ferq09@gmail.com

UW Medicine
SCHOOL OF MEDICINE

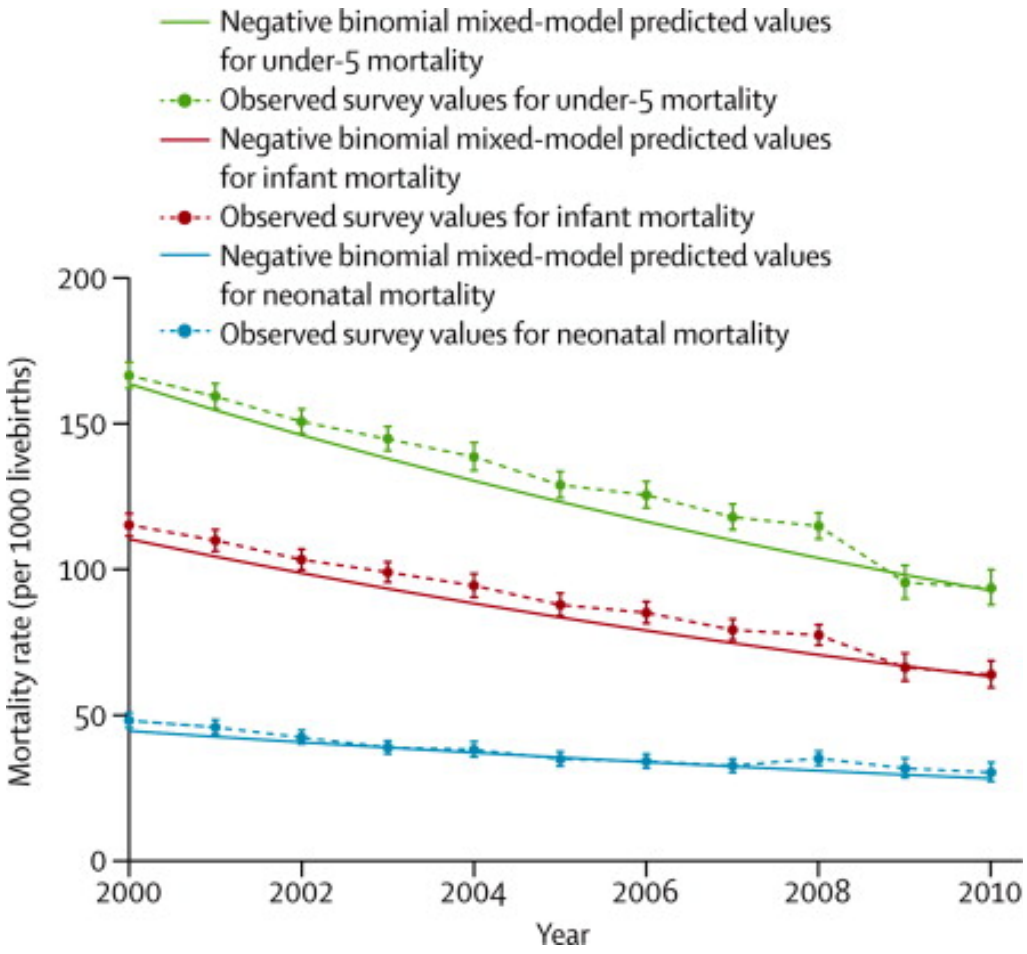
SCHOOL OF PUBLIC HEALTH
UNIVERSITY of WASHINGTON

Agenda

- Introduction to the IDEAs project and evaluation design (KS)
- Reflections on implementation science and its link with policy (QF)

IDEAs Rationale

- <5 Mortality has decreased substantially, but is stagnant due to deaths in the neonatal period
- MOH policies based on strong evidence, though application is uneven
- PHC service utilization continues to be high
  - >95% 1 ANC
  - >70% institutional births



Source: Fernandes, et al. Lancet Global Health. 2014

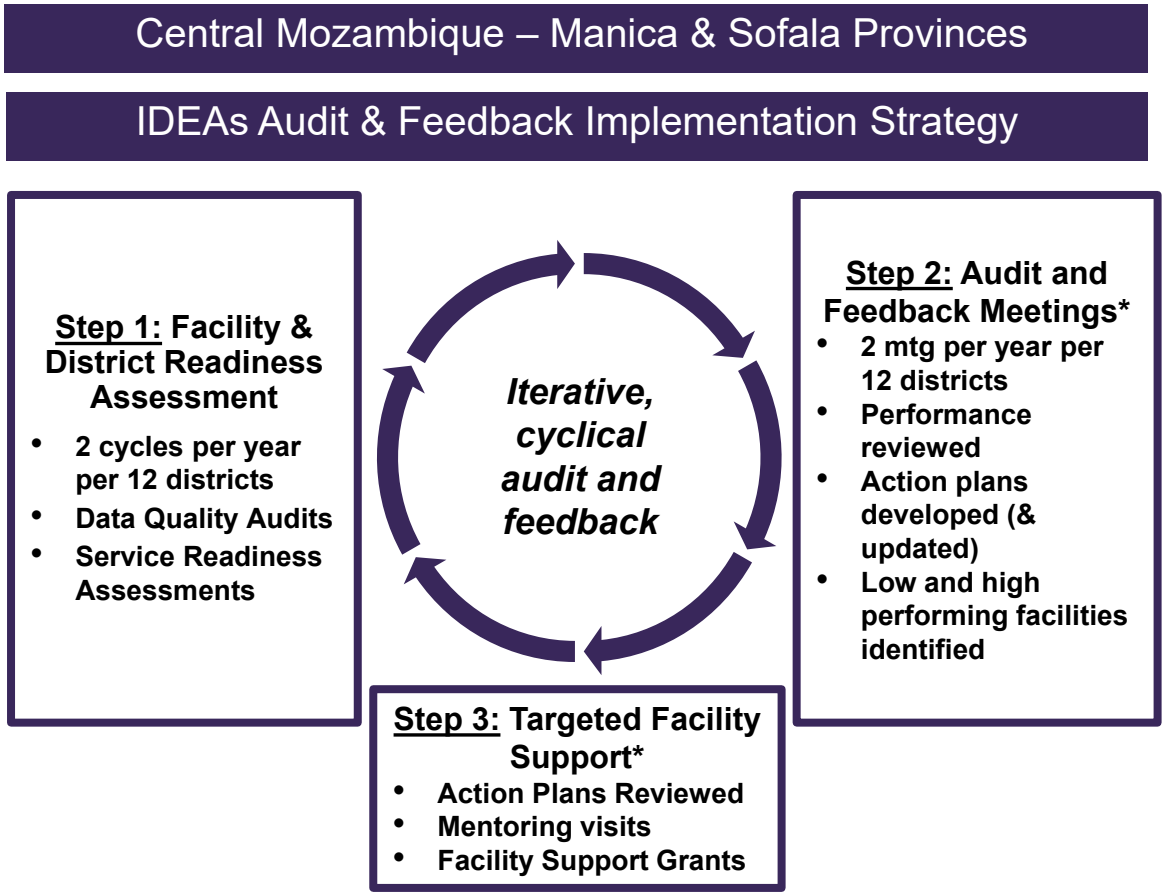
IDEAs Initiative

Goal 1 (supported through the DDCF/African Health Initiative; https://bit.ly/3ay1IcO): Reduce neonatal mortality by improving health system capacity to deliver a package of evidence-based interventions delivered at or around the time of birth

Goal 2 (supported through NIH/NICHD R01HD092449):

2a: Generate evidence on the IDEAs strategy, using the RE-AIM model to assess the program's Reach, Effectiveness, Adoption, Implementation, and Maintenance.

2b: *Via* activity based micro-costing and health outcomes modeling, estimate the potential budget and program impact from the payer perspective to scale-up IDEAs compared to the standard of care

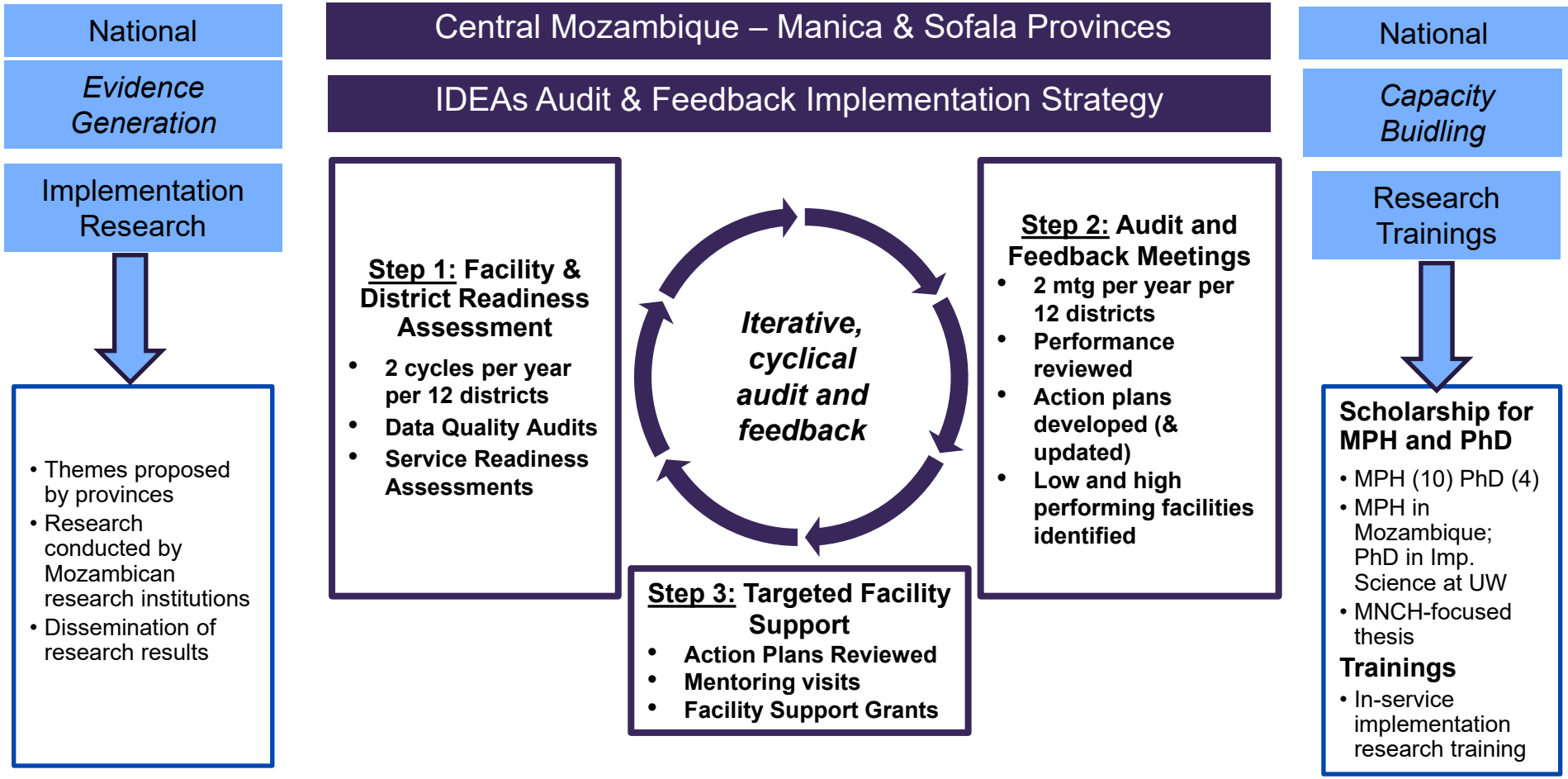


*Led by District Health Management Teams, with support from Provincial leadership & external facilitation

IDEAs A&F Districts

12 districts (of 25) and 154 facilities (of 269) in Manica and Sofala provinces

	2015 Pop.	Coverage	Health Facilities	Coverage
Manica Province	**1,933,522**	**100%**	**112**	**100%**
Chimoio City	314,751	16%	6	5%
Gondola District	340,574	18%	8	7%
Manica District	281,878	15%	17	15%
Vanduzi District	NA*	NA*	7	6%
Sussundenga District	165,616	9%	13	12%
Mossurize District	278,133	14%	11	10%
Barue District	224,884	12%	14	13%
Total Coverage Manica	**1,605,836**	**83%**	**76**	**68%**
Sofala	**2,048,676**	**100%**	**157**	**100%**
Beira City	460,904	22%	14	9%
Dondo District	173,005	8%	14	9%
Nhamatanda District	282,331	14%	19	12%
Gorongosa District	159,223	8%	18	11%
Buzi District	190,975	9%	13	8%
Total Coverage Sofala	**1,266,438**	**62%**	**78**	**50%**
Total Population (Manica + Sofala)	**3,982,198**	**100%**	**269**	**100%**
Overall Coverage	**2,872,274**	**72%**	**154**	**57%**



For more on how the embedded research approach fosters resilient health systems: https://bit.ly/3pD5Qap

RE-AIM Framework

Dimension	Definition (Proportions)	Level
Reach	Target population participating	Individual
Effectiveness	Positive minus negative outcomes	Individual
Adoption	Settings planning to implement	Organization
Implementation	In place as intended in "real world"	Organization
Maintenance	Program sustained over time	Individual & Organization

Impact = **R** x **E** x **A** x **I** x **M**

Source: Glasgow et al. Am J Pub Hlth 1999; 99:1322-7.

Aim 1 Evaluate the IDEAs program's Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM)

R

- **Reach:** % health facilities and estimated pregnancies reached in Manica & Sofala provinces & estimation of populations not reached

E

- **Effectiveness:** Effect on structural and process quality, service coverage, and neonatal mortality

A

- **Adoption:** % of districts & facilities adopting IDEAs, and determinants of adoption (*via* ORIC assessment and IDIs/FGDs)

I

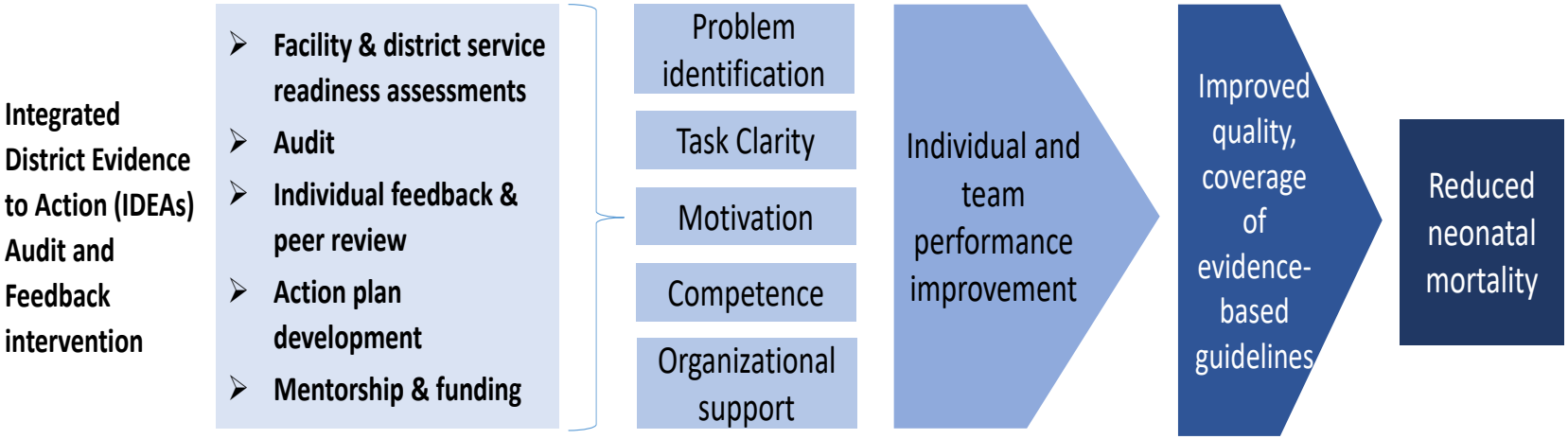
- **Implementation:** Core elements and determinants of implementation successes and failures (fidelity tracking, repeated CFIR-guided IDIs/FGDs)

M

- **Maintenance:** % of districts and facilities sustaining the intervention (2/cycles per year) at 12, 36, and 54 months post introduction

UNIVERSITY of WASHINGTON

Effectiveness



Effectiveness Domain	Structural & process quality	Service coverage & mortality
What's assessed?	-Structural readiness (health system readiness, data quality) -Provider capabilities (knowledge of MOH norms, practice observation)	-Service coverage (of evidence-based MNCH interventions) -Child mortality
Assessment approach	Repeated annual health facility surveys	Health management information system, population-based surveys
Sampling	36 facilities in 12 intervention districts 36 facilities in 12 matched control districts	Nationwide

Aim 1 Evaluate the IDEAs program's Reach, Effectiveness, Adoption, Implementation, and Maintenance (RE-AIM)

R

- **Reach:** % health facilities and estimated pregnancies reached in Manica & Sofala provinces & estimation of populations not reached

E

- **Effectiveness:** Effect on structural and process quality, service coverage, and neonatal mortality

A

- **Adoption:** % of districts & facilities adopting IDEAs, and determinants of adoption (*via* ORIC assessment and IDIs/FGDs)

I

- **Implementation:** Core elements and determinants of implementation successes and failures (fidelity tracking, repeated CFIR-guided IDIs/FGDs)

M

- **Maintenance:** % of districts and facilities sustaining the intervention (2/cycles per year) at 12, 36, and 54 months post introduction

Why Implementation Sciences matters for policymaking? A practical perspective from the field

Quinhas Fernandes, MD, MPH

Knowledge Translation to Practice

- Moving from “What we Know” works (EBIs) to a “real-world” effective implementation and scale-up is the “foundation” for Implementation Research (IR)
  - Addressing policymaker and community information needs makes IR relevant for policy and decision-making
- Barriers impede and/or delay evidence translation to practice, including:
  - **Lack of engagement (throughout the research design and implementation phases)**
  - Failing to address relevant questions
  - Failing to provide evidence when it is needed
- IR, particularly if “embedded”, can help remove these barriers

The Risk of not Engaging Decisionmakers or Implementers?

Lesson from scaling up post-partum hemorrhage prevention and family planning in Mozambique

- Community post-partum hemorrhage prevention through Traditional Birth Attendants (TBAs)
  - 2009 – 2010: Community distribution of Misoprostol (safety and acceptability study)
  - 2011: MoH adopted the results
  - 2015: MoH officially launched the strategy
  - 2016: 6 districts
  - 2017: Scale-up to targeted 35 districts
- Oral and Injectable contraceptives provision through Community Health Workers (CHWs)
  - 2014 -2015: Community provision of Contraceptives (safety and acceptability study)
  - 2015: MoH adopted the results, updated the CHWs scope of work, and started the program on a small scale
  - 2016: Nationwide scale-up
- What was the difference between these two programs?
  - Leadership engagement/involvement throughout the research

Essential Design Elements of IDEAS

- Leadership engagement across the levels of the health system
  - Facilitate program follow-up and lesson's adoption
- Embedded within the routine delivery system
- Robust implementation and evaluation frameworks
  - Enables understanding implementation weaknesses

Supported through the National Institutes of Health/*Eunice Kennedy Shriver* National Institute of Child Health and Human Development (R01HD092449) & the Doris Duke Charitable Foundation's African Health Initiative