IMPLEMENTATION RESEARCH

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Senior Program Officer, HIV/Integrated Delivery

FHI 360 Meeting
September 4, 2014
OVERVIEW OF PRESENTATION

• Examples of foundation work
• Deep dive into one example, Avahan
• Concluding remarks
IMPLEMENTATION RESEARCH AT THE FOUNDATION

Foundation does not classify grants as Implementation Research

Wide variety of opinions regarding Implementation Research (very informal survey)

- “My experience is that much of what is being called implementation science is really just process evaluation of health interventions. It is actually disappointing to see that many of the counterfactual-based methods used in health are ignored once a question moves into the “implementation” realm.”

- “Is it the same as operations research?”

- “It is implementation analysis to inform and guide the scale up of programs.”
“Existing interventions have potential to cost effectively avert most neonatal and maternal deaths. The barriers that are preventing these life-saving interventions from reaching people who need them are primarily implementation barriers and often not technical barriers.”

“Life-saving drugs and vaccines, and diagnostic tools are expensive in the developing world, can take years to introduce, and are difficult to make widely available.”
SOME EXAMPLES OF FOUNDATION GRANTS ADDRESSING SCALE

- Malaria Control and Elimination Partnership in Africa (MACEPA)
- Better Immunization Data (BID)
- Demand creation for Voluntary Medical Male Circumcision (VMMC)
- Reduction of Maternal and Infant Mortality in Bihar (Ananya)
- Reducing infant mortality through Kangaroo Mother Care
OVERVIEW OF PRESENTATION

• Examples of foundation work
• Deep dive into one example, Avahan
• Concluding remarks
AVAHAN I - SNAPSHOT

High risk groups

- FSW: 220,000
- MSM / TG: 80,000
- PWID: 18,000

Men at risk

- 5 million

Investment:
US$ 235 million

6 states, 82 districts
Combined State Population
~ 300 million
High risk groups covered
FSW – 220,000
MSM / TG – 80,000
PWID – 18,000
Men at risk – 5 million
AVAHAN’S GOALS OVER A 13 YEAR PERIOD

**Disseminate learnings**
- Actively foster opportunities for creating learnings from Avahan
- Disseminate learnings through a wide variety of mechanisms and fora

**Build / Operate HRG prevention program at scale**
- Demonstrate program at scale with coverage, quality
- Document declining HIV infection trends in core, bridge, general population

**Transfer program to government, other stakeholders, communities**
- Sustain funding / management without program disruption
- Strengthen communities to sustain transition post-handover

**Disseminate learnings**
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**Sustainable communities**
- Strengthen CBOs to sustain strong HIV response

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2004 ---- -----2008---- ---- 2017

Avahan I

Avahan II

Avahan III
PHASE I DESIGN (2003-2009)

Focused Prevention (57%)
- High Risk Groups in 6 States:
  - Female Sex Workers, high-risk MSM / transgenders, PWIDs
  - Male Clients of Sex Workers:
  - Truckers on National Highways, Hotspots in 4 States

Communication for Social Norm Change (3%)

Advocacy (7%)

Best Practices Transfer (18%)

M&E, Dissemination (15%)

The Prevention Package
- Outreach, Behavior Change Communication
- Commodities (condoms, lubricants, needles)
- Clinical services for STIs + counseling
- Case managed approach to referral - TB, HIV testing, ART
- Local advocacy – police sensitization, crisis response, community advisory committees
- Community mobilization

100% -- US$ 235 Million
AVAHAN IMPACT EVALUATION QUESTIONS

Scale / coverage / quality / costs

- Are services adequate (~80% of population) over time?
- What were the costs?

Epidemic impact

- Increase in condom use in high-risk groups?
- Reduction in STI and new HIV in high-risk groups?
- Decrease in HIV in general population?
- Can be attributed to high-risk group interventions?
- What was Avahan's contribution?

Cost effectiveness

- Cost effectiveness high-risk groups reached?
- Cost effectiveness of infections averted?
- Cost efficiency of the various service components?
Declines in HIV prevalence in ANC clinics in four southern states *

* As measured in antenatal clinics (ANC) consistent sites

Source: National AIDS Control Organization (NACO) HIV Sentinel Surveillance
**CONTEXT THAT CONTRIBUTED TO AVAHAN SCALE-UP**

**Indian context:**
- Key population programming priority for GoI.
- GoI under NACP-II investing in NGOs for prevention.
- Routine KP surveillance, enumeration exercise, behavioral survey.
- Comprehensive TI strategy.
- Long history of participatory development approaches and global model for FSW – Sonagachi.
- Nonetheless, significant stigma, violence, low social status of target population.

**Avahan context:**
- NGO program
- Completely outside government
- “Sufficient” funding
- Controlled all elements of intervention
ELEMENTS OF SCALE-UP – DATA USE, REFINEMENT, PUSHING DATA USE DOWN TO FRONTLINES

- District level mapping for hot spots and size estimates – largest first
- Site level mapping for outreach and service placement
- Network mapping to assign peer outreach worker to clients
ELEMENTS OF SCALE-UP – DATA USE, REFINEMENT, PUSHING DATA USE DOWN TO FRONTLINES

- Common minimum program with targets
- Phase specific indicators
- Routine MIS
- Use at all levels (informed through mentoring)
- Intensive field engagement, regular reviews at all levels
THE COMMON MINIMUM PROGRAM

Define set of activities to be accomplished by all implementers in areas:
• Community mobilization
• Advocacy
• Communication for behavior change
• Clinical services
• Monitoring for management
• Management

Basis for indicators and data review in supervision visits

• Informed by program experience
• Mechanism for program learning (most changes in CM section)
• Set standards but allowed for innovation

Additional learning mechanisms established later in project.
**ROUTINE MIS DATA AND PROGRAMMING DECISIONS – EARLY EXAMPLE**

**Background:**
Avahan offers free condoms to high risk groups

**Data:**
- <50% of condoms distributed by 1200 peers
- >50% of condoms distributed by 131 NGO staff

**Relevance:**
Scaling and speeding condom distribution

**Investigation:**
- Lack of trust
- Lack of confidence in peer educator ability
- Concern for position

**Action:**
- Skill building / tools for peers
- Coaching for NGO staff

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**Condoms distributed by peers and outreach workers**

<table>
<thead>
<tr>
<th>Month</th>
<th>Outreach Workers</th>
<th>Peer Educators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr-05</td>
<td>50000</td>
<td>100000</td>
</tr>
<tr>
<td>May-05</td>
<td>50000</td>
<td>100000</td>
</tr>
<tr>
<td>Jun-05</td>
<td>50000</td>
<td>100000</td>
</tr>
<tr>
<td>Jul-05</td>
<td>50000</td>
<td>100000</td>
</tr>
<tr>
<td>Aug-05</td>
<td>50000</td>
<td>100000</td>
</tr>
<tr>
<td>Sep-05</td>
<td>50000</td>
<td>100000</td>
</tr>
</tbody>
</table>

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PEER OUTREACH WORKERS BECAME DATA USERS AND CASE MANAGERS
OUTREACH CONTACTS INCREASED WITH MICROPLANNING

Monthly outreach
Total reached climbed steadily as peers skills enhanced

Source: Avahan program data for FSW and MSM/TG for the four southern states (Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu)
SERVICE UTILIZATION INCREASED WITH MICRO-PLANNING

Condom distribution
Steady rises since peers began doing bulk of outreach

Clinic attendance
Rose and stayed steady since micro-planning introduced

Source: Avahan program data for FSW and MSM/TG for the four southern states (Andhra Pradesh, Karnataka, Maharashtra, and Tamil Nadu)
AVAHAHN KEY EVALUATION MILESTONES 2004-14

Evaluation grants issued

2004
EAG 1

2005
EAG 2

2006
EAG 3

2007
EAG 4

2008
EAG 5

2009
EAG 6

2010
EAG 7

2011
EAG 8

2012
NSR 1

2013
NSR 2

2014

Avahan costing data

ANC/PPTCT

Avahan MIS

IBBA R1, GPS, SBS

NFSH 3, NACO BSS

Phases

Phase I

Phase II

IBBA data access

2008 AIDS supplemental

2010 STI supplemental

2011 BMC supplemental

2012 BMJ CM supplemental

IHME Avahan evaluation results

Avahan impact dissemination Sept 2012

Avahan impact paper 2013

Avahan cost/ CEA paper 2014

Avahan open data access

IBBA R2, GPS

Avahan CMIS stabilized

Avahan MIS

NACO CMIS

2008 AIDS supplemental

EAG 1

EAG 2

EAG 3

EAG 4

EAG 5

EAG 6

EAG 7

EAG 8

2004

2005

2006

2007

2008

2009

2010

2011

2012

2013

2014
AVAHN KEY DISSEMINATION MILESTONES 2004-14

Phase I

- 2004: EAG 1
- 2005: EAG 2
- 2006: EAG 3
- 2007: EAG 4
- 2008: EAG 5
- 2009: EAG 6

Phase II

- 2010: EAG 7
- 2011: EAG 8
- 2012: EAG 9
- 2013: EAG 10
- 2014: EAG 11

- IHME Avahan evaluation results
- Avahan impact dissemination Sept 2012
- Avahan cost/CEA paper 2014

- Elements replicated in ongoing normative guidance revision.

Foundation staff and partners on operational manual development and training material

National TSU (staffed from partners)

Government Capacity Building Support (state and national)

International dissemination

Phased transition of programs to government Management and support

Programs aligned with NACO model

Planning

NACP-III

- Phase I
- Phase II

SWIT Published

Elements replicated in ongoing normative guidance revision.

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NACP-III

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Foundation staff and partners on operational manual development and training material

Foundation staff and partners on select working groups for NACPIII
**DISSEMINATION AND INFLUENCE**

**Within India**
- “Inside track” communication
- Enough experience at the right policy window.
- Avahan was successful at what India aspired to do
- Significant investment to help operationalize the design with Avahan approaches.

**Global**
- Publication of evaluation results and programmatic learnings in peer reviewed publications, monographs, tools.
- Incorporation of learnings into global manuals and protocols
- Support for replication of elements in other countries
- Former partners and employees in key positions
TENSIONS IN OUR MEASUREMENT LEARNING, AND EVALUATION WORK…

<table>
<thead>
<tr>
<th>Proving Impact</th>
<th>Improving Programming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlling through M&amp;E</td>
<td>Building ownership through M&amp;E</td>
</tr>
<tr>
<td>(it’s for us)</td>
<td>(it’s for them)</td>
</tr>
<tr>
<td>Using only High Quality Data</td>
<td>Integration with Govt system</td>
</tr>
<tr>
<td>(doing it ourselves)</td>
<td>(building on, using, and strengthening)</td>
</tr>
<tr>
<td>Using MLE to enforce fidelity</td>
<td>Building in, and anticipating, multiple paths to the goals</td>
</tr>
<tr>
<td>Keeping accountability on process and activities</td>
<td>Keeping Attention on Outcomes</td>
</tr>
</tbody>
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CONCLUSIONS

1. Goal of IR should contribute to implementation / policy issues relevant to the country. Global learning is a secondary benefit.
   - Most implementation issues are context specific
   - Good documentation is necessary to “extract” global learnings

2. Improving routine data systems in countries is critical for IR
   - To identify implementation issues, local innovations
   - Key data source for implementation research
   - Improve country management
     - Use doesn’t just happen, it needs to be facilitated
     - Strengthen connection between analysis and action
     - Using data improves data, improved data is more likely to be used
   - Single view of data is important
3. Dissemination and influence → program change is complex

- Important to be aware of policy windows in countries
- For most interventions, policy makers, implementers and managers need evidence of improvement (less uncertainty), not proof (certainty).
- Even “simple” changes need support for institutionalization

- International processes currently require peer reviewed publications:
  - WHO – GRADE evidence
  - Cochrane reviews – prefers RCTs
THANK YOU