DECISION MAKING - BARRIERS & ENABLERS	
Government decision making	
Political/policy context	Governance: including leadership, accountability, corruption, strength of democracy
	Political will/commitment: including openness to new ideas and innovations, risk taking/aversion
	Political interests/ vote-bound context
	Continuity: including frequent policy/programme changes / changes in govt/ turnover of government officials – elected and bureaucrats
	Capacity of decision makers: including quality, skills, numbers, reliance on technical assistance
	Fear and mistrust
Economic/financial context	Overall public resource envelope
	Overall public resource allocations for health
	Budget setting processes - health vs. non-health MNH vs. other health issues priorities
	Financial commitments – rhetoric verses practice
Institutions	Institutional rules and laws enabling/undermining policy change
	Legislative basis for introduction of innovations e.g. human resource and imports legislation
Concentration/decentralisation of power	Extent of individuals' power including national leaders, state governors
	Extent of power and autonomy at different levels of government: federal, state, district
	Variations in commitment between regions
Problem framing	How policy problems are framed: including health verses non-health/MNH verses other health priorities
	External influences on problem framing/priority setting: donors, global priorities – e.g. MDGs, PPPs
Technologies and commodities	Availability of appropriate commodities in country
	Availability of m-health technology in country
Harmonisation/coordination of external programmes	Coordination among external partners: coordination, fragmentation, competition, duplication

	Coordination among govt departments; between govt levels
Actor power: actors influencing government decision making	
Development community: bilateral donors and multilaterals	Influence on decision making at different levels – federal, state, district
	Donor budgets as % of govt budgets
Development community: civil society organisations	Influence on government decision making – federal, state, district levels
	Strength of civil society to advocate and hold government to account
Traditional authority; community and religious leaders	Influence on government decision making – federal, state, district levels
	Resistance to/acceptance of external actors, programmes and innovations
Academic institutions	Influence on government decision making – federal, state, district levels
	Research, monitoring and evaluation capacity
Professional associations	Influence on government decision making – federal, state, district levels
	Resistance to/acceptance of MNH innovations
Media	Mass media
	Local media including local radio and theatre
	Social media

DECISION MAKING - CATALYSING MECHANISMS	
Policy advocacy	Methods of advocacy including etiquette

	Degree of engagement with decision makers: involving government in planning and design of programme and evaluation, intensive discussion and persuasion, continual advocacy
	Advocacy at multiple levels of govt
	Advocating non-government actors to scale-up innovations including donors and private sector
Policy alignment	Targeting govt as main owner of innovations at scale in terms of legitimacy and resources
	Aligning programmes/innovations with govt policy and programmatic frameworks, targets & priorities
	Framing a programme/innovation within policy discourse/evoking political interests
	Working with/within govt systems
Harmonisation/coordination and coordination mechanisms	Harmonised/coordinated/unified external partners' voices more powerful when advocating govt to adopt innovations at scale
	Coordination/partnership mechanisms effective route to input on govt policy/programmes
	Govt oversight, coordination of donors programmes at scale, avoiding duplication
	Exchanging learning to improve innovations – other development partners, private sector
Co-financing arrangements	Fostering co-financing agreements with government
	Fostering co-financing agreements with other external funders
Invoking policy champions	Among government officials – elected and bureaucrats
	"Boundary spanners" (actors spanning different spheres e.g. government, civil society)
	Traditional authority/ community and religious leaders
	Media – print, TV, radio, celebrities – local and mass media
	Civil society organisations as policy advocates
	Influential social figures e.g. first ladies
Catalysing effect of BMGF	BMGF program officers/country offices engaging directly with partners' fora/ coordination mechanisms
	BMGF program officers/country offices signing MoUs with government
	BMGF program officers/country offices: catalysing effects/removing blockages
	Country visits from BMGF Co-chairs
Strength of grantees to catalyse scale up	Building a reputation/ credibility, creating trusting relationships with govt and other actors

	Longer-term programme/innovation grants more scalable than short term
	Capacity and experience in scale-up and advocacy
Integrating scale-up in grantee programme design	Scale-up is a programmatic deliverable
	Having an advocacy/scale-up plan of activities
	Resources available for scale-up activities – financial, human, technical resources
	Assessing potential blockages to scale up in health systems, institutions, policymaking
	Assessing potential blockages to scale up in sociocultural contexts
	Stakeholder mapping of potential allies and rivals
Strengthening government capacity	Strengthening/ facilitating the strengthening of government decision making capacity and systems
Generating and communicating **evidence**	SEE SECTION BELOW

DECISION MAKING – EVIDENCE	
Using multiple **types** of evidence	Quantitative impact evidence
	Qualitative evidence
	Demonstration to decision makers, field visits
	Cost estimates of taking innovation to scale
	Process data – explaining why things changed
	Implementation lessons
Strength of evidence	Difficulties proving impacts of specific programme components in complex contexts
	Trustworthy/unbiased – evaluation independently conducted and not influenced by interests
	Different types of evidence perceived as stronger by govt decision makers e.g. quantitative evidence verses qualitative
	Geographically relevant evidence more powerful than overseas evidence
Capacity of researcher/evaluator	Limited capacity to produce research/quality research

	Limited investment in research capacity in geography
Communicating the evidence	Targeting the right audience
	Format, packaging appropriate to audience
	Right place, right time – decision making cycles; short interface time with decision makers
	Credibility of the messenger
	Decision makers involvement in designing evaluation – buy in and trust
	Continual advocacy - regular presentation of evidence to decision makers
	Invoking evidence champions within government
	Evidence sharing among external partners
	Empowering civil society/beneficiaries with evidence
	Empowering lower levels of govt with evidence
	Evidence that contradicts govt may be resisted
Using the evidence	Culture of evidence-based decision making vs political decision making
	Structures and systems in govt to capture and assess evidence and spread best practices
	Decision makers' ability to understand and value evidence
	Decision makers' time, bandwidth to make sense of and use evidence

DELIVERY - BARRIERS & ENABLERS	
(Weak) health services	
Healthcare delivery	Availability and coverage
	Infrastructure including water and electricity
	Functioning of services including quality and opening times
	Referral systems including ambulances
Medicines, equipment and consumables	Availability
	Quality, functionality

	Supply systems/chains including logistics management information
Leadership and governance	Management/supervision systems including SOPs and protocols
	Accountability mechanisms including reporting mechanism and sanctions
	Complex hierarchies
	Corruption including informal out of pocket payments and nepotistic recruitment practices
Information systems	M&E systems including HMIS
Healthcare financing	Flow of health budgets to frontline providers
Human resources	Sufficient numbers and distribution of health workers to meet patient load
	Health worker skills and training and broader educational context including ToT, training curricula and education levels among girls and women
	Health worker motivation, financial/non-financial incentives/incentive systems, salaries including differential pay scales
	Health worker workloads
	Health worker turnover
	Health worker absenteeism
	Attitudes of health workers to beneficiary communities especially marginalised communities
	Broader human resources policies
Other	
Security	Service interruptions
	Difficult to recruit/ retain staff
Technology	Mobile phone coverage; network coverage; cost of mobile phones
Policy implementation	Extent of/lack of policy implementation in practice
	Variance in policy compliance across facilities

DELIVERY - CATALYSING MECHANISMS	
Capacity strengthening	Generating and communicating technical evidence e.g. toolkits/ manuals to aid implementers to scale-up innovations
	Documenting and communicating implementation lessons to aid implementers to scale-up innovations
	Strengthening/ facilitating strengthening of technical skills among implementers

DEMAND - BARRIERS & ENABLERS	
1st delay – demand for health services	
Sociocultural	Socially embedded norms, beliefs and practices surrounding health and illness, pregnancy, childbirth, motherhood and newborn care
	Hegemonic gender relations including women having no voice and purdah
	Social relations within families – intergenerational, mothers in law
Community gatekeepers	Endorsement or resistance from community/religious leaders/groups
Demand for services	Demand for improvements to poor health services
	Communities mobilised to demand services
	Low expectations, subdued demand
	Perceptions of service quality
Knowledge	(Limited) awareness of services
	Education/illiteracy
2nd delay – access to services	
Economic barriers	Poverty

	Costs of using services: users fees; cash incentives
	Opportunity costs of seeking care: harvesting and over economic activities/ seasonal variations
	Transportation costs
Geographical barriers	Transport, roads
	Terrain
	Climate
	Distance - population distribution, density, pastoralism
	Vast size of geography; scale of problems makes scale up challenging
Heterogeneity	Heterogeneity between districts in terms of socioeconomic status, ethnicity, caste, climate, health issues etc

DEMAND - CATALYSING MECHANISMS	
Community demand	Fostering community awareness, engagement and demand for innovation
Mobilising community actors to demand services and foster service uptake among communities	Traditional authority
	Religious/community leaders
	Women's groups
	Civil society organisations including CBOs and FBOs
	Mass media
	Local media including theatre and local radio

INNOVATION ATTRIBUTES [crosscutting – decision making & demand]	
Simplicity	Simple, low cost, cost effective

	Ease of use
Effectiveness	Effectiveness including refining innovation over time; ensuring they are based on correct assumptions
	Addresses community needs
Demand	Type of innovation e.g. product, behaviour change, approach or system
	Desirability – iPod
	Packaging, branding
	Non-controversial (do not subvert interests, power, dominant ideas)
	Beneficial to FLWs – achieving tasks; not increasing workloads; not increasing accountability/scrutiny
Efficiency	Alignment with existing systems; harnessing existing systems, technologies and actors – 'system friendly'
	Positioned *outside* government systems
Legitimacy	Working with *local* partners
	Culturally/religiously acceptable and trusted
	Seen as coming from communities rather than imposed/western
Adaptability	Adaptable to different contexts – health provision, health problems, sociocultural and economic contexts