

# IDEAS qualitative study of scale-up: draft protocol

Neil Spicer, agreed version 14<sup>th</sup> June 2012

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## 1 Background and aims

The IDEAS project (Informed Decisions for Actions to improve maternal and newborn health) will provide evidence to help decision making about the strategies, content and direction of maternal and newborn health programmes between 2010 and 2015. Led by the London School of Hygiene and Tropical Medicine (LSHTM), IDEAS will work in three ‘focus geographies’ that suffer a high burden of maternal and newborn deaths: Tigray, Amhara, Oromiya and SNNP in Ethiopia, the six states of northeast Nigeria (Gombe, Adamawa, Taraba, Bauchi, Yobe and Borno) and Uttar Pradesh in India. Further details of the IDEAS project can be found at: <http://ideas.lshtm.ac.uk/>

IDEAS is working in partnership with innovative maternal and newborn projects funded by the Bill & Melinda Gates Foundation (BMGF) to answer the following learning questions:

1. Are interactions between families and frontline workers more, better, efficient and equitable, in the particular districts where implementation grantees are working, and does coverage increase as a result?
2. Is there any evidence of the implementation grantees' intervention models being scaled up across the entire focus geography? Why, or why not?
3. If there is evidence of scale-up, does this lead to coverage change and improved newborn survival?

IDEAS Objective 3<sup>1</sup> will explore the second of these learning questions and consists of a quantitative component (described in Schellenberg, 2012) and a qualitative component described here. A *Draft Framework of Scale-up and Diffusion* (Spicer, December 2011) was developed to organize and frame a set of detailed research questions that we will explore through annual qualitative interviewing in the three focus geographies (detailed below). There are two driving questions of the qualitative component:

1. **To understand the ways BMGF implementation grantees are catalysing scale-up of MNCH innovations, which approaches are working and why;**
2. **To identify the factors which enable or inhibit scale-up of MNCH innovations, and understand how these factors vary between geography, grantee and innovation model.**

This draft protocol describes the common methodology for the comparative qualitative study of scale up in Ethiopia, Uttar Pradesh and northeast Nigeria. It is based on detailed discussions at a planning workshop held in Addis Ababa 1<sup>st</sup> to 4<sup>th</sup> May 2012 between the IDEAS team and Measurement Learning and Evaluation (MLE) Partners Jarco, Health Hub and Sambodhi, and builds on the methodology scoping paper *Qualitative Study of Scale-up and Diffusion* (Spicer, February 2012). Data collection will consist of between 50 and 75 individual in-depth, semi-structured interviews with a range of stakeholders in each geography in the period July – September 2012.

*This protocol describes the methodology in detail based on the Addis Ababa workshop. MLE Partners are invited to review this document carefully prior to it being finalised and data collection starting.*

## 2 Qualitative study of scale-up: principles and approach

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<sup>1</sup> IDEAS objectives are as follows: Objective 1: To strengthen grantee and sub-grantee capacity for measurement, learning and evaluation through a Technical Resource Centre; Objective 2: To gather, analyse and synthesise evidence in key districts for enhanced interactions between families and front line workers, whether these lead to increased intervention coverage, with reasons why this has or has not been achieved; Objective 3: To assess the extent to which MNH intervention models implemented by foundation grantees are scaled-up in North-Eastern Nigeria, Ethiopia and Uttar Pradesh, and investigate enabling and inhibiting factors for scale-up; Objective 4: To gather, analyse and synthesise evidence across the key geographies on whether integrated community-based demand and supply side intervention models implemented at scale improve newborn survival; Objective 5: Develop and disseminate best practices for learning and actionable measurement in maternal and newborn health

## 2.1 Methodological approach

The data collection methods detailed in this protocol will explore the themes identified in the *Draft Framework of Scale-up and Diffusion* (Spicer, December 2011). The framework and major themes are summarised in Annex A, and detailed research questions listed in Annex B. The framework was agreed with the Foundation in January 2012, and was discussed and agreed between MLE Partners and IDEAS during the Addis Ababa planning workshop in May 2012.

Our approach will be inductive: qualitative data collection will be guided by our framework but will also be open to unexpected themes emerging from interviews. The aim is to build theory based on empirical evidence, rather than constructing and deductively testing theory since the latter approach is less likely to capture complexity. Indeed, while our framework needs to be sufficiently generalisable to enable comparison across the three focus geographies we need to capture and understand the differences between the grantees, the diverse interventions they are implementing and the substantial differences between and within the three geographical settings. Hence, we will use the framework to address what will be a relatively broad set of themes in 2012. In conducting data collection in 2013 and 2014 it may be appropriate to adjust our research questions to reflect themes emerging in 2012 by, for example, focussing on a narrower or broader set of factors, or indeed changing the focus altogether.

Epistemologically and ontologically the study takes a realist approach, and is based on interpretivist rather than positivist thinking. This means we assume interviewees' accounts reflect an external reality and through our data collection we can build a true (valid) picture of that reality. However we acknowledge that an interviewee's account will always be partial, and also that our interpretations of the data influence the conclusions we reach. It will therefore be important take steps to try to capture the truest (most valid) account from each interview, to cross check multiple interviews to gain the most valid picture of reality as possible, to be reflexive about our interpretations of the data and to cross-check different investigators' interpretations of the data. These steps are described in Section 7 Data quality and Supervision (below).

## 2.2 Key concepts

Scale-up can be defined as: '*...an increase in the coverage of health interventions that have been tested in pilot and experimental projects in order to benefit more people...*' (Mangham and Hanson, 2010:2 after Simmons et al 2007). Scale-up can embrace multiple dimensions including:

- Increasing the reach of a health programme so that it benefits a greater number of people over a wider geographical area;
- Increasing programme inputs in the form of financial, human or capital resources;
- Broadening the scope or range of interventions within a health programme (Mangham and Hanson 2010).

Operationally we focus on the first of these dimensions: geographical scale-up within the three focus geographies.

Further, we are not examining the scale-up of innovations *directly by grantees as part of their BMGF-funded programmes*. Instead we are interested in the ways grantees are catalysing the adoption their innovations *by other actors* – including decision makers, implementers and community beneficiaries – leading to the scale-up of innovations *beyond grantee programme districts*.

For this component of IDEAS we cannot define precisely a minimum threshold whereby an innovation is considered ‘scaled’. We are interested in *any* examples of scale-up beyond grantee districts – even relatively modest examples. Indeed, it is possible at this stage in the development of the grants there will be minimal or no examples of innovations being scaled up in which case we will focus more on the barriers to scale-up. Hence our working definition of scale-up of innovations is: *adopting at least one innovation and making some notable progress in implementing them beyond grantee districts*.

It will be important in this round of interviews to elicit a descriptive account of the extent of any examples of scale-up. Follow-up data collection in 2013 will link closely to the quantitative study of scale-up (District Evaluation Platform) where we will measure levels of scale-up and use the corresponding qualitative study to explore factors enabling/undermining scale-up that we measure.

Additionally IDEAS uses the following concepts to frame its evaluation:

**‘Innovation’**: a new method to enhance ‘interactions’ between frontline workers and household members, for example mobile phone technology, materials to improve communications with families or incentives for frontline workers;

**‘Interaction’**: an interaction between a frontline worker and family to foster *more, better, efficient, equitable* ‘(critical) interventions’, for example a frontline worker home visit;

**‘(Critical) intervention’**: a proven direct biological mechanism or action to improve the health of mothers and/or newborns, for example breastfeeding.

The focus of the qualitative study of scale-up is on the first of these concepts: the *scale-up of innovations*, and not interactions or critical interventions (which are explored by other IDEAS objectives).

## 3 Data collection

### 3.1 Topic guides

- A long (five page) topic guide will serve as a source of interview questions (Annex C). For each interview the most relevant questions will be extracted to create a short (one-page) bespoke guide to help focus that interview on what is likely to be most important, thereby avoiding the situation where all themes are covered in an interview but with limited depth/detail. Interviewers will therefore need to do some preparation/planning in advance of each individual interview. See the four short topic guides created for the practice interviews during the workshop as examples (Annex D).

- Care needs to be taken to use terms that are easily understood and grasped by the intended audience and avoid jargon or complex terms. It may also be appropriate to translate the topic guides into appropriate languages. Each MLE Partner will decide how to manage this. This is likely to be more important in 2013 when we interview frontline workers and communities.
- This study embraces a non-static study design. Interviewers and their supervisors will hold regular debriefing meetings to identify emerging, unanticipated themes that are seen as important during the fieldwork period. Such themes should be explored in subsequent interviews, and hence modifications to the long topic guide may be needed over the course of the 2012 data collection.

### 3.2 Piloting interviews

- The four practice interviews should be sufficient in terms of piloting in Ethiopia, especially since it was agreed that adjustments to the topic guide may be needed during the data collection phase.
- Sambodhi and Health Hub will do a small number of similar pilots in their countries to ensure clarity and relevance, but these will be done after ethical approval is granted and will be recorded and treated as real data. In the case of India IRB approval is now received meaning interviews can now be started.

### 3.3 Introducing interviews

- While introducing interviews interviewers should briefly summarise IDEAS as a whole, explain in more detail the aims and nature of this component of the study – including our operational definition of scale-up and briefly about the grantees and innovations we are focusing on (see 4.2 and 4.3), and clarify with interviewees what they can expect if they agree to participate. This is also important because an engaging and informed introduction can improve rapport and the utility of the entire interview.
- As part of the introduction interviewers will need to explain how IDEAS understands scale-up, and that while our focus is on Gates grants, we are also interested in broader (but relevant) country context themes that help explain why Gates grants are scaled-up or not.
- An introductory script for interviewers, including matters of informed consent and confidentiality can be found in Annex E.
- While introducing interviews interviewers will need to be able to justify the value of the study and allay concerns, especially among representatives of implementation grantees who might be reluctant to reflect on negative aspects of their grants. See Annex E and Section 9.2 – Research ethics – Confidentiality.
- Interviewers will also give each interviewee a standard information sheet (Annex F) and will ask them to complete a concern form (Annex G). There are also two information sheets (short and long) on the IDEAS website which interviewers can print and give to interviewees if they would like further information - <http://ideas.lshtm.ac.uk/what-we-do>

### 3.4 Conducting interviews in practice

Individual face-to-face semi-structured interviews will be used to collect rich qualitative data to explore relevant themes in depth, to allow interviewees' frames of experience and meaning to emerge and to surface unanticipated themes and connections. The aim will be to conduct a set of high-quality interviews covering themes in depth that are relevant to the study aims with appropriate stakeholders.

A number of important practices should be adopted:

- Interviewers should aim to memorise the topic guide, and also practice conducting interviews with colleagues and peer review each other. This should lead to improved confidence, and help avoid hesitations and improve flow;
- Interviewers should prepare for each interview to ensure it focuses on the most important themes for each individual interviewee through creating a one-page bespoke topic guide for each interview (see also 3.1 Topic Guides above);
- Interviewers should ensure what interviewees say is precise and relevant by asking for concrete examples where appropriate and politely interrupting if an interviewee speaks at length on an irrelevant topic;
- Flexibility in the order of questions will be important: emerging themes that are of interest to the study should be followed and less important questions can be missed in order to explore key themes in depth depending on the area of knowledge of each interviewee. This will be particularly important for government interviewees who may have less time to commit to our interview. In some case where all the key themes are not covered in an interview it will be necessary to request a follow up interview to fill in the gaps.
- Where appropriate/possible interviews should be conducted in the preferred language of the interviewee – see also 3.1 translating topic guides.

## 4 Sampling

### 4.1 Interviewee sampling frame

The 2012 fieldwork consists of between 50 and 75 individual in-depth semi-structured interviews with a range of stakeholders at national and state/regional levels. The final agreed number of interviews will be based on populating the sample template (Annex H) to establish the most appropriate interviewees in each geography. MLE Partners will continue to work on populating their sampling templates (using information collected as part of the stakeholder mapping), including suggesting the most important potential interviewees and work closely with the London IDEAS team to agree the initial sample, and make revisions during the fieldwork period as required. Potential interviewees will be identified based on purposive and snowball (cascade) sampling. Selection criteria are:

- Stakeholders who have a role in the field of MNCH working within an organisation with an MNCH programme in the geography who know the Gates grants/innovations well or have some knowledge of the grants;;
- Stakeholders with the ability to speak about the subject area knowledgably who know the Gates grants/innovations well or have some knowledge of the grants;.



The sampling frame relates to different organizations as follows (see also the sampling template – Annex H):

- Government officials at national and/or state/regional levels;
- Development agencies including bilateral donors and multilateral agencies with MNCH programmes;
- Relevant private sector actors (if applicable in each geography);
- Relevant civil society actors;
- Relevant professional associations;
- Academics working in a relevant field;
- Other key informants with relevant expertise;
- BMGF implementation grantees;
- BMGF sub-grantees;
- BMGF programme officers with knowledge of the grantees and/or geographies.

BMGF Programme Officers and implementation grantees will be interviewed first subject to their availability, since this will help focus the remaining interviews – especially in terms of sampling innovations (see 4.3 below). We will interview representatives from each implementation grantee as part of the overall sample (details in 4.2 below). Implementation grantees included in the 2012 study are given below (additional implementation grantees are likely to be introduced over the course of the IDEAS project):

- Northeast Nigeria: Maternal and Newborn Health Project (SFH);
- Ethiopia: Last 10KM (JSI); Saving Newborn Lives (Save the Children); MaNHEP (Emory University);
- Uttar Pradesh: Sure Start (PATH); Manthan (Intrahealth); Better Birth (Harvard School of Public Health); Community Mobilisation grant (PHFI).

Since the focus of the study is on the scale-up of implementation grantees' innovations we will sample interviewees on the basis that they have some knowledge of these grants and are willing to comment on them. However this may not be immediately obvious before starting an interview, and as a consequence snowball sampling may become an important approach in practice to help identify the most appropriate interviewees. It will be important to regularly review the sample and make changes if required during the fieldwork period. Nevertheless, it will be important to build a picture of how the broader country context impacts on scale-up: interviewing some stakeholders with limited knowledge of these specific grants will still be valuable.

Hence there will be two groups of interviewees:

- a) People who know the Gates grants/innovations well – interviews will focus on these.
- b) People who do not know the Gates grants/innovations well – interviews will touch on the Gates grants/innovations as much as possible, but also explore the scale up of MNCH programmes more generally.



As far as possible we should speak to people in group a) with some knowledge of the Gates grants. However at this stage it is difficult to define what proportion of interviewees will fall into each group – since it may not be obvious how much people on our sample list know about the Gates grants. This is why we need to treat the list as provisional at this stage – when we start to interview this should become clearer and snowballing will be useful.

In advance of fieldwork MLE Partners will work with Neil to agree a list of potential interviewees based on the selection criteria and sampling frame (above), and will also agree who should contact different stakeholders to arrange interviews. Generally Neil will contact the implementation grantees in the first instance since he has either met or been in contact with them before.

The accounts of innovation beneficiaries and household members not receiving BMGF-funded innovations, and those of frontline providers will be elicited through qualitative data collection in districts where BMGF implementation grantees are working in 2013. The grant(s) this data collection focuses on will be decided nearer the time. This work will form a part of the qualitative component of IDEAS Objective 2 and is not described in this protocol.

## 4.2 Sampling grantees

We will interview at least one representative from each of the eight implementation grants, including the new grants starting 2011/12. However the 2012 fieldwork will focus on the more *established/completed grants* (one from each geography), that is: L10K (Ethiopia), SFH (northeast Nigeria) and Sure Start (Uttar Pradesh). This is based on the assumption that these grants are more likely to have catalysed scale-up of at least some of the innovations they have invested in. We will interview four or five informants from each of these grants and a similar number of sub-grantees. These interviews will focus on:

- Grantee innovations that are most important in terms having been scaled-up;
- Innovations they have positioned for scale-up but have not been successful;
- Mechanisms they have used to catalyse scale-up and their effectiveness;
- Barriers and enablers to scale up.

We will also interview one or two informants from the *newer grants*: SNL and MaNHEP (Ethiopia), and Manthan, Better Births and PHFI (Uttar Pradesh), but not their sub-grantees. Indeed the Better Births and PHFI grants are only starting later in 2012. We are assuming scale-up will be less evident among these grantees than the established/completed grants – hence we will not explore these grants in depth in 2012.

These interviews will focus on:

- Planned grant activities;
- Innovations they are positioning for scale-up;
- Mechanisms in place or planned in order to catalyse scale-up of their innovations;
- Barriers to implementation and expected/early barriers to scale-up of their innovations.

Stakeholder interviewees (that is the broader cross-section of government, donors, academics, professional associations, civil society and other key informants in each

geography detailed above) will be asked to focus on L10K, SFH or Sure Start to the extent of their knowledge, but will also be asked to comment on the barriers and enablers to scale-up of MNCH programmes more generally.

### 4.3 Sampling grantee innovations

The IDEAS project engages with implementation grantees that have adopted a number of innovative models of working that are both ‘shaping demand and improving health practices’ and building supply: ‘enhancing frontline worker capabilities and performance’ (examples are given in Annex I). It is beyond the scope of this study to explore all innovations across all implementation grantees, but it is important to contrast different innovations and different experiences of successful or unsuccessful scale up in order to gain a rich picture of which grantee mechanisms for catalysing scale-up are effective (or not) and which factors enabling and undermining scale-up are most important. Hence we will explore a sample of ‘tracer’ innovations from each of the established/complete grants: L10K, SFH and Sure Start selected on the basis of:

- a) Innovations that grantees report as having been successfully scaled-up: we will focus on what factors *enabled* scale-up;
- b) Innovations positioned for scale-up but not successful: we will focus on the factors that *undermined* scale-up.

The approach to identifying these tracer innovations is that we will aim to interview the implementation grantees initially – and will ask them to suggest up to four innovations corresponding to a) and b) above that we will then use as tracers. While we do not have definitive characteristics/thresholds of ‘successful’ and ‘unsuccessful’ we should ask grantees to explain and justify why they feel each suggested tracer innovation is successful or not.

Stakeholder interviewees will be asked to comment on these innovations to the extent of their knowledge, but will also be asked about the barriers and enablers to scale-up of MNCH programmes more generally in their respective geography.

In advance of implementation grantee interviews it will be important to better understand the innovations – this will help focus the interview and ensure we are sensitive to grantee thinking. The London team is currently working on characterising implementation grants including innovations which will be important background formation for interviewees – these together with appropriate grantee documents will be sent to MLE Partners as soon as possible. Field visits may be a good way to understand grantee work better.

### 4.4 Geographical focus

It will be important to capture variations *within* what are highly complex geographies. It is therefore expected we will need to collect qualitative data to explore scale-up across the course of the IDEAS project in each of the six states of northeast Nigeria, Tigray, Amhara, Oromiya and SNNP in Ethiopia and the five regions of Uttar Pradesh. However in 2012 it is appropriate to target our interviewing to those states/regions where scale-up has been experienced to date, and to broaden our geographical focus in 2013 and 2014 subject to

scale-up occurring. Early interviews with implementation grantees will help to inform our geographical focus. In 2012 interviews are expected to take place as follows:

- Northeast Nigeria: national stakeholders in Abuja and stakeholders in Adamawa and Gombe states;
- Ethiopia: national stakeholders in Addis Ababa and stakeholders in each of the four regions of Ethiopia (Amhara, Oromiya, SNNP and Tigray);
- Uttar Pradesh: state-level stakeholders in Lucknow, informants in Delhi, and stakeholders in each of the regions of Uttar Pradesh where implementation grantees are active and/or scale up has occurred.

## 5 Staffing and training

### 5.1 Field teams

For this component of the IDEAS study MLE Partners will use field teams consisting of a relatively small number of researchers experienced in qualitative interviewing to cover all interviews in 2012. This will help to ensure each interviewer becomes 'expert' in the content of the interviews (thereby enhancing interview quality) and is well-positioned to work directly with IDEAS during the analysis phase. For some interviewees (for example senior government officials) a senior member of staff may be more appropriate to lead the interview in some cases. Neil Spicer will participate directly in some of the qualitative data collection in 2012.

Specific arrangements for the 2012 qualitative data collection are as follows:

**Nigeria:** Yashua, Ritgak and Professor Ola Will conduct most interviews, with experienced research assistants from Gombe and/or Adamawa interviewing in those states for security reasons. These interviewers will act in a supporting role as note takers until they are comfortable with the process. Interviewers will speak appropriate languages, that is, Hausa or Fulani.

**India:** Sonali will lead most interviews, with Swapnil or Dipankar leading interviews that are likely to be challenging for Sonali such as senior government officials. Sambodhi will clarify who will do which interviews when the sample has been agreed. Sambodhi will use senior level advisors to help identify and negotiate access to key government officials. If time is short they may use research assistants from within the team to do some interviews closely supervised by Swapnil. These interviewers will be Hindi speakers.

**Ethiopia:** Jarco are currently considering staffing of this component of IDEAS.

### 5.2 Training and orientating interviewers

It will be the responsibility of each MLE Partner to train additional staff brought in to contribute to the qualitative interviews appropriately. New staff should be experienced in qualitative interviewing, and so their training will mainly consist of orientation on the aims and focus of this component of the IDEAS study to help ensure validity and reliability in data collection and capture. MLE Partners are requested to outline existing levels of experience of data

gathering and analysis among their qualitative interviewing staff and the level of research training that is required. Where possible IDEAS will respond by inputting training and/or orientation.

Neil will work with new staff when he visits the geographies in July/August 2012 so that they are fully orientated, including conducting some of the early interviews together and helping interviewers practice making expanded field notes and completing pre-analysis templates (detailed below).

A set of standard operating procedures (SOPs) will be developed to outline specific steps at all stages of the data collection process for interviewers to refer to while in the field. Neil will draft a set of SOPs and MLE Partners will be asked to review, comment and agree.

## 6 Data capture and management

### 6.1 Data capture

'Expanded field notes' backed up with sound recordings will be the main method of data capture (as an alternative to full transcripts). Interviewers will write these directly after each interview based on the notes they took *in situ* and memory, with sound recordings being used to fill gaps as required. Expanded field notes should organize the major themes according to analytic category, and should include with some insightful and illustrative quotes captured to illustrate/bring to life interviewees' voices. Using this approach data capture and analysis will happen concurrently with interviewers writing up interviews using the agreed *pro forma* including tentative interpretations and emerging hypotheses for further exploration after each interview. The expanded field notes based on the practice interviews during the Addis Ababa planning meeting serve as models (Annex J).

Professional digital sound recorders will be used for all interviews subject to respondent agreement (see Research ethics). This method of data capture will serve as a backup to interviewers' notes particularly for capturing useful quotes accurately.

A 'pre-analysis' template will be used in each of the three geographies (Annex K). Interviewers within each geography will populate these on an ongoing basis as interviews are completed. This will be an effective way of identifying major emerging themes while in the field, comparing accounts of different types of interviewees (by organisation type), triangulating data by identifying consistencies and inconsistencies across different interviewee accounts, comparing emerging themes across the three geographies and identifying gaps in data to be filled with subsequent interviews.

### 6.2 Data management

A standardised interview referencing system will be used to identify each interview. The interview reference should be included at the head of each set of expanded field notes. Each interview will be assigned a unique reference based on the following country\_interviewee number\_interviewee type\_date format:

- **Country:** E Ethiopia interviewees; N Nigeria interviewees; U Uttar Pradesh/India interviewees

- **Interviewee number:** sequentially starting with 1 in each country
- **Interviewee type:** GN government national level; GS government sub-national level; DB development agency bilateral; DM development agency multilateral; PS private sector; CS civil society organisation; PA professional association; AR academic/research; OK other key informant; IG implementation grantee; IS implementation sub-grantee; PO Foundation Program Officer
- **Date:** day, month, year
- **Version:** e.g. 1, 2, final.

For example first draft expanded field notes of an implementation grantee in Ethiopia interviewed on 1<sup>st</sup> May 2012 would be **E\_1\_IG\_01may12\_1**; final draft of expanded field notes of a Nigerian national level government official interviewed on 15<sup>th</sup> June 2012 would be **N\_5\_GN\_15jun12\_final**

A standardised interview log sheet will be used to summarise basic information on each interview, including the interview reference (Annex L). This will be a valuable tool for managing the data collection process, and will also serve as a useful record of the sample which is a standard requirement of most journals. One form will be completed for each geography, and each MLE Partner team will be responsible for updating their form and sharing regularly with the London IDEAS team.

Sound recordings, electronic and/or paper interview notes, log sheets and other related documentation will be stored by MLE Partners in a secure place/network space in order to maintain anonymity and confidentiality (see also Section 9 Research Ethics).

## 7 Data quality and supervision

Interviewers will be responsible for writing up their own expanded field notes directly after each interview, and all will contribute to field team de-briefings. If an interview involves both an interviewer and a note taker both should contribute to writing and agreeing expanded field notes. Interviewers will also make some reflective notes after each interview considering the context and atmosphere of each interview, major emerging (new) themes and possible adjustments to the topic guide/sample if appropriate. A list of prompts is included in the revised long topic guide (Annex C). For examples see expanded field notes in Annex J.

Interviewers and supervisors will hold regular de-briefing meetings to discuss progress, identify emerging themes and consider possible adjustments to the topic guide/sample. Brief minutes will be made of each meeting. These will probably be held at the end of each week depending on progress. See Annex M for a list of prompts for guide these meetings.

During the fieldwork period there will be regular telephone calls between MLE Partners and Neil (possibly attached to Bilal's weekly calls) to review progress, discuss emerging themes and agree possible changes. Early in the fieldwork these telephone calls will take place every two weeks, and later on the frequency may drop.

After each interview, interviewers will email expanded field notes to Neil for review (within 48 hours of doing the interview), or will upload them onto an online system if one can be created that is secure and easy to use. After every five interviews interviewers will send

updated pre-analysis forms to Neil for review (see Section 8 Data Analysis for details of pre-analysis forms). Neil will review and comment on expanded field notes within 24 hours of receipt and pre-analysis forms at regular intervals as they are populated. Based on comments the expanded field notes may need to be revised before being finalised.

IDEAS Country Coordinators (research fellows) will have a role in the qualitative study of scale-up, specifically helping to expedite and keep track of progress during fieldwork and in peer review of outputs including expanded field notes and pre-analysis forms. In some cases IDEAS Country Coordinators' visits to government officials may be used as an opportunity to identify potential interviewees or agree to an interview at a later date.

The documented standard operating procedures (SOPs) will define in clear steps how the fieldwork is to be conducted including ethics, introducing and conducting interviews, data capture and data quality assurance procedures. Draft SOPs are included in Annex N.

## 8 Data analysis

IDEAS will work collaboratively with MLE Partners to analyse the interview data. This will involve undertaking a systematic thematic analysis of the qualitative data using a framework approach described by Pope and Mays (2006) whereby *a priori* and emerging themes will be synthesised by tabulating them in a common analytic framework to enable direct comparison across the three geographies (Dixon-Woods et al 2005).

It will also be important to adopt *data triangulation* and *investigator triangulation* approaches to enhance validity of the findings. Data triangulation involves cross-checking different interviewees' accounts for consistency, and in cases where accounts disagree, conducting further analysis or data collection. Investigator triangulation involves multiple analysts contributing to the analysis, and in cases where interpretations differ, data being re-examined before reaching an agreed interpretation.

The analysis will involve a multiple-stage process:

- 1 Expanded field notes will be completed after each interview by MLE Partner interviewers;
- 2 Pre-analysis forms will be filled in MLE Partner interviewers to capture major themes in each geography with inputs from Neil;
- 3 Regular MLE Partner debriefing sessions/brainstorming will be a way to surface and agree major themes – and this will serve as an opportunity for investigator triangulation.
- 4 Major themes and cross-geography comparisons will be drawn out and summarised by the London IDEAS team using an agreed common analytic framework;
- 5 Member checks will be used to enhance validity involving IDEAS learning workshops in each geography (timing to be decided) and a 'webinar' (expected to be 5<sup>th</sup> September 2012) where Neil will present emerging findings to implementation grantees and other stakeholders and invite comments and agreement that the findings have face validity;



6 An analysis workshop in London involving qualitative leads from the three MLE Partner teams is proposed for October 2012 where we will synthesise and agree main messages and make cross-country comparisons and triangulate different investigator interpretations.

## 9 Research ethics

Qualitative data collection depends on ethical approval and permissions at national and sub-national level as appropriate for each geography. Ethical approval for the IDEAS study has already been gained through the LSHTM research ethics review committee. On this basis the following principles and practices will be embraced:

### 9.1 Informed consent

- It will be essential to seek an interviewee's informed consent prior to commencing an interview including explaining the nature and purpose of the study and what can be expected during the interview. This will involve giving each interview an information sheet to help inform them about the study (Annex F) and asking them to sign a consent form to signal their agreement to participate (Annex G).
- As part of the introduction to each interview (written into the introduction script) the principle of informed consent should be explained to the interviewee. This will involve clarifying that they are free to choose to participate in an interview, they are free to decide whether interviews are sound recorded or not and that it is their decision about whether they agree they can be quoted verbatim in any study outputs.
- Interviewers will seek to avoid distressing or upsetting interviewees, and will clarify that interviewees are free to withdraw from an interview at any time.
- No direct benefits are provided for participants of the study except getting the chance of sharing her/his views and experiences related to issue under study, which is critical to study scale up of innovations and identifying enablers and inhibitors to success of these innovations. The proposed study is considered to pose no risk or minimal risk to the participants; limited to experience and view sharing. There will be no money payment for participation.

### 9.2 Confidentiality

- All data will be treated as confidential during all stages of the research process including data collection, data capture and management and reporting/outputs.
- Private spaces should be used to conduct interviews although in practice this may be difficult (for example a busy government official's office). Interviewers will be trained in how to deal with such challenging situations.
- Names will not be recorded or linked to the results of the study. No one outside of the study team will have access to any of the information collected.
- All interview sound recordings, expanded field notes, pre-analysis forms and interview log sheets will be stored electronically on password protected PCs. Hand notes will be stored in a secure cabinet.
- Particular care will be needed when including quotations in study outputs to avoid identifying interviewees and their organisations.
- Individual interviewees' identities will not be disclosed in any outputs of the study.



## 10 Activities and timelines

Major activities are as follows:

### Fieldwork preparations

Preparations for fieldwork in all geographies will be complete by the end of June 2012. Preparation will include completing: IDEAS Milestone 3.4: qualitative study design and tools available and Milestone 3.5: qualitative field teams prepared.

Major tasks will be: agreeing the study protocol; agreeing the interviewee sample in each geography; agreeing a set of SOPs; MLE Partners training/orientating interviewers.

### Qualitative data collection

Qualitative data collection will take place between 2<sup>nd</sup> July and 28<sup>th</sup> September 2012. Jarco and Sambodhi will start fieldwork the 1<sup>st</sup> week of July. While fieldwork will occur in the rainy season/monsoon in Ethiopia/India this will not impact on this part of the IDEAS study since interviews will take place in major towns and cities. Health Hub will collect data during the first three weeks of July, and then break until 20<sup>th</sup> August due to Ramadan.

Neil will visit Abuja, Delhi/Lucknow and Addis Ababa during July/early August to take part in interviews, review emerging findings and train/orientate interviewers.

MLE Partners will complete qualitative fieldwork by the end of September 2012. This task will consist of: interviews and expanded field notes completed and agreed for all interviews; a pre-analysis template completed and agreed for all interviews in each geography; and regular reporting to London over the period.

### Data analysis

An analysis meeting will be held in October in London to synthesise and agree cross-geography findings. The MLE Partner qualitative leads will be essential participants.

In November/December MLE Partners to input into country-specific and multi-country outputs including a multi-country journal article by the end of December.

The following table summarises key activities/ timings for the qualitative study of scale-up:

Activities	Dates
<b>Fieldwork preparations</b>	<b>9<sup>th</sup> January - 30<sup>th</sup> June 2012</b>
Planning workshop to discuss/agree 2012 methodology	1 <sup>st</sup> – 4 <sup>th</sup> May 2012
Neil to revise protocol following planning workshop and circulate to MLE Partners	By 28 <sup>th</sup> May 2012
MLE Partners to review revised protocol	By 4 <sup>th</sup> June 2012

Follow on phone calls with each MLE Partner team to review revised protocol and agree any changes and next steps	Week of 4 <sup>th</sup> June 2012
Neil to finalise protocol and circulate	By 14 <sup>th</sup> June 2012
SOPs drafted and agreed	By 30 <sup>th</sup> June 2012
Interviewee sample agreed	By 30 <sup>th</sup> June 2012
<b>Qualitative data collection</b>	<b>2<sup>nd</sup> July – 28<sup>th</sup> Sep 2012</b>
Neil to visit geographies	July/early August
<b>Data analysis</b>	<b>Oct - Dec 2012</b>
Analysis meeting in London	October 2012
First draft multi-geography comparative paper	December 2012

## 11 References

Dixon-Woods M Agarwal S Jones D Young B and Sutton A 2005 Synthesising qualitative evidence: a review of possible methods. *Journal of Health Services Research and Policy* 10(1):45-53.

Mangham L and Hanson K 2010 Scaling up in international health: what are the key issues? *Health Policy and Planning* 25:85-96.

Marchant T and Schellenberg J *Measuring enhanced interactions between families and frontline workers and whether these lead to increased intervention coverage for mothers and newborns in Ethiopia* LSHTM 5<sup>th</sup> January 2012.

Pope C and Mays N 2006 *Analyzing Qualitative Research in Health Care*. London: Wiley-Blackwell.

Schellenberg J *Discussion Paper on Measuring Scale-Up* LSHTM 4<sup>th</sup> January 2012.

Simmons R Fajans P Ghiron L (eds) 2007 *Scaling Up Health Service Delivery: From Pilot Innovations to Policies and Programmes* Geneva: World Health Organization.

Spicer N *Draft Framework of Scale-Up and Diffusion* LSHTM 12<sup>th</sup> December 2011.

Spicer N *Qualitative Study of Scale-up and Diffusion* LSHTM 3<sup>rd</sup> February 2012

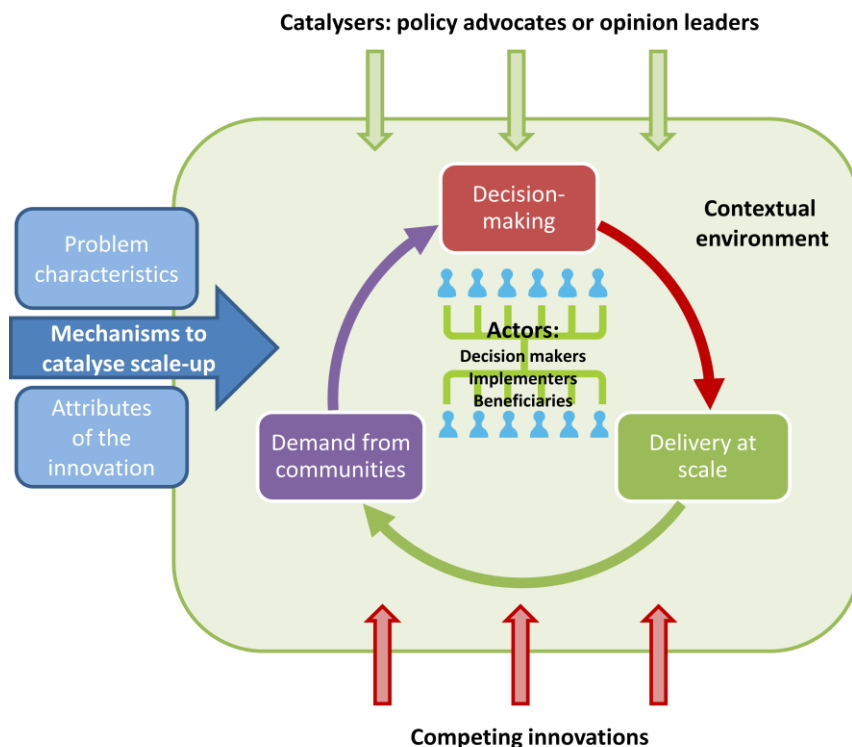
## Annex A: Analytic framework overview

The IDEAS qualitative study of scale-up has two aims:

1. To understand the ways Bill & Melinda Gates Foundation (BMGF) implementation grantees are catalysing scale-up of MNCH innovations, which approaches are working and why;
2. To identify the factors which enable or inhibit scale-up of MNCH innovations, and understand how these factors vary between geography, grantee and innovation model.

BMGF implementation grantees have introduced innovations to promote changes in behaviour within communities (for example, health promotion campaigns and non-financial incentives to encourage households to uptake healthcare) and to improve maternal and newborn child health (MNCH) services (for example, training, non-financial incentives and communication/demonstration materials to strengthen the capacity of frontline health workers). BMGF grantees are adopting different approaches to catalysing the scale-up of these innovations.

We developed a conceptual framework (Figure) to structure data collection and analysis drawing on diverse disciplinary approaches including the diffusion of innovations literature, health policy analysis, and health systems and services research. Our draft '3Ds' framework organises aims to capture and understand the multiple and complex factors influencing scale-up. It unpacks key stages: *decision making*, *delivery at scale* and *demand from communities*, and explores the factors enabling and undermining scale-up at each of these stages.



## **Actors**

Actors have an important role in shaping health policies and implementing health programmes. There are many, diverse actors (organisations and individuals – government, civil society and private-for-profit) that may support, accept or indeed oppose the introduction of an MNCH innovation. The major actors influencing scale-up are *decision makers*, *implementers* and *innovation users*. We will explore the influence of these actors on *decision making*, *delivery at scale* and *demand from communities*.

## **Decision making**

This element of the framework explores why actors support or reject the scale-up of an innovation. Actors' *ideas*, *beliefs* and *ideologies* are likely to shape their perceptions of an innovation, for example belief in the market may motivate an actor to resist an innovation involving government community workers. Actors' *interests* are also likely to be important, and might include private sector financial interests in investing in an innovation, or whether a politician gains or losses politically if they support an MNCH innovation.

## **Delivery at scale**

Assuming decision makers agree to an innovation, do government, private sector or civil society implementers have the *capability* to deliver new innovations at scale? This element of the framework explores the effect of implementation barriers on scale-up including: frontline workers' skills and experience; management and supervision systems; strength of supply chains and infrastructure.

## **Demand from beneficiaries**

Assuming innovations are delivered at scale will they be accepted and used by beneficiary communities? This element of the framework explores the most important factors shaping innovation uptake including geographical, economic, sociocultural and bureaucratic factors.

## **Mechanisms to catalyse scale-up**

This element of the framework captures the mechanisms BMGF grantees use to catalyse the adoption and scale-up of an innovation by different actors. Examples may include policy advocacy or presenting evidence to persuade decision makers to fund or support innovations; developing guidelines and toolkits to support implementers deliver at scale or mass media or engaging community opinion leaders to foster community demand.

## **Problem characteristics**

This element of the framework explores how the nature of a problem (for example high levels of maternal and newborn mortality) influences whether it is adopted by decision makers, implementers and end users. For example if MNCH mortality is perceived as relatively minor compared to other health problems, or indeed non-health problems, it is less likely to be supported or funded by government or a donor.



### **Attributes of the innovation**

The attributes of an innovation affect whether it is amenable to adoption. Some innovations implemented at small scale may be difficult to scale-up, while others may not be attractive to potential funders, implementers or indeed end users. Important innovation attributes may include: its relative advantage, complexity, cost, and adaptability to different community contexts.

### **Contextual environment**

This element of the framework captures how aspects of the contextual environment in the three focus geographies may promote or undermine scale-up. For example: *policy, sociocultural, economic, technological, legal/regulatory, and institutional/systems* factors.

### **Competing innovations**

The framework acknowledges that there may be competitors such as other donors and their implementers seeking to introduce alternative innovations. This element of the framework seeks to understand what policy alternatives (within and outside the health sector) are competing with those of BMGF grantees and what methods competitors are applying to influence decision makers.

### **Catalysers**

This element of our framework aims to identify the major actors catalysing innovation scale-up, such as policy advocates or opinion leaders, and to understand their role in promoting and enabling an innovation to be scaled up at each stage of the policy process.

## Annex B: Detailed research questions

Domain	Research questions
<b>How do different actors promote or undermine scale-up?</b>	Who are the main actors impacting on decision making, delivery at scale and innovation take up (for example government, private sector, civil society; decision makers, implementers and beneficiaries)?
<b>Are there barriers and enablers in relation to decision making</b>	<p>Have decision makers accepted and supported implementation grantee innovations?</p> <p>How do actors make decisions about the introduction of MNCH innovations? What influences their decisions to accept and support an innovation?</p> <p>Which actors have most influence on decisions to scale-up innovations?</p> <p>Do different actors' ideas and beliefs (for example belief in the market; belief in equal gender relations) influence their acceptance of an innovation?</p> <p>Do actors' financial and political interests influence their decision to support, fund or adopt a new innovation (for example private sector profit motives; political gains/losses; doctors' professional turf being threatened by an innovation) influence their acceptance of an innovation?</p>
<b>Are there barriers and enablers in relation to delivery of innovations at scale?</b>	<p>Do different actors have the capability or capacity to implement innovations at scale?</p> <p>What aspects of the health system enable or undermine scale-up (for example financial, human and technical resources within the system; health workers' training, skills motivation and incentives; management and supervision systems; strength of supply chains, equipment and infrastructure)?</p> <p>How are innovations planned to be taken to scale (for example ...)?</p> <p>How do these approaches influence whether scale-up is achieved?</p>
<b>Are there barriers and enablers in relation to demand and up take among communities?</b>	<p>Have community beneficiaries accepted and taken up implementation grantee innovations?</p> <p>What factors influence community acceptance and up take of innovations (for example geographical, economic, sociocultural, bureaucratic and service delivery-related factors and perceptions of quality and effectiveness)?</p>
<b>Does the country contextual environment enable or undermine scale-up?</b>	<p>Are economic resources sufficient to support scale-up (for example government resources; donor funding; private sector investment)?</p> <p>What are the effects of sociocultural norms and practices?</p> <p>Does the political environment support the introduction of innovations?</p> <p>Do legal/ regulatory systems enable or inhibit scale-up?</p> <p>Do government institutional rules and procedures make introducing innovations difficult (for example e.g. institutions for passing legislation; regulations on health worker roles or imports).</p> <p>Are there technological enablers and barriers to scale-up (for example mobile phone networks)?</p>
<b>How are implementation grantees attempting to catalyse scale-up?</b>	<p>What mechanisms are implementation grantees using to persuade other actors to support or fund innovations at scale (for example policy advocacy, presenting evidence)?</p> <p>How much pressure are implementation grantees exercising on other actors (for example active dissemination or passive diffusion of</p>

	<p>ideas)?</p> <p>Are implementation grantees supporting other actors to implement interventions at scale (for example capacity building within the health sector)?</p> <p>Are implementation grantees promoting take up of interventions among communities (for example mass media; working with opinion leaders)?</p>
<p><b>Do the nature of the health problem and characteristics of the innovation impact on its adoption?</b></p>	<p>Are MNCH problems perceived as severe or minor compared with other health and non-health problems? Which health and non-health problems are considered a higher priority? How does this influence how decisions are made?</p> <p>Is the innovation better than other approaches? Is it too complex or expensive to effectively scale-up? Can it be adapted for different contexts?</p>
<p><b>Are actors acting as catalysers of an innovation?</b></p>	<p>Are there policy advocates, or community opinion leaders championing an innovation?</p> <p>What methods do they use? What effects do they have?</p>
<p><b>Are there alternative health problems or innovations competing for decision makers' attention?</b></p>	<p>What methods are competitors using to promote adopt of their innovations?</p>





## Annex C: Draft topic guide v5 (Ethiopia)

Participant ID No. |\_|\_|\_|\_| Gender Female / Male Researcher initials |\_|\_|\_|\_|

Interviewee type |\_|\_| Date |\_|\_|/|\_|\_|/|\_|\_| Audio file number |\_|\_|\_|\_|

Interviewee job title \_\_\_\_\_

Length of time in organisation \_\_\_\_\_

Interviewee's organisation \_\_\_\_\_

### Introduction

I am \_\_\_\_\_ from \_\_\_\_\_

- ✓ General purpose of IDEAS study
  - To evaluate community-based MNCH innovations funded by the BMGF in Ethiopia
- ✓ Aims of the interview
  - To understand the factors enabling or inhibiting the scale-up of MNCH innovations in Ethiopia
- ✓ Why the participant's cooperation is important
  - Need to know their perspectives to help better understand how to foster the scale-up of essential MNCH innovations in Ethiopia
- ✓ What will happen with the collected information
  - Results of the evaluation will be presented in reports, papers and presentations in Ethiopia and globally
- ✓ Expected duration:
  - 1 hour maximum
- ✓ Confidentiality guaranteed throughout all stages of the study including study outputs
- ✓ Any questions?
- ✓ Sound recorder ok? Happy to be quoted verbatim (anonymously)?
- ✓ Consent given to go ahead with the interview?

Domain	Questions	Probes
<p><b>1 Overview: what are the main barriers and enablers to scale-up? Who are the main actors?</b></p>	<p>1.1 Have BMGF MNH innovations have been scaled-up in Ethiopia? Which ones?</p> <p>1.2 What are the most important factors <b>enabling</b> MNH scale-up?</p> <p>1.3 What are the most important factors <b>inhibiting</b> MNH scale-up?</p> <p>1.4 Who are the main actors <b>enabling</b> MNH scale-up?</p> <p>1.5 Who are the main actors <b>inhibiting</b> MNH scale-up?</p>	<p>Decision makers; implementers; beneficiary communities</p> <p>Government; development agencies; private sector; civil society; professional organisations</p>
<p><b>2 Decision making: why are innovations accepted or rejected?</b></p>	<p>2.1 Has your organization accepted (or not) BMGF MNH innovations? Which ones and why?</p> <p>2.2 <i>How</i> has your organization supported MNH scale up?</p> <p>2.3 <i>Why</i> did your organisation <b>accept</b> different innovations?</p> <p>2.4 <i>Why</i> did your organisation <b>not accept</b> different innovations?</p>	<p>For example by committing financial, technical or human resources?</p> <p>Private sector agreeing to invest?</p> <p>Innovation incorporated into government policy?</p> <p>Do the innovation attributes and perceptions of the health problem influence the decision to accept/ not accept?</p> <p>Do ideas/beliefs about MNH and MNH innovations influence support/lack of support for different innovations?</p> <p>Are there benefits/costs to this organisation resulting from support/ lack of support for different innovations (e.g. political or financial costs)?</p>

	<p>2.5 Who are the major decision makers in the field of MNH policy in Ethiopia?</p> <p>2.6 Which actors have most influence on MNH policy in Ethiopia?</p> <p>2.7 To what extent is MNH policy in Ethiopia determined by the Ethiopian government or by international development agencies?</p> <p>2.8 Which BMGF grantee innovations have been accepted by decision makers?</p> <p>2.8 Which BMGF grantee innovations have <i>not</i> been accepted by decision makers?</p> <p>2.10 What form does acceptance/support take?</p> <p>2.11 <i>Why</i> have different decision makers <b>accepted</b> different innovations?</p> <p>2.12 <i>Why</i> have different decision makers <b>not accepted</b> different innovations?</p>	<p>Government national, state/regional/district; civil society; private sector; development agencies; professional bodies; community actors; others?</p> <p>Which decision makers have accepted/not accepted different innovations? Why?</p> <p>Does acceptance/support include: committing financial, technical or human resources; Private sector investment; Innovation incorporated into government policy?</p> <p>Do ideas and beliefs about MNH and MNH innovations influence different organisations' support or rejection of different innovations? Are there benefits (political, financial) to different organisations resulting from support (or rejection) of different innovations? Explore whether current government policy and donor priorities influence scale up Are innovations disseminated or diffused through networks of actors?</p>
<p><b>3 Delivery/ implementation of MNH services at scale: what are the barriers/ enablers to delivery at</b></p>	<p>3.1 Are there factors that have <b>enabled</b> the implementation of different MNH innovations at scale? What are they?</p> <p>3.2 Are there factors that have <b>undermined</b> the implementation of different MNH innovations at scale? What are they?</p>	<p>Possible factors may include: time; financial, human or technical resources; communication of the innovation to implementers; implementers' pre-existing skills and experience;</p>

<p>scale?</p>		<p>implementers' ability to integrate new knowledge and approaches;  management and supervision systems; strength of supply chains;  infrastructure;  networks of implementers and other actors through which ideas may spread;  Method of scaling-up:  – Scale-up as a single event or incremental?  – Innovations replicated in all contexts or adapted for different communities?</p>
<p><b>4 Demand and uptake of MNH services: why communities/families accept/ take up or reject/ do not take-up</b></p>	<p>4.1 Are communities/families <b>accepting</b> and <b>taking-up</b> different MNH innovations? Which communities?  4.2 Are communities/families <b>not accepting/taking-up</b> different MNH innovations? Which communities?  4.3 What factors <b>enabled</b> communities/families to take-up MNH innovations?  4.4 What are the <b>barriers</b> to communities/families taking up MNH innovations?</p>	<p>Different geographical areas?  Different social groups?    Geographical;  Economic;  Sociocultural;  Community networks propagating ideas;  Bureaucratic (health systems) factors.</p>
<p><b>5 Mechanisms to catalyse scale-up</b></p>	<p>5.1 Are BMGF grantees employing mechanisms to encourage, promote or support innovation scale-up? What mechanisms?  5.2 Have certain mechanisms been effective? Which? Why?  5.3 Have certain mechanisms <i>not</i> been effective? Which? Why?  5.4 Are changes planned in the future?  5.5 Which approaches have been most important: <b>dissemination</b> or <b>diffusion</b> of innovations?</p>	<p>Explore different methods including: policy advocacy; presenting evidence; supporting implementers to scale-up delivery; promoting community demand; working with opinion leaders or community networks?    Explore diffusion of innovations (<i>passive spread of an innovation, typically informal and largely uncontrolled</i>) vs. Dissemination (<i>active/ planned</i>)</p>

	5.6 Have other actors contributed to the scale-up of BMGF innovations? What has their contribution been?	<i>efforts to encourage target groups</i> [decision makers, implementers & beneficiaries] <i>to adopt an innovation</i> )
<b>6 Innovation attributes</b>	6.1 Do the attributes of the different tracer innovations mean they are <b>amenable</b> to adoption? 6.2 Do the attributes of different tracer innovations mean they are <b>not amenable</b> to adoption? 6.3 What is the origin of the different tracer innovations?	Explore different attributes including: relative advantage, complexity, cost, adaptability to different contexts?  Explore whether the grantee developed the innovation, if they adopted an existing innovation, or if they modified an existing innovation
<b>7 Problem characteristics</b>	7.1 Are MNCH problems perceived as important compared to other health problems? 7.2 Which health and non-health problems are perceived as greatest priority?	Link to decision making - does this influence decision makers' prioritizations? Link to mechanisms to catalyse scale-up - do grantees <i>frame</i> the problem as important?
<b>8 Evidence to policy</b>	8.1 Are there national and subnational structures or organisations assess research evidence and make recommendations for policies/practices? 8.2 To what extent does research inform priorities and policies/practices in health policy? 8.3 What are the <i>constraints</i> to the translation of research findings into policy/practice? 8.4 What factors <i>facilitate</i> the translation of research into policy/practice? 8.5 What future changes would make policies more responsive to existing evidence?	Are there examples where locally conducted or international research has resulted in a change in health policy/ practice?
<b>9 Environmental context</b>	9.1 Does the country context in Ethiopia <b>enable</b> the scale-up of MNH innovations? Which factors are important and why?	Explore possible factors including: <b>political and policymaking context</b> (type of

	<p>9.1 Does the country context in Ethiopia <b>inhibit</b> the scale-up of MNH innovations? Which factors are important and why?</p>	<p>government, centralized or decentralized decision making);  <b>economic resources</b> (government budget, external donor resources, private sector’s ability to invest);  <b>sociocultural ideas and beliefs</b> (ethnicity, religion, caste, gender relations);  <b>technological</b> (mobile phone networks);  <b>legal and regulatory</b> systems (national laws regulating imports, laws on medical practices);  <b>institutional rules</b> (mechanisms and processes through which decisions are made);  <b>global context</b> (ideas, agreements and priorities beyond Ethiopia)</p>
<p><b>10 Catalysers</b></p>	<p>10.1 Have there been <b>policy advocates</b> who have actively promoted or spread particular innovations? Who are they? What has their effect been?  10.2 Have there been <b>opinion leaders</b> who have actively promoted or spread particular innovations? Who are they? What has their effect been?</p>	<p>Examples may include: influential individuals in national, regional/state or district decision making   Examples may include: community leaders; religious leaders</p>
<p><b>11 Competing innovations</b></p>	<p>11.1 Are alternative (non-BMGF) innovations competing for decision makers’ attention?  11.2 What are these alternative (non-BMGF) innovations?  11.3 Who has promoted these alternatives?  11.4 What has the effect been (on scale-up of BMGF innovations)?  11.5 Are any alternative (non-BMGF) innovations complementing BMGF innovations? Which ones? How?</p>	<p>Competing actors  Competing innovations</p>
<p><b>12 Summing up</b></p>	<p>12.1 In addition to what you have told us so far, is there anything else you would like to add?  12.2 Are there any questions we should have raised/asked, but did not</p>	

	<p>in relation to the various aspects of MNH scale up and how BMGF grantees are catalyzing MNH scale up in Ethiopia?</p> <p>12.3 Could you suggest other stakeholders we might approach who are knowledgeable about this topic?</p>	
<p><b>13 Reflections on the interview</b></p>	<p>13.1 How did the interview go?</p> <p>13.2 How did the interviewee behave (e.g. nervous, spoke quickly, appeared cautious)?</p> <p>13.3 What was the interview context (e.g. meeting room, office, private space, interview was overheard, there were distractions)?</p> <p>13.4 Were there any methodological problems or concerns?</p>	<p>Interviewer to make brief notes after the interview</p>



## Annex D: Example short topic guides

### Dr Ali Karim (L10K) 02/05/12

Ice breaker - Tell us a bit about your role – for benefit of our guests

We know you have published some papers on uptake (relevant and interesting to us) – could you tell us a bit about them?

What are the best/most important 3 or 4 innovations (L10K inputs) ... which have been accepted/taken up by other organisations?

Could you tell about L10k's thinking and approach to scaling-up a) within your districts b) beyond?

Present status re. Scale-up? Future plans/directions re. Scale-up

Specific innovations

Geographical scale-up; beneficiaries; inputs

What mechanism/approaches are you using/planning to catalyse scale-up?

Which have been effective? Examples? Any mechanism not effective? Why? (e.g. scalability, evidence)

Factors enabling and challenges to scale-up? Examples?

Main enablers; main challenges?

Different regions? Different problems in different regions?

Different innovations – different problems? Successful/not?

Decision making

Which L10K innovations have been accepted/supported by decision makers (e.g. govt/donors/other) and why/why not?

What influences govt decision making in MNCH/ scale-up? / donors?

Delivery/implementation

What factors enabled/undermined implementation at scale (health systems barriers, resources, infrastructure etc)

Demand/ up-take

Has community accepted/ taken up different innovations? Why/not – factors?



Geographically/ social groups

Other factors(?) – alternative innovations, catalysers, context

Any additional themes not covered?

## Dr Feven (CARE International) 03/05/12

Icebreaker - tell us a bit about your role in your organisation

Could you briefly review the CARE interventions in the field of family and reproductive health?

Are these interventions innovative? How?

What are the best/most important 3 or 4 innovations/interventions (CARE inputs) in terms of:

To what extent have these been taken to scale? Geographical scale-up; beneficiaries; inputs

Have any been accepted/taken up by other organisations/Govt/Policy makers and taken to scale in Ethiopia?

What mechanisms/approaches are you (CARE) using/planning to catalyse scale-up?

Which have been effective? Examples? Any mechanism not effective? Why? (e.g. scalability, evidence)

Main factors enabling and challenges to scale-up? Examples?

Different regions? Different problems in different regions?

Different innovations – different problems? Successful/not?

Do you know about any other organisations/grantees and what they are doing in the area of MNCH?

Do you know (much) about the Gates grants we are tracking – L10K, SNL, ManHEP?

Do you link with/partner with these grants? How?

Decision making

Have CARE innovations been accepted/supported by decision makers (e.g. govt/donors/other) and why/why not?

What influences govt decision making in MNCH/ scale-up? / donors?

Delivery/implementation



What factors enabled/undermined implementation at scale (health systems barriers, resources, infrastructure etc)

Demand/ up-take

Has community accepted/ taken up different innovations? Why/not – factors?

Geographically/ social groups

Other factors (?) – alternative innovations, catalysers, context

Any additional themes not covered?

What should we focus on – key questions? Who should we interview? Can we return?

## **Dr Mesganew (Addis Ababa University) 03/05/12**

Ice breaker: Tell us about the MNCH policy landscape in Ethiopia? Historical perspectives, change, major actors, changes in priorities, current and future issues?

We know that you have been very active in this field. Could you tell us a bit more about your work in the sector? Are there publications that might be useful for us?

Overview

What are the major interventions/innovations presently happening in the country in the MNCH field? Probe for BMGF interventions/innovations in Ethiopia.

In your opinion what are the best/most important 3 or 4 innovations that have been accepted/taken up at scale? By whom: government, donors? Probe specifically about BMGF interventions/innovations.

What is your opinion on the present status of MNCH scale-up? Future plans/directions?

Gates grantees' work in Ethiopia: L10k, SNL, Manhep - specific strategies and innovations

Type of scale-up: e.g. geographical scale-up; increased number of beneficiaries; increased programme inputs

Catalysing mechanisms

Are there mechanisms/approaches are you aware of are being used to catalyse scale-up? (probe – Gates grantees)

Which have been effective? Examples? Any mechanism not effective? Why? (e.g. scalability of innovation, evidence)

Factors enabling and challenges to scale-up?

Main enablers; main challenges? Examples?



Different regions? Different problems in different regions?

Different innovations – different problems? Successful/not?

Decision making

Which BMGF interventions/innovations have been accepted/supported by decision makers (e.g. govt/donors/other) and why/why not?

What influences govt decision making in MNCH/ scale-up? / donors? Academicians?

Delivery/implementation

What factors enabled/undermined implementation at scale (health systems barriers, resources, infrastructure etc)

Demand/ up-take

Has community accepted/ taken up different innovations? Why/not – factors?, Geographically/ social groups

Other important factors missed (?) – alternative innovations, catalysers, context

Any additional themes not covered?

What should we focus on in the study – key questions? Who should we interview? Can we return?

## **Dr. Tewabech Biswah (Ethiopian Public Health Association) 03/05/12**

Ice breaker - for benefit of our guests, will you please tell us a bit about the work of EPHA in taking forward public health work in Ethiopia)? MNCH specifically?

Are you aware about BMGF's work with any MNCH innovations (L10k's work - JSI, also Saving Newborn Lives - SNL and MaNHEP - Emory) in Ethiopia (relevant and interesting to us) – could you tell us a bit about them in terms of their importance / contribution to MNCH in Ethiopia?

What in your opinion are the best/most important 3 or 4 innovations that are being tried out in the area of MNCH in last couple of years in Ethiopia (specifically about L10K, SNL and MaNHEP inputs) ... which have been accepted/taken to scale by other organisations / Govt.?

Could you tell about thinking and approach to scaling-up by these organizations (L10k, SNL and MaNHEP) within their own districts b) beyond?

Present status re. Scale-up of MNCH? Future plans/directions re. Scale-up – a) generally, b) L10K, SNL and MaNHEP specifically?

Specific strategies and innovations

Type of scale-up - geographical scale-up; increased beneficiaries; increased program inputs

Any plans/support by EPHA contributed in these processes of scaling up?

What is your/EPHA's view on L10K, SNL and MaNHEP MNCH innovations/interventions? Do you support them or do you have doubts?

What mechanisms/approaches are you supporting to catalyse scale-up?

Which have been effective? Examples? Any mechanism not effective? Why? (e.g. scalability, evidence, advocacy etc)

Factors enabling and challenges to scale-up?

Main enablers; main challenges? Examples?

Different regions? Different problems in different regions?

Different innovations – different problems? Successful/not?

Decision making

Which of these MNCH innovations (L10K, SNL, ManHEP) have been accepted/supported by decision makers (e.g. govt/donors/other) and why/why not?

What influences govt decision making in MNCH/ scale-up? / donors?

What influence does EPHA have on govt decision making in MNCH/ scale-up? / donors?

Delivery/implementation

What factors enabled/undermined implementation at scale (health systems barriers, resources, infrastructure etc)

Demand/ up-take

Has community accepted/ taken up different innovations? Why/not – factors?

Geographically/ social groups

Other factors(?) – alternative innovations, catalysers, context

Any suggestions for scaling up / innovations by any initiatives (specifically L10k, SNL, MaNHEP)

Any additional themes? What should we focus on in the study – key questions? Who should we interview? Can we return?

## Annex E: Interview introduction script

### The IDEAS study

- IDEAS is a Gates M&E grant led by LSHTM working with Jarco/Health Hub/Sambodhi. We are working with several Gates grantees delivering community-based maternal and newborn child health interventions in NE Nigeria, Uttar Pradesh (India) and Ethiopia.
- IDEAS aims to understand: 1) how innovations are enhancing frontline worker – household interactions; 2) the scale-up of these innovations in our focus geographies; 3) the impacts of the innovations on maternal and child health.

### The qualitative study of scale-up

- We are interviewing experts and professionals in the maternal and newborn child field in Nigeria in order to understand: a) the factors enabling and inhibiting scale-up of Gates MNCH innovations; and b) how Gates grantees are catalysing scale-up of MNH innovations.
- When we talk about scale-up we are interested in the expansion of innovations beyond the districts where Gates implementation grantees are working rather than the direct scale-up of innovations within grantees' projects (see Protocol page 4 Key Concepts).
- In Ethiopia/Nigeria/India we are most interested in the L10K/SFH/Sure Start grants [delete as appropriate], and we are focusing on a number of innovations as examples – these are [briefly mention names of tracer innovations] – but also in more general themes relating to the scale-up of MNCH innovations. When we talk about innovation we mean a new method introduced by these grantees to enhance 'interactions' between frontline workers and household members.
- Your perspectives will be valuable in understanding the best ways to enable essential community-based services to be scaled-up and offering policy recommendations to government, the Gates Foundation and other stakeholders in this country and internationally.
- We will be producing a number of reports, papers and presentations based on this work in Ethiopia/Nigeria/India and globally.

### Ethical issues

- We have ethical approval for the study through LSHTM and in Ethiopia/Nigeria/India.
- Informed consent is an important principle of our study: you are free to choose to participate in this interview, you may withdraw at any time, you are free to decide whether the interview is sound recorded or not and it is your decision about whether we can be quote you verbatim in any study outputs.
- We will maintain confidentiality at all times – and this will mean there is no potential risk/harm from your participation in the interview: we will not discuss your interview with people outside of the project team, we will store interview data securely at all times, and will not attribute your views to you in any study output.

### This interview

- The interview will take up to an hour if you are happy with that?
- Can we sound record this interview?
- Are you happy to be quoted (anonymously)?
- Are you happy to sign the consent form?
- Do you have any questions at this stage?

## Responding to concerns about the value of the study

Replies include: a) we are not evaluating implementation grantees' work – our focus is on scale-up *beyond* grantee districts; b) the cross-geography comparison will yield insights that should be valuable for grantees including practices that work well and why.

## Annex F: Standard information sheet

### IDEAS qualitative study of scale-up in northeast Nigeria

#### What is IDEAS?

IDEAS (Informed **D**ecisions for **A**ctions to improve maternal and newborn health) is a measurement, learning and evaluation project. IDEAS is funded between 2010 and 2015 by a grant from the Bill & Melinda Gates Foundation to the London School of Hygiene & Tropical Medicine. We aim to improve the evidence base for future maternal and newborn health programmes, ultimately to improve the survival and health of mothers and newborn babies. We will do this using measurement, learning and evaluation to study the impact of innovative maternal and newborn health projects. IDEAS is working in four regions of Ethiopia, six states in northeast Nigeria and throughout Uttar Pradesh in Northern India. These areas have high maternal and newborn mortality, where many deaths could be prevented with improved access to effective health care.

In northeast Nigeria our focus is the Society for Family Health's 'Maternal and Newborn Health Project'. Along with our country research partner Health Hub we are evaluating the combined effects of this project's innovations to improve the demand for and supply of maternal and newborn health interventions. We will look at the number, quality, efficiency and equity of interactions between families and frontline workers, and their impact on health outcomes. We are also studying the scale-up of innovations in maternal and newborn health, and if we find innovations that are being scaled up, we will study whether this leads to better intervention coverage and improved newborn survival.

Further information about IDEAS can be found at: <http://ideas.lshtm.ac.uk/>

#### What is the purpose of this interview?

We are interviewing experts and professionals in the maternal and newborn child field in Nigeria to better understand the scale-up of maternal and newborn child health innovations in Nigeria. Our particular interest in scale-up is in the expansion of innovations beyond the original focus districts where the Society for Family Health works to reach a larger geographical area, benefiting more people. Specifically we want to understand: a) the factors enabling and inhibiting scale-up of the Society for Family Health's maternal and newborn child health innovations; and b) how the Society for Family Health is catalysing scale-up of these innovations.

Your perspectives will be valuable in understanding the best ways to enable essential community-based services to be scaled-up and offering policy recommendations to government, the Gates Foundation and other stakeholders in this country and internationally. We will produce a range of reports, papers and presentations based on this work in Nigeria and draw out comparisons with our work in Ethiopia and Uttar Pradesh.



For more information please contact:

Dr Yashua Hamza (Health Hub) [yahamza@africahealthub.com](mailto:yahamza@africahealthub.com)

Dr Neil Spicer (LSHTM) [neil.spicer@lshtm.ac.uk](mailto:neil.spicer@lshtm.ac.uk)

## Annex G: Interviewee consent form

### IDEAS qualitative study of scale-up

**Please tick all boxes that apply:**

I have read the study information sheet and/or have been given a clear overview of the study	
I am happy for you to write about what I have said during our interview on the understanding that you will not reveal my identify in any study outputs	
I am happy for the interview to be sound recorded on the understanding that you will not reveal my identify in any study outputs	
I am happy for you to include quotations from this interview on the understanding that you will not reveal my identify in any study outputs	
I am willing to be interviewed	

<b>Interviewee (name in BLOCK CAPITALS)</b>	
<hr/>	
Signature	Date
<hr/>	
<b>Researcher (name in BLOCK CAPITALS)</b>	
<hr/>	





Signature

Date

## Annex H: Interviewees sample

Category	Name	Role/position	Organisation/agency or unit
Government (national)			
Government (sub-national)			
Development agency (bilateral)			
Development agency (multi-lateral)			
Private sector			
Civil society			
Professional association			
Academic/ research			
Other key informant			
Implementation grantee			
Implementation sub-grantee			
Foundation program officer			

## Annex I: Summary of supply and demand-side grantee innovations

### Supply-side innovations

- **Training** frontline health workers (FLWs) on effective interactions with families
- **Supportive supervision for FLWs** from formal health staff
- **Non-financial incentives** for FLWs for example certificates for good performance
- **Communication/ demonstration materials** for FLWs to communicate messages with households e.g. picture books, games and models
- **Quality assurance measures for FLWs** such as mentoring, checklists and logbooks
- **Mobile phone technologies** such as text query and reminder services for FLWs
- **Supporting data use by FLWs** to monitor healthcare access and quality of interactions
- **Emergency transport schemes**
- **MNCH call centre/hotline**

### Demand-side innovations

- **Non-financial incentives for households** to encourage care uptake for example badges
- **Enabling conversations** between FLWs and households to improve care seeking
- **Health promotion** campaigns at population, community and household levels
- Fostering **local priority setting, decision making** and **health awareness**

### Health systems innovations

**Innovations to strengthen government systems** including technical assistance, strengthening decision making processes and advocacy

## Annex J: Model expanded field notes

### Interview E1\_IG\_020512

#### Background

Senior M&E officer for L10K

#### What are the key L10K innovations that have been scaled up?

A key innovation is the Family Health Card – a pictorial way of capturing information [used by HEWs?] – this is now part of IRT. SNL also contributed to this innovation.

#### Are there any innovations that have been positioned for scale but not successfully taken to scale?

The non-financial incentives scheme and the ‘community solutions’ were not taken up.

#### Have other actors accepted and taken to scale L10k’s innovations?

- The interviewee said that government does not always acknowledge that it has adopted an innovation put forward by another actor. For example the USAID ISHI [?] programme, which government adopted and took to scale. L10K contributed to this process by modifying it to MNCH and delivering it as part of the L10K programme.
- Government adopted L10K innovations CBCM, Essential Newborn... [??] as a module [?] within its Integrated Refresher Training (IRT) programme as a major part of HEP.
- WHO and Unicef agreed to fund the printing costs of the Family Health Card.

#### Mechanisms for L10K catalysing scale-up? Which are effective? Role of evidence?

- There are different structures – steering committees and similar - at federal level intended for coordinating or informing decision making – including in the field of MNC. These are good fora for L10K to introduce their ideas into government discussions.
- Building trust with government, and particular individuals within government, is an important way to influence government thinking.
- An important way to foster buy in is to take decision makers to the field to show them the work on the ground. Also, telling powerful stories are a good way to get buy-in. This may be more important than formal evidence.
- Dissemination meetings are an important method of feeding into government discussions and decisions.

#### Evidence

- Evidence was a major mechanism to catalyse scale up. The L10k baseline survey was instrumental in encouraging government to decide to adopt innovations. Indeed, the interview said L10k data was instrumental in their decision to formulate the Health Development Army (HDA) policy.

- Rather than L10k trying to push government to accept its evidence/ knowledge, the opposite is true – when a senior government official was convinced of L10k’s work he strongly requested L10k help government by contributing its insights, knowledge and evidence.
- It is not always easy to generate evidence that convincingly demonstrates the effectiveness/impacts of on an innovation. This is due to the complexity of programmes and methodological difficulties showing effects/impacts.

### **L10K’s approach to scale-up**

L10k’s objective 6 states that the project should aim to document and disseminate evidence, and to position its innovations for scale. However this is not binding as part of the funding.

### **What other factors influence government decision making?**

- Rather than external donors shaping Ethiopian policies government tends to develop policy ideas and then seek funders. They work through a government-led child survival working group? For example government asked Unicef for support in supplying delivery tables at health centres.
- A minister visited Nepal and was influenced by an approach there. S/he then brought this idea back to Ethiopia. An SSF (supply-side financing?) approach is under serious consideration because evidence from other countries is strong. The government is looking for donors to support this policy.
- The government is determined to reach the MDG targets in 2015 and this shapes policy.
- When government decide to take a programme to scale they do it quickly: *‘If government believe in a strategy they scale-up’*

### **Barriers to scale up: delivery level**

- There are (government) health systems weaknesses that make implementation difficult. Important factors include – commodity supply chains and human resources (there is a huge turnover of health workers – especially at Health Centres, less so Health Posts)
- USAID has a separate supply chain which is more efficient but in parallel to the government system.

### **Barriers to scale-up: demand/ take up level**

- A major barrier is geographical distance to healthcare services. A high proportion of people live at least 10km away. This problem is exaggerated by the policy of insisting on deliveries in Health Centres rather than at a more local level or indeed home births.
- Some variations in programme delivery are needed between different regions e.g. gender relations. Although the IRT programme is uniform across the country.

### **Catalysing actors**

Mary Taylor is an important actor in catalysing discussions with government and other actors.

### **Who should we interview/follow up with?**

- We should interview Hibret the Technical Director [?]
- Also, Wuleta Betemariam – specifically about her knowledge of decision making partners, structures etc and themes at community level
- Tarabech – knowledge of community themes.

### **General impressions**

- Interviewee was rather cautious (nervous?) at first but opened up later in the interview. This could be due to the broader IDEAS work which is viewed as evaluating L10k as a project.
- I felt I should have been much more familiar with L10K's innovations before doing the interview. Several specific innovations were mentioned – it will be important to concentrate on themes of scale-up rather than trying to understand the nature of an innovation in the interview.

## **Interview E2\_AC\_030512**

### **Context**

Indicators of maternal and child mortality in Ethiopia have not improved very much over recent decades as demonstrated by Demographic and Health Surveys. Health levels are worst among rural, (semi) nomadic pastoralist areas/groups.

### **Decision making**

#### Government policy in the field of MNCH

There are two key policy documents in the field of MNCH: the Reproductive Health Strategy (recently revised) and the Maternal Road Map 2011. The WHO and Addis Ababa University contributed to the latter Federal Government document.

#### Influence of non-government actors on policy? Multi-agency coordination structures

- Government welcomes donors to fund health programmes. However they must come into the framework of the government.
- There are a number of committees at federal level involving government and development agencies. For example – the Health and Nutrition Committee (govt and donors) and the Joint Consultative Committee (govt, donors, civil society) [?]. These offer non-government organisation an opportunity to input into government decision making. Academics are not part of these committees.
- The World Bank's mobile health programme [?].

#### Influential actors

Professional associations – Gynaecology, EPHA, Midwifery

### **Delivery**

- A substantial problem relates to operationalising government policies. Major reasons include:
- High staff turnaround, recruitment problems and staff shortage. Skills including communication skills among FLWs are limited.
- Equipment is frequently stolen.
- Management and supervision systems are weak.
- There is a need for better linking between communities and the health system. For example there is a need for better clarity among the community in terms of HEW roles.
- Referral systems are weak.

## **Demand**

- Community culture, values, attitudes, religion are barriers to scale-up. Many households prefer childbirth within the home rather than institutions - to be attended by a familiar family or community person. TBAs continue to attend a high proportion of births.
- There is quite a lot of diversity across the country.
- Geographical access including access to transport is problematic.
- Important community opinion leaders are preachers and teachers.

## **Mechanisms to catalyse scale-up**

### Use of evidence in policy

It may take some time for evidence to influence policy. Generally evidence is more influential if: a) you agree with government, b) you work with/through government structures c) you involve government in the research.

### Strengthening implementation

It is important to motivate implementers. You need to understand their priorities, and show that what you are doing corresponds with their priorities.

## **Emerging themes**

### Civil society

'Community' is framed by the HEP – model families and the Health Development Army (HDA).

## **Follow up**

### Documents

- Reproductive Health Strategy (recently revised)
- Maternal Road Map 2011
- L10K's publications are valuable including a special issue of the Journal of Ethiopian Health and Development.

### Potential interviewees

- Dr ? – State Ministry [Henok noted name?]
- WHO (Dr Adnaf?) and Unicef
- Professional associations – Gynaecology, EPHA, Midwifery

## Interview E3\_CS0\_030512

### Background – work of CARE Intl

The interviewee described several aspects of the reproductive health component of CARE's work in Ethiopia. CIDA funds quite a lot of the work which includes a community-based insurance pilot and work to empower women and girls including fostering changes in the broad sociocultural determinants of gender relations rather than changing behaviours within households.

### Coordination between activities

There is not a great deal of coordination between CARE's work and that of Gates grantees. The Zonal level MOH selects specific kebeles for different donors to work in – hence there is no overlap with Gates projects on the ground. Humanitarian aid tends to be coordinated more at the federal level.

### Decision making/coordination structures/ other actors

- There is a national Reproductive Health Taskforce – a multi-agency committee that is useful for experience sharing although less about coordination.
- There is a group called 'Girl Hub' – a multi-agency body focussing on health themes such as harmful traditional practices. DFID is a member.
- CARE is a member of the Consortium of Reproductive Health Associations (CORA). There are various FBOs on this group.
- Major actors include donors such as CIDA and the Nike Foundation; WHO; interest groups.

### Catalysing scale-up

- CARE aims to expand its projects into other parts of Ethiopia by 'selling' ideas to actors – donors and government.
- It is important to build rapport with donors and to pay attention to packaging ideas that they will be attracted to.
- It is important to have government buy in for everything.

### Catalysers



Interest groups are important actors advocating government at the national level. One role is to hold government to account for implementing policies including ensuring finances flow from the national to woreda level. Save the Children UK is important in this respect.

### Evidence

- Information/evidence is important – promising practices should be documented and used to sell the idea to others.
- A problem is while an intervention can be demonstrated as working well in one geographical area it is difficult to prove it works well in another area since there is great variation across the country in terms of social contexts.
- A further problem relates to the nature of interventions – it is difficult to attribute the effectiveness/impacts of more complex interventions.
- The government is not always responsive to evidence because it is overburdened with information - it is bombarded with information from many different organisations and it is difficult to synthesis and make meaningful decisions based on the information it has.

### **Barriers – innovation attributes**

A common problem stems from projects not being designed with scaling in mind.

### **Barriers – delivery**

- Problems include: poor infrastructure; problems of physical access; weak referral linkages; perceptions of the quality of services among communities.
- Shortages of qualified people is also a big problem. While the HEW approach attempts to get round this issue there remain problems of HEWs being young and inexperienced, not well trained, illiterate.
- It is common to find policies not being implemented.

### **Barriers – demand**

- Local context and cultural issues are important for example husbands' attributes to family planning are difficult to change – there is resistance.
- There are several significant 'gate keepers' to change within communities including religious leaders, teachers, mothers in law and husbands. Husbands and mothers-in-law have a major say in community discussions – younger women are other left out. CARE aims to speak to younger women directly by bypassing gate keepers. Religious leaders/preachers are key opinion leaders

### **Follow up**

- Manhep's and L10k's report are useful background reading.
- Interviewee would be happy for us to return to ask more questions.

### **Impressions**

- The interviewee was eager to describe the work of CARE and did not have much knowledge of the Gates grants although she provided several useful and relevant insights.
- It will be important to try to focus interviews more on Gates grants if possible.
- It was difficult to note down all the points which were made very quickly reinforcing the need to record interviews.

## Interview E4\_PA\_030512

Respondent: Dr. Tewabech Bishaw, President, Ethiopian Public Health Association

Date: Thursday, May 3<sup>rd</sup>, 2012

Interview time: 1430hrs

Duration: 57”

Interview Language: English

Setting: The interview took place on the 4<sup>th</sup> floor of the EPHA office at Dr. Biswah’s small but very private office. Present at this interview were Zwerdu (JaRCO), Dipankar (Sambodhi) and Ritgak (Health Hub). The team was introduced by Zwerdu, after which Dipankar and Ritgak interchangeably asked questions.

JaRCO had pre-arranged the interview as part of a series of field test interviews using variations of the revised qualitative key-informant interview guide for the IDEAS Objective 3 study.

Who recommended Tewabech and why?

Tewabech consented to speaking with the team but informed the team that she would only be available for about an hour after which she needed to commence preparation for her next meeting (happening in 1.5hrs). She also made it clear from the beginning of the interviews, that she would be unable to respond to BMGF questions specifically but would be able to give more general responses as regards MNH in Ethiopia generally.

### CONTEXT

*Dr. Bishaw*

Has worked for several multi-laterals and was at one point the head of maternal and neonatal health interventions for UNICEF in India.

*EPHA*

EPHA is a professional body established since 1989 and has since then worked with the government through the Ministry of health and other partners to support Public Health work in Ethiopia.

The organization has four main objectives namely;

- i) to ensure high standards of service delivery in the country
- ii) to build capacity of service provider professionals
- iii) to increase awareness of communities on public health issues using evidence based approaches to community education and advocacy.

The EPHA has multiple government partners. Most of EPHAs work is carried out through training activities since they themselves are not funded to implement programmes. Activities predominantly training.

The organization's scope increases every year and they are now working in multiple regions. For example, they are now working with Community Health Extension workers including North Wurno, South Wurno on Implanto and community education.

EPHA is also working on HIV/AIDS programmes particularly with youth, ensuring youth have the right access to reproductive health information and are making healthy decisions. These programmes are well received by the public, especially the healthy lifestyles for the young. EPHA also does work on PMTCT.

Other projects include substance abuse, related early pregnancies and childbirth at young ages.

### ***MNH Landscape/Policy Environment***

Maternal and Neonatal Health in Ethiopia is still considered a huge but surmountable public health challenge. Many donors are seen to be making significant contributions to it. The main issue seems to be that the country suffers from lack of a clear, cohesive strategy for MNH. In general, the donors have the will, there are avenues for resource injection, there is sufficient local and international experience to use the funds and Ethiopia is able to absorb them.

The government has provided relevant guidelines for those wanting to implement MNH programmes in the country so the policies are supportive and enabling. However, what is lacking is a common strategically coordinated implementation since donors and NGOs come and select their own sites. EPHA opines, the government needs to tell donors:

- i) its need areas (geographically)
- ii) its need areas (thematically) – and then coordinate the efforts of the donors according to those outlined demands.

### ***Actors***

The government, NGOs, the multilaterals and the communities themselves all play a part within this MNH space. NGOs operate very independently; because individual NGOs have their various programmatic interests and strengths, they will implement programmes that align only with their skill sets. Also, the NGOs operate in specific geographies and so the services received by communities will differ. There is no synthesis in NGO activities

Tewabech has proposed that donors should seek to fund NGOs through government agencies rather than directly;

*A curiosity for me is whether there have been considerations from the government end of things to initiate such talks and indeed, whether they have a clear cut strategy for accountability. Secondly, as regards scale-up, since it seems that the government has identified some interventions/innovations as needful, what fundraising plans have they put in place to take this own. Where is the ownership of MNH in general?*

### *Community*

CHEWs are considered a critical interface in the delivery of MNH services. As such, programmes need to be focused on them. On the other hand, the communities themselves need to be ready and willing to accept some of the interventions projects will propose which are interrelated with MM in the country e.g. prohibition early marriage

## **MAIN**

### **Knowledge of BMGF grantees and contributions to MNH landscape**

Didn't have a great level of detail about BMGF grantee projects but acknowledges that there are some programmes in Ethiopia. Also mentions that they are not the only donor, there are numerous donors working on various projects.

### **Innovations that have been scaled-up**

L10k family health card

### **Mechanisms for catalyzing scale-up**

#### Barriers:

Government donor relations; extent of government involvement in donor's selection of partners, sites, etc.

Would like to see this work as an integrated approach that sees i) donors working through government ii) government coordinating local NGO efforts, more substantive input from the Ministry in their work, decision of where to operate iii) ensuring that international and local NGOs are implementing a full range of relevant MNH services and across a geography rather than sub-components of the services in pockets of the country. This integrated approach should also see resources for MNH being appropriated to all healthcare facilities. Unfortunately, the government is not empowered to promote such sweeping interventions due to a lack of resources.

Channeling resources; coordination

In her own research and work, has severally made recommendations to the government to have a donor pool for supplies and commodities including IEC materials i.e. when a donor has a programme with a dedicated sum of say \$10, 000 to IEC materials, this would go to

the central pool rather than have them develop their IEC materials independently– all NGOs, facilities and those working in related fields would access these commodities and materials from this pool. Thus, ensuring accuracy of partners' messages and uniformity of health promotion messaging across board.

*I wonder if this is something that has actually been considered, whether the government would be supplementing these resources as well and indeed, what considerations have been made for the supply chains to avoid stock-outs. Information for interview with government officials. Basically, are recommendations based on evidence from other programmes taken up?*

Regardless of approach, rather than make silos of impact, respondent is advocating for donors to be working with the government to address the big picture.

#### Enablers:

Queues should be taken from the multi-laterals such as UNICEF and other UN agencies who, when working a country, cover all geographies (*Although I wouldn't say this is actually the case in reality but perhaps 'seemingly'*).

#### Example:

L10k was instrumental to the development of the family health booklet was initially only available/limited to their interventions. Through a series of consultations with the government and donors, the scope of the book has been expanded based on the country's MNH needs. The government is planning to ensure that every household in Ethiopia receives a family booklet through the CHEWs. This way, CHEWs are empowered with one common message and their work is uniform. This has been taken over is currently being driven by the Agrarian Directorate of the Ministry of Health. Karida MacDonald (*someone we should talk to*) is currently spear heading the studies as regards the full adaptation and leading negotiations on the overall approach.

Other partners are working on similar models as the innovations. E.g. The World Bank is collaborating with the Ministry of Transport to develop a subsidized transportation scheme for women to receive EoCare. They are also working to ensure use of the local modes of transport ?Bijaj? where young men lift the women on their shoulders. Also involved in this project is a frontline army of women for community mobilization activities on MNH and means of accessing EoCare. Every 5 'army' women will work with 2 CHEWs to reach 5000 people. This is currently being piloted in Tigray.

*Strong elements of male involvement, use of pre-existing structures, collaboration between medical and non-medical FLW... are these elements scaled-up from BMGF ---> enquire in further interviews*

The Malaria Consortium is also working with the government to provide some Malaria related services. So it would indeed seem that the government itself is trying various combinations to tackling the MNH issue with only three years to go to reach the MDGs. It

will, over time, need to disaggregate the effectiveness of these various combinations to see what is working.

*Noted that despite respondent's initial request about being unable to respond specifically to BMGF, amidst conversation, this was the first example referred to.*

*There is some knowledge of BMGF projects and some degree of 'unintended' scale-up. In future, consider asking about mechanisms of scale-up in a manner that reflects as collaborations between BMGF grantees and other government or civil society actors bearing in mind that BMGF grantees themselves might be catalysers of this scale-up?*

*KII with Karida MacDonald?*

*World Bank collaboration seems to have elements of Emergency Transport and FLW – it would be interesting to speak with them also about whether they have collaborated or discussed with BMGF grantees or BMGF grantees' influence on the development of these programmes. Is it possible that similar activities will be happening concurrently yet independently... How do we in fact know that they are entirely 'independently' initiated? The issue of attribution emerges...*

### Enablers

#### *Political Will*

There is a willingness from the government and a commitment in principle. However, the lack of sufficient resources results in limited capacity to perform.

#### *Advocates*

EPHA is and has been advocating on multiple issues including MNH. However, they are also lacking resources. For example, in 2010 EPHA hosted a conference on MNH in Tigray. During this conference, they brought in over 100 community members [women and youth] to dialogue and make recommendations on what would be best suited for them. These recommendations were forwarded to the Regional Health Bureau.

EPHA has also been working with the Society of Obstetricians and Gynaecologists and Midwives Association. In Ambo, these parties were brought together for experience sharing and discussions on the possibility of collective action. EPHA used this platform as an opportunity to appeal to the various associations to synergize their efforts in MNH. Recommendations were also passed on to the Ministry of Health.

### Challenges

#### *Resources – Financial – Human - Infrastructural*

The key challenge of resources means that the government is limited in its ability to drive some of the interventions itself. However, respondent proposes as a first step, for the government to identify which interventions are low cost and focus on those ones. In a way,

she suggests this has already begun happening through trainings being provided to special categories of healthcare workers such as CHEWs.

### *Community Awareness*

Whether communities themselves accept some of these interventions is also a whole different story. There are still challenges with early marriage and birth spacing due to a lack of education. Respondent proposes that these can and should be strengthened through – Other challenges such as sexual abuse also still persist. Community awareness needs to be tackled more holistically.

### *Dualizes as both challenge and*

### *Donor Support and Approach*

Donors are quite instrumental to the ongoing work but as mentioned are funding interventions in a patchy manner. Respondent proposes for donors to sit with the government, identify the critical interventions that are working and then scale them up through the government. Donors are operating with an enabler-barrier space where their work is making impact in geographies where they operate but this high concentration approach is seen to be a challenge in achieving coherence and working strategically towards the common goals of reducing MMR and IMR. It would also seem that donors are not speaking to each other enough and therefore ‘repeating’ the regions they all work with. Lastly, donors are funding sub-interventions of the full scale of interventions required to tackle MNH

(Patchiness is not only geographical but also in terms of intervention components).

## **Decision-making**

Difficult to separate challenges and barriers:

*Government – the ‘willful but weak’* have a leadership willing to act to address the issue of MM in the country but are limited by their resources and at sub-national levels their capacity (even though the capacity issues at subnational levels are still all tied into the lack of resources)

*Donors – the ‘powerful but patchy’* – it would seem that they rarely take queues from the government on what to fund and through whom. On the other hand however, through some of their funded programmes like the L10K example, they are able to instigate some level of government action.

*NGOs – ‘dedicated to donors’* overreliance on donor funding means that NGOs are also working in this seemingly patchy and non-cohesive manner but in pockets are making an impact

EPHA – ‘*man in the middle*’ have the potential to mediate and foster coherence of the actions of donors, professional associations and the government but they also lack financial resources for activities.

Factors influencing decision-making revolve around –

- i) Resources: the government knows what needs to be done, the technical ‘know how’ is available and where not available, accessible, it is the health system that is not ready because it lacks what it needs in terms of financial, human and infrastructural resources;
- ii) Influence of advocates especially professional associations who are thought to ‘know’

### **Delivery/implementation**

#### Barriers

Supply side issues predominating.

#### *Healthcare facilities*

First level facilities should ideally be equipped with sufficient human resources

#### *Healthcare workers*

#### Enablers

### **Demand/up-take**

#### *Community acceptance*

#### *Professional groups*

## **SPECIAL QUOTES; STORIES**

### **SUMMARY**

#### ***Emerging themes-***

- Scale-up as intended or unintended activities
- Dynamics of donors with government and other in-country partners
- Aligning donor interests with local/country systems
- Supply side issues/systemic issues
- Competing versus complementary innovations



***Methodological themes-***

- Re-emphasizing bespoke topic guides
- Interviews from in-country partners to precede interviews from some of these associations
- Re-emphasis to anticipate interviewees proximity to BMGF projects
- Snow-balling will prove absolutely useful
- Care to distinguish between respondent's opinion (as a professional/expert) versus an organization's position on the issues

## Annex K: Draft pre-analysis template

<b>What are the <i>most important</i> barriers/ enablers to scale-up?</b>			
What factors <i>enable</i> scale-up	How/why do they <i>enable</i> scale-up?	What factors <i>inhibit</i> scale-up	How/why do they <i>inhibit</i> scale-up?
<b>Who are the main actors enabling/inhibiting scale-up? Government; development agencies; private sector; civil society; professional associations</b>			
Which actors <i>enable</i> scale-up	How/why do they <i>enable</i> scale-up?	Which actors <i>inhibit</i> scale-up	How/why do they <i>inhibit</i> scale-up?
<b>Decision making: why are innovations accepted or rejected? Interests; ideas; power</b>			
What factors <i>enable</i> scale-up?	How/why do they <i>enable</i> scale-up?	What factors <i>inhibit</i> scale-up?	How/why do they <i>inhibit</i> scale-up?
<b>Delivery/implementation of MNH services at scale: what are the barriers/enablers to delivery at scale?</b>			
What factors <i>enable</i> scale-up?	How/why do they <i>enable</i> scale-up?	What factors <i>inhibit</i> scale-up?	How/why do they <i>inhibit</i> scale-up?
<b>Community demand and uptake of MNH services: why communities accept/take-up or reject/do not take-up? Geographical; economic; sociocultural; bureaucratic</b>			
What factors <i>enable</i> scale-up?	How/why do they <i>enable</i> scale-up?	What factors <i>inhibit</i> scale-up?	How/why do they <i>inhibit</i> scale-up?
<b>Environmental context: political/policy; economic; sociocultural; technological; legal/regulatory; institutional; global</b>			

What factors <i>enable</i> scale-up?	How/why do they <i>enable</i> scale-up?	What factors <i>inhibit</i> scale-up?	How/why do they <i>inhibit</i> scale-up?
<b>Attributes of the innovation: is the innovation amenable to scale-up? Relative advantage; complexity; cost; adaptability</b>			
Which attributes of the innovation <i>enable</i> scale-up?	How/why do they <i>enable</i> scale-up?	Which attributes of the innovation <i>inhibit</i> scale-up?	How/why do they <i>inhibit</i> scale-up?
<b>Problem characteristics</b>			
Do the problem characteristics <i>enable</i> scale-up?	How/why do they <i>enable</i> scale-up?	Do the problem characteristics <i>inhibit</i> scale-up?	How/why do they <i>inhibit</i> scale-up?
<b>Are BMGF grantee mechanisms to catalyse scale-up effective?</b>			
What mechanisms to catalyse scale-up have been effective?	Why are they effective?	What mechanisms to catalyse scale-up have <i>not</i> been effective?	Why are they <i>not</i> effective?
<b>Evidence to policy and practice: has evidence catalysed scale-up?</b>			
What evidence has catalysed scale-up of innovations?	How has it catalysed scale-up of innovations?	What evidence has <i>not</i> catalysed scale-up of innovations?	Why has it <i>not</i> catalysed scale-up of innovations?
<b>Catalysers and competing innovations</b>			
Who is <i>catalysing</i> scale-up?	How do they <i>enable</i> scale-up of BMGF innovations? How effective are they?	Are the <i>competing</i> actors/innovations?	How do they <i>inhibit</i> scale-up of BMGF innovations? How effective are they?



<b>Other emerging themes</b>			

### Annex L: Interview log sheet

Interview code	Interviewer initials	Interviewee name	Role	Organisation name	Org. type**	Gender (F/M)	Date	Agrees to re-interview? (Y/N)	Agrees to quote verbatim? (Y/N)	Comments

## Annex M: Draft weekly team de-briefing agenda

**Date:** |\_|\_|/|\_|\_|/|\_|\_|

**List those present:** \_\_\_\_\_

**Meeting chair:** \_\_\_\_\_

**Interviews discussed:** IDI NOs: |\_|\_|\_|\_|\_| to |\_|\_|\_|\_|\_|

### Progress

1. Were all the interviews planned for this period completed? If not, what were the reasons for incompleteness? What steps are needed to complete the expected interviews?

### Emerging themes

2. What were the main points made by the respondents during these interviews (keep a tally by each point for number of interviews identifying the same point)?
3. What information or ideas were new in these interviews compared with previous interviews (keep a tally by each point for number of interviews identifying the same point)?
4. Going through each domain, are there still new ideas emerging of interest to the study objectives? If no, consider whether saturation is complete (this may apply to one or more domain which could be removed from the topic guide for subsequent interviews. Only remove domains or terminate data collection after discussion with the study investigators).

### Adjustments to methodology

5. Discuss the impact of the findings so far on intervention design and note ideas arising.
6. Are additional interviewees identified we could approach?
7. Discuss any problems with the topic guides (e.g. wording, order of topics, missing topics) and make changes to the guides.

## Annex N: draft standard operating procedures (SOPs)

### 1 Preparing for interviews

1.1 Prepare and print a one-page topic guide for each interview drawing on questions from the full (five-page) topic and previous examples of one-page topic guides as appropriate.

1.2 Always check you have your essential equipment/materials with you before each interview as follows:

- Sound recorder with fresh batteries and sufficient memory space to record the interview;
- Spare batteries for the sound recorder;
- The one-page topic guide for that interview;
- The full (five-page) topic guide;
- Study information sheets;
- Study consent forms;
- Sufficient paper/notebook and pens.

1.3 It is important to not arrive late for an interview: never keep interviewees waiting. It is your job to work around the participant's schedule and not for her/him to fit in with yours.

### 2 Introducing interviews

2.1 Before starting give the interviewee your business card and point out the best way for them to contact you if needed.

2.2 The interview should be conducted in a private place. If other people come to listen to the interview, explain what you are doing and politely ask them to leave.

2.3 Explain the IDEAS project and the purpose of the interview (using the interview introduction script and information sheet).

2.4 Give interviewees opportunities to ask any questions they may have. Answer their questions honestly and openly as far as you can, and refer any question you cannot answer to your supervisor. Ensure you get back to the interviewee with answers to any outstanding questions by email within a few days of the interview.

2.5 Always obtain informed consent for every interview consisting of the following steps:

- Give the interviewee a copy of the study information sheet and allow them time to read it, or alternatively summarise the main points verbally if the interviewee prefers;
- As part of the introduction (written into the interview introduction script) the principle of informed consent should be explained to the interviewee. This involves clarifying that the interviewee is free to choose to participate in an interview, they are free to withdraw at any time, they are free to decide whether interviews are sound recorded or not and that it is their decision about whether they agree they can be quoted verbatim in any study outputs;
- When you are satisfied that the interviewee understands the study and you have answered their questions, ask if they agree to be interviewed or not. Never coerce or unduly influence an interviewee to participate in the study. If they say that they do not

want to be interviewed because they are too busy ask if there is a convenient time when you can return to interview them. If they still do not want to be interviewed thank them for their time and report any refusals to your supervisor;

- If the person agrees to be interviewed explain that we want to keep a record of the fact that they have willingly agreed to participate. Ask them to sign and date the consent form. You must also sign and date the form;
- You can now start the interview.

2.6 Interviewers should always avoid distressing or upsetting interviewees, and will clarify that interviewees are free to withdraw from an interview at any time.

2.7 If a participant withdraws from the interview, their data should not be used. If the interview is not completed for other reasons any collected data can be used.

### 3 Conducting interviews

3.1 You should be professional and courteous when dealing with interviewees or other members of their organisations. Keep in mind that your work depends on the cooperation of the people you interview. Interviewers and supervisors should avoid being abrupt, disrespectful, or inconsiderate to interviewees, including not making or receiving mobile phone calls or sending text messages while conducting an interview.

3.2 Conduct the interview in the preferred language of the participant, using a translator if necessary.

3.3 Record the interview using the voice recorder which should be put near to the interviewee. Note the recording number in your field notes.

3.4 During the interview be enthusiastic and show interest and use techniques that encourage the respondent to talk and that makes them feel at ease.

3.5 Address as many topics listed in the topic guide bearing in mind that particular interviewee's special areas of knowledge. The interview guide should not be completed as a questionnaire and you:

- May need to rephrase questions to get detailed responses;
- May change the order of topics if it makes sense to do so;
- Should allow the participant to talk freely and ask clarifying questions as needed;
- Should probe for further information and follow up on interesting leads;
- Should use your knowledge from one interview to feed into the next.

3.6 Write down key points in your notebook in the language of your choice.

3.7 Observe the context of the interview and record this in your notebook (e.g. where the interview took place, how the interviewee behaved etc).

3.8 Finish the interview by thanking the interviewee for her/his time and asking them if they would mind being interviewed again in the future if you have further questions for them. Ensure they have a copy of the study information sheet before you leave.



## 4 Writing up interviews

4.1 Always write up your interview notes on the day of the interview, or if that is not possible within 24 hours of carrying out the interview while your memory is still fresh. Expanded field notes should be written up in English and should be typed directly into the appropriate Word format.

4.2 Use the sound recorder as an effective way to help with the expanded notes. You may find it easiest to write the expanded notes without the tape recorder and then listen to the recording and add in quotes from the recording, or you may prefer to listen to the recording as you type up each section.

4.3 Remember your expanded notes should:

- Capture as much detail as possible, including information that puts responses in context;
- Include plenty of verbatim statements (quotes). Put exact quotes in “.....”;
- Try to capture the voice of the interviewee, this means that you should use their exact words and tone as much as possible;
- Where you had to probe an interviewee on a particular topic, indicate by writing [probed] in the expanded notes;
- Make references to other sections, for example if an interviewee talked about something connected to question 3.1 in question 1.1 you should write in section 3.1 ‘(See *section 1.1 for information on XX*)’.
- Include your comments and observations on each interview. These could be things you noticed during the interview, reflections on the responses or things that help the reader understand the interview. Put these in a comments and reflections section of the text;
- Your writing up will speed up over time; remember you do not need to have perfect English and grammar.

4.4 Your supervisor will give you individual feedback on each interview. Revise your interview notes based on these comments and take note of any areas where your supervisor suggests that you could have probed more so you can do so in future interviews.

4.5 Use catch up days to catch up on write ups and review progress.

## 5 Data storage and management

5.1 Participate in routine debriefing sessions with other interviewers and your supervisor to discuss progress and provide feedback. Look for recurring themes and identify interesting/surprising findings. Look for gaps in the data to be filled in subsequent interviews, and identify possible additional interviewees (snowballing). Use these meetings to ask for support and technical assistance from your supervisor if required.

5.2 Maintain interviewees’ confidentiality at all times. This includes:

- Not discussing your interviews with people outside of the project team (but you can and should discuss problems encountered during interviews with your supervisor and other members of the project team);
- Not writing full names in your notebooks or typed expanded notes;
- Handing completed consent forms to your supervisor at the end of each day;
- Keeping your note books, consent forms, any interview printouts, voice recorders, laptops, USB sticks etc. secure at all times and storing them in a locked drawer/cabinet when not in use;
- Password protecting your computer;
- Giving your notebook to your supervisor at the end of the study so they can be stored under and key.

5.3 Each interview is assigned a unique reference based on the following country\_interviewee number\_interviewee type\_date format:

- **Country:** E Ethiopia interviewees; N Nigeria interviewees; I India interviewees
- **Interviewee number:** sequentially starting with 1 in each country
- **Interviewee type:** GN government national level; GS government sub-national level; DB development agency bilateral; DM development agency multilateral; PS private sector; CS civil society organisation; PA professional association; AR academic/research; OK other key informant; IG implementation grantee; IS implementation sub-grantee; PO Foundation Program Officer
- **Date:** day, month, year format ddmmyy

For example an implementation grantee in Ethiopia interviewed on 1<sup>st</sup> May 2012 would be **E\_1\_IG\_010512**; a Nigerian national level government official interviewed on 15<sup>th</sup> June 2012 would be **N\_5\_GN\_150612**

5.4 The interview reference should be included at the head of each set of expanded field notes.

5.5 Save your data using the following format:

- On your computer create two main folders: expanded field notes\_*your initials* and sound recordings\_*your initials*.
- Save your draft expanded field notes in the expanded field notes folder using the correct ID number as a file name (see above).
- Save your sound recordings in sound recordings folder using the correct ID number as a file name (see above). You will ultimately need to delete the original recording from the sound recorder, but do not do this until your supervisor has made backups.
- When your supervisor or another team member comments electronically on your expanded notes, they should give the new version a file name with their initials e.g. **E\_1\_IG\_010512\_EL**. Save this in your expanded field notes folder.
- When your expanded notes have been finalised save the final version called '*ID\_final*' e.g. **E\_1\_IG\_010512\_final**

5.6 Set computer to autosave Word documents every 10 minutes, as well as saving manually at the end.

5.7 Your supervisor will back up your whole computer onto the external hard drive 2-3 times a week. Do not download large personal files such as movies or music onto your laptop and be aware that the project will have access to any personal files and photos.

#### 5.8 Keep your work safe by:

- Scanning any USB stick that has been in an external computer for viruses;
- Ensuring that your automatic virus scan is set for a full virus scan every 2 days.

## 6 Roles and responsibilities of qualitative leads/fieldwork supervisors

6.1 Coordinate the scheduling of interviews and interviewer availability.

6.2 Complete the interview log daily and routinely monitor the range of respondents being interviewed. If we are not getting the required range prioritise those in categories where there are gaps. Keep track of refusals and participants who withdraw from the study.

6.3 Read the expanded field notes and give comments to interviewers within 24 hours to ensure they conduct and write up high quality interviews. Comments should include research themes requiring further exploration in subsequent interviews. In initial weeks of data collection, listen to sound recordings and check interview notes for completeness and accuracy.

6.4 Check on the quality of interviews being conducted through random checks and observing interviews.

6.5 Handle difficult cases such as interviewees who are upset or distressed or would like further information.

6.6 Collect consent forms from interviewers and store under lock and key.

6.7 Ensure sound recordings and expanded field notes are labelled and filed correctly.

6.8 Backup all data files two or three times a week. Data should be backed up onto an external hard drive which should be stored securely or a secure server.

6.9 Facilitate routine debriefing meetings with interviewers to discuss progress and provide feedback. Look for recurring themes and identify interesting/surprising findings. Look for gaps in the data to be filled in subsequent interviews, and identify possible additional interviewees (snowballing). Use these meetings to provide support and technical assistance to interviewers as required.

6.10 Based on the expanded field notes and debriefing meetings populate the pre-analyse template on an ongoing basis. Use this to guide debriefing meetings.

6.11 Ensure all expanded field notes are sent to Neil Spicer within 24 hours of your review.

6.12 Send the updated interview log sheet and updated pre-analysis template to Neil Spicer weekly.