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Presentation outline

- Implementation science:
 - Why should we invest in it?
 - What is it?
 - How should we do it?
- Suaahara II experiences with implementation science
- What are the implementation and science tensions?





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**Implementation science: what, why
and how?**



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What is implementation science?

“Use-inspired science”

1. Aim is to learn about/improve implementation
2. Methods come from the aims
3. Built with experiential learning



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Why should we investing in implementation science?

We have 35 proven preventative and curative maternal and child health and nutrition interventions, but coverage remains low (Lance Child Survival Series 2003).... But we only have a few studies per intervention and almost no comparison of delivery strategies.

We need more evidence on:

- delivery strategies (HOW)
- delivery points (WHERE) especially non facility based
- varying contexts (geography; low-scale/short-term vs large-scale/longer-term and research/lab vs. real world systems)

In short, we need to focus on IMPLEMENTATION of interventions and not just IMPACTS. And we don't want to wait 15-20 years to get knowledge into action (biomedical approach)



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When? Where? Which methods?

All the time – before, during, and after implementation

Everywhere you work – it should be embedded within all interventions to learn and adapt


Research questions (and resources and context) drive the methods. Sometimes quantitative is best and sometimes qualitative is best and sometimes you need both.

Examples: monitoring, formative research, process evaluations, organizational assessments



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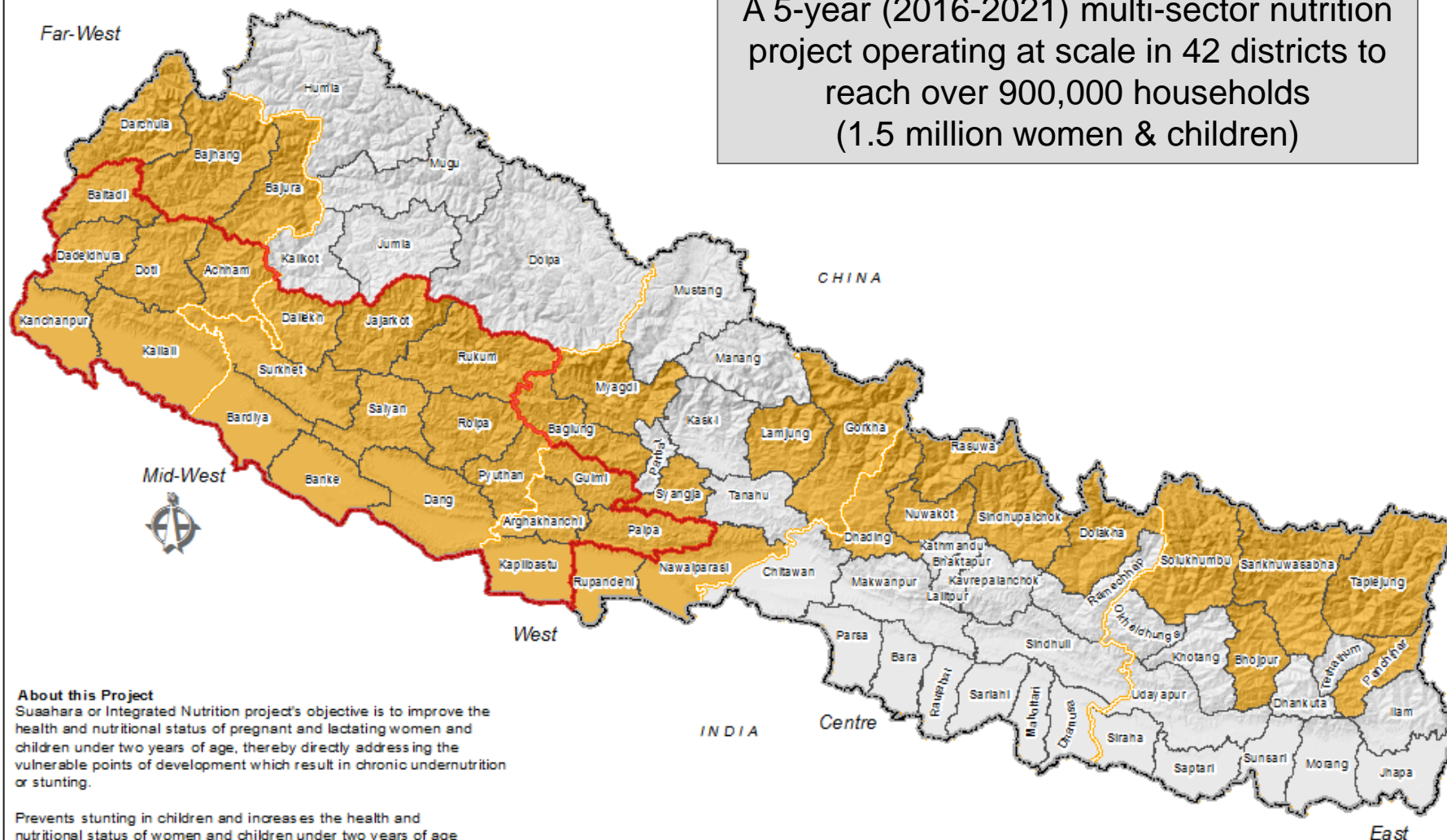
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Suaahara II Interventions and Implementation Science

Suaahara II

A 5-year (2016-2021) multi-sector nutrition project operating at scale in 42 districts to reach over 900,000 households (1.5 million women & children)





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Suaahara II: intervention packages for life cycle

CORE package **(n=3,353 wards)**

- **SBCC Package**
- **MIYCN Package**
- **IMAM Package**
- **CB-IMNCI Package**
- **Nutrition advocacy**
- **GESI**

SBCC=Social Behavior Change and Communication
MIYCN=Maternal, Infant, Young Child Nutrition
IMAM=Integrated Management of Childhood Illness
MCH/FP=Maternal and Child Health and Family Planning
WASH=Water, Sanitation and Hygiene
GESI=Gender Equity and Social Inclusion

CORE + package **(n=1,504 “disadvantaged” wards)**

CORE package **AND the following interventions**

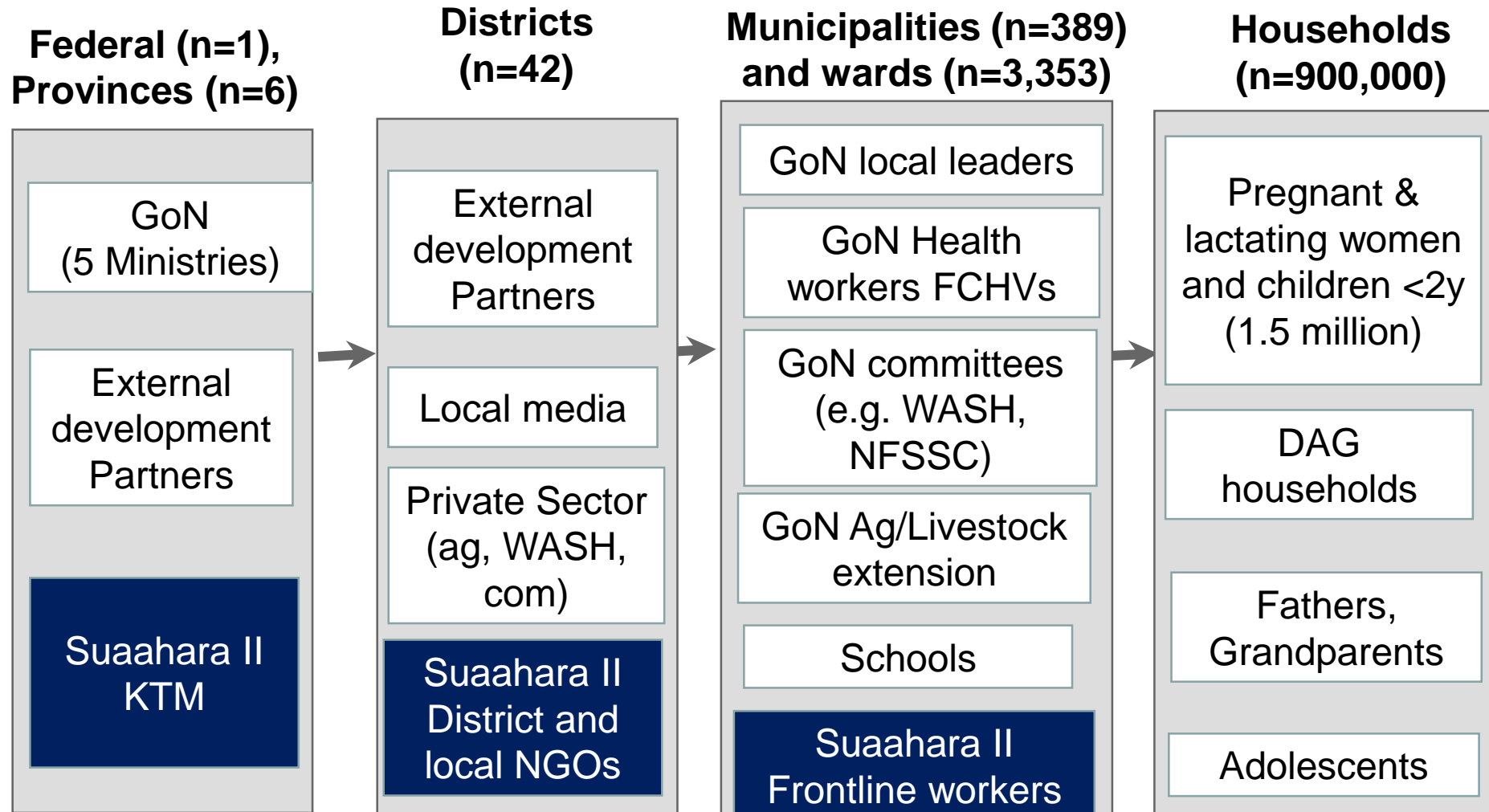
- **Enhanced Homestead Food Production**
- **Intensive SBCC**
- **Intensive WASH**
- **Intensive Health**
- **Intensive GESI**



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Suaahara II: Intervention delivery context





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Example: SBC package during the first 1000-days



**Interpersonal
Communication
(4-6 home visits)**



**Community Mobilization
(3 key life events,
Monthly group meetings
Quarterly food demos)**

भण्छिन् आमा
परिवारकै स्वास्थ्यका लागि



**Mass Media: “Bhanchhin Aama”
(Weekly localized radio drama
and live call-in components)**

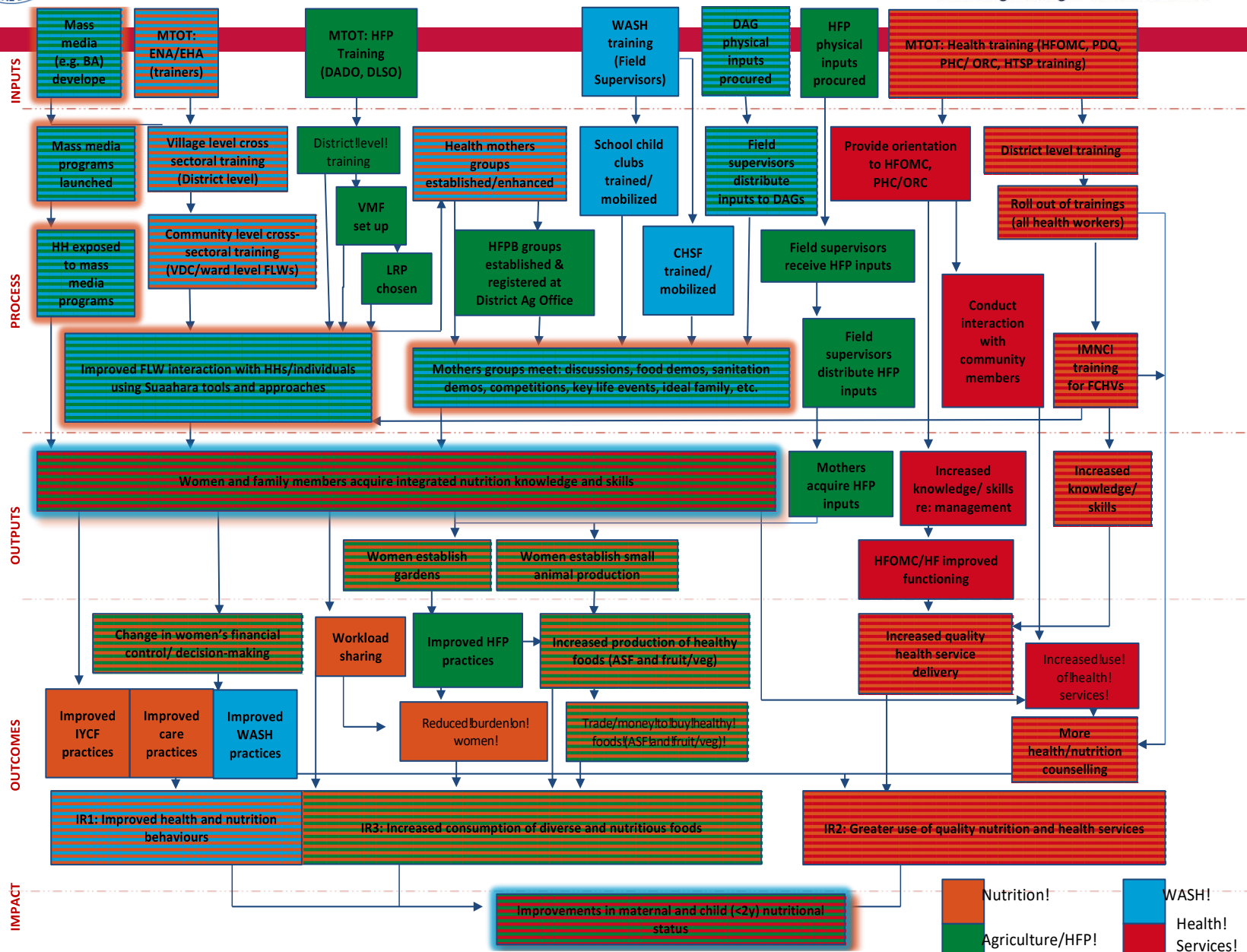


**Mobile technology
(35 SMS;
Interactive Voice
Response for FP)**



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Suaahara II: monitoring, evaluation and research

1 DIFFERENT people have
2 DIFFERENT data needs and wants, requiring
3 DIFFERENT approaches

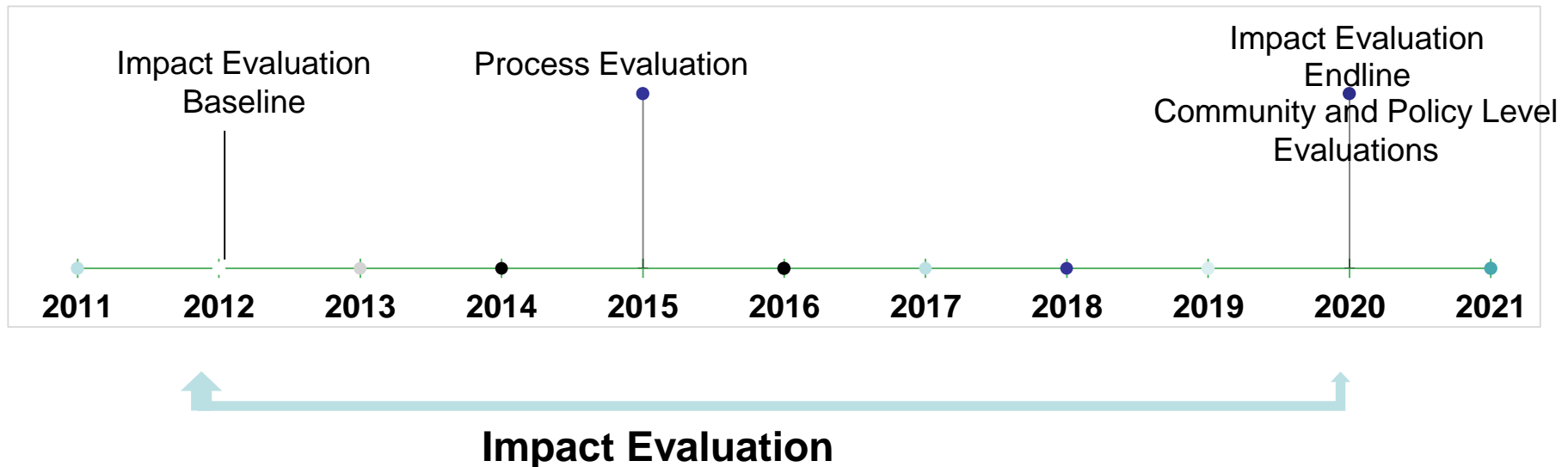
4 **Challenge:** how to prioritize so that data
generated is guided by program needs, used by
5 implementers at all levels and to answer
important questions about implementation and
science!



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Suaahara II evaluation (an IS starting point)



Evaluation: (attribution)

- Did Suaahara improve nutritional status among mothers and young children and related behaviors?
- Did Suaahara improve health services, including the providers' skills and knowledge?
- Did Suaahara improve the policy environment for nutrition?



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Suaahara II research (3 IS examples)



“Adolescent Girls’ Panel (16 districts; N=1150)

What are adolescent girls’ nutrition-related knowledge and practice and how can they be reached? How does this vary by stage of adolescence?



SMS RCT

(1 district: N=3,350)

Is SMS an effective means of improving diets of young children, in the context of pre-existing multi-platform SBC interventions?



Formative Research (purposive sampling)

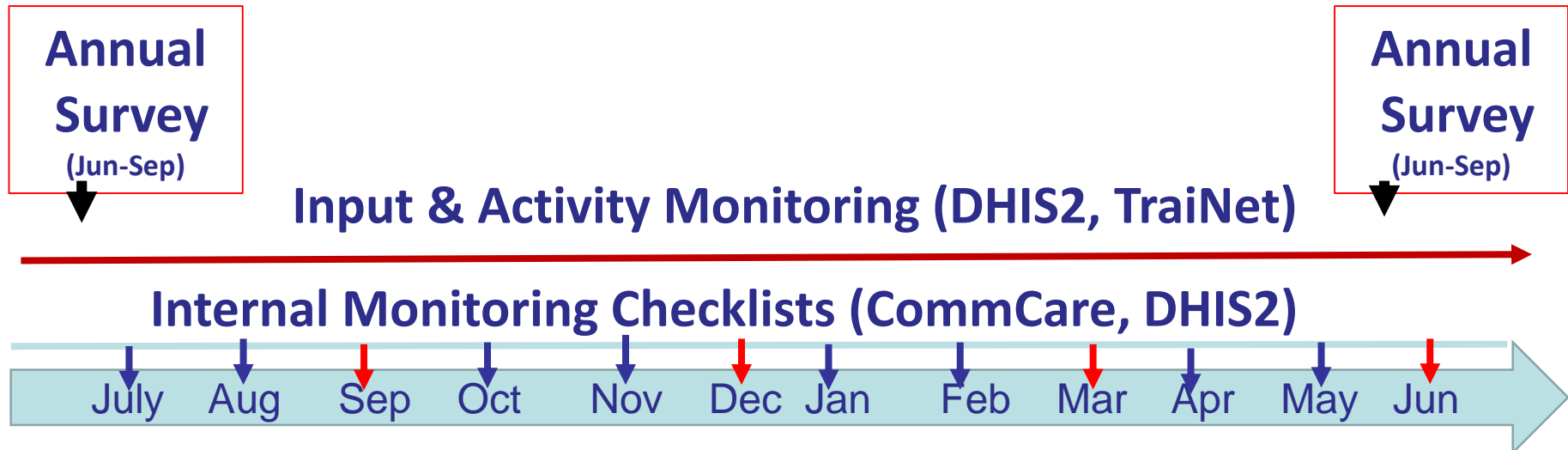
What are barriers & facilitators for key behaviors?
What factors are important for program design and implementation?



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Suaahara II monitoring (IS as real-time data use)



Monitoring: (tracking)

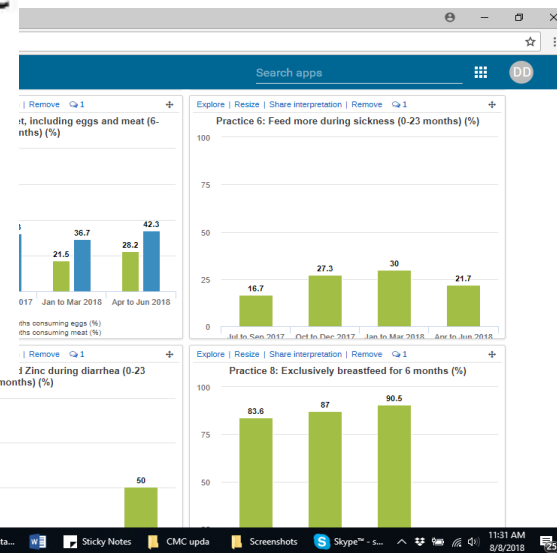
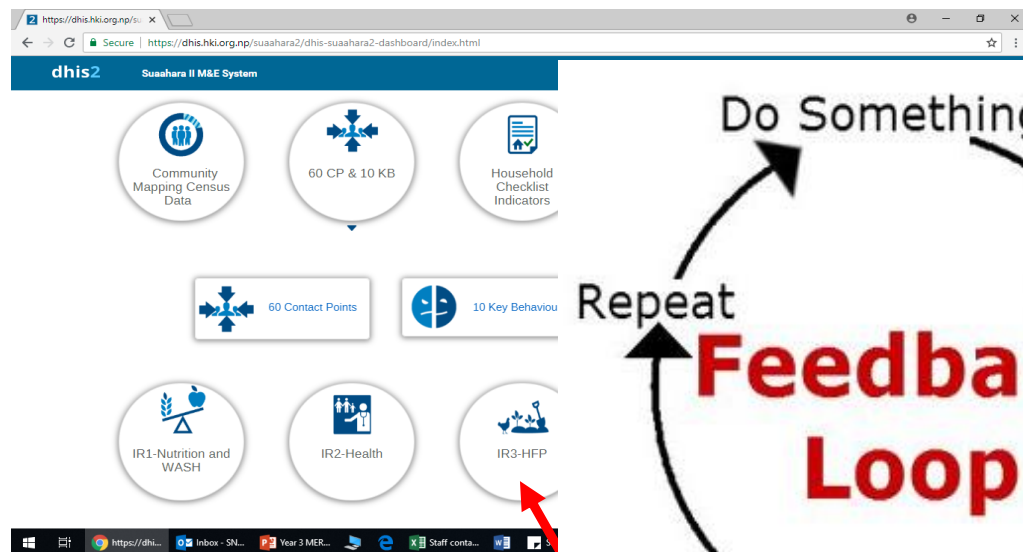
- Are activities approved in annual workplans being implemented at a rate to reach targets?
- How many/who was reached (gender, caste/ethnicity, post) by each activity?
- What is the quality of those activities being implemented?



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Use the findings internally **OFTEN** and **ASAP**

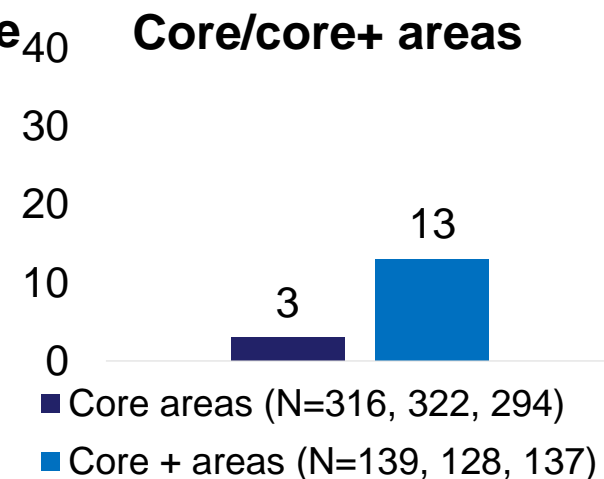
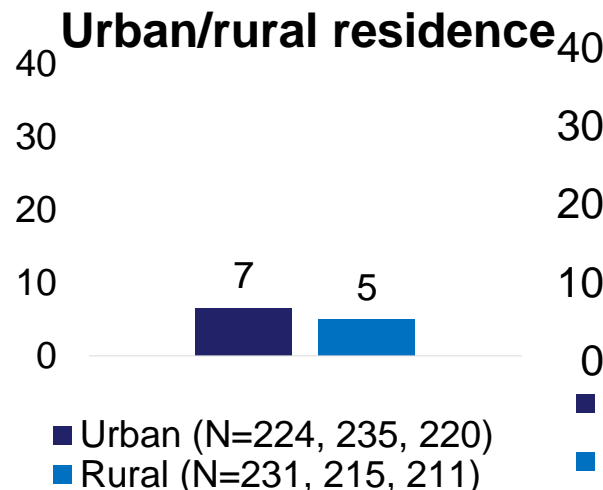
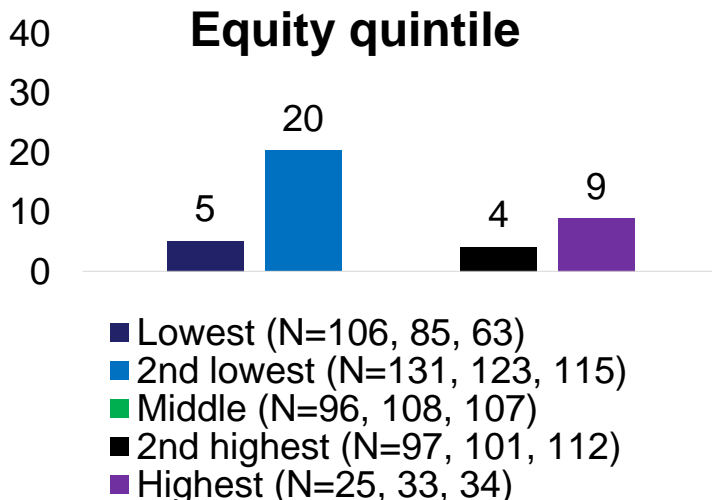
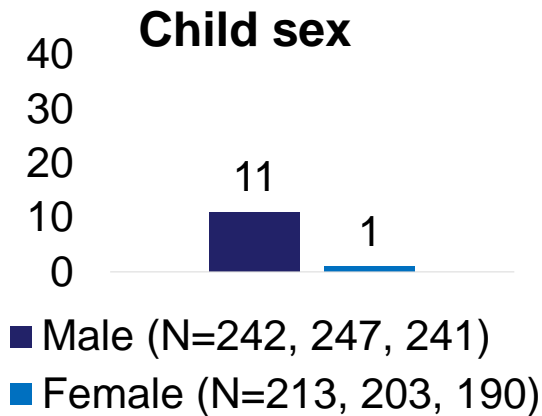
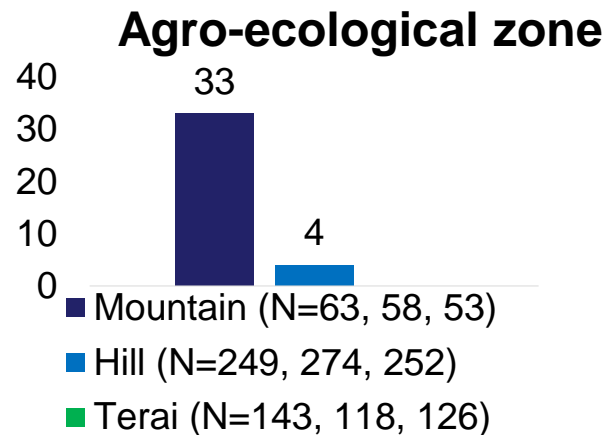
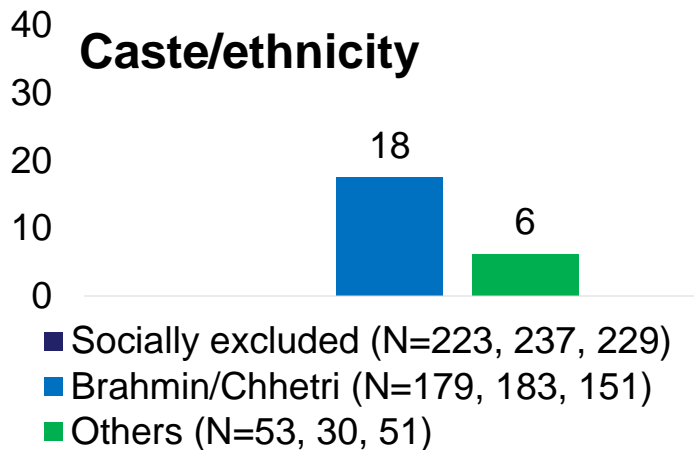




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Exclusive breastfeeding (6PP increase): percentage point increase by sub-group, 2017-2019





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Year 1 Results: 5 examples of use for refining targeting, programming and monitoring

1. Design phase:

- Adolescent program (95% in schools; SMS wouldn't work)
- Grandmothers (separate intervention not needed)

2. Mid intervention (adapt interventions):

- Fathers' MCHN knowledge was low, and thus "letter to the father" designed and implemented
- Increase in activities to promote BA, as exposure was low but listenership high among those who were aware of BA
- WASH focus on 3 handwashing "before" given gaps identified

3. Mid monitoring (adapt tools):

- Equity quintile used for HH level targeting to distribute inputs and tools changed to collect willingness to pay data



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Share findings with diverse audiences to generate new questions and insights



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SUAAHARA II GOOD NUTRITION PROGRAM ANNUAL SURVEY YEAR TWO (2018)



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MULTI-SECTORAL NUTRITION PROFILE PROVINCE - 3

MAP AND DEMOGRAPHICS



Province 3, borders China to the east, Gandaki Province 2 and India to the south. Province 3 is about 6.2 across 13 districts, including municipalities made up of total of 9,439 female (FCHV) and 685 public health care services in the 119 municipalities, 94 open defecation free (ODF) Suahara II (Good Nutrition) districts of Province 3, co urban municipalities.

Suahara II districts

NUTRITION STATUS

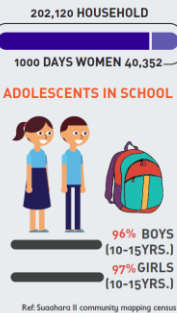
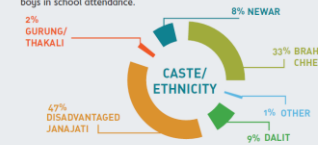


INFANT AND YOUNG CHILD FEEDING



SUAAHARA II PROGRAM

In the 5 Suahara II districts of Province 3 (Dhading, Nuwakot, Sindhupalchok, Dolakha, Rasuwa), Suahara II reached about 203,000 households through May 2018. Among these households, nearly 41,000 are in the 1000-day period between conception and a child's second birthday and nearly 71,000 have a child 10-15 years of age. About half of the households are disadvantaged Janajatis. For every 10 households, 7 own a radio or phone to be able to listen to the radio. Among the 196,000 adolescents, nearly all who are 10-15 years of age are currently in school, with no statistically significant difference found between girls and boys in school attendance.

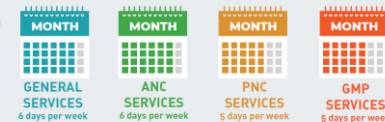


HEALTH SERVICE AVAILABILITY



In the 5 Suahara II districts in this province, Suahara II surveyed 62 health facilities. On average, facilities are open 6 days a week, but the regularity of service provision varies by type of service. Similarly, while immunization clinics are conducted on average 3 times a month, outreach clinics where growth monitoring and promotion services are provided, are conducted on average only 2 to 3 times a month.

NUMBER OF DAYS PER WEEK HEALTH FACILITIES ARE OPEN



PHC/ORC AND EPI CLINICS CONDUCTED IN LAST MONTH

2.3 PHC/ORC

3.0 EPI CLINICS

Note: PHC/ORC = Primary Health Care Outreach Clinic; EPI = Expanded Programme on Immunization
Ref: Suahara II health facility monitoring checklist



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**What are the tensions with
implementation science?**



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Conflicting interests
between researchers
(study now!) and
implementers (act now!)

Research and intervention
timelines, budgets, etc.
may not align and/or be
flexible (donors key too!)

Research ethics (need ethical
approval) vs intervention
ethics (need ethical actions)

Understanding and
assessing complicated
implementation
environments is
limited

Shifting budgets, activities
and modalities, staffing,
etc. making measurement
nearly impossible



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Resolving the tensions...

1. **Communication:** Involve implementation scientists in major program planning meetings and workshops to think, discuss, and revise budgets, staffing, training, etc. Meet often and discuss planned programming changes and jointly decide how to adjust both implementation and research plans.
2. **Clarity:** Implementers can define their priority questions and stick to these requests with MER teams. Implementers should also stick to the implementation plans, when possible.
3. **Methods innovation:** researchers should bring in methods and collaborators who focus on systems and leadership, management. We need more nuanced ways to merge quantitative and qualitative findings.
4. **Trade-offs:** what is essential, important, and nice to do?
5. **SIMPLIFY:** Researchers can simplify findings to be actionable and disseminate the learnings in user-friendly ways and timings!



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Good luck to us!



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PNGO partners



Consortium partners





Suaahara II would like to thank the Government of Nepal for their leadership.



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Connecting Knowledge with Action for Impact

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