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Viewpoint

Scaling With Evidence

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WHEN MONITORING AND EVALUATION ARE IN AN ORGANIZATION'S DNA, AS THEY ARE AT SNEHA, IT'S MUCH EASIER TO CREATE PARTNERSHIPS WITH GOVERNMENT AGENCIES AND NGOS.

By Dr. Armida Fernandez & Vanessa D'Souza

When we launched The Society for Nutrition, Education & Health Action (SNEHA) in 1999, we set out to empower women from Mumbai's slums with the information and tools they desperately needed to build healthier families. The level of need was extraordinary, and one of us (Dr. Fernandez) had witnessed it first-hand, working for more than three decades at Mumbai's busiest public hospital, where it was a daily struggle to save underweight and premature infants born to poor mothers with little or no basic health knowledge.

Looking back to those early days, the idea of "achieving scale" was quite foreign to most of SNEHA's leadership team; they were doctors and health providers. As Dr. Fernandez recalls, "Truthfully, I didn't even know what an NGO was. When we got our first money, I remember asking, now what?"

But a lot has changed. Today, SNEHA has a staff of roughly 380, operates in 12 of Mumbai's 23 municipal wards, is a presence in six municipal corporations outside Mumbai, and has an annual budget of INR 16.26 crores ($2.45 million). Over our 17 years, we've served more than one million women and children across Mumbai. Scale is now something we talk about regularly. And along the way, we have learned that scale comes in a variety of ways: Evidence attracts funders who support growth and stretch; government programs and NGOs adopt proven approaches; and advocacy can lock in gains, providing strong roots from which to grow.

EVIDENCE ATTRACTS FUNDERS

Our journey to scale came by accident, not by design. We started as a group of doctors going into the Dharavi slum, where up to a million people squeeze into tiny makeshift homes and lack even the most basic services. We were there to offer basic advice and guidance to women and families about maternal and newborn health. The fact that we were doctors lent us credibility. And our timing was right, because not many NGOs working in urban slums were focusing on this niche. We focused on it because that's what we knew.

We also came naturally to running pilot projects; it was an approach we had experience with in the medical field. (Not that we had a choice; one could also say that we were forced to do pilots because we didn't have enough funds to run a bigger program.) And we were used to learning as much as possible, as quickly as possible, before taking action. Before launching a pilot, we would do a baseline survey. For one nutrition program, for example, we wanted to know about adult and infant eating patterns to get at the larger question of why people in Dharavi were malnourished. The pilot that followed involved a few hundred babies and received funding from a women's organization in the United Kingdom. We learned from that program, and that gave us the courage to plan a bigger one for the community.

We realize now that our efforts to grow have been greatly helped by the fact that whatever we do starts with knowledge built on a solid research base. We were accumulating evidence from the start, but our initial funders didn't ask us for it.

Then, our evidence was suddenly more important to funders, even critical. We were seeking larger grants, but we were finding that very few people in India understood that health and nutrition were important stepping-stones out of poverty. So it was quite a battle for us to prove the linkage. And initially, no one was interested in funding our program to prevent violence against women and children. We spent five or six years developing model programs and collecting evidence that they worked before major grants started coming our way. Fortunately, those battles are behind us.

Today, of course, evidence is a must to get quality funding. (The 2013 law requiring India's largest companies to contribute 2 percent of earnings to corporate social responsibility had a lot to do with elevating the role of evidence in securing funding.) So we're fortunate that monitoring and evaluation are part of SNEHA's DNA. When a prospective corporate donor realizes that we have a baseline study and that we feed data back into our work, they say, "Okay, these people are not just randomly doing activities; there is some thought going into what they are doing."

Dr. Armida Fernandez (left) is the founding trustee of SNEHA. She was a professor and head of neonatology at Mumbai's Lokmanya Tilak Municipal General Hospital and Medical College for more than 25 years and dean of the hospital for three years. She was named an Ashoka Fellow in 2004 and is the past president of the National Neonatology Forum.

Vanessa D'Souza is the CEO of SNEHA. She worked with Citibank India for 21 years and in her last position was director of Citi Private Bank.

Photographs courtesy of Dr. Armida Fernandez and Vanessa D'Souza

WORKING WITH GOVERNMENT

Our focus on evidence has also helped smooth the way for us to work with government health agencies. These agencies have already achieved a large scale, but in many cases they are not performing as well as they could. So we partner with them and advocate for improvements in existing services. They're looking for proven ways to improve, and we share our evidence-based models in hopes that they will be adopted. We collaborate with Mumbai's public health department, which covers a city of more than 18 million people, and health departments of six smaller nearby cities. We also work with the Indian government's Integrated Child Development Services.

Health agencies across Mumbai and six nearby cities have adopted SNEHA's Maternal and Newborn Health program, which seeks to improve pregnancy care for low-income women by creating a referral network in cooperation with public hospitals. The idea is to promote appropriate care for women with potential complications. But the program also does what we call "load balancing," steering a woman who expects normal delivery to a maternity home rather than to a public hospital that is best suited for the highest-risk cases. We started this program in Mumbai in 2003, and after 10 years it really took off.

Whenever we set up a program, we give a lot of thought to how our model will fit and work with the related government system. Typically, we use a similar government program as a benchmark, and we map our resources to what the government provides. So, for example, if the government pays for one *aanganwadi* (nutrition and early childhood education) worker for every 1,000 people, our program will budget one front-line worker for every 3,000 because our worker focuses only on, say, nutrition. We're trying to make the case that the government can apply existing funds to hire people with deep expertise in a single area that can be a powerful lever for improving nutrition and health.

Another example? We recently bought our health workers mobile phones. Using the phones, our health workers can collect data in real time, and the results can be fed back into programs to tailor processes and improve outcomes. We know that this move would represent an expensive proposition for the government, but we believe strongly that sometimes you need to make that extra investment to create evidence in order to advocate for change.

SCALING THROUGH PARTNERS

We spent a lot of time over the past few years thinking about the different ways we could reach more people with our programs cost effectively. We discussed many scenarios, including trying to grow our own organization, and also different models through which we could teach others to implement our programs.

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We decided in favor of partnerships, in large part because we don't understand the local situations in states like Jharkhand or Bihar. So we partner with NGOs that are already working in other states because they understand the local context, and they work with us to adapt our models to their specific context. We contextualize the models, share the protocols, provide the technical training, and monitor the implementation with them.

For example, two partner NGOs have taken our program to prevent violence against women and children to seven Indian states. Save the Children is implementing our maternal health program in Pune. And the SETCO Foundation is implementing our child health and nutrition program in Gujarat. Many organizations have recently come to SNEHA and asked how they can borrow our models or elements of our models. For us, it's a low-cost way to extend our impact; it's far more efficient than having to hire and manage staff members across India. NGOs want to partner with us because they don't have to reinvent the wheel; they can use our model, after adapting it to their local context. This partnership model reduces implementation time and lowers costs, and so it is a way to efficiently scale up.

We've also realized that we need advocacy at the highest level, not just the program level, to lock in gains. And we've learned this the hard way. We would put all our energies into working with, say, people in charge of a health department program. We would create great rapport, and things would be going well. But overnight, that person would get transferred, and we would have to start all over again.

Put another way, individuals don't make policy. So we know now that when we work with government commissioners or health officers, we are not influencing policy, and that's something we have to learn how to do. To date, we still do advocacy piecemeal. We know someone, we call someone, or we ask someone. Part of the answer will likely be developing in-house expertise in advocacy.

EXPANDING ACROSS INDIA

Our goal over the next five years is to extend our programs across India and beyond. We think certain programs, especially our nutrition program, could be not only national but international—extending across Southeast Asia and even to Africa. We have been saying all along that what we are doing in urban Mumbai could be replicated across urban centers in India and, for that matter, urban centers outside of India.

We see ourselves becoming a resource center where we develop models that work and then train others how to implement them. If we go national in five years, that would be quite an achievement. If we manage to go international, all the better. ✱