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COMMENTARY

Utilizing Principles of Private Enterprise to Improve Maternal and Child Health Programs

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ABSTRACT

High quality maternal and child health (MCH) programs are needed to meet the global Sustainable Development Goals 1, 2, 3, and 10. Yet, the vast majority of MCH programs are small, lack capacity and personnel, and are judged based on their relationships with funders, rather than their performance in the field. Adopting principles common among private enterprise could have a significant impact on shifting MCH to focus on implementing larger, higher quality programs and to routinely evaluate MCH as meeting/not meeting their primary mission. For example, focusing on recruiting personnel who have excellent social skills and are pragmatic problem-solvers reflects a principle of *Hire the Best Staff*. Similar principles such as *Leadership Matters* and *Create a Culture of Discipline* are guideposts that can improve the quality of MCH programs over time. This commentary outlines criteria which could both guide MCH organizational development and funders' evaluations of MCH.

Key words: • Leadership • Private Sector • Maternal And Child Health Programs • Global Health • Developing Countries

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Maternal and child health programs (MCH) are the front-line providers that potentially insulate children from the impact of poverty, trauma, absent parents, migration, or a lack of food and shelter. Policy makers have set Sustainable Development Goals to end poverty (Goal 1), end hunger (Goal 2), improve good health and well-being (Goal 3) and reduce inequity (Goal 10) by the year 2030. If we are to meet these goals, high functioning, effective MCH programs are necessary.

Yet, in many low and middle income countries (LMIC), small, non-government organizations (NGOs) supplement the formal health system. These agencies are often relatively new, have unstable funding streams, unsustainable ratios of staff members to the number of families served,¹ and donor/funder priorities guide the local programming. These are the very characteristics which ensure that many programs will not be effective. Even when efficacious programs have been scaled, the results have often been unimpressive.²

In a series of randomized controlled trials (RCT) in both Asian and African LMIC, our team has had the opportunity to observe the characteristics of well-functioning and effective MCH.³ For example, in India, DURBAR is an organization that initially began in the early 1990s as a union organizing NGO that aimed to improve the circumstances of sex workers. Today it has a large MCH program that provides educational, nutrition, and recreational programs for children and parenting programs for mothers. We found the operating principles of DURBAR to also underpin an MCH program that had been successfully intervening with pregnant mothers and their young children for 20 years – The Philani Maternal Child Health and Nutrition Trust Program in South Africa. Both MCH programs have now been diffused extensively to multiple countries and have expanded to become organizations that are training the next generation of MCH program staff. Each of these programs have been evaluated by our team.⁴⁻⁷ In addition, other researchers have concurrently evaluated the programs. For example, the Gates Foundation created the Avahan Project from DURBAR in Calcutta, India, diffused it throughout India, and conducted a thorough evaluation.⁸ Similarly, the perinatal home visiting program of the Philani model is currently being evaluated in Sweden among new immigrants. Multiple observers of these programs recognize the benefits of these models.

This commentary reviews the features of these effective MCH, and of an additional 20 agencies involved in our RCT. Our aim is to encourage funders to redirect resources from creating new MCH to ensuring that existing MCH become great by systematically adopting and implementing lessons acquired from the study of successful corporations.

Organizational experts have identified seven key principles endemic to the cultures of great organizations in private enterprises. In 2001, Collins identified 11 of 1,435 “great” global companies.⁹ Each of these 11 companies had existed for a sustained period of time, typically decades, with substantial financial success and concurrently created authentic, credible, and accountable organizations. Our team has conducted 22 RCT in MCH and NGO in many LMIC. These seven principles also characterized the

NGOs that were most effective in delivering high quality MCH services.

Principle 1: Leadership matters. According to Collins,⁹ leaders who are highly strategic, but do not need to personally be in the spotlight, are most likely to engineer great organizations. In the global health field, MCH organizations are often started by articulate, charismatic leaders who garner media and/or community attention and establish good relationships with donors.¹⁰ Repeatedly, these NGOs initially grow exponentially, but then struggle to feasibly implement competent programs. Funding is typically based more on the social networks of the leader than the organization’s deliverables on-the-ground.¹⁰ Greatness occurs only when the MCH’s mission guides daily operations, not the leader’s personality.

Principle 2: Recruit the best staff. Collins observes that great companies first consider who will be the best staff to support your mission and then consider what and how they will execute the mission. Due to country-specific development of MCH, selection of community health workers is often based on community nomination, rather than professional competence or capacity to benefit from training. Great organizations identify socially competent and committed individuals who are good problems solvers and then train them in the specific skills needed.^{9,11} This principle has long been known in the MCH community.¹² For example, up to 67% of MCH fail to engage mothers or sustain engagement.¹³ Having likable, committed, smart staff who are invested in the MCH’s mission makes daily operations much easier and, ultimately, offers the opportunity to deliver a high-quality program.

Principle 3: Change is a 20-mile march, not a sprint. MCH often focus on leverage points, especially the first 1,000 days of life. Mothers and children in LMICs face a broad range of stressors which can derail a healthy development at multiple points during development. MCHs are typically designed for only a narrow developmental window. The benefits of early intervention in the first 1000 days are likely to disappear (particularly in the most vulnerable families) if the supports are eliminated or reduced. MCH must plan to sustain benefits

over time. Individual programs should not be the sole organization creating a context that helps children thrive, but should rather link and integrate a coordinated set of interventions that evolve with children's evolving developmental challenges.

Principle 4: Great organizations are driven by big hairy audacious goals. These goals inspire staff and encourage staff to exceed their performance expectations and are sustained over time. Low expectations are toxic.¹⁴ Our experience finds that this principle is best characterized in MCH in two ways: (a) by inspiring and buffering employees from burn-out with systematic support structures such as supportive supervision; and (b) by aligning their resource allocations with the organization's goals and mission. Staff in MCH repeatedly face the death of children and families, see abused mothers and children, and are themselves living in very difficult circumstances, especially in LMIC. Great MCH programs plan how to routinely support their staff in the face of challenges to meet their goals. Similar to inspiring staff, the most-effective MCH often buck local norms, especially norms that allocate organizational perks to the most senior staff who hold the highest status. In contrast, MCH with the best outcomes carefully allocate resources based on the functions needed to be accomplished, in order to meet the organization's mission.¹⁰

Principle 5: Know when to do less. Similar to the tenets of disruptive innovators,¹⁵ it is critical to know when and how to offer fewer services. One MCH with which we worked had a 900-page training manual for paraprofessional community health workers. There are many facts to know about pregnancy, breastfeeding, nutrition, alcohol or drug abuse prevention, or HIV prevention for MCH. However, a review of more than 800 manuals of psychotherapeutic evidence-based intervention (EBI) manuals found that 14 skills were repeatedly used in more than 80% of the EBI manuals.¹⁶ Training in these skills is likely to be much more robust and sustainable than training in a manualized EBI. By building skills that facilitate health workers' judgments on when and how to use each strategy with a family, the MCH can create a novel way to utilize scientific evidence to influence daily practice of MCH. The informational

messages must be concrete, demonstrated with a visual prompt (e.g., showing a baby doll with Fetal Alcohol Spectrum Disorder, rather than describing the disorder), and there must be a limited number of messages.

Principle 6: Create a culture of discipline. Accountability is central to effective organizational management. MCH programs are typically accountable to their donors for delivering services, but typically not for having changed families' lives – indicators of delivery rather than of outcome.¹⁰ The organization's primary accountability needs to be to the MCH recipients – the mothers and children served and the outcomes achieved. Supervision and management are key requirements for sustaining an efficacious MCH over time and supervision has to be based on data. If home visitors are not routinely monitored, at least some staff will not be in the field visiting households, and will fake their reports. Equipping health workers with mobile phones allows routine location tracing, facilitating supervision, and creates opportunities for broad diffusion of prevention messages, text and phone reminder calls, both automated and personalized, and ways for staff to reach supervisors easily while in the field, especially when facing emergency or crisis situations. Technology facilitates accomplishing familiar MCH functions at low cost, with greater ease and to more people, but, over time, the technologies' capacities will create novel strategies for effecting long term change.

Principle 7: There is an additive effect of many small, specific initiatives; the actions function on each other like compound interest. Policy makers and researchers are consistently looking for silver/magic bullets – typically a low cost, single dose intervention which will eliminate a specific threat (e.g., a vaccine or a “miracle drug”). Magic bullets are elusive, especially in MCH. Healthy children only emerge with consistent daily routines, warm stable relationships, and with ongoing support, with effective modeling of how to manage hassles and crises. Working with organizations over 20 years allows us to observe how organizations improve slowly over time with small steps, in the context of positive relationships and organizational

cohesion – and with opportunities and rewards. These are the same processes by which mothers and children change over time.¹¹ Applying the change principles to organizations is far more complex than applying the principles to individuals, a family, or even a small group such as a classroom. Organizations need to have realistic organizational goals that are repeatedly re-evaluated, recalibrated, and with clear markers to know if the organization meets its targeted goals and mission. MCH often select talented clinicians and promote these individuals into management positions. A manager's skills are not the same as a clinician; in fact, the role often requires less sensitivity to one's employees' feelings or conflicts. The implementation of the MCH's mission and the quality of an employee's job performance are the key outcomes for managers – not for line staff. Far more training in management is needed globally by MCH – not a typical investment made by governments or donor agencies.

Conclusion and Global Health Implications

These seven principles have significant applications within MCH programs. Far less attention has been focused on the organizational functioning of non-profit and governmental organizations, in contrast to the commercial sector. These principles also apply to the donor agencies who select which MCH programs to fund. While many improvements were made in achieving the Sustainable Development Goals, there is a long way to go to ensure that the next generation of children thrive. We encourage evaluations of how many and to what degree MCH reflect the principles of great organizations and stimulate improved MCH implementation. Collins' criteria may serve as one way to evaluate whether these characteristics are consistently linked to the efficacy of MCH. If adopted, these principles suggest the criteria that local, regional and national governments can utilize to evaluate efficacious organizations. Rather than only evaluating how many contact hours or how many mothers and children are reached by an MCH, the organizations' operating principles and implementation of work habits, staffing, and leadership strategies are additional evaluation criteria which must be considered.

Compliance with Ethical Standards

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Key Messages

1. Almost all interventions focus on what MCH organizations do -now it is time to focus on HOW an organization operates.
2. Exceptional organizations are recognizable to observers and are similar to each other, whether a private enterprise or an MCH program.
3. MCH programs may better reach their goals if they have the opportunity to iteratively improve over time. Evaluation data are needed in order to know HOW to improve organizations' operating principles.

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