IMPLEMENTING BEST PRACTICES
IN REPRODUCTIVE HEALTH

A Guide for Fostering Change to Scale Up Effective Health Services

USAID
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World Health Organization

A Guide for Fostering Change to Scale Up Effective Health Services

Implementing Best Practices Consortium

2007

This Guide was produced for the Implementing Best Practices (IBP) Consortium by the Leadership, Management, and Sustainability (LMS) Project of Management Sciences for Health (MSH) under the terms of Cooperative Agreement Number GPO-A-00-05-00024-00 supported by the US Agency for International Development, Office of Population and Reproductive Health.

Foreword

The Implementing Best Practices (IBP) Initiative is a global partnership involving 26 international agencies dedicated to demonstrating a dynamic model of international and local cooperation to:

- develop mechanisms and strategies to improve the introduction, adaptation, utilization and scaling up of proven effective technical and managerial practices to improve access to and the quality of reproductive health;
- promote an evidence-based approach to the provision of quality services;
- support Ministries of Health to facilitate the coordination of partners implementing reproductive health activities in-country;
- work together to reduce duplication of effort;
- harmonize approaches and identify synergies that can accelerate the implementation and scaling up of effective practices;
- promote creativity and innovation;
- maintain momentum by keeping networks connected and communicating.

The IBP Initiative was initiated by the WHO Department of Reproductive Health and Research in collaboration with USAID, UNFPA, and a small group of international agencies in 1999 and was formalized as the IBP Consortium in 2003.

IBP partners self select to work in "IBP Task Teams" on specific assignments identified by partners, as contributing to our goal of improving access to and the quality of reproductive health.

This Guide is a product of a joint effort between USAID's Maximizing Access and Quality (MAQ) Initiative (www.maqweb.org) and a team of partners from the IBP Consortium, including the WHO Department of Reproductive Health and Research, Chemonics, EngenderHealth, Pathfinder International, Johns Hopkins University/Center for Communications Programs, IntraHealth International, Management Sciences for Health, Public Health Institute, University Research Co., LLC, and the United States Agency for International Development.

The IBP partners identified the missing link between introducing and effectively implementing best practices as the ability to foster, lead, and manage the change process required to implement effective practices, and to improve performance and the quality of services. There is a large body of knowledge on change management; to avoid duplication of effort, the IBP Task Team has undertaken a consultative and collaborative process to share experience and review existing published guidelines and tools detailing different approaches to the management of change. The outcome of this extensive review process was the development of this Guide. The Guide provides a clear pathway that links proven change practices to "how to" steps for successful change. In addition, the partners identified key managerial tools produced by IBP partners referenced in the Guide that will support the implementation of the change process.

Acknowledgements

This collaborative process has developed a *Guide to Fostering Change to Strengthen Health Services* that all IBP partners will support the dissemination and use of at country level through their networks, projects, and programs.

The IBP Partners would like to acknowledge:

- USAID and the IBP Secretariat, supported by the WHO Department of Reproductive Health and Research, for their technical support in the preparation of this document;
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- the members of the Leadership, Management and Sustainability (LMS) Project of Management Sciences for Health who assumed the role of team leader and will on behalf of the IBP Consortium publish this document under the terms of Cooperative Agreement Number GPO-A-00-05-00024-00.

The following partners collaborated on the preparation of this Guide on behalf of all partners of the IBP Initiative:

Chemonics
EngenderHealth
Pathfinder International
Johns Hopkins University Center for Communication Programs
IntraHealth
Management Sciences for Health
Public Health Institute
United States Agency for International Development
University Research Co., LLC
World Health Organization/Department of Reproductive Health and Research

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Contents

"It is not the strongest of the species that survives, nor the most intelligent, but rather the one most responsive to change."

— Charles Darwin

Introduction

The Need for a Guide to Fostering Change

This guide is based on the recognition that change is inevitable for survival and that directed, planned change is essential for improvement. A systematic change process underlies all successes in development, including improved reproductive health.

We in the development community have the medical/clinical knowledge, technology, and experience to make substantial improvements in maternal and child health, reproductive health and family planning, HIV/AIDS, and other infectious diseases. We also have the knowledge and approaches to successfully implement and scale up changes in health care practices. The missing link is the connection between these two factors: technical knowledge and the known approaches to successful change. Using evidence-based change practices can significantly increase the chances for success and sustainability as we introduce, adapt, apply, and scale up clinical practices.

Everyone working to improve health—whether at international donor, research, or technical agencies, at the national, district, clinic/community, and family levels—is fundamentally in the business of *fostering, leading, or implementing change.* But not everyone involved in this work has a clear pathway that links proven change practices with evidence-based clinical and programmatic practices. This guide offers one such pathway.

Purpose of the Guide

Successful change is not an end in itself. Rather, it is a means of improving performance and quality of services and, ultimately, of improving health. This guide links effective change practices with proven clinical and programmatic practices to achieve results by:

- increasing awareness of proven approaches to effective change;
- describing principles that are fundamental to effective change;
- providing "how-to" steps for successful change;
- describing key challenges related to the steps and recommending strategies, tools, or approaches for meeting those challenges;
- offering cases that show how the steps have been implemented in real situations.

Primary Audience for the Guide

There are several players in this change process:

- the change coordination team, which is in a position to foster change—to identify, encourage, and support the efforts of change agents;
- the change agent, who manages health services and leads change at a program level or service delivery site, or in his or her community or home;
- the change agent's change team, comprised of co-workers who assist the agent in developing, applying, and advocating for new practices;
- the implementers of change, whose daily work is directly affected by the change.

Although this guide is applicable to all these groups, it is primarily aimed at the first group: those who are in a position to foster change and support change agents and change teams. This group includes Implementing Best Practices (IBP) Consortium members at regional and country levels; Ministries of Health and national nongovernmental organizations (NGOs)/faith-based organizations (FBOs); regional or provincial offices of Ministries of Health (MOHs) or country NGOs and FBOs; regional and country World Health Organization (WHO), United Nations Population Fund (UNFPA), and International Planned Parenthood Federation (IPPF) offices; United States Agency for International Development (USAID) missions; and regional and country offices of USAID cooperating agencies.

At the international level, the audience for this guide includes WHO Geneva, UNFPA, IPPF, USAID, international offices of NGOs and FBOs, and headquarters of USAID cooperating agencies. This audience can use the parts of the guide that relate to overall support for change and to the use and scale-up of evidence-based practices in reproductive health. Change agents themselves will find information and "how-to" steps for initiating and implementing change in the issue of The Manager, "Leading Changes in Practices to Improve Health Services."1

If you fall into one of these or similar professional groups, this guide is likely to enhance what you are already doing. You will find that this change process is consistent and can be used with performance improvement, quality improvement, management by objectives, COPE, and other familiar models and processes for achieving results.

Levels and Types of Change

Within the wide array of possible change agents—service providers, clinic or hospital managers, organizational leaders, community outreach workers, community leaders, or mothers who introduce evidence-based practices to keep their children healthy—this guide focuses on those at the service delivery level.

At this level, relevant changes can occur in:

- clinical practices
- health providers' behaviors or practices

1 Management Sciences for Health, "Leading Changes in Practices to Improve Health," *The Manager* (Boston) vol. 13., no. 3 (2004).

- management practices
- management systems.

Of course, changes can also occur in organizational strategies or structures, as well as in society at large, but these are more complex and take place at levels higher than the service delivery site which is the focus of this guide.

Contents of the Guide

In the following sections of this guide you will find sections covering:

- principles for fostering and leading change
- a "how-to" process for fostering change
- illustrative examples of fostering change.

In the CD-ROM accompanying this guide, you will find:

- an electronic version of the complete text of "Fostering Change to Strengthen Health Services";
- a two-page introduction to the guide;
- a PowerPoint presentation that introduces the guide;
- selected tools referenced in the section on the "how-to" process for fostering change.

Another useful resource for understanding the principles and process of fostering change is the eLearning Module, "Leading Change to Improve Health Services," which is available on USAID's Global Health eLearning Center at www.globalhealthlearning.org.

Principles for Fostering and Leading Change: Creating a Supportive Environment

The principles presented here are applicable to both actors in the change process: you (who can foster change) and the change agents (whom you are supporting). Much of the thinking behind these principles is influenced by John Kotter, whose writings present a wealth of information and ideas that offer a solid context for organizational and structural change.[2] His Eight Steps for Organizational Change are widely viewed as the framework for successful change at all levels of an organization.[3]

Principle 1: Change must matter to those making the change.

Paying attention to the benefits of change, and to people's perceptions of those benefits, allows you to put ownership into the hands of the implementers of change: those who must actually alter the way they do their work at a service delivery site. To create this sense of ownership, the implementers need to recognize how the change will benefit their own work and lives. To influence and foster change, you need to help the change agent to clearly convey these benefits for the work environment and satisfaction of service providers.

The greater the perceived advantage, the more rapid the adoption.[4] Five perceived characteristics of an innovation are key in influencing whether implementers view it favorably or unfavorably:

- *relative advantage:* offers clear benefits to them and to the people they serve;
- *compatibility:* is consistent with accepted organizational values;
- *simplicity:* is easy to understand and apply;
- *trialability:* can be carried out without seriously disrupting current services;
- *observability:* can be measured to show concrete examples of progress.[5]

Principle 2: A credible, committed internal change agent is critical for change in health care practices.

As described above, change agents are the people who facilitate the work of groups in developing, applying, and advocating for new practices. They transmit their commitment and enthusiasm to those who need to do the day-to-day work, resulting in new practices becoming the norm.[6] Successful change agents hold themselves and management accountable for supporting staff in the change effort and have the skills and temperament to lead teams to achieve results.

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2 John P. Kotter, *Leading Change* (Boston: Harvard Business School Press, 1996).

3 The steps are: 1.Establish a sense of urgency; 2. Form a powerful guiding coalition; 3. Create a vision; 4. Communicate the vision; 5. Empower others to act on the vision; 6. Plan for and create short-term wins; 7. Consolidate improvements and produce still more change; 8. Institutionalize new approaches.

4 Everett Rogers, *Diffusion of Innovations* (Detroit: Free Press, 2003), 15–16.

5 Roy Jacobstein, "Some Considerations Drawn from the Theory of the Diffusion of Innovations and the Characteristics of Medical Settings," Paper for International Best Practices Consortium (July 2005), 3.

6 Ken Miller and Robin Lawton, *The Change Agent's Guide to Radical Improvement* (Milwaukee, WI: ASQ Quality Press, 2002).

Identifying a respected change agent inside the system links the new practice with someone who is known to and has worked with those who will implement the change. Studies of successful change show that a category of people known as "early adopters" are the ones with the characteristics and credibility to influence others.[7] These people are typically the most effective internal change agents.

Scaling up a successful change will often require change agents from the various levels of large organizations with the same characteristics as early adopters.[8]

Principle 3: Supporting the internal change agent gives the agent the credibility and confidence to lead.

Those who are in positions to foster change can support local change agents (and their teams) with data and resources not locally available. They can also share knowledge about pathways to successful change, including the skills to plan for scale-up and sustainability right from the introduction of the proposed change.

Principle 4: Change is more likely to succeed when leadership at each organizational level supports it and when it is introduced into an environment where change is an ongoing practice.

Studies and experience show that successful adoption of new practices occurs most often in organizations or work groups with five characteristics:

- Senior managers and leaders at all levels readily share information and knowledge, and encourage their staff to do the same. They give a clear message: "This change is important and we stand behind it."
- Leading change is part of ongoing practice: staff are encouraged to make small, practical improvements, not just to undertake big changes in a crisis.
- Working teams are designed to bring together people with varied and complementary perspectives.
- Staff are rewarded or acknowledged for asking questions, taking risks, and challenging the status quo, in order to better fulfill the organization's mission.
- Staff members trust the honesty and credibility of the people who are promoting change.[9]

The following three principles pertain to the role of the change agent: leading change at the local or service delivery level.

7 Rogers, 27–28.

8 Early adopters are opinion leaders in their respective work or social settings. They are well connected and respected as opinion leaders and role models. They are more willing to take risks and try new things than those known as "later adopters," and they are often chosen as leaders or representatives in their work or social groups.

9 Management Sciences for Health, "Leading Changes in Practices to Improve Health," 8.

Principle 5: Clarity is needed about the purpose, benefits, and anticipated results of the change.

Those implementing the change should ensure that it meets the criteria described under Principle 1: relative advantage, compatibility, simplicity, trialability, and observability. Early success is a key element in reinforcement and provides motivation for continued investment and energy.

Measurement and data will help staff to see evidence of improvement. Small-scale trials lessen risk and influence adoption by individuals, especially if the demonstrator is an opinion leader.[10] In connection with ongoing measurement and course corrections, it has often been observed that failing on a small scale leads to greater success than starting on large, expensive, untested programs.

Principle 6: Motivating and supporting staff throughout the change process will help to maintain their dedication and create a support network for the change agent.

Too often, we underestimate the effort and support needed to make change permanent. Support throughout the change process and then for scale-up significantly increases the motivation of the implementers and the likelihood of institutionalizing the change. Interpersonal communication—one-to-one and in small groups—is critical to the adoption of new practices and behaviors. Being conscious of and respecting cultural differences in your work environment and adapting to these differences will make your communication more powerful.

Principle 7: Clearly assigned and accepted responsibility for implementing the change increases the chances of sustaining the change as a part of ongoing work.

The change agent needs to influence the assignment of responsibilities for implementing the change and encourage team members to accept it. One of the major obstacles to successful change is *not* taking the time to incorporate new behaviors into regular work routines and systems. If staff are to be held accountable for making the change happen, they need to:

- be encouraged to recognize the urgency and priority of the proposed change;
- be provided with the information, resources, and skills they need in order to take on their new responsibilities;
- integrate new responsibilities into their performance expectations and be held accountable for achieving their part of the change effort.

Principle 8: Start where you can and start now.

The literature says that top-level leadership must be supportive for change to succeed. This is true in the long run, and especially in scaling up change throughout and beyond an organization. But many successful changes have started in a tucked-away corner of a hospital, health or community center, district, or province with a committed change agent and team.

Your task is to help the change agent persevere even if support is not readily forthcoming at all levels. In fact, it is often the documented evidence of success in a new practice that convinces higher-level decision-makers to support institutionalization. If you cannot begin with top-level support, it is a useful strategy to progressively enroll people at higher levels as you show success.

10 Rogers, 171.

A "How-To" Process for Fostering Change

The process detailed in this guide is directed at change coordination teams whose members are dedicated to initiating and supporting a needed change in a health practice or set of practices. A change in health practices may originate at different levels. Sometimes an evidence-based practice is introduced nationally or regionally to resolve a widespread public health concern. For example, a Minister of Health or donor may initiate the provision of insecticide-treated bed nets to reduce infant deaths from malaria.

But sometimes the change "bubbles up" from the staff of a health facility seeking to improve a situation that is keeping them from serving their clients as they would like to. There are many examples of hospital directors who introduced proven practices to reduce an unacceptably high infection rate, or clinic nurses who mobilized their staff to improve counseling to increase family planning acceptors. For a discussion of changes originating at health facilities, please refer to Management Sciences for Health, "Leading Changes in Practices to Improve Health."

As mentioned in the introduction to this guide, whatever the source of a change in practices, there is a great variety of groups that can act as coordination teams to support the change. Among the most likely are regional and country members of the IBP Consortium; Ministries of Health; NGOs and FBOs (national and provincial); regional and country WHO, UNFPA, and IPPF offices; USAID missions; and regional and country offices of USAID cooperating agencies.

A change coordination team may form in either of two ways. It may be established in direct response to a practice or practices that could be improved, before a change agent has been selected. Or the team may form to support a change agent who has already been selected to carry out an agreed-upon change in a practice or practices. In the IBP context, this guide is written with the former assumption—that the team is formed and that the choice of a change agent does not occur until Phase 2. In a situation where a change agent is already in place, that person will be an active participant throughout the rest of the steps of the process.

The phases and steps below are applicable to any change coordination team. For each step, the reader will find:

- the factors that will help carry out this step (basic assumptions, needs, and prerequisites);
- the purpose of the step;
- the challenges that may be encountered in taking the step;
- the underlying causes of the challenges;
- suggested strategies for addressing the causes and meeting the challenges;
- tools that will help teams meet the challenges, based on the documented experience of teams that have carried out similar change processes.

The steps represent a suggested sequence of events, but this sequence may vary in different situations.

There are also a number of tools that apply to the change process as a whole. These tools are identified on page 9.

The guide also includes three case studies. These cases are examples of how coordination teams have applied the phases and steps in making important changes in health practices. Case topics are: active management of the third stage of labor by trained community health volunteers in Indonesia, postabortion care for mid-level providers, and provision of intrauterine devices in an environment with a high rate of sexually transmitted infections.

The Change Process: An Overview

Preliminary Phase: Forming the Change Coordination Team

Phase I: Defining the Need For Change

a. Identify the problem—a practice or set of practices that is impeding the provision of high-quality services—analyze the root causes, and reformulate the problem as a challenge.

b. Identify and agree on the desired change, its purpose, the anticipated results, and the potential obstacles. (Why are we doing this? How will the services benefit from doing it? What may make it hard to achieve?)

Phase II: Planning for Demonstration and Scale-Up

a. Select a dedicated change agent (if one has not already been appointed) and a change team.

b. With the change agent, identify and analyze relevant effective practices from other settings.

c. Choose and adapt an effective practice that is appropriate for the service delivery context and the needed change.

d. With the change agent and change team, make a plan to implement and monitor the demonstration of the desired change at test sites.

e. Building on the implementation plan, make strategic choices for scaling up a successful change effort.

Phase III: Supporting the Demonstration

a. Help to create and maintain an environment that will encourage change by supporting the change agent, change team, and other staff throughout the change process at the test sites.

b. Use the change plan and indicators to continually assess, monitor, and modify the change effort.

Phase IV: Going to Scale with Successful Change Efforts

a. Evaluate, consolidate, and disseminate lessons learned from the demonstration, and decide whether or not to scale up the new practice or set of practices.

b. If the demonstration succeeded, select a scale-up strategy that best suits the country or regional program environment.

c. Engage the commitment of a broad group of stakeholders and secure resources to support the selected scale-up strategy.

d. Implement the scale-up strategy, incorporating the new practice or set of practices into existing policies, systems, programs, plans, budgets, and performance expectations.

e. Measure and communicate the results of the scaled-up practices.

Overall Change Process Tools and Approaches

- Change Facilitation (Global Network for Exploring, Creating, and Celebrating Change). "Change Management Toolbook." http://www.change-management-toolbook.com/. This work is a collection of more than 60 tools, methods, and strategies applicable in different stages of personal, team, and organizational development, in training, facilitation, and consulting. It is divided into three main sections: Self, Team, and Larger System.
- Management Sciences for Health. *Developing Managers Who Lead: A Handbook for Improving Services*. Boston: Management Sciences for Health, 2005. The handbook provides practical approaches for applying key leading and managing practices that managers can use with their teams to face challenges, overcome obstacles, and realize their vision of better health for all.
- Management Sciences for Health. "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). This issue of *The Manager* helps health managers work with a team as change agents to address community and organizational challenges that require a change in clinical or management practices. It spells out key success factors for change and presents the five phases of a change process.
- Management Systems International. "Implementing Policy Change Series" http://www.msiworldwide.com/ipc. This collection of documents was written as part of the USAID-funded Implementing Policy Change (IPC) program, which worked in developing countries around the world to improve policy implementation and democratic governance.
- Management Systems International. "Institutional Development Toolkit." http://www.msiworldwide.com/gral/nwproductsinfo/institutional_dev.htm. The integrated Toolkit for Institutional Development is intended to be used by nonprofit organizations to address shortcomings in the field of institutional development of nonprofit organizations. The toolkit emphasizes participation, the use of management systems, and the independence of the organization.
- Massoud, Rashad, et al. *A Modern Paradigm for Improving Healthcare Quality.* Bethesda, MD: Quality Assurance Project, 2001. This guide to quality improvement contains a section with tools for flowcharting, root-cause analysis, force-field analysis, data collection, brainstorming, affinity analysis, creative-thinking techniques, and priority setting. It also contains a practical matrix illustrating various stages at which the different tools can be applied.
- Sirkin, Harold L., Perry Keenan, and Alan Jackson. "DICE Assessment Tool" in "The Hard Side of Change Management" *Harvard Business Review* 83 (October 2005): 108–18.

Preliminary Phase: Forming the Change Coordination Team

Regardless of which comes first—forming the team or selecting the change agent—there is no doubt that even the most energetic, committed, and astute change agent and change team will benefit from ongoing support. Your coordination team should have clear leadership capacity. You and your fellow team members will be responsible for identifying evidence-based practices with which the change agent may not be familiar, and for obtaining political support and resources from relevant stakeholders. If the change agent has already been chosen, he or she will be a valuable member of the coordination team.

Sometimes a new team can be formed specifically to support a change initiative. IBP change teams, for example, are ideally placed to help to move major reproductive health efforts forward in the participating countries and states. In other instances, a team that already exists for other purposes can be officially mobilized on behalf of a change effort. A national reproductive health council, for example, might support the introduction of an evidence based practice on improved forecasting and ordering of family planning methods. Or an international NGO might form a country team to support new practices for effective client-provider relations.

The members of a change coordination team will, of course, vary with the setting and the nature of the proposed change. Team members may be selected by the Minister of Health or other senior government officials, sometimes in conjunction with donors or international organizations.

If you are to provide strong support throughout the change effort, your team members should meet several important criteria. They should represent a broad variety of stakeholders and have decision-making power and influence among those stakeholders. This will enable your team to advocate with institutions or individuals to supply the resources needed to carry out the change process. Some coordination team members should be well acquainted with the technical content pertaining to the relevant health practices, and all should motivated by the need to improve those practices.

Beyond these specifics, you and your team should be prepared to contribute the time, thought, and energy required to provide consistent support throughout the change process. If the team is to work effectively together in support of the desired change, there must be buy-in from all members. You should share a common understanding of the task, the expected results, and your individual responsibilities. You must agree on and present consistent messages to all audiences.

This is not always easy: members of different organizations or units of an organization may answer to different authorities, with different policies, priorities, and approaches. There may be competition among the disparate organizations or units, and the organizational environment may reward competitive behavior.

Successful change teams have overcome these obstacles by:

- selecting team members with a broad perspective, enabling them to rise above their loyalty to their organization or unit;
- creating incentives for team members to neutralize their competitiveness and work together towards a common purpose;
- having someone in authority clearly state the results the team is expected to achieve;

- making it widely known that the team and its members will be held accountable and rewarded for achieving these results.

There are many tools and approaches aimed at forming teams and enabling members to work effectively together. Among the most useful tools are:

- Institute for Health Care Improvement. "*Forming the Team.*" http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/ formingtheteam.htm.
- IntraHealth. "Performance Improvement Stage 2: Obtain and Maintain Stakeholder Agreement." http://www.intrahealth.org/sst/stage2.html.
- Management Sciences for Health. "Analyzing Stakeholder Interests and Concerns" in *Developing Managers Who Lead: A Handbook for Improving Services*, 195–197. Boston: Management Sciences for Health, 2005.
- Management Sciences for Health. "*Effective Meetings.*" Internal communication.

Phase I: Defining the Need for Change

In this phase of the process, the coordination team begins by recognizing that a practice or set of practices is causing a problem and needs to be changed if the program is to meet its health goals. The team then identifies the underlying causes—the reasons that the problematic practices persist. They reformulate the problem as a challenge by asking, "How can we achieve the result we want to achieve in the face of the obstacles we have to overcome?" This turn of phrase provides the context within which to move positively towards needed change, rather than getting mired down in an endless reiteration of the problem and its causes.

Step 1. Identify the problem—a practice or set of practices that is impeding the provision of high-quality services—analyze the root causes, and reformulate the problem as a challenge.

Basic assumptions, needs, prerequisites

- Some service delivery practice or set of practices needs to change if the program is to improve its performance and carry out its mandate.
- National or regional leaders recognize that something needs to change. These leaders may be formally appointed senior managers or service providers with informal authority and influence.

Purpose of this step

- Establishes the need for change and the reasons for making that change.
- Establishes ownership of the change process ahead.
- Focuses on causes rather than symptoms, resulting in sustainable changes.
- Turns negative complaints into positive spurs to change.

Challenges

- To promote widespread recognition that there are problems with the way things are now and that change is a priority.
- To reach agreement on one practice or set of practices as a priority for change.
- To thoroughly explore the reasons for the problem and not settle for superficial analysis.
- To avoid discouragement leading to inactivity.

Underlying causes of the challenges

- The negative impact of the current practice on service performance may not be widely known.
- Different perspectives will yield different views of which practices are most detrimental to performance.
- Some influential people are benefiting, directly or indirectly, from the current situation.
- It is not always easy or comfortable to look below the surface of a problem, name the factors that are causing it, and actively seek ways to address those factors.

Strategies for meeting the challenges

- Discuss with the team the impact of various practices on performance and, ultimately, on the population to be served.
- Reach consensus on one practice or set of practices that has a particularly damaging impact and, if changed, could make a big difference in services.
- Analyze the root causes of the persistence of the practices.
- Turn the negative problem ("We are facing these persistent obstacles in trying to achieve our results.") into a challenge ("How can we achieve the results we want by overcoming these obstacles?").
- Encourage team members to share this information with appropriate staff in their own organizations or units.
- Work with organizational leaders to identify and eliminate or significantly reduce the benefits gained from maintaining the undesirable practice.

Tools and approaches

- ACQUIRE Project. "Integrating Best Practices for Performance Improvement, Quality Improvement, and Participatory Learning and Action to Improve Health Services." http://www.acquireproject.org/fileadmin/user_upload/ACQUIRE/ Guidelines_PI_QI_PLA_06-16-05.pdf.
- IntraHealth. "Performance Improvement Stage 6: Find Root Causes." http://www.intrahealth.org/sst/stage6.html.
- Management Sciences for Health. "Leading Teams to Face Challenges." Ch. 2 in *Developing Managers Who Lead: A Handbook for Improving Services*. Boston: Management Sciences for Health, 2005.

- Management Sciences for Health. "Phase 1—Recognizing a Challenge" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- Management Sciences for Health. "Using the Challenge Model" in *Developing Managers Who Lead: A Handbook for Improving Services*, 179–181. Boston: Management Sciences for Health, 2005.

Step 2. Identify and agree on the desired change, its purpose, the anticipated results, and the potential obstacles. (Why are we doing this? How will services benefit from doing it? What may make it hard to achieve?)

Basic assumptions, needs, prerequisites

There is a clear, logical purpose that all can buy into.

- If carried out effectively, the change will yield important results for organizational performance.
- The coordination team members share values and beliefs consistent with the purpose of the change.
- The coordination team members will have to take on some important and difficult challenges to make the change happen.

Purpose of this step

- Gives everyone on the coordination team a common goal.
- Acknowledges that meaningful change is seldom easy.

Challenges

- To enable people with different institutional or program perspectives to agree on one change or set of changes that they will undertake together.
- To foster a belief in and enthusiasm for the agreed-upon change that will persist throughout the process, among members of the coordination team and other stakeholders.

Underlying causes of the challenges

- Cultural, political, or professional differences among coordination team members can foster divergent views of how best to change the negative practice or set of practices.
- People are weary of unsuccessful change efforts and skeptical about the possibility that any meaningful change will happen.

Strategies for meeting the challenges

- Emphasize that there is no single "right" change.
- Openly air and value the different views on the desired change.

- Work to find one changed practice or set of practices that all participants agree has the potential to make a difference for all their organizations or programs.
- Make clear what success will look like, how everyone will know it has been achieved.
- Use examples of successful changes to counteract skepticism and generate a belief that difficulties can be overcome and change is possible.

Tools and approaches

- EngenderHealth. COPE: Client-Oriented and Provider Efficient: A Process and Tools for Quality Improvement in Family Planning and Other Reproductive Health Services. New York: EngenderHealth, 2003. Sections related to self-assessment will help achieve this step.
  - Handbook: http://www.engenderhealth.org/res/offc/qi/cope/handbook/
  - Toolbook: http://www.engenderhealth.org/res/offc/qi/cope/toolbook/index.html
- Pretty, Jules N., et al. "Participatory Learning and Action" in Participatory Learning and Action: A Trainer's Guide. London: International Institute for Environment and Development, 1995.
- Population Information Program. "Performance Improvement Approach." Population Reports vol. 30, no. 2, 2002. http://www.infoforhealth.org/pr/j52edsum.shtml.

Phase II: Planning for Demonstration and Scale-Up

In this phase, the coordination team actively engages with the change agent, if they have not already done so in Phase I. Together they scan for practices that have effectively addressed a similar challenge in a comparable setting, beginning close to home and extending the search to other countries or regions if necessary. They choose a practice that best meets the criteria, make any adaptations that are needed to address this specific challenge, and plan the details of a demonstration of the change at one or more test sites, including the indicators of success that will be monitored throughout the demonstration and evaluated at the end. It is at this time that the coordination team and change agent begin to plan for scaling up the practice. If it succeeds at the test sites, they will be ready for rapid scale-up; if it fails, little will have been lost.

Step 1. Select a dedicated change agent (if one has not already been appointed) and a change team.

- Agree on the criteria for a successful change agent.
- Scan for individuals who meet the criteria.
- Clearly communicate the details of the change to candidates, and clarify the expectations of the job.
- Choose a change agent who is willing and able to meet these expectations.
- Offer adequate training, counseling, and mentoring to enable the change agent to fulfill her or his role.

- With the change agent, form a change team whose members will share responsibility for making the desired change happen.

Basic assumptions, needs, prerequisites

- The country or regional program has one or more people who meet the criteria and are willing to take on the challenge of leading the change.
- The program leadership is willing to entrust an individual with responsibility for the change process and to let go of some decision-making power.
- There are other motivated, capable individuals who can form a change team to work with and support the change agent.

Purpose of this step

- Makes one person accountable for the process.
- Puts someone in charge who is familiar to and trusted by his or her colleagues.
- Creates buy-in among those who will have to live with the change.
- Gives the responsible person a team to provide support and assistance.
- Provides energy to initiate the changes and ongoing motivation to sustain them.

Challenges

- To choose a change agent who:
  - meets the criteria and is willing and eager to accept the assignment;
  - has the full backing of the program leadership and the trust of his or her colleagues;
  - does not have a conflicting personal agenda or priorities;
  - has been allocated the time and resources to take this on in addition to his or her other responsibilities;
  - has the courage to take risks.
- To form a change team whose members:
  - have the skills needed to bring about the change;
  - recognize the benefits the change will have for the country or regional program;
  - are enthusiastic about working with the change agent;
  - have been allocated the time and resources to take this on in addition to their other responsibilities.

Underlying causes of the challenges

- Some excellent potential change agents may not meet all the criteria.
- People with the characteristics needed to be a change agent or change team member often have other, conflicting responsibilities.

- In leading a controversial change effort, the change agent may encounter risks to job security or to his or her reputation among colleagues and within the broader community.

Strategies to meet the challenges

- Train, coach, and/or mentor a capable, motivated change agent to build skills that she or he may be lacking.
- Be sure that some members of the change team have complementary skills so they can effectively support the change agent.
- Gain the support of the leadership to free the change agent and change team members from some other duties.
- Provide vigorous ongoing support for the change agent with senior management, colleagues, and community members.

Tools and approaches

- Management Sciences for Health. "Coordinating Complex Health Programs." *The Manager* (Boston) vol. 12, no. 4 (2003).
- Management Sciences for Health. "Have a Dedicated Change Agent Lead the Way" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.

Step 2. With the change agent, identify and analyze relevant effective practices from other settings.

Basic assumptions, needs, prerequisites

- There are practices that other organizations or programs within the country or region have successfully used to make comparable changes.
- The coordination team has access to information about these practices.

Purpose of this step

- Confirms that the proposed change is possible.
- Avoids re-inventing the wheel.
- Reduces the chance of expending energy, good will, and resources on measures that are unlikely to work.

Challenges

- To create awareness of and access to practices with the potential to succeed in this situation.
- To determine objectively which practices have actually proven effective in comparable settings.

Underlying causes of the challenges

- The organization or program has limited opportunities to read about or communicate with other programs that may have relevant experience.
- Claims of effectiveness of practices may surpass reality.

Strategies for overcoming challenges

- Establish criteria for a practice that has proven effective.
- Search systematically for practices that meet the criteria and are applicable to the needs of the country or regional program.

Tools and approaches

- Advance Africa. *Best Practices Compendium*. http://www.advanceafrica.org/compendium.
- INFO Project. "A Tool for Sharing Internal Best Practices." http://www.infoforhealth.org/practices/InternalBPs/index.shtml.
- INFO Project. "Best Practice Signpost." http://www.infoforhealth.org/practices.shtml.
- The Cochrane Collaboration. "Informed Health Online." http://www.informedhealthonline.org.
- Management Sciences for Health. *The Health Manager's Toolkit*. http://erc.msh.org. The Toolkit is an electronic compendium of tools designed to assist health professionals at all levels of an organization in their efforts to provide accessible high-quality and sustainable health services.
- World Health Organization. "Reproductive Health and Research." http://www.who.int/reproductive-health. This website contains information on health topics and cross-cutting issues related to sexual and reproductive health.

Step 3. Choose and adapt a proven practice that is appropriate for the service delivery context and the needed change.

Basic assumptions, needs, prerequisites

- There is convincing evidence that one practice or set of practices will be most effective in meeting the chosen challenge.
- The coordination team and change agent have the capability and tools to adapt the practice(s) to their setting.

Purpose of this step

- Allows the coordination team, change agent, and change team to focus energy and resources on one promising practice or set of practices.

Challenges

- To select the most appropriate practice from those that have been considered.

- To make the case for the choice with decision-makers in the country or region.

Underlying causes of the challenges

- Key decision-makers may be skeptical about adopting and supporting a new practice with which they are unfamiliar.

Strategies for overcoming challenges

- Communicate to decision-makers the results of the search and the justification for choosing a new practice to adopt.

Tools and approaches

- Management Sciences for Health. "Phase 2—Identify Promising Practices" and "Phase 3—Adapt and Test One Promising Practice or Set of Practices" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- INFO Project. "Best Practice Signpost." http://www.infoforhealth.org/practices.shtml.
- ACQUIRE Project. "Integrating Best Practices for Performance Improvement, Quality Improvement, and Participatory Learning and Action to Improve Health Services." http://www.acquireproject.org/fileadmin/user_upload/ ACQUIRE/Guidelines_PI_QI_PLA_06-16-05.pdf.

Step 4. With the change agent and change team, make a plan to implement and monitor the demonstration of the desired change at test sites.

- Develop indicators to monitor progress and, ultimately, to evaluate if the changed practice or set of practices has been successful.
- Clarify roles and responsibilities for the coordination team and for the change agent and the change team.
- Identify tools that have proven useful in carrying out comparable changes.
- Identify and plan for linkages to other sectors, systems, and programs.
- Include the activities needed to sustain the change.

Basic assumptions, needs, prerequisites

- Demonstration sites are small enough to test the practices rapidly and inexpensively, but representative of the broad geographic and cultural divisions of the country or region.
- Various types of support will be available from members of the coordination team:
  - technical support to oversee the implementation;
  - financial support, if applicable;
  - motivational support to provide incentives, recognition, and rewards for successful implementation.

- The change agent and change team are fully involved in every step of the planning process.

Purpose of this step

- Gives the change agent guidelines to lead the change process.
- Enables the change agent, change team, and coordination team to determine if they are on track, and if not, adjust accordingly.
- Allows every player to know what she or he should do, and to be held accountable throughout the process.
- Makes it possible to determine and demonstrate success.
- Starts all players thinking about sustaining the changed practices.

Challenges

- To be sure that members of the coordination team accept their obligation to treat this as a priority in their own working lives.
- To provide convincing evidence of what practices work best in the local context.
- To fit the plan for implementing change within the organization's existing workplan and deliverables.
- To provide the financial and human resources needed to implement and sustain the desired change.

Underlying causes of the challenges

- The coordination team members did not completely understand or accept their responsibilities throughout the change process.
- Relevant local practices have not been adequately explored and analyzed.
- The relevant leadership has not fully endorsed the change and provided the needed resources to implement and sustain it.

Strategies to meet the challenges

- Clarify—in writing—the responsibilities and obligations of members of the coordination team.
- At any stage in the process, either assist or replace coordination team members who cannot carry out these responsibilities.
- Assign one or more coordination team members to study any potentially applicable local practices.
- Take into account the requirements for sustainability throughout the planning process.

Tools and approaches

- Management Sciences for Health. "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- USAID, "Family Planning/HIV Integration: Technical Guidance for USAID-Supported Field Programs." http://www.maqweb.org//maqtools/docs/fphiv.pdf.
- MEASURE Evaluation and USAID. "M&E Fundamentals." Global Health eLearning Center. www.globalhealthlearning.org.

Step 5. Building on the implementation plan, make preliminary strategic choices for scaling up a successful change effort.

- Determine whether the change, if successful, will be appropriate for extension or expansion to new settings. If so, consider:
  - type of scale-up—within or beyond the organization;
  - issues that may require advocacy;
  - barriers that must be overcome;
  - people who need to be on board;
  - dissemination strategies.
- Develop indicators for successful scale-up and add them to the implementation plan.

Basic assumptions, needs, prerequisites

- There are convincing indications that the changed practice or set of practices are likely to succeed in this setting.
- Coordinating committee members are ready to think ahead even before the change has been fully implemented.
- The country or regional program leadership has made a decision about whether or not to scale up a successful change.
- Potential stakeholders in a scaled-up practice have been identified and are willing to participate in initial planning.

Purpose of this step

- Gives all players an early start in thinking about scaling up changed practices that are expected to succeed.
- Allows the coordination team to:
  - anticipate and lay the groundwork for the complexities of scaling up (see Phase IV);
  - determine needed resources and plan to acquire them.
- Helps to motivate all players to succeed in this change effort.

Challenges

- To engage stakeholders in thinking ahead to scale-up early in the change process.
- To find the resources needed for scale-up.

Underlying causes of the challenges

- Evidence of successful change may not appear until later in the process.
- The change is viewed as simply a pilot; requirements of scale-up are not thought through.
- There are real resource constraints.

Strategies for meeting the challenges

- Develop and carry out a monitoring plan with interim indicators and milestones, to confirm that the change is progressing as planned.
- Document the process, emphasizing:
  - achievement of milestones;
  - adherence to the schedule and budget;
  - unanticipated roadblocks and how the change agent and change team have addressed them.
- Evaluate the benefits of the change.
- Share the documented process and benefits with stakeholders as a way of engaging them in finding resources for scaling up.

Tools and approaches

- Management Sciences for Health. "Phase 5—Scale up the Successful Practice" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- Management Sciences for Health. "Leading Teams to Face Challenges" Ch. 2 in *Developing Managers Who Lead: A Handbook for Improving Services*. Boston: Management Sciences for Health, 2005.
- Cooley, Lawrence and Richard Kohl. *Scaling Up: From Initial Vision to Large-Scale Change: A Management Framework*. Washington, DC: Management Systems International, 2005. http://www.msiworldwide.com/documents/ScalingUp.pdf.
- Advance Africa. *Scaling Up.* http://www.advanceafrica.org/tools_and_approaches/Scaling_Up/index.html.
- Simmons, Ruth, Peter Fajans, and Laura Ghiron. *Scaling-Up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. ExpandNet. http://www.expandnet.net/volume.htm.
- ExpandNet and World Health Organization. *Practical Guidance for Scaling Up Health Service Innovations.* http://www.expandnet.net/volume.htm.

Phase III: Supporting The Demonstration

The coordination team plays a crucial role during this phase, helping to maintain the energy, focus, and consistency of the change process at test sites, and oversees the continuous assessment and modification of the process. What is accomplished and learned during this demonstration period will strongly influence decisions about scale-up.

Step 1. Help to create and maintain an environment that will encourage change by supporting the change agent, change team, and other staff throughout the change process at the test sites.

Basic assumptions, needs, prerequisites

- The coordination team has the mandate and capacity to closely monitor the change process and give appropriate feedback.
- It is normal for staff members react to the potential change in different ways.
- Change takes time and a steady, persistent effort.
- Mechanisms are in place to motivate, acknowledge, and reward staff members for changing their accustomed practices.

Purpose of this step

- Helps to encourage a positive mindset across the organization.
- Motivates and encourages the change agent and change team to persist when they encounter roadblocks and frustration.
- Provides the basis for sustainability and scale-up.

Challenges

- To foster open communication across all relevant units and levels of the organization.
- To maintain commitment over time, despite setbacks and frustrations.
- To deal with resistance to change among a variety of people, for many different reasons.

Underlying causes of the challenges

- This effort may engage parts of the organization that do not customarily work together.
- Any changes will be uncomfortable for some people in the organization
- The pace of change may be too slow for those who are eager to see results.
- It is normal for staff members to go through the phases of denial, resistance, exploration, and acceptance of change at different paces.

Strategies for addressing the challenges

- At the start of the process and periodically throughout, work with the change agent to:

- describe the change process in detail; point out what has happened to date and what will happen next;
- clarify how the change will enhance the work of every unit in the organization;
- specify the roles of every organizational unit in contributing to successful change.

- Assist the change agent to create cross-organizational working groups responsible for specific activities within the process.
- Focus energy on credible people who recognize how the change will improve services, but be patient with those who resist or are slower to accept the change.
- Help the change agent to accept the normality of differing reactions to change and address the needs of people at each phase: denial, resistance, exploration, and acceptance.

Tools and approaches

- Management Sciences for Health. "Dealing with People's Reactions to Changing a Practice" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- Management Sciences for Health. "*Workgroup Climate Assessment*" http://erc.msh.org/mainpage.cfm?file=96.9.htm&module=toolkit&language=English.
- Sirkin, Harold L., Perry Keenan, and Alan Jackson. "DICE Assessment Tool" in "The Hard Side of Change Management" *Harvard Business Review* 83 (October 2005): 108–18. This article contains clear criteria on decision making regarding the chance of success for change efforts and support needed.
- Kotter, John. *Leading Change.* Boston: Harvard Business School Press, 1996.

Step 2. Use the change plan and indicators to continually assess, monitor, and modify the change effort.

Basic assumptions, needs, prerequisites

- Indicators have been carefully chosen to measure key aspects of the change process.
- Selected members of the coordination team and the change agent have accepted responsibility for:
  - monitoring the performance of staff members vis-à-vis their tasks on the change plan;
  - giving staff members feedback on their performance.

Purpose of this step

- Supports a dynamic change environment by:
  - encouraging honest feedback;
  - pinpointing determinants of success and making them visible to all players;
  - enabling the change agent and change team to identify and address resistance and other barriers to change.

- Supports the refinements needed for scaling up.

Challenges

- To take the time for thorough, objective evaluation.
- To give honest feedback when performance falters.

Underlying causes of the challenges

- Coordination team members and the change agent may be:
  - unfamiliar with the use of indicators to objectively evaluate performance;
  - uncomfortable or unskilled in giving what they consider negative feedback.

Strategies for addressing the challenges

- Find or develop written guidelines for effective feedback.
- Hold a brief training session to discuss the guidelines and practice using them.
- Acknowledge the difficulties staff may be encountering, and be prepared to make practical suggestions for improvement.
- Introduce an approach and methodology for evaluating performance.

Tools and approaches

- Wolff, James A., Linda J. Suttenfield, and Susanna C. Binzen, eds. "Providing Effective Feedback" in *The Family Planning Manager's Handbook: Basic Skills and Tools for Managing Family Planning Programs*. W. Hartford, CT: Kumarian Press, 1991.
- Management Sciences for Health. "Using Evaluation as a Management Tool." *The Manager* (Boston) vol. 11, no. 1 (1997).
- MEASURE Evaluation and USAID. "M&E Fundamentals." Global Health eLearning Center, 2006. www.globalhealthlearning.org.
- Population Reference Bureau. "*Guidelines for Effective Data Presentations.*" http://www.prb.org/Content/NavigationMenu/PRB/PRB_Library/Guidelines_for_Effective_Data_Presentations/Guidelines_for_Effective_Data_Presentations.htm.

Phase IV: Going to Scale with Successful Change Efforts

Scaling up brings new responsibilities to the coordination team and may well require additional members representing new locations and stakeholders. The team brings the findings from the demonstration to a larger audience and works with decision-makers to select, carry out, and evaluate an appropriate implementation strategy. An influential coordination team can contribute substantively to sustainability by assisting governments in mainstreaming new practices into policies, systems, and programs. And finally, the team oversees the careful and honest measuring and widespread communication of interim and final results of the scaled-up practice or practices.

Step 1. Evaluate, consolidate, and disseminate lessons learned from the demonstration, and decide whether or not to scale up the new practice or set of practices.

Basic assumptions, needs, prerequisites

- The evaluation was designed to show clearly the extent to which the change effort succeeded or failed in changing practices.[11]

Purpose of this step

- Provides the information needed to support the "go/no-go" decision on scaling up.

Challenges

- To evaluate the results of the change effort systematically, honestly, and objectively, so that plans for scaling up will be realistic.

Underlying causes of the challenges

- Coordination team members and change agents who have invested time, energy, and their professional reputations in the change effort may be tempted to exaggerate positive results and overlook less successful aspects of the change effort.

Strategies for addressing the challenges

- Acknowledge that ignoring negative factors will produce unrealistic plans for scale-up, with a higher likelihood of failure.

Tools and approaches

- World Health Organization. *An Approach to Rapid Scale-Up: Using HIV/AIDS Treatment and Care as an Example.* Geneva: World Health Organization, 2004. http://www.who.int/hiv/pub/prev_care/en/rapidscale_up.pdf.
- MEASURE Evaluation. "Compendium of Indicators for Evaluating Reproductive Health Programs." http://www.cpc.unc.edu/measure/publications/html/ms-02-06.html.
- Management Sciences for Health. *M&E Guide to Leadership Development Programs.* Boston: Management Sciences for Health, forthcoming 2007.
- Management Sciences for Health. "Using Evaluation as a Management Tool." *The Manager* (Boston) vol. 6, no. 1 (1997). http://erc.msh.org/TheManager/English/V6_N1_En_Issue.pdf.

11 Obviously some change efforts fail and are not candidates for scale-up. In this instance, the role of the coordination team is to objectively analyze the reasons for failure and share the disappointing findings with stakeholders, even when they feel their judgment and professional reputations are at stake. An effective team can encourage the organization to learn from the failure and try again with this or another practice or set of practices.

- Management Sciences for Health. "Phase 5—Scale up the Successful Practice" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- Simmons, Ruth, Peter Fajans, and Laura Ghiron. *Scaling-Up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. ExpandNet. http://www.expandnet.net/volume.htm.
- ExpandNet and World Health Organization. *Practical Guidance for Scaling Up Health Service Innovations.* http://www.expandnet.net/volume.htm.

Step 2. If the demonstration succeeded, select a scale-up strategy that best suits the country or regional program environment. Consider the requirements, risks, and benefits of:

- quantitative scale-up: replicating the new practice or set of practices in new geographic areas;
- functional scale-up: increasing the scope of the activities;
- political scale-up: building relations with public-sector decision-makers to create an enabling environment, and advocating for changes in relevant policies and laws.

Basic assumptions, needs, prerequisites

- The coordination team has the information needed to determine the likelihood that the change will be institutionalized in public-sector policies and programs.
- Planning for scale-up has been an integral part of the process from the beginning.

Purpose of this step

- Maximizes the potential for success by adapting the type of scale-up to the environment.

Challenges

- To understand the requirements, risks, and tradeoffs among different types of scale-up (e.g., the speed and relative ease of *quantitative* and *organizational* scale-up vs. the sustaining power of more complex, risky, resource-demanding *functional* or *political* scale-up).

Underlying causes of the challenges

- There is a tendency to select scale-up strategies that yield the most immediate, visible results and require the fewest new resources and skills.

Strategies for addressing the challenges

- Become familiar with and weigh the requirements, risks, advantages, and disadvantages of each type of scale-up before selecting a strategy that has the greatest chance of success.
- Review scale-up models that have been tested in varied settings, to find strategies that best suit this environment.

Tools and approaches

- Advance Africa. "*Scaling Up*." http://www.advanceafrica.org/ tools_and_approaches/ Scaling_Up/index.html.
- Cooley, Lawrence, and Richard Kohl. *Scaling Up: From Initial Vision to Large-Scale Change: A Management Framework*. Washington, DC: Management Systems International, 2005. http://www.msiworldwide.com/documents/ScalingUp.pdf.
- Simmons, Ruth, Peter Fajans, and Laura Ghiron. *Scaling-Up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. ExpandNet. http://www.expandnet.net/volume.htm.
- ExpandNet and World Health Organization. *Practical Guidance for Scaling Up Health Service Innovations.* http://www.expandnet.net/volume.htm.

Step 3. Engage the commitment of a broad group of stakeholders, and secure resources to support the selected scale-up strategy.

Basic assumptions, needs, prerequisites

- The coordination team understands the key elements of disseminating information to a variety of stakeholders:
  - the flow of institutional policymaking and the process by which decisions are made;
  - the communications channels available;
  - the need to shape messages differently for interpersonal communication or dissemination to a broader audience.
- Appropriate channels and skills are available to communicate to and get feedback from all stakeholders.
- Resource needs have been analyzed, and the coordination team is prepared to advocate for those resources.

Purpose of this step

- Enables the coordination team to advocate effectively for scale-up with organizations and players not already involved.
- Ensures that scale-up is financially feasible, increasing the likelihood of success.

Challenges

- To shape messages that will convince selected audiences to support the new practice or set of practices.
- To know and use the most effective communications channels for each audience.
- To make an accurate resource assessment for an initiative that has no precedents in this setting.

Underlying causes of the challenges

- Not all stakeholders may agree on the wider applicability of the new practice or set of practices.
- There may be no member of the coordination team with expertise in effective communication strategies.
- The coordination team may lack the information needed for an accurate estimate of needed resources.

Strategies for addressing the challenges

- Test the effectiveness of communication strategies on a small scale before launching a full-blown dissemination initiative.
- Conduct desk research and interviews with those who have scaled up practices that are in any way comparable.
- Clearly communicate to stakeholders all the elements of scaling up:
  - adapting or redesigning the practice for new settings;
  - finding and training new change agents;
  - establishing organizational and/or governmental partnerships;
  - introducing new management systems and tools;
  - handling publicity and other communication strategies.

Tools and approaches

- IntraHealth. "Performance Improvement Stage 2: Obtain and Maintain Stakeholder Agreement." http://www.intrahealth.org/sst/stage2.html.
- Cooley, Lawrence, and Richard Kohl. *Scaling Up: From Initial Vision to Large-Scale Change: A Management Framework*. Washington, DC: Management Systems International, 2005. http://www.msiworldwide.com/documents/ScalingUp.pdf.

Step 4. Implement scale-up strategy, incorporating the new practice or set of practices into existing policies, systems, programs, plans, budgets, and performance expectations.

Basic assumptions, needs, prerequisites

- The groundwork for scaling up has been completed, and all required resources are in place.
- Change agents for scale-up are available at all sites, with the same qualities as the original change agent.

Purpose of this step

- Mainstreams the new practice or set of practices, fostering sustained improvement.

Challenges

- To introduce and institutionalize the new practice or set of practices in unfamiliar settings.
- To maintain momentum and enthusiasm among the coordination team and multiple change agents and change teams.
- To preserve the critical features of the new practice as it is expanded and extended.

Underlying causes of the challenges

- Implementers can become frustrated by the time, persistence, and energy needed to carry out a complex, multifaceted set of activities.
- New practices can become diluted and lose their impact as they spread to new settings.
- Qualified, willing change agents may not be immediately available.
- There may be an assumption that a successful pilot change will not require additional attention and support to scale up.

Strategies for addressing the challenges

- Recognize and reinforce the new practices and discourage the old ones.
- Conduct an intensive search for the new change agents.
- Systematically maintain incentives, public recognition, and rewards for change agents and their change teams.
- Plan carefully for every phase of scale-up and monitor progress, so as to anticipate and deal with problems before they become crises.
- Establish and adhere to criteria to maintain the essential features of the practice or set of practices.

Tools and Approaches

- Cooley, Lawrence, and Richard Kohl. *Scaling Up: From Initial Vision to Large-Scale Change: A Management Framework*. Washington, DC: Management Systems International, 2005. http://www.msiworldwide.com/documents/ScalingUp.pdf.
- Management Sciences for Health. "Phase 5—Scale up the Successful Practice" in "Leading Changes in Practices to Improve Health." *The Manager* (Boston) vol. 13, no. 3 (2004). http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf.
- Management Sciences for Health. *Mainstreaming to Scale Up: Model and Guide.* Leadership Management and Sustainability Program, Program Notes, October 2006.
- Simmons, Ruth, Peter Fajans, and Laura Ghiron. *Scaling-Up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. ExpandNet. http://www.expandnet.net/volume.htm.
- ExpandNet and World Health Organization. *Practical Guidance for Scaling Up Health Service Innovations.* http://www.expandnet.net/volume.htm.

Step 5. Measure and communicate the results of the scaled-up practices.

Basic assumptions, needs, prerequisites

- The scaled-up practice or set of practices yields health, social, and financial results, some of which will become apparent while implementation is still underway.
- There are relevant indicators that reflect national and international standards and are already monitored through such mechanisms as the Demographic and Health Surveys.
- The coordination team is committed to accurate communication of interim and final results to decision-makers and implementers.

Purpose of this step

- Makes known both benefits and shortcomings of changed practices.
- Makes it possible to adapt practices midstream to counteract shortcomings, as well as to plan for future iterations.

Challenges

- To obtain health, demographic, social, and financial information that is accurate and timely enough to justify action.
- To communicate needed information as it emerges, without leaping to conclusions.

Underlying causes of the challenges

- Existing information systems may not be adequate.
- Existing indicators may not cover all the anticipated results.
- Social indicators may be more difficult to specify and agree on than health, demographic, and financial indicators.
- It is often uncomfortable to communicate negative results.

Strategies for addressing the challenges

- Recognize management information systems inadequacies, agree on an acceptable level of accuracy and timeliness, and remedy deficiencies that can be rapidly improved.
- Add relevant indicators to standard data-collection instruments.
- Establish sentinel surveillance sites between major surveys.
- Seek social indicators from NGOs that provide and assess social services.
- At the start of scale-up, establish a principle of transparent and honest reporting, and make a plan for communicating negative results.

Tools and approaches

- Wolff, James A., Linda J. Suttenfield, and Susanna C. Binzen, eds. "Managing Information" in *The Family Planning Manager's Handbook: Basic Skills and Tools for Managing Family Planning Programs*. W. Hartford, CT: Kumarian Press, 1991.
- MEASURE Evaluation. "Compendium of Indicators for Evaluating Reproductive Health Programs." http://www.cpc.unc.edu/measure/publications/html/ms-02-06.html.
- Population Reference Bureau. "Guidelines for Effective Data Presentations." http://www.prb.org/Content/NavigationMenu/PRB/PRB_Library/Guidelines_for_Effective_Data_Presentations/Guidelines_for_Effective_Data_Presentations.htm.
- East-West Center. "Communication Strategy Worksheets." Summer Seminar. Honolulu: East-West Center, 2004. http://www2.eastwestcenter.org/research/popcomm/.

Illustrative Examples

The following examples show how coordination teams have applied the phases and steps in making important changes in health practices.

Reinvigorating IUD Services in Kisii, Kenya: The ACQUIRE Project Experience

A Community-Based Approach to Preventing Postpartum Hemorrhage: The Indonesia Experience

The Right Provider in the Right Place: Scaling up Primary-Level Postabortion Care in Kenya

Reinvigorating IUD Services in Kisii, Kenya: The ACQUIRE Project Experience

The Context

Despite its proven safety, effectiveness, acceptability, and low cost, the IUD has virtually disappeared from the national mix of modern family planning methods in Kenya over the past 20 years. While the percentage of Kenyan women using any modern contraceptive has more than tripled since 1984, the proportion of contraceptive users choosing the IUD decreased from 31 percent to 8 percent between 1984 and 2003. Despite the increased use of contraceptive methods, as more Kenyan women enter reproductive age, unmet need continues to grow. Limited donor resources and a method mix skewed toward short-term (and more costly) methods compounds this unmet need.

Concerned about this trend, in 2001 the Kenya MOH and partners embarked on an initiative to revitalize the provision and use of the IUD in Kenya as part of a balanced and sustainable contraceptive method mix and within the context of expanding client choice. The MOH undertook several activities to cultivate ownership and consensus among various stakeholders (service providers, trainers, program managers, professional associations, and funding agencies). Global and local research on IUDs was disseminated and discussed during a series of panels and stakeholder meetings. In 2002, an MOH IUD Task Force was established to develop a strategy for the IUD's reintroduction.[12]

The reintroduction strategy was officially launched in February 2003 at the annual conference of East, Central, and Southern African Association of Obstetrical and Gynaecological Societies (ECASOGS). It sought to combine national education and advocacy efforts with targeted community outreach and capacity building in pilot health facilities served by the EngenderHealth-led AMKENI project in Western and Coast provinces. The strategy was designed to address all the barriers to IUD access and use identified by previous assessments by building support for the IUD services among policymakers and program managers, assessing client and provider knowledge, training providers, strengthening service delivery, dispelling misconceptions about IUDs among clients and providers, and improving logistics.

The national reproductive health training curriculum was updated and, over the next two years, was used to train 171 family planning providers in IUD counseling, insertion, and removal. Members of the MOH's recently formed decentralized training and supervision teams also received training before they were deployed to ensure that the pilot facilities had sufficient training, commodities, and supplies to offer clients a full range of contraceptive methods, including the IUD. As a result of their efforts, the number of AMKENI-supported sites with the capacity to

12 Task force members include the AMKENI Project; United Kingdom Department for International Development (DFID); Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ); GngH/MOH; Family Planning Association of Kenya (FPAK); Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO); Division of Reproductive Health, Kenya MOH; Population Council; PRIME/IntraHealth; the United States Agency for International Development (USAID), Africa Population Advisory Committee; John Snow, Inc.'s DELIVER project; Family Health International; Maendeleo Ya Wanawake Organization; Marie Stopes International; and several Kenyan professional organizations, including the Kenya Obstetrical and Gynaecological Society, Nursing Council of Kenya, Kenya Clinical Officers Association, National Nurses Association of Kenya, and the Kenya Medical Association.

provide IUDs rose from 13 in 2001 to 68 by 2003. A national advocacy campaign targeting policymakers, program managers, and providers built support for IUD reintroduction, while a community education campaign led by AMKENI's 500 volunteer behavior change communication (BCC) agents focused on increasing demand for IUD services. From 2003 to 2005, the number of IUD acceptors in AMKENI-supported sites doubled.

Following the June 2004 regional Implementing Best Practices Conference held in Uganda, the Kenya MOH and its partners combined the IUD reintroduction activities with a larger effort to revitalize family planning in six focus districts. Two additional scale-up activities were initiated. First, the MOH and Marie Stopes/Kenya began an IUD social franchising project in two provinces. Second, the MOH Division of Reproductive Health designated Kisii as a seventh district in which to expand access to and use of the IUD, and requested the ACQUIRE Project to assist the Kisii district MOH in establishing sustainable systems and services for IUD provision. This case study describes how that process unfolded at the local level in Kisii as part of the broader national effort.

While data on the prevalence of the IUD in Kisii District is not available, results from the 2003 Demographic and Health Surveys data indicate that IUD prevalence in Nyanza Province (where Kisii is located) is only one fifth the national figure. Unmet need for family planning is also significantly higher in Nyanza Province than in Kenya overall. Approximately one out of three (35%) married women of reproductive age in Nyanza have an unmet need for family planning, as compared with one out of four (25%) married women of reproductive age in Kenya as a whole.

ACQUIRE's response to the request for assistance was an integrated approach that consisted of the following essential programmatic principles:

- identification, adaptation, and use of proven and promising practices;
- applying principles of change management to effect sustained program improvement;
- the use of data for decision-making (especially locally-generated data);
- stakeholder involvement and participation in programming to foster ownership and sustainability;
- a commitment to the fundamentals of care (informed and voluntary decision-making, clinical safety, and quality assurance and management);
- strengthening both supply and demand by taking a holistic, coordinated systems approach.

It should be noted that although this project is designed to address the specific gaps related to the provision and use of the IUD, all work is being conducted in the context of balanced family planning choice.

Process and Experience

Preliminary Phase: Forming the Change Coordination Team

Bringing together the key stakeholders to discuss the state of long-acting and permanent methods and the IUD within the family planning program in Kenya was a crucial first step toward improving program performance. For IUD revitalization to succeed, stakeholders needed to

agree on the need for change and the importance of improving the family planning method mix. Moreover, they needed to make a commitment to implementing changes within the system and individual facilities. To this end, ACQUIRE planned and facilitated a consultative meeting. Participants representing the public sector, NGOs, and private providers were identified and invited by the local MOH.

A core team was set up, including the District Public Health Nurse (DPHN) and the Continuing Medical Education Coordinator from the Kisii MOH. Oversight and support is provided from the national level by the Deputy Head of the Division of Reproductive Health, as well as the National Information, Education, and Communication (IEC) Working Group. This national-level engagement legitimizes the activities in Kisii and demonstrates ownership of the project by the MOH. ACQUIRE/Kenya staff confer with their MOH counterparts on a regular basis, facilitating the implementation of an action plan and helping to resolve problems encountered.

Phase I: Defining the Need for Change

To gauge the status of the program and needs for improvement, a performance needs assessment (PNA) was conducted. The PNA involved stakeholders in gathering data about program strengths and challenges, identifying "root causes," and developing an action plan. The PNA included both supply and demand components, examining all of the elements in the system that needed to be addressed.

In Kisii, the PNA process included three main steps:

(1) An initial stakeholders meeting was held to introduce the PNA process and to reach consensus on the importance of improving family planning in general and revitalizing IUD use to improve method mix and to provide clients with long-term options. At this meeting, the core group defined desired performance.

(2) Data were collected on actual performance in 12 selected health facilities in Kisii (four hospitals, four health centers, and four dispensaries). This task was carried out by a team that included representatives from the national and district MOH levels, facility managers, and the ACQUIRE team. Focus groups with IUD users, non-users, and husbands of IUD non-users were gathered to assess what issues existed on the consumer side that needed to be addressed.

(3) Results of the data collection effort were presented at a second stakeholders meeting. Based on the actual performance data, stakeholders identified and prioritized performance gaps. They analyzed the gaps to determine the root causes of the gap in order to identify the most appropriate interventions for improving performance in regard to the ideal performance levels originally established.

Preliminary action plans were subsequently developed, and the desired change was expressed, discussed, and agreed on in the action plan.

To identify and adapt proven practices, the IBP Task Force was consulted during the project planning phase to review interventions used previously that ACQUIRE might be able to adapt. For example, the IUD advocacy tool/folder developed by the IUD Task Force in Kisii was used for advocacy and sensitization purposes.

Effective Application of Best Practices

- Getting commitment from political stakeholders. Political commitment among high-level, national, and local decision-makers helped ensure availability of resources for IUD services.
- Involving the community. The program features a strong community component. Trained and mobilized community-based distribution agents—a corps of peer educators from local community organizations trained to do outreach, talks with women's groups, and community-level promotional events—are expected to contribute to program ownership, buy-in, success, and ultimately, sustainability.
- Getting input from individual stakeholders. Client and provider beliefs affect service use and availability. Qualitative investigations among clients, providers, and communities yielded information on what motivates each of these groups and their circles of influence. Each of these groups reviewed the program design and communications materials.
- Integrating supply and demand. Supply and demand components of service programs should be considered in tandem. For example, provider champions are often instrumental in recruiting clients; their buy-in and acceptance of the communications campaign is important to ensure that they give information consistent with the messages clients are hearing on the radio and in the community. All ACQUIRE promotional messages channel clients to sites where services are being strengthened.

Phase II: Planning for Demonstration and Scale-up

Champions were identified and appointed by local partners. The main contact, the DPHN referred to above, was deemed to be both interested in the topic, competent, and to have the time to address this in her work.

Planning for scale-up was done from the start. Action plans were defined by stakeholders. A concept paper allowed ACQUIRE and other stakeholders to assess lessons learned and best practices, looking at work from the IBP districts and allowing us to replicate the program as efficiently as possible.

We agreed with the MOH at the national and district levels that while we were asked to develop a communications campaign for use in Kisii, the campaign materials should be adaptable for use in any part of the country. Listings of facilities offering IUDs were printed separately, so that they could be changed and adapted for use in other districts.

Phase III: Supporting the Demonstration

The Kenya IUD initiative has champions at all levels—national, district, local, site. We will be supporting champions by showcasing them in our media and public-relations activities, highlighting the successful changes achieved by certain providers, facility teams, community-based distribution (CBD) agents, community peer educators, and satisfied clients.

Supervision and support systems have been built into the project, including bimonthly facility visits by the local DPHN/project manager and by a BCC consultant, who will check in with providers about equipment availability, inquire about any problems and needs, replenish IEC materials as needed, observe community-level activities, and collect records of community-level out-

reach. These supervisory visits will identify any problems, support areas of need, and reward champions and others with thanks for a job well done. Refresher training will be conducted as needed.

Phase IV: Going to Scale with Successful Change Efforts

An expansion project has been proposed that would adapt the model piloted in Kisii to five additional districts, as well as support scale-up of project activities in Kisii. If funded, the work will be planned closely with regional, national, and district MOH management systems in order to integrate and build local resources for the institutionalization and sustainability of these activities.

The scale-up project would begin with a meeting of local and national stakeholders to analyze the results of work conducted to date, identify the most successful tools and project components, and share lessons learned. Findings will be gleaned from work done to address barriers to IUD access and use by partners in AMKENI, the ACQUIRE Project, and the National IUD Task Force/IBP initiative, and the process will benefit from the birds-eye view of the Kenya MOH's Division of Reproductive Health, donors, and other stakeholders.

Measuring and communicating the results will happen in a future phase. ACQUIRE will complete a case study towards the end of the Kisii project that will evaluate the initiative, exploring best practices and lessons learned that can inform scale-up decisions.

A Community-Based Approach to Preventing Postpartum Hemorrhage: The Indonesia Experience

The Context

Postpartum hemorrhage (PPH) is the largest direct cause of maternal death in developing countries. PPH is defined as excessive bleeding during the third stage of labor (the time period between the birth of the infant and the delivery of the placenta). The amount of blood lost depends on how quickly the separation and delivery of the placenta occur. If the uterus does not contract normally, the blood vessels at the placenta site do not adequately contract, and severe bleeding results.

Even if the new mother does not die, PPH cases can leave her too weak and anemic to enjoy and care comfortably for her baby. To prevent death or incapacity, PPH often requires emergency care, including blood transfusions, which are expensive and/or unavailable in many rural areas.

Studies have shown that 60% of PPH can be prevented by active management of the third stage of labor (AMTSL) to help the uterus contract more quickly by:

- administering a uterus-contracting drug within one minute of the birth;
- applying controlled cord traction and counter-traction to the uterus;
- massaging the fundus of the uterus through the abdomen;
- monitoring for further signs of bleeding within two hours.

The most commonly used drug in AMTSL is oxytocin, which must be injected by a trained, skilled health worker. But many studies have demonstrated that misoprostol, which can be administered orally, is equally safe and effective and has the advantages of being less expensive and not requiring cold storage.

In 2002–2003, with USAID support, JHPIEGO carried out a demonstration study in rural West Java, Indonesia, to prevent PPH among women living in areas where a high proportion of births are not attended by skilled providers. The purpose of the study was to demonstrate the safety, acceptability, feasibility, and program effectiveness of an intervention in which trained community volunteers provided women with information about preventing PPH, distributed misoprostol to pregnant women, and provided follow-up support.

The Process and Experience

Preliminary Phase: Forming the Change Coordination Team

Before data collection began, an extensive infrastructure was put in place to coordinate and monitor the project. This included a National Steering Committee made up of stakeholders with strong professional reputations and national influence, including the Director General of Public Health and a representative of the National Society for Obstetrics and Gynaecology. This team

obtained the required ethical reviews and obtained MOH approvals at the national, provincial, and district levels.

Phase I: Defining the Need for Change

The steering committee, acting as the coordination team, was well aware of the problem: Half of maternal deaths in Indonesia related to pregnancy and childbirth were due to PPH, and even when it does not result in the death of the mother, PPH gives a poor start to the baby's life and is the source of serious physical, emotional, and financial stresses for a mother and her family. Despite ongoing efforts to promote the advantages of giving birth with a skilled provider in attendance and extensive training of community midwives to practice AMTSL, the coordination team knew that nearly half the women in the area had unattended births in their homes. The challenge was to find a way to reduce PPH without access to sophisticated health services.

Phase 2: Planning for Demonstration and Scale-up

The coordination team identified a principal investigator to play the role of change agent, overseeing and leading the implementation of the new set of practices in the selected West Java communities. An obstetrician/gynecologist with strong academic credentials and practical experience, he oversaw the demonstration of these new practices, with the assistance of a change team composed of a field epidemiologist, a study manager, and a counterpart principal investigator from JHPIEGO.

The coordination team, change agent, and change team were fully informed of the relevant effective practice: AMTSL, endorsed by the International Confederation of Midwives and International Federation of Obstetricians & Gynecologists, and used in Western countries and, increasingly, in developing countries. For this rural setting, they adapted the usual practices, which involved administration of either oxytocin (in conjunction with other components of AMTSL) by a trained midwife or misoprostol by the woman herself, immediately after birth. At both demonstration and comparison sites, a trained community volunteer (kader) offered counseling on the dangers and prevention of PPH as soon as she identified a pregnant woman. At the demonstration sites, the kader distributed misoprostol during the eighth month of the pregnancy and provided a second round of counseling.

The demonstration was designed to show whether this new practice could overcome potential obstacles: Could community health workers properly train volunteers? Would mothers accept the misoprostol and be willing to take it on their own? Could they use misoprostol safely and effectively where no trained birth attendant was available? Could counseling mitigate the negative impact of such side effects as shivering, fever, cramping, and nausea? As one approach to overcoming these obstacles, there were extensive stakeholder discussions and consultations as the study was being proposed and designed. Physicians, nurses, midwives, women's groups, community and informal leaders, kaders, and government officials participated in these discussions.

Trained community volunteers made home visits to pregnant women and recruited them into the study. Verbal informed consent ensured that women could refuse to participate in the study and yet benefit from counseling about the risks and danger signs of PPH as well as access to free medical care in cases of a referral. In the demonstration area, volunteers offered additional information about the timing and safe use of misoprostol and the risks associated with taking

the tablets too soon. The side effects of misoprostol were described, as well as steps to alleviate these effects. The pre-packaged packets of misoprostol also included a safety reminder card.

Looking ahead to the possibility of a successful intervention, the MOH began to consider scale-up during this phase, proposing an incremental expansion of misoprostol distribution for home births that are not attended by a skilled attendant.

Phase 3: Supporting the Demonstration

During and after the intervention, the field study team conducted interviews to collect information on the safety, acceptability, and feasibility of taking misoprostol. An obstetrician investigated all serious complications that occurred during childbirth. In addition, in-depth interviews were conducted among husbands, support persons, *kaders*, community midwives, and traditional birth attendants.

Phase 4: Going to Scale

The measures of program effectiveness used to evaluate the change intervention were impressive:

- Coverage of the population with oxytocin or misoprostol was significantly higher in the demonstration area (93.7%) than the comparison area (76.8%).
- The number of emergency referrals due to birth complications was less than 10% (176 of 1,811), with only 47 emergency referrals suspected to be PPH.
- Significantly fewer women in the demonstration area had emergency referrals for any birth complication, including PPH. Adjustment for differences in age, parity, education, economic status, and antepartum hemorrhage history showed that women in the demonstration area, were:
  - 25% less likely to perceive excessive bleeding;
  - 30% less likely to need an emergency referral to a health facility;
  - 45% less likely to need an emergency referral for PPH.

The PPH study established the safety of home-based community distribution of misoprostol. Study participants were able to repeat safety information after receiving counseling from the trained kaders. Women understood that they should seek care if excessive bleeding occurred with or without use of the intervention drug. None of the study participants who used misoprostol required referral for additional care because of increased symptoms or side effects following childbirth.

The demonstration study concluded that the intervention was acceptable. Trained and supervised kaders successfully provided counseling and information on prevention of PPH, and then safely distributed misoprostol. Women were aware that the medication might result in some short-duration side effects and knew what to do if side effects occurred. Most participants and their families had favorable comments about the counseling intervention and drug use to prevent PPH, and a large proportion of users stated their willingness to take misoprostol in the next pregnancy, recommend it to a friend, and pay for it.

At the conclusion of the study, the steering committee met and took several steps to facilitate scale-up:

- recognized that PPH is still a major preventable cause of maternal mortality in Indonesia;
- presented key findings of the PPH study to the Minister of Health;
- recommended an expansion of the PPH preventive health strategy;
- disseminated the study results widely;
- advocated for commitment from regional health authorities and donors.

As a result of the proven success of this change process, the MOH is implementing an action plan for wider implementation of the plan for community-based use of misoprostol for PPH prevention. Results of the study are being disseminated to provincial and district governments. As part of the dissemination, the central MOH is emphasizing two key messages: 1) implementation must include the training of health personnel, with an emphasis on how to counsel pregnant women, and 2) systems for strict monitoring of misoprostol supplies must be established, with the head midwife of each community health center held responsible and accountable. Local implementers have to develop their own locally adapted ways of identifying and contacting pregnant women, using the West Java experience with community volunteers as an example. The central MOH also recommends strongly that documentation systems be established to monitor safe use of misoprostol, and if misoprostol is given to women during pregnancy, that they must be counseled on its safe use.

As a result of the steering committee's efforts, the Minister issued an official resolution in July 2003 that called for incorporating the dual options for PPH prevention (AMTSL and community-based distribution of misoprostol) into the national health strategy. To ensure the availability of misoprostol and its distribution to peripheral health facilities, the MOH is working to order the drug in bulk and repackage it for purposes of PPH prevention. The MOH and JHPIEGO are also working to further emphasize PPH prevention in the birth preparedness campaign.

After disseminating the model to local governments, the MOH has now implemented the program in 15 districts in seven provinces, and plans to identify a few districts in different regions of the country in which to roll out the intervention. Expansion will be done incrementally from each district within its region. Specific line items of the budget are being prepared for socialization, preparation/adaptation of training materials and job aids, preparation of monitoring tools, and training of midwives and community volunteers as well as for procurement and repackaging of misoprostol. Recently, the national-level budget was authorized and meetings have been conducted with West Java provincial and district officials who have developed a plan of action for that province. Drug procurement efforts have begun and are ongoing.

The above example was taken from "Prevention of Pospartum Hemorrhage Study, West Java, Indonesia." The study was the product of a collaboration among members of Depkes (Ministry of Health) Indonesia; POGI (the Indonesian society of Obstetrics and Gynecology); and JHPIEGO, and was supported by funding from USAID's Maternal and Neonatal Health (MNH) Program. Authors of the study were Harshad Sanghvi, Gulardi Wiknosastro, Gail Ghanpong, Joy Fishel, Saifuddin Ahmed, and Mohammed Zulkarnain.

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The Right Provider in the Right Place: Scaling-up Primary-Level Postabortion Care in Kenya

The Context

Complications from unsafe or incomplete abortion are a major cause of hospital admissions and maternal mortality in Kenya, and strain the already overburdened public-sector health care system. The 2004 report, "A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya," indicated that more than 300,000 unsafe abortions are performed in the country each year, causing an estimated 20,000 women and girls to be hospitalized with related complications (these include long-term consequences such as chronic pain, pelvic inflammatory disease, tubal occlusion, and secondary infertility).

In an effort to foster positive change in the availability and use of postabortion care (PAC) services and decrease the chances of repeat abortion among PAC clients, IntraHealth International and partners in the PRIME and PRIME II projects developed a pilot program to train private-sector nurse-midwives in PAC services. Through the Nursing Council of Kenya (NCK), the nurse-midwives themselves had asked PRIME to help them respond to the needs of women suffering from abortion complications, after several Nairobi-based nurse-midwives attended a seminar on PAC held by PRIME in early 1997. Following the two-year pilot program (1998–2000), PRIME II implemented a scale-up in two phases from 2000 to 2004.

Private nurse-midwives are an ideal cadre for scaling-up PAC services in Kenya as they are the major source of prenatal care, family planning, and other reproductive health services in many parts of the country. Their role at the primary level meshes with the Government of Kenya's strategy to decentralize health care and expand the role of the private sector in the delivery of health services. Because many private nurse-midwives own their facilities, they represent the potential for a national, financially sustainable base of non-hospital PAC services. Perhaps most importantly, they are experienced providers who must spend ten years in public, private, or mission institutions before being licensed for private practice.

The pilot program introduced a comprehensive approach to primary-level PAC services. In addition to providing treatment for potentially life-threatening complications from unsafe or incomplete abortion, the nurse-midwives counsel clients about family planning and contraceptive options and provide or refer for methods to help clients prevent future unintended pregnancies and practice birth spacing. The nurse-midwives also offer selected reproductive and other health services either at their clinics or via referral to another facility accessible to the client.

The strategy to reach underserved populations of Kenyan women with PAC services relies on building community support and awareness, especially since PAC services have the potential to become controversial and even confused with abortion itself. Maintaining the confidentiality of clients and providing nonjudgmental counseling and treatment are essential to ensure that women in need seek these services.

The Process and Experience

Preliminary Phase: Forming the Change Coordination Team

Funded by USAID, the pilot program designed by PRIME was sanctioned by the MOH and supported by NCK, which licenses the private nurse-midwives, and the National Nurses Association of Kenya (NNAK), a professional association. Support from provincial directors of health and district medical officers was also essential. Effective collaboration among the PRIME and PRIME II partners, the MOH and NCK, and the trained nurse-midwives proved vital to achieving a sustainable and replicable program. As part of the change coordination process, PRIME assisted the MOH in developing PAC performance standards for health workers in Kenya.

Phase I: Defining the Need for Change

Before launching the pilot program, PRIME conducted a baseline assessment to gauge both the potential of the private nurse-midwives to offer PAC services and the acceptability at the community level of the provision of PAC by nurse-midwives. Results of this assessment factored into the design of the approach for training and supporting the providers in the pilot program.

Phase II: Planning for Demonstration and Scale-up

In addition to being certified by NCK for private practice, nurse-midwives were required to satisfy several other criteria in order to be considered for participation in the pilot program. Their facilities had to meet minimum standards for sanitation and have running water and essential equipment, adequate space to ensure client privacy and confidentiality, and access to the basic infrastructure for restocking supplies and making referrals. The nurse-midwives had to demonstrate an interest in PAC services and show that they were already integrating other reproductive health care into their prenatal and delivery services.

As part of a strategy to promote the financial sustainability of the pilot program and projected scale-up, the private nurse-midwives shared the cost of training, paying for their own transportation, room, and board. Training took place in Nairobi so that the providers could benefit from PAC clinical training opportunities at Kenyatta National Hospital, with its high caseload of postabortion clients. By training providers 10 at a time in groups from the same geographic areas, PRIME endeavored to keep the sessions intimate and encourage post-training peer support. Training concentrated on 13 key components:

- introduction and clarification of values;
- client-provider interaction and counseling;
- management of complications from unsafe or incomplete abortion;
- manual vacuum aspiration (MVA) procedures;
- infection prevention;
- pain management;
- postabortion family planning and method provision (including emergency contraception pills);

- STI/HIV management;
- record-keeping;
- legal aspects of providing PAC services;
- introduction to peer supervision;
- community outreach and participation;
- performing practical procedures under supervision.

Phase III: Supporting the Demonstration

Key priorities to support a successful pilot program with potential for scale-up and sustainability included enhancing supervision, promoting cost-share, and building and maintaining community support and awareness for PAC services.

Follow-up and post-training support to providers at their facility is important to ensure high-quality PAC services. Providers may need help in incorporating elements of PAC into their ongoing range of services, or may need assistance in reorganizing services. Establishing a viable supervision and support system for the trained nurse-midwives presented a challenge as their formal supervisors, DPHNs, were overworked with public-sector responsibilities and often faced logistical problems such as not having enough fuel to drive to the nurse-midwives' facilities. Furthermore, PRIME did not have adequate staffing to provide sufficient post-training support. To supplement efforts by the DPHNs and visits from PRIME staff, nurse-midwives were encouraged during training to support one another as peers and to build, strengthen, and expand their own provider peer networks, or clusters, to help solve problems, share information, and pool resources.

As mentioned earlier, providers shared the cost of their training. While providers participating in the pilot program received MVA kits free of charge, private nurse-midwives later purchased MVA kits at a subsidized rate (about one-fifth of the market price) from Ipas' in-country distributor. Cost-sharing also occurred with training in Norplant, with nurse-midwives paying a tuition fee to the training organization and PRIME and NNAK facilitating the process of selecting appropriate candidates for training.

During the pilot program and scale-up, the POLICY Project conducted community advocacy to promote PAC services as a means of addressing the problem of death and disability from unsafe abortion. Extra effort on community outreach for PAC was made in conjunction with the training of providers during scale-up.

Phase IV: Going to Scale with Successful Change Efforts

The pilot program at 44 facilities in three provinces (Nairobi, Central, and Rift Valley) clearly demonstrated that private nurse-midwives are capable of delivering comprehensive PAC services, that women with abortion complications will access and use the private sector for PAC services, and that this care can increase the accessibility and use of family planning.

During the initial two-year scale-up in the same three provinces, 155 trained providers successfully treated more than 1,600 women with postabortion complications using MVA and counseled 81% of these women in family planning, resulting in 56% leaving with or agreeing

to return for a family planning method. The subsequent scale-up in Coast Province resulted in the training of 101 private nurse-midwives and clinical officers. More than 650 clients received treatment for complications, with 98% being counseled in family planning after the procedure and 72% accepting a family planning method.

Data were also collected during scale-up activities on reproductive health and other health services offered to women postabortion. Records show that three-quarters were counseled on STI/HIV prevention and/or treatment. Around half received counseling and screening for breast cancer and nearly 40% received counseling about the need to screen for cervical cancer. Half of the women also received nutrition counseling.

The peer support clusters established by the nurse-midwives proved to be a promising approach for enhancing supervision and support. For example, one large cluster developed during PRIME II later added two branches registered with the government under social services, raised funds for facility improvements and investments, and established a continuing education program for its members.

However, an evaluation of the initial scale-up found that as many as 20% of the providers who were trained in PAC did not offer the service post-training. The evaluation found that provider attitudes contributed to whether or not a provider will offer PAC services. Further evidence from trained nurse-midwives indicated that PAC services might not be profitable, which could discourage providers from offering the service.

To document the key determinants for further scale-up of PAC services in Kenya, PRIME II assisted in a 2004 study that used a provider survey and case studies to identify the factors contributing to the sustainability of PAC services. These included provider attitudes, competition, business acumen, range of services offered, quality of services, and participation in peer support networks. The study recommended strengthening providers' business and management capacity, identifying an organization to represent providers' needs, redirecting PAC advocacy to be more broad-based, supporting provider peer clusters, linking providers to ready sources of capital, and fostering an appreciation for monitoring and evaluation among PAC providers. The study concluded that PAC services can be sustainable if the provider's facility is viable, but that private providers need technical assistance in improving general business practices and stronger initiatives to enhance understanding and acceptance of PAC services in the community.

IBP Initiative Consortium Members

Academy of Education and Development

CARE International

Centre for African Family Studies (CAFS), Nairobi, Kenya

Centre for Development and Population Activities (CEDPA)

CORE Consortium

EngenderHealth

Family Health International (FHI)

Innovative Technologies for Health Care Delivery (IntraHealth)

Institute for Reproductive Health, Georgetown University

International Council on Management of Population Programmes (ICOMP), Malaysia

International Planned Parenthood Federation (IPPF), London, United Kingdom

Johns Hopkins Program of International Education in Gynaecology and Obstetrics (JHPIEGO)

Johns Hopkins University/Bloomberg School of Public Health Center for Communication Programs (JHU/CCP)

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White Ribbon Alliance

The following partners collaborated on the preparation of this Guide on behalf of all partners of the IBP Initiative:

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