

# Guide to fostering change to scale up effective health services





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

*-Charles Darwin*

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## Introduction to the Guide to Fostering Change

This guide is based on the recognition that change is inevitable for survival and that directed and planned change has a much greater chance of success than ad hoc attempts to introduce new practices. Everyone working to improve health, including donors, researchers, technical experts, service providers and advocates at the global, national, district, community and family level is 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 innovations.

### Purpose of the Guide

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

- Describing principles fundamental to effective change.
- Increasing awareness of proven approaches to effective change.
- Providing “how-to” steps for successful change including scale-up.
- Describing key challenges of scaling up and recommending strategies, tools or approaches for meeting those challenges.
- Offering cases that show how the steps have been implemented in real-life situations.

### Audience for the Guide

This guide is for policy-makers, programme managers, operations researchers or other health professionals who want to bring about change in a health practice or set of practices. Changes in health practices can 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 might initiate the provision of insecticide-treated bed nets to reduce infant deaths from malaria or the provision of MgSO<sub>4</sub> to prevent deaths from eclampsia.

But sometimes the change “bubbles up” from the staff of a health facility seeking to address a service delivery challenge. There are many examples of hospital directors who introduced proven practices to reduce infection rates or clinic nurses who mobilized their staff to improve counselling to increase family planning acceptors.

A range of groups can act together as a Change Coordination Team to support change, including international, regional and country members of the IBP Consortium; representatives from Ministries of Health and other government ministries; non-governmental organizations (NGOs) and faith-based organizations (FBOs); regional and country WHO, UNFPA, and IPPF offices; USAID missions; and regional and country offices of USAID cooperating agencies and other donors and decision makers. Active players in a successful change process often include representatives of national, regional or institutional organizations who are in a position to support the change as part of the coordination team, as well as those who are implementing the change on the ground at a programme level, service delivery site or in the community.

### About the IBP Consortium

The IBP Initiative is a global partnership involving 38 international agencies dedicated to demonstrating a dynamic model of international and local cooperation to:

- Encourage the introduction, adaptation, utilization, scaling up and monitoring of proven technical and managerial practices to improve utilization and the quality of reproductive health services.
- Promote evidence-based provision of quality services.
- Support ministries of health or other national bodies to facilitate the coordination of partners implementing reproductive health activities in-country.
- Reduce duplication of effort.
- Harmonize approaches and identify synergies that can accelerate the implementation and scaling up of effective practices.
- Promote creativity and innovation.
- Sustain momentum by keeping networks connected and communicating.

The IBP Initiative was started 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 task teams on specific assignments identified by partners as contributing to our goal of improving access to quality reproductive health and family planning services.

The IBP partners identified a key missing link between introducing and effectively implementing best practices: the ability to foster, lead and manage the change process required to implement effective practices and improve quality and performance. The IBP Task Team undertook a consultative and collaborative process to develop *A Guide for Fostering Change to Scale Up Effective Health Services*, published in 2007, that built on the large body of knowledge on change management.

In 2012, a task team surveyed users and non-users of the 2007 Guide and reviewed recently published guidelines and tools for effective change to produce this revised guide. The updated Guide provides a pathway that links proven change practices to “how to” steps for successful change. In addition, the Guide references key managerial tools produced by IBP partners that can support the implementation of the change process.

All IBP partners are encouraged to support the dissemination and use of the revised *Guide to Fostering Change to Scale up Effective Health Services* at the country level through their networks, projects and programmes.

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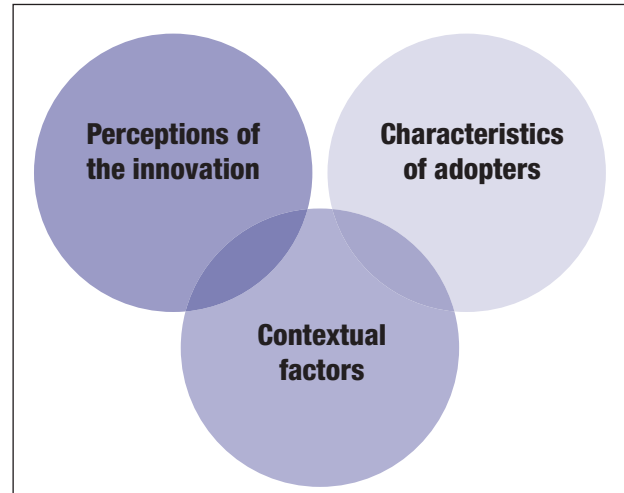
## Leading Changes in Practices to Improve Health

Change is not easy. Only a small percentage of efforts to change or scale up a practice meet expectations. Studies have shown that change efforts fail more often than they succeed.<sup>(1)</sup> Effective change management, often termed *diffusion of innovations*, is a science that has been studied and documented by many people.<sup>(2, 3)</sup>

One thing is clear: developing an effective process for change helps avoid the chronic mistake of underestimating what it takes to make change stick. Establishing a systematic approach to managing change is a critical factor for successfully adapting, implementing, scaling up and sustaining best practices.

In his book *Diffusion of Innovations*,<sup>(2)</sup> Everett Rogers discusses a theory of effective change and describes how innovations are spread and how the process of change works. Rogers describes three main clusters of influence (Figure 1) that relate directly to the rate of adoption or diffusion.

Figure 1. Clusters of Influence



## Consider Perceptions of the Innovation

According to Everett Rogers, adopters' perceptions of an innovation predict the extent of an innovation's adoption. Rogers stated, "The greater the perceived advantage, the more rapid the adoption." (2) Building on the work of Glaser et al., (4) the ExpandNet/WHO publication *Nine Steps for Developing a Scaling-Up Strategy* presents an approach to assessing the potential of an innovation to be successfully implemented: CORRECT.

Decades of work on the diffusion of innovations and documentation of international experience with scaling up have confirmed that innovations with the following seven CORRECT attributes are most likely to be successfully transferred to individual users or user organizations.

**Credible.** Adopters want strong evidence that an innovation will work. Innovations should be based on sound evidence and should be advocated by respected persons or institutions, or both.

**Observable.** Potential users would like to see the innovation in practice. Testimonials, study tours and peer-to-peer education work well because they give adopters a chance to see for themselves what to expect.

**Relevant.** Just because an innovation works well with one population does not mean it will work for everyone. An innovation should be designed for the context in which it is being introduced, and it should address persistent challenges.

**Relative Advantage.** Another important variable is how potential users perceive the benefit of the innovation. Is the perceived benefit greater than the perceived time and effort adoption of the innovation requires? Is it better than existing practices?

**Ease of transfer.** Research shows that potential users are more likely to adopt the innovation if it is simple and easy to implement. Innovations often spread faster or can be scaled up more quickly when they are simple rather than complex.

**Compatible.** Is the innovation compatible with the values, beliefs, history and needs of the potential users? Potential users will more readily adopt innovations that align with their values and meet their needs or the needs of their organization.

**Testable.** The innovation is more likely to be adopted if the potential users can test the innovation on a small scale to see if it really works in their context. This step is essential to reduce fears and increase ownership.



Perceptions of the innovation are also influenced by the level of communication with, and support for, staff throughout the change process and by the organizational culture.

### *Encourage Staff Buy-in and Acceptance of Assigned Responsibilities*

It is crucial to gain staff buy-in, clarify staff responsibilities for implementing the change and encourage staff to accept the change. If staff members are to be held accountable for implementing the change, they need to:

- Understand how they will benefit professionally from this change
- Understand how the change will improve client services
- Recognize the urgency and priority of the proposed change
- Have access to the information, resources and skills needed to fulfil their new responsibilities
- Integrate the new responsibilities into their performance expectations
- Be held accountable for their role in the change effort

### *Promote an Environment that Encourages Change*

Organizational culture is the shared work values, beliefs, assumptions and traditions that have kept an organization alive and are considered the appropriate ways to handle day-to-day interactions and activities. Consider your organization's culture with respect to change. Organizations that are generally open to change have more success introducing and scaling up new evidence-based practices than organizations that resist change and have little experience with successful change.

## Identify the Characteristics of Potential Adopters

Many players are involved in the process of introducing a best practice or set of practices.

**Beneficiaries** will benefit from a new service or product.

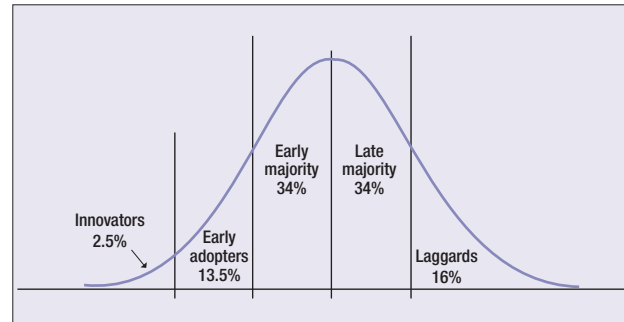
**Health service providers** will implement the new practice or set of practices.

**Managers and leaders** within and outside the organization will provide the necessary support for implementation.

**Policy-makers** provide highly valuable support for scale-up efforts.

Examining the characteristics of these different potential adopters can be quite useful in shedding light on how they can influence the rate and success of adoption. The general population can be divided up into five groups according to their willingness to adopt innovations (Figure 2).

Figure 2. Willingness to adopt



The **innovators**, only 2.5 percent of the population, are risk takers or risk tolerant. They like to try new things and can be seen as strange or reckless.

**Early adopters** are a larger group at 13.5 percent of the population. Early adopters are well-known opinion leaders. Because of their leadership, early adopters command attention and respect, and they function as cross-pollinators. Like bees fertilize flowers by bringing pollen from one flower to another, early adopters spread new ideas from innovators to others.

The **early majority**, 34 percent of the population, learn from others and are somewhat more risk averse than innovators and early adopters. Members of the early majority observe and then follow the early adopters.

The **late majority**, also 34 percent of the population, adopt an innovation once it has become the status quo or a standard of practice in the community. They need proof before accepting an innovation.

**Laggards, or traditionalists**, represent 16 percent of the population. While change agents should strive to understand and address their concerns, they should not be fixated on convincing laggards to adopt the innovation.

Any change coordination team should develop a strategy that involves different actors in the process of implementing the best practice or set of practices. The strategy must include ways to reach the different types of people who typically work in an organization.

### *Mobilize Opinion Leaders*

Begin by bringing on board the opinion leaders – the adventurous innovators who spearhead new practices – and the early adopters, who are not far behind. These supporters are quick to envision how a new practice will help them reach their goals.

### *Encourage Others to Follow*

Encourage the opinion leaders to mobilize the majority of staff – the early and late majorities – to understand and adopt the new practice or set of practices. This majority will need to understand how this practice or practices will address important organizational challenges that affect their work, how their acceptance is linked to their own standing within the organization, and how the practice will help them improve client care. In other words, they need to understand “what’s in it for them.”

### *Address Slow Changers Indirectly*

Finally, studies on the diffusion of innovations show that a small percentage of almost any group lags behind in making the change. Do not focus your efforts on this small group of traditionalists, or laggards, but let the improved results eventually pull this group forward. When the change in practice becomes official, changes in expected standards and performance will motivate slow changers to adopt the new practice.

### *Address People’s Reactions to Change*

As word about the proposed change spreads, not everyone will immediately perceive its benefits or commit to supporting it. Change has been likened to a trapeze act: Author Marilyn Ferguson once said, “It’s not so much that we’re afraid of change or so in love with the old ways, but it’s that place in between that we fear. . . It’s like being between two trapezes.” This is especially true if the change involves risk.

A successful change agent recognizes how different individuals are likely to react to the change and take this into account when planning and implementing the new practice. A staff member’s reaction will depend, in part, on how much he or she believes the change will affect his or her job or status. Some people initially respond to change by denying and resisting it. Under effective leadership, most people are willing to explore the change and its implications, and, ultimately, accept and commit to the change. Effective change agents understand these stages, recognize where people are in accepting change and know how to help them move from denial to commitment.

Figure 3 summarizes typical reactions to change and offers productive responses to people’s fears and concerns to help them move forward in the change process.



Figure 3. Dealing with individual responses to change

Dealing with individual responses to change			
FOCUS ON PAST	<p><b>DENIAL</b></p> <p>Change agent strategy</p> <ul style="list-style-type: none"> <li>• provide information on need for change</li> <li>• reinforce that change will happen</li> </ul>	<p><b>COMMITMENT</b></p> <p>Change agent strategy</p> <ul style="list-style-type: none"> <li>• validate commitment</li> <li>• set long-term goals</li> <li>• let people manage themselves, providing support when requested</li> </ul>	FOCUS ON FUTURE
	<p><b>RESISTANCE</b></p> <p>Change agent strategy</p> <ul style="list-style-type: none"> <li>• create opportunities for expressing fears and doubts</li> <li>• show empathy with people's concern</li> <li>• resist the impulse to explain or defend</li> <li>• build supportive coalitions and find individuals who can influence individual resisters</li> </ul>	<p><b>EXPLORATION</b></p> <p>Change agent strategy</p> <ul style="list-style-type: none"> <li>• make available opportunities and resources</li> <li>• involve people in planning</li> <li>• encourage people to get together and support one another</li> </ul>	

Source: Leading Change. *The Manager*. Management Sciences for Health, 2005.

**Denial:** Initially, some people are uncomfortable giving up what is familiar. They might deny that the change will happen and hope they can continue operating as they always have. To address denial, provide clear information. State unmistakably when and how the change will take place, and offer coping mechanisms.

**Resistance:** Some people resist change by questioning whether it will succeed, wondering about their ability to cope and worrying about their job security. Create opportunities for staff members to express their anxiety, and listen attentively to their concerns. Resist the impulse to defend the change. Instead, show compassion and respect for people's feelings of loss and worry. A stakeholder analysis can help you understand existing incentives that might cause resistance to the change and inform the creation of coalitions that will support the change. These exercises will reveal supportive individuals who can approach likely resisters and persuade these resisters to join them.

**Exploration:** Having had the opportunity to express concerns, people will be more likely to explore the possibilities that the changes could bring to their work, even if they are still apprehensive about how they will be personally affected. A change agent should provide opportunities and resources for discovering what is possible. At this stage, involve your staff in planning for the new practice: establishing priorities, setting short-term goals and offering training. Encourage people to prepare themselves in teams and to support one another.

**Commitment:** When people recognize and understand the benefits of the new practice for their client services, for the organization, and for themselves, they commit to the change. They accept the new practice, are ready to comply with its requirements, and commit themselves to carrying it out. You no longer need to "manage" the change process, for if you validate and reward their commitment, people will manage themselves. Set long-term goals, provide whatever support is needed and then get out of the way.

## Create a Supportive Context: Principles of Fostering and Leading Change

The principles presented in this section of the Guide are applicable to all actors in the change process. 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. His Eight Steps for Organizational Change (1) are widely viewed as the framework for successful change at all levels of an organization.<sup>1</sup>

### *Principle 1: Change must matter to those making the change*

To foster change and create a sense of ownership among staff, those leading the process must clearly convey how the innovation will benefit the implementers of change – those who must actually alter the way they do their work at a service delivery site – and the clients they serve.



### *Principle 2: A credible, committed change agent is critical for change in health practices*

Change agents facilitate the development, application and advocacy for new practices. They transmit their commitment and enthusiasm to those who do the day-to-day work, resulting in the implementation and institutionalization of

<sup>1</sup> 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.

new practices.<sup>(6)</sup> Successful change agents work with management to support staff in the change effort. Their skills and temperament lead teams to achieve results.

An effective change agent is well respected inside the system so that the new practice is linked with someone credible and familiar with the organization's staff and operations. Studies of successful change show that *early adopters* possess the characteristics and credibility to influence others (2). Early adopters are typically the most effective internal change agents.<sup>2</sup>

Change agents cannot succeed alone; implementing change requires a team approach. Change agents are more successful when they are embedded in a team that is well supported by leaders and decision makers to work with a unified purpose and clear direction.

### *Principle 3: Supporting the change agent gives the agent the credibility and confidence to lead*

Those who are in positions to foster change can strengthen the efforts of local change agents by providing them with data and resources that support the innovation. They can also share knowledge about pathways to successful change, including the necessity of planning for sustainability and future scaling up from the beginning of the programme.

### *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:

1. 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."

<sup>2</sup> 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.

2. Leading change is part of ongoing practice: staff are encouraged to make small, practical improvements, not just to undertake big changes in a crisis.
3. Working teams are designed to bring together people with varied and complementary perspectives.
4. Staff are rewarded or acknowledged for asking questions, taking risks and challenging the status quo in order to better fulfil the organization's mission.
5. Staff members trust the people who are promoting change. (6)

Change is an ongoing process, and building these characteristics can help with current and future initiatives.

***Principle 5: Clarity about the purpose, benefits and results of the change is necessary***

Those implementing the change should ensure that it meets the CORRECT criteria described in the section of this guide titled Consider Perceptions of the Innovation. Early success reinforces motivation for continued investment and energy.

Measurement and data will help staff see evidence of improvement. Small-scale trials lessen risk and influence adoption by individuals, especially if the demonstrator is an opinion leader. (6) In ongoing measurement and course corrections, it has often been observed that failing on a small scale leads to greater success than starting with large, expensive, untested programmes.

***Principle 6: Motivating and supporting staff throughout the change process will help 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. Supporting the implementers throughout the change process, including scale-up, can significantly increase their motivation and the likelihood of institutionalizing the change. Interpersonal communication is critical to the adoption of new practices and behaviours.

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

When roles and responsibilities for instituting change are laid out clearly, and measures are put in place to monitor progress,

accountability for continuing progress is maintained. One obstacle to successful change is failure to incorporate new behaviours 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 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***

Top-level leadership must be supportive for change to succeed. This is especially true in scaling up change throughout and beyond an organization. But many successful changes have started in a small corner of a hospital, health or community centre, 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. Documented evidence of success is often what convinces higher-level decision makers to support institutionalization. If you cannot begin with top-level support, it is useful to progressively enrol people at higher levels as you demonstrate success.



## A “How To” Process for Fostering Change

The process detailed in this guide is directed at individuals and teams who wish to initiate and support a needed change in a health practice or set of practices. A change coordination team can form in two ways:

1. The team might be established in direct response to a practice or practices that could be improved, before a change agent has been selected.
2. The team might form to support a change agent who has already been identified to carry out an agreed-upon change in a practice or practices.

This guide is written with the first situation in mind – that the team is formed before a change agent has been chosen. In a situation where a change agent is already in place, that person will be an active participant throughout the process.

The phases, and the steps within each phase, outlined below and detailed throughout this Guide, are applicable to anyone working systematically to institute change. For each step, the reader will find:

- The action and its purpose
- Challenges that might be encountered in taking the step
- Underlying causes of the challenges
- Strategies for addressing the challenges
- Tools to 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 the sequence can vary in different situations.

The guide also includes three case studies which provide illustrative examples of how coordination teams have applied the phases and steps in this Guide to the process of making important changes in health practices.





## The Change Process: An Overview

### *Preliminary Phase: Forming the Change Coordination Team*

#### *Phase I: Defining the Need For Change*

1. Identify the problem – a practice or set of practices that is impeding the provision of high-quality services. Analyse the root causes, and reformulate the problem as a challenge.
2. Identify and agree on the desired change, its purpose, the anticipated results, and the potential obstacles.

#### *Phase II: Planning for Demonstration and Scale-Up*

1. Identify a dedicated change agent and an implementing team.
2. With the change agent, identify and analyse relevant effective practices from other settings.
3. Select and plan to adapt/implement a proven practice.
4. Plan to implement and monitor the pilot of the practice at test sites.
5. Take actions and make choices in implementation that will enhance sustainability and future scaling up.

#### *Phase III: Supporting the Demonstration*

1. Help create and maintain an environment that will support the change agent and implementing team throughout the change process.
2. Implement the change effort at test sites.

### *Phase IV: Going to Scale with Successful Change Efforts*

1. Evaluate, consolidate and disseminate lessons learned from the pilot, and decide whether the practice warrants scale up.
2. If the pilot succeeded, use a systematic approach and participatory process involving key stakeholders to develop a scaling-up strategy and secure resources to support implementation of the strategy.
3. Implement the scaling-up strategy.
4. Monitor the process of scaling up to ensure sustainability and encourage evidence-based decision-making.
5. Measure and communicate the results of the scaled-up practices.



## Preliminary Phase: Form the Change Coordination Team

Regardless of which comes first – formation of the change coordination team or identification of the change agent – even the most energetic, committed, and astute change agent and implementing team will benefit from ongoing support, encouragement and guidance. The change coordination team should have clear leadership capacity, as it will be responsible for identifying evidence-based practices and obtaining political support and resources from relevant stakeholders. If the change agent has already been identified, he or she will be a key member of the team.

A new team can be formed specifically to support a change initiative. Teams involving IBP members, for example, are well placed to help to move major reproductive health efforts forward in the participating countries and states. In other instances, an existing team can be mobilized on behalf of a change effort. A national reproductive health council or family planning working group, for example, might support the introduction of an evidence-based practice on improved forecasting and ordering of contraceptive methods. Naturally, the members of the change coordination team will vary with the setting and the nature of the proposed change. Team members might be appointed by the Minister of Health or other senior government officials and can include representatives of nongovernmental, donor and international organizations.

Strong support is required from the change coordination team until the change is fully institutionalized at all levels. Therefore, team members should meet several important criteria.

- Team members should represent a broad variety of stakeholders and have decision-making power and influence among those stakeholders. This will enable the team to advocate with institutions or individuals to provide the resources needed to carry out the change process.
- Some team members should be well acquainted with the technical content pertaining to the change, and all should be motivated by the need to improve practice.
- Team members 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 together effectively in support of the desired change, there must be buy-in from all members, as well as a shared understanding of the goal, the task, the expected results and individual responsibilities. Members must agree on consistent messages to provide other audiences.

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

Successful change coordination 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 an authority clearly state the results the team is expected to achieve.

### Preliminary phase indicators

Indicators
The change coordination team has been formed.
Evidence that the change coordination team has the available resources (e.g. data, training finances) to support the change process,



## Phase I: Defining the Need for Change

Changing the way things are done can upset existing balance and power structures, and some stakeholders might feel threatened. Political will and support must be strong to overcome such challenges. In Phase I of the process, the coordination team recognizes that a practice or set of practices is causing a problem and needs to be changed if the programme is to meet its health goals. The team then identifies the underlying reasons that the problematic practices persist. They reformulate the problem as a challenge by asking, “How can we achieve the desired result 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.

### *Step 1. Identify the problem*

Establish the need for change and the reasons for making that change in order to cultivate ownership of the change process ahead. The activities in this step turn complaints into positive actions and focus on causes rather than symptoms to set a foundation for sustainable changes.

#### Challenges

- Leaders can be reluctant to highlight problems within their organization.
- Demonstrating that change is beneficial and should be prioritized can be difficult.
- Reaching agreement on one practice or set of practices to prioritize for change can be challenging.
- It is important to thoroughly explore the reasons for the problem and not settle for superficial analysis.
- Discouragement can lead to inactivity.

#### Underlying causes of the challenges

- Leaders sometimes feel that they are expected to have ready answers for all problems.
- Some people are open to change, while others are not.
- The negative impact of the current practice on service performance might not be widely understood.
- Different perspectives will yield conflicting views of which practices are most detrimental to performance.

- Some influential people might be 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.
- Without analysis, the cause of the problem is not well understood.

#### Key activities to address 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, if changed, could make a big impact.
- Analyse the root causes of the persistence of the practices.
- Re-frame the problem as a challenge to be overcome, and 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.
- Understand and address the psychology related to resistance to change.
- Consider sustainability from the beginning as well as during later scale up stages.

### *Step 2. Identify and agree on the desired change, its purpose, the anticipated results and the potential obstacles*

This step gives everyone on the coordination team a common goal and acknowledges that meaningful change will require coordinated effort and is seldom easy.

#### Challenges

- Enabling people with different institutional or programme perspectives to agree on one change or set of changes that they will undertake together.
- Fostering a belief in and enthusiasm for the agreed-upon change that will persist throughout the process.

### Underlying causes of the challenges

- Cultural, political or professional differences can result in divergent views of how best to institute the change or whether it is needed or desirable.
- People are weary of unsuccessful change efforts and sceptical that meaningful change will happen.

### Key activities to address the challenges

- Emphasize that there might be a few options in your approach to change.
- Openly and respectfully discuss the different views on the desired change.
- Identify one changed practice or set of practices that all participants agree has the potential to improve their organizations or programmes.

- Ask the questions: Why are we doing this? How will service providers and their clients benefit? What challenges lie ahead?
- Clarify what success will look like and how everyone will know it has been achieved.
- Use examples of successful changes to counter scepticism.

### Phase I indicators

Steps	Indicators
1. Identify the problem.	The problem has been identified.
2. Identify and agree on the desired change, its purpose, the anticipated results, and the potential obstacles.	As agreed upon by all stakeholders, the desired change, purpose, and expected results have been stated.



## Phase II: Planning for Demonstration and Scale-Up

In Phase II of the Process for Fostering Change, the coordination team works with the change agent to identify practices that have effectively addressed a similar challenge in a comparable setting. They choose a practice that best meets their needs, make any necessary adaptations, plan the details of a pilot test at one or more test sites and identify the indicators of success that will be monitored throughout the pilot and evaluated at the end. The coordination team and change agent should think ahead to scaling up the change. They should, for example:

- Anticipate where the change will be implemented and involve members of that organization from the outset.
- Test the change in settings that are comparable to those where large-scale implementation is expected to take place.
- Try to work with the level of resources that are likely to be available in the routine programme during scale-up.

In this manner, they will have anticipated some of the requirements for expansion and institutionalization and already be somewhat prepared for scale-up.

### ***Step 1. Identify a dedicated change agent (if one has not already been appointed) and an implementing team***

Identify a change agent who is familiar to and trusted by his or her colleagues, and assemble a team to provide support and assistance. The change agent is dedicated to and accountable for the process. Involving the team creates buy-in among those who will implement and be affected by change, providing energy to initiate the changes and ongoing motivation to sustain them.

### **Challenges**

- Finding a change agent who:
  - » Meets the criteria and is eager to accept the assignment.
  - » Has the support of programme 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 role.
- » Has the courage to take risks.
- Forming an implementation team whose members:
  - » Have the skills needed to bring about the change.
  - » Recognize the benefits of the change.
  - » Are enthusiastic about working with the change agent.
  - » Have been allocated the time and resources to take this role.

### **Underlying causes of the challenges**

- Some excellent potential change agents might not meet all the criteria.
- Potential change agents or team members often have other conflicting responsibilities.
- In leading a controversial change effort, the change agent might encounter risks to job security or to his or her reputation among colleagues and within the broader community.

### **Key activities to address the challenges**

- 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, counselling and mentoring to enable the change agent to fulfil her or his role.
- With the change agent, form a change coordination team whose members will share responsibility for implementing the change. Be sure some members of the team have complementary skills so they can effectively support the change agent.
- Gain the support of leadership to free the change agent and team members from some other duties.

- Provide vigorous ongoing support for the change agent from senior management, colleagues and community members.

### ***Step 2. With the change agent, identify and analyse relevant effective practices from this or other settings***

This step helps the team confirm that the proposed change is possible and avoid expending energy, good will and resources on measures that are unlikely to work.



#### **Challenges**

- Creating awareness of and access to practices with the potential to succeed in this situation.
- Objectively determining which practices have proven effective in comparable settings.

#### **Underlying causes of the challenges**

- The organization or programme has limited opportunities to read about or communicate with other programmes with relevant experience.
- Claims of effectiveness of practices might surpass reality.
- Practices implemented elsewhere might not have been done so with comparable human, technical or financial resources.

#### **Key activities to address the challenges**

- Establish criteria for a practice that has proven effective.
- Look for effective practices that have already been implemented in your region or country to address the identified problem and its causes.
- If effective practices are not available locally, consult resources for evidence-based practices internationally.
- Document what practices are available and your rationale for choices.

### ***Step 3. Select and plan to adapt a proven practice***

The coordination team, change agent and implementing team now focus energy and resources on one promising practice or set of practices.

#### **Challenges**

- Selecting the most appropriate practice from those that have been considered.
- Making the case for the choice with decision makers in the country or region.
- Providing convincing evidence of what practices will work best in the local context, especially if the change is entirely new in the country or setting.

#### **Underlying cause of the challenges**

- Key decision makers might be sceptical about adopting and supporting a new practice with which they are unfamiliar.
- Relevant local practices have not been adequately explored and analysed.

#### **Key activities to address the challenges**

- Analyse the selected practice to ensure it has the CORRECT attributes (as described on page 4).
- Plan to adapt the practice(s) to the local environment being careful to maintain the key attributes that make the practice effective.
- Communicate to decision-makers the results of the search and the justification for choosing a new practice to adopt.

#### ***Step 4. Plan to implement and monitor the pilot of the practice at test sites***

This step involves developing guidelines to lead the change process and determine and demonstrate success, establishing a clear path for the change agent, the implementing team and the change coordination team. Every player should know his or her role and should be held accountable throughout the process. The plan should encompass strategies for sustaining the changed practices.

#### **Challenges**

- Ensuring that members of the coordination team continually prioritize the change effort.
- Identifying what the objectives of the change process are and agreeing to what successful change will look like.
- Integrating the implementation plan into the existing work plan, monitoring and evaluation (M&E) plan and deliverables.
- Identifying the type, level and variety of setting where implementation should be tested, focusing on those which are representative of future scale up sites.
- Mobilizing the financial and human resources needed to implement, monitor and sustain the desired change.

#### **Underlying causes of the challenges**

- The coordination team members do not completely understand or accept their roles in the change process.
- Poor understanding of what the proposed change is or the rationale for its importance or benefit.
- Leadership has not fully endorsed the change and provided the necessary resources for sustainable implementation.
- There is temptation to implement the demonstration in stronger or otherwise easier settings or facilities.

#### **Key activities to address the challenges**

- Clarify roles and responsibilities for the coordination team, change agent and the implementing team.
- Involve stakeholders, especially beneficiaries, in decision-making from the start.

- Discuss and clearly document what the objectives (and, if appropriate, the sub-objectives or milestones) are for the change process.
- Limit the use of external inputs and keep the pilot as simple as possible.
- Test the change in settings representative of future sites for scale-up.
- Identify tools that have proven useful in carrying out comparable changes.
- Identify and plan for linkages to other sectors, systems and programmes.
- Specify all the activities needed to implement, monitor and sustain the change as well as who will take responsibility for them and over what period of time.

#### ***Step 5. Take actions and make choices that will enhance sustainability and future scaling up of the innovation***

The coordination team should anticipate and lay the groundwork for the complexities of scaling up (see Phase IV), begin determining the needed resources for future scale up and develop a plan to acquire them.

#### **Challenges**

- Engaging stakeholders in thinking ahead to scale-up early in the change process.
- Cultivating ownership of the change more widely in the organization that will need to adopt it.
- Believing that scale up simply entails “doing more of what we’re already doing” and will automatically be successful if the demonstration worked on a small scale.
- Securing the resources (for example, human, financial, and systems) needed for scale-up.

#### **Underlying causes of the challenges**

- Evidence of successful change might not appear until later in the process.
- The change is viewed as simply a pilot; requirements of bringing the change to scale are not considered.

- There is a lack of understanding regarding what is involved with scaling up and what should be considered and monitored from the onset and throughout to ensure sustainability.
- There are limited resources and/or constraints with accessing existing resource options.

### Key activities to address the challenges

- Determine whether the change, if successful, will be appropriate for expansion to new settings. If so, consider:
  - » Whether it should be implemented within or beyond the organization.
  - » The need for advocacy, policy change or alternative funding possibilities.
- Socio-cultural, political or institutional barriers that must be overcome.
  - » Stakeholders who need to be on board.
  - » Dissemination strategies.
- 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.

### Phase II Indicators

Steps	Indicators
1. Identify a dedicated change agent (if one has not already been appointed) and an implementing team.	<ul style="list-style-type: none"> <li>• A dedicated change agent and implementing team with a clear vision for leading the change have been identified.</li> <li>• Identified change agent communicates effectively with team and with senior management /decision-makers.</li> </ul>
2. With the change agent, identify and analyse relevant effective practices from this or other settings.	<ul style="list-style-type: none"> <li>• Practices that will address the problem have been identified and communicated to implementers.</li> <li>• Identify where desired change has already started and develop a plan to build on that.</li> </ul>
3. Select and plan to adapt a proven practice.	<ul style="list-style-type: none"> <li>• A practice has been chosen.</li> <li>• The implementing team has stated how their work practices will be modified as a result of the change.</li> <li>• Influential stakeholders support and have demonstrated commitment to the change.</li> </ul>
4. Plan to implement and monitor the pilot of the practice at test sites.	<ul style="list-style-type: none"> <li>• A work plan has been developed for the pilot with listed objectives, activities, indicators, timeline, budget and persons responsible.</li> <li>• Terms of reference are in place for the change agent.</li> <li>• Stakeholders are continuously engaged in and consulted with on the change process.</li> </ul>
5. Take actions and make choices in implementation that will enhance sustainability and future scaling up.	<ul style="list-style-type: none"> <li>• Recognition is regularly provided to the implementing team staff.</li> <li>• A clear process has been developed for identifying additional change agents for upcoming expansion and continuity of leadership.</li> </ul>



## Phase III: Supporting the Demonstration

During Phase III, the implementing team undertakes the demonstration. They are supported by the coordination team, which helps maintain the energy, focus and consistency of the change process at test sites and oversees the continuous assessment and modification of the process. The accomplishments and lessons learned during the pilot test will strongly influence future scale-up.

### *Step 1. Help create and maintain an environment that will support the change agent and the implementing team throughout the change process*

The change agent and implementing team need motivation and encouragement to persist when they encounter roadblocks and frustration. Providing needed inputs at critical moments will help encourage a positive mindset across the organization and will lay the foundation for sustainability and scale-up.

### Challenges

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

### Underlying causes of the challenges

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

### Key activities to address the challenges

- At the start of the process and periodically throughout, work with the change agent to:
  - » Describe the change process in detail; highlight progress and explain what will happen next.
  - » Clarify how the change will enhance the work of the organization.
  - » Specify the roles of each organizational unit in contributing to successful change.
- Help the change agent 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 accept the normality of differing reactions to change and address the needs of people at each phase: denial, resistance, exploration and acceptance.
- Find ways to motivate, acknowledge and reward staff members for changing their accustomed practices.



**Step 2. Implement the change effort at test sites**

Use the implementation plan to test the demonstration. Use the monitoring data to identify what aspects of the demonstration are and are not working.

**Challenges**

- The demonstration is not proceeding on time or on budget.
- Lack of evidence that the change effort has a relative advantage over existing practices.
- Health systems, staff and procedures are ill-equipped to embrace and manage the change.

**Underlying causes of the challenges**

- The scope and extent of the resources needed for the demonstration (for example, time, financial, staff resources) were not fully anticipated.
- The M&E plan lacks the right indicators to determine the success of the demonstration.
- The demonstration was implemented in haste, without full preparation, knowledge and acceptance of the change.

**Key activities to address the challenges**

- Review the implementation plan and ensure the timeliness, budget, responsible staff and objectives are clearly noted. Refer back to the implementation plan frequently to ensure deadlines are met, the demonstration is on-budget, staff are held accountable and objectives are met.
- Modify the existing M&E plan, including selection of indicators, to accurately reflect the key elements of the change efforts.
- Take the time to carefully monitor staff confidence with adapting to the change. Solicit their feedback on how well the practice is being incorporated into existing practices and procedures.
- Make plans for and follow through on documenting the process of implementation including key decisions and activities.

## Phase III Indicators

Steps	Indicators
1. Help create and maintain an environment that will support the change agent and the implementing team throughout the change process.	<ul style="list-style-type: none"> <li>• A functional system is in place for how to share information on how the demonstration is progressing.</li> <li>• Supportive supervision is in place and is being followed on a regular basis.</li> <li>• Staff have been provided with the necessary training and resources to implement and maintain the change.</li> </ul>
2. Implement the change effort at test sites.	<ul style="list-style-type: none"> <li>• Indicators for this step should be specific to the implemented change (e.g., per cent of beneficiaries reporting they are receiving services in line with the expected change; number of sites implementing the change; per cent of audience with a favourable attitude towards the change).</li> </ul>

## Phase IV: Going to Scale with Successful Change Efforts

Scaling up brings new responsibilities to the coordination team, which might expand to include representatives from new locations and institutions. The team shares the findings from the pilot test to a larger audience and works with decision makers to select, carry out and evaluate an appropriate implementation strategy. An influential coordination team can ensure sustainability by assisting governments in mainstreaming new practices into policies, systems and programmes. In addition, the team oversees the careful and honest measuring and widespread communication of the results of the scaled-up practice(s).

### *Step 1. Evaluate, consolidate and disseminate lessons learned from the pilot, and decide whether the practice warrants scale up*

The results of the pilot will inform the decision of whether to scale up and will lend credibility to the practice.

#### Challenges

- Evaluating the results of the change effort systematically, honestly and objectively so that plans for scaling up are realistic.
- Shaping messages that will convince selected audiences to support the new practice(s).

- Knowing and using the most effective communications channels for each audience.
- Having sufficient information to assess whether the capacity exists to implement the change in routine programme settings.
- Feeling pressure to scale up the change, even in the absence of conclusive results.

Note: Some change efforts fail and are not appropriate for scale-up. In such a case, the coordination team should objectively analyse the reasons for failure and share the findings with stakeholders. An effective team can encourage the organization to learn from the failure and try again.

#### Underlying causes of the challenges

- Coordination team members and change agents who have invested time, energy and their professional reputations in the change effort might be tempted to exaggerate positive results and overlook less successful aspects of the change effort.
- Members of the implementing team might lack expertise in effective communication strategies.
- The pressure to move ahead with scale-up can be strong because the change addresses a perceived need.

#### Key activities to address the challenges

- Evaluate and document lessons learned, results and adaptations for different audiences.
- Share the documented process and benefits with stakeholders to engage them in identifying resources for scaling up.
- Acknowledge that ignoring negative factors will result in unrealistic plans for scale-up with a higher likelihood of failure.
- Share with decision makers the benefits of a systematic review of the chances of success in order to avoid a premature decision on whether to scale up the practice.
- Use both personal (for example, peer exchanges) and impersonal (for example, reports and websites) means of dissemination.



***Step 2. If the pilot succeeded, use a systematic approach and participatory process involving key stakeholders to develop a scaling-up strategy and secure resources to support implementation of the strategy***

The coordination team must advocate effectively for scale-up with new organizations and players. This will be facilitated if some members of the new organizations have been involved in the demonstration process and advocacy for scale-up was initiated early on. Scale-up should be approached systematically and should be technically and financially feasible. Capacity building for scale-up will enhance ownership, cultivate champions and provide opportunities to mobilize resources to institute change on a larger scale.

### Challenges

- Mobilizing the needed resources for scale up.
- Simplifying the implementation package to lend itself to expansion.
- Building capacity to expand implementation of the change package.

### Underlying causes of the challenges

- Not all stakeholders might agree on the wider applicability of the new practice(s).
- Few are prepared to support implementation of a systematic approach to scale up.

- The coordination team might lack the information needed for an accurate estimate of needed resources.
- Resources for scale up are limited.
- The organizations newly adopting the change might lack certain necessary capacities.

### Key activities to address the challenges

- Apply an evidence-based scale-up framework or model to the strategy development process.
- Identify and mobilize stakeholders with experience in scaling up change to support the development of an appropriate scaling up strategy.
- Plan actions to increase the scalability of the change.
- Strengthen the capacity of the implementing organizations to scale up the change.
- Assess the environment and identify actions to increase the potential for scaling up success.
- Build the capacity of the implementing team to support scaling up.
- Make strategic choices to support institutionalization, expansion or replication in other sites.
- Determine whether adaptation of the innovation is needed for new contexts.
- Plan to address spontaneous scale-up in case it occurs.
- Prepare and circulate a written statement that documents the scaling up strategy, the time frame and who is responsible for key activities.
- Become familiar with and weigh the requirements, risks, advantages and disadvantages of different approaches to scaling up.
- Be cautious making plans and commitments for overly rapid scale up.
- Mobilize resources from a variety of donors.
- Look for economies of scale and partner with other change efforts where possible and efficient.



### ***Step 3. Implement the scaling-up strategy***

In this step, the practice is mainstreamed according to the implementation plan, fostering sustained improvement.

#### **Challenges**

- Lack of resources to support large-scale implementation or difficulty maximizing existing resources to gain the most benefit for scale-up.
- The need for a change coordination team will not be apparent to all stakeholders.
- If the innovation is complex or requires new systems, structures, technology or patterns of behaviour in the implementing organization, time and possibly considerable funding and training and support might be needed.
- Preserving the critical features of the new practice as it is expanded.
- If institutionalization requires working within existing rhythms of policy change, progress can be slow. Maintaining momentum and enthusiasm can be especially difficult over the long process of national scale up.

#### **Underlying causes of the challenges**

- Health managers often feel pressure from donors or political leaders to start whole new initiatives, which diverts attention and resources away from scaling up ongoing practices that do not have new funding. Many stakeholders consider scaling up to be part of routine programme implementation and fail to recognize that the change requires nurturing and buy-in at expansion sites.
- Implementers can become frustrated by the time, persistence and energy needed to carry out a complex, multifaceted scale-up effort and often prefer to work on new initiatives.
- New practices can become diluted and lose their impact as they spread to new settings.

#### **Key activities to address the challenges**

- Ensure the continued presence of a strong, motivated change coordination team.
- Ensure that additional change agents and implementing teams are established in new sites so that scaling up receives the needed support at the local level.

- Conduct training and other supportive activities to ensure that the innovative change practice is well understood at all levels.
- Ensure that the practice is adapted to the local context while maintaining fidelity to its key components.
- Establish and adhere to criteria to maintain the essential features of the practice(s).
- Advocate for necessary policy and related institutional change.
- Adjust the scaling up strategy based on lessons learned from experience and M&E.
- Partner with other relevant change efforts.
- Review the indicators that were selected for the demonstration and determine whether they are all still appropriate for the scale-up.
- Monitor the process to identify barriers to scale-up.
- Mobilize resources that support the costs of scaling up, including continued support of the change coordination team.
- Recognize and reinforce the new practices and discourage outdated ones.
- Identify new change agents in the sites where the innovation is expanded.
- Systematically maintain incentives, public recognition and rewards for implementing teams.

### ***Step 4. Monitor the process of scaling up to ensure sustainability and provide evidence-based decision making***

Monitor implementation of the practice to understand both the benefits and shortcomings of the practice in order to adapt practices midstream and address challenges.

#### **Challenges**

- The need or desire to move quickly and not take the time to measure progress and results.
- Integrating systematic M&E, which is typically already a weak area, into the change effort without overburdening the change agents or system.

- Finding relevant indicators that accurately capture the key elements of the change.
- Data might be of poor quality (incomplete, inaccurate, confusing), too difficult to obtain or reported inconsistently.
- Gathering information on the process of implementation, not just on the outcomes, outputs and impacts.

### Underlying causes of the challenges

- The coordination team members might not appreciate the value of monitoring progress in order to make mid-course corrections and avoid failures down the road.
- The M&E plan might be too long or complex and might not be capitalizing on existing systems and reporting practices.
- The M&E plan does not define what information should be collected for each indicator, from which data sources, by whom and how frequently.
- The selected indicators might not reflect all the anticipated results, both quantitatively and qualitatively.
- Implementing teams might not be accustomed to collecting process data and information.

### Key activities to address the challenges

- Ensure that monitoring activities are built into the implementation plan or work plan (including the budget) and adhere to the predetermined monitoring schedule.
- Keep the M&E plan simple and, to the extent possible, linked to existing reporting structures, systems, processes and practices.
- Add relevant indicators to standard data collection instruments.
- Establish sentinel surveillance sites between major surveys.
- Seek social indicators from organizations that provide and assess social services.
- If necessary, revise the indicators so that they are clearly defined, useful, not redundant and not trying to capture information that is too difficult to obtain.
- Create a reference sheet for each indicator specifying what information is needed, how the indicator is

calculated (if relevant), what the sources are for required data, who will be responsible for collecting the data and how often data will be collected.

- Establish mechanisms through which change agents and their teams can learn from each other.
- Use both qualitative and quantitative approaches to monitoring including service statistics, where available, as well as special studies.
- Looking at the monitoring data, assess whether the core elements of the innovative change practice are being maintained.
- Assess results and outcomes of large scale implementation, including any unanticipated results.
- Recognize inadequacies of management information systems, agree on an acceptable level of accuracy and timeliness and remedy deficiencies that can be rapidly improved.
- Undertake special studies to capture information on progress that cannot be assessed from other sources.
- Identify new change agents in the sites where the innovation is expanded.
- Systematically maintain incentives, public recognition and rewards for implementing teams.

### *Step 5. Evaluate and communicate the progress of the scale-up to key stakeholders*

Evaluate the monitoring data and use the information to make decisions. Communicate the findings from monitoring activities to key stakeholders and collaboratively plan for future iterations.

### Challenges

- Reporting on the indicators but not analysing the data to identify areas where the change process might be faltering or need extra attention.
- Communicating key information to decision makers in a constructive and timely manner.
- Giving honest feedback when performance falters.
- Dedicating time for thorough, objective evaluation.

### Underlying causes of the challenges

- There is not a strong culture of data use and making decisions on evidence-based findings.
- Coordination team members and the change agent might be unfamiliar with the use of indicators to objectively evaluate performance or unaccustomed to giving constructive feedback.
- It is often uncomfortable and even difficult to communicate negative results, particularly to superiors or donors.

### Key activities to address the challenges

- Encourage the coordination team members to provide evidence from the monitoring and evaluation results for their recommendations and decisions. If needed, provide

tools and resources on how to use data for optimal success.

- At the start of scale-up, establish a principle of transparent and honest reporting, and make a plan for communicating negative results.
- Present results to those who are implementing the change (service providers, policy-makers, community leaders) as well as national and international audiences.
- Find or develop written guidelines for effective, constructive feedback.
- Hold a brief training session to discuss the guidelines and ways to develop and use indicators.
- Acknowledge the difficulties staff might encounter, and be prepared to make practical suggestions for improvement.

### Phase IV Indicators

Steps	Indicators
1. Evaluate, consolidate and disseminate lessons learned from the pilot and decide whether the practice warrants scale up.	<ul style="list-style-type: none"> <li>• The pilot has been analysed and lessons learned have been documented and disseminated,</li> </ul>
2. If the pilot succeeded, use a systematic approach and participatory process involving key stakeholders to develop a scaling-up strategy and secure resources to support implementation of the strategy.	<ul style="list-style-type: none"> <li>• A scale-up strategy has been developed with listed objectives, activities, indicators, timeline, budget and persons responsible.</li> <li>• Evidence that resources (e.g. human, financial, and capital) are available to support the scale up.</li> <li>• Stakeholders are continuously engaged in and consulted with during the scale up.</li> </ul>
3. Implement the scaling-up strategy.	<ul style="list-style-type: none"> <li>• Indicators for this step should be specific to the implemented change (e.g. percent of beneficiaries reporting they are receiving services in line with the expected change, number of sites implementing the change; per cent of audience with a favourable attitude toward the change).</li> <li>• Extent to which essential features of the innovation are being implemented.</li> </ul>
4. Monitor the process of scaling up to ensure sustainability and provide evidence-based decision making.	<ul style="list-style-type: none"> <li>• The indicators for this step can come from the “<i>guide to monitoring scale up</i>”.</li> </ul>
5. Evaluate and communicate the progress of the scale-up to key stakeholders.	<ul style="list-style-type: none"> <li>• Regular meetings are conducted with the implementers and key stakeholders to review progress and identify where mid-course corrections need to be made to ensure success and sustainability.</li> </ul>

## Fostering Change Indicators

Steps	Indicators
<b>Preliminary Phase: Form the Change Coordination Team</b>	
	The change coordination team has been formed.
	Evidence that the change coordination team has the available resources (e.g. data, training, finances) to support the change process.
<b>Phase I: Defining the Need for Change</b>	
1. Identify the problem	The problem has been identified.
2. Identify and agree on the desired change, its purpose, the anticipated results, and the potential obstacles.	As agreed upon by all stakeholders the desired change, purpose, and expected results have been stated.
<b>Phase II: Planning for Demonstration and Scale-Up</b>	
1. Identify a dedicated change agent (if one has not already been appointed) and an implementing team.	A dedicated change agent and implementing team with a clear vision for leading the change have been identified.
	Identified change agent communicates effectively with team and with senior management/ decision-makers.
2. With the change agent, identify and analyse relevant effective practices from this or other settings.	Practices that will address the problem have been identified and communicated to implementers.
	Identify where desired change has already started and develop a plan to build on that.
3. Select and plan to adapt a proven practice.	A practice has been chosen.
	The implementing team has stated how their work practices will be modified as a result of the change.
4. Plan to implement and monitor the pilot of the practice at test sites.	Influential stakeholders support and have demonstrated commitment to the change.
	A work plan has been developed for the pilot with listed objectives, activities, indicators, timeline, budget, and persons responsible.
	Terms of reference are in place for the change agent.
5. Take actions and make choices in implementation that will enhance sustainability and future scaling up.	<ul style="list-style-type: none"> <li>• Stakeholders are continuously engaged in and consulted with on the change process.</li> <li>• Recognition is regularly provided to the implementing team staff.</li> <li>• A clear process has been developed for identifying additional change agents for upcoming expansion and continuity of leadership.</li> </ul>



Steps	Indicators
<b>Phase III: Supporting the Demonstration</b>	
1. Help create and maintain an environment that will support the change agent and the implementing team throughout the change process.	<ul style="list-style-type: none"> <li>• A functional system is in place for how to share information on how the demonstration is progressing.</li> <li>• Supportive supervision is in place and is being followed on a regular basis.</li> <li>• Staff have been provided with the necessary training and resources to implement and maintain the change.</li> </ul>
2. Implement the change effort at test sites.	<ul style="list-style-type: none"> <li>• Indicators for this step should be specific to the implemented change (e.g., percent of beneficiaries reporting they are receiving services in line with the expected change; number of sites implementing the change; percent of audience with a favourable attitude toward the change).</li> </ul>
<b>Phase IV: Going to Scale with Successful Change Efforts</b>	
1. Evaluate, consolidate, and disseminate lessons learned from the pilot, and decide whether the practice warrants scale up.	<ul style="list-style-type: none"> <li>• The pilot has been analysed and lessons learned have been documented and disseminated.</li> </ul>
2. If the pilot succeeded, use a systematic approach and participatory process involving key stakeholders to develop a scaling-up strategy and secure resources to support implementation of the strategy.	<ul style="list-style-type: none"> <li>• A scale-up strategy has been developed with listed objectives, activities, indicators, timeline, budget, and persons responsible.</li> <li>• Evidence that resources (e.g. human, financial, and capital) are available to support the scale up.</li> <li>• Stakeholders are continuously engaged in and consulted with during the scale up.</li> </ul>
3. Implement the scaling-up strategy.	<ul style="list-style-type: none"> <li>• Indicators for this step should be specific to the implemented change (e.g., percent of beneficiaries reporting they are receiving services in line with the expected change; number of sites implementing the change; percent of audience with a favourable attitude toward the change).</li> <li>• Extent to which essential features of the innovation are being implemented.</li> </ul>
4. Monitor the process of scaling up to ensure sustainability and provide evidence-based decision making.	The indicators for this step can come from the <i>“guide to monitoring scale up”</i> .
5. Evaluate and communicate the progress of the scale-up to key stakeholders.	Regular meetings are conducted with the implementers and key stakeholders to review progress and identify where mid-course corrections need to be made to ensure success and sustainability.

## Illustrative Examples

This section of the Guide contains example cases that show how coordination teams have applied the phases and steps in making important changes in health practices.

### Scaling up and institutionalizing essential obstetric care in Ecuador

Jorge Hermida and Linsey Jaco, The ASSIST Project. November 2012

#### *The Context*

With USAID technical support, Ecuador's Ministry of Health began in 2003 to apply Improvement Collaborative to address essential obstetric care. The programme started with eight sites and within the first year grew to 55, all working on improving antenatal and delivery care. Quality improvement (QI) teams were formed and trained to monitor indicators of quality and test changes to ensure that evidence-based practices were routinely implemented. From a limited demonstration experience in eight sites, with significant external support from the Quality Assurance Project (QAP), the initiative evolved into a national scale obstetric and newborn care improvement programme covering the whole country (more than 100 hospitals and 60 health centres), totally managed and financed by the Ministry of Health (MOH) of Ecuador.

#### *The Process and Experience*

##### **Preliminary Phase: Form the Change Coordination Team**

In early 2003 the MOH of Ecuador started a coordinated activity aimed at improving the quality of maternal health care. With technical assistance from the QAP, the MOH appointed a steering team composed of delegates from the Maternal and Child Health Directorate, as well as from the Free Maternity Programme. This team embarked in preliminary activities such as defining quality standards and indicators for key maternal care processes as well as a standard procedure for facilities to report on these indicators to the MOH provincial offices. Key processes to be improved included antenatal care, delivery care, immediate post-partum care and care for complications such as pre-eclampsia, post-partum haemorrhage and obstetric infections. The steering team also developed a training curriculum on quality improvement methods and selected initial provinces and facilities.



### Phase I: Define the Need for Change

A baseline assessment of quality of care, measured as compliance with maternal care quality standards was conducted early on. QI teams, formed in initial facilities, conducted self-audits of clinical records obtaining data that was transformed in percentages of clinical records in compliance with standards. These baseline assessments showed markedly low quality levels for most maternal care processes. The fact that these baseline measures were self-assessments helped facility-based teams to accept data depicting low quality of care and fostered a sense of need to improve.

### Phase II: Plan for Demonstration and Future Scale-up

With the aim of reaching the entire country, an initial demonstration phase was planned. This phase comprised of 14 county hospitals in 8 out of the 22 provinces of Ecuador. Health professionals were selected from each of the 14 hospitals and 8 provincial MOH offices to be trained as local QI facilitators. QAP staff trained facilitators of selected hospitals and MOH provincial offices during three workshops conducted in 2003. Workshops took place at intervals of 8 to 10 weeks, each one lasting approximately 16 to 20 working hours. In turn, these provincial and facility-based facilitators were to form a QI team at each of the 14 hospitals and train team members.

The Coordination Team's plans were to launch a scale-up phase after all 14 hospitals completed formation and training of a QI team to work steadily on improving maternal care. The planned scale-up phase consisted in expanding the QI model to all county hospitals in each of the 8 initial provinces. A follow-up second scale-up phase would expand the model to the rest of the 20 provinces in Ecuador. These scale-up plans could not be followed strictly as planned, since several other hospitals and health centres began to join the QI initiative early on, resulting in a first wave of around 55 hospitals in 2003-2004, a second wave of 21 facilities in a scale-up phase in 2005 and a third wave of 10 facilities in 2006-2007.

### Phase III: Support and Implement the Demonstration

QAP trained around 35 facilitators from 14 hospitals in 8 provinces from 2003 to 2004. These facilitators formed CQI teams with staff from district hospitals or health centres in each of the 14 counties. Teams were composed of physicians, nurses, midwives, administrators and statistics staff, who attended three training workshops on quality improvement

methodology replicated by the facilitators at their respective facilities. Provincial MOH facilitators followed up the work of teams from every facility through monthly visits to support monitoring and improvement activities. Every facility reported monthly measurements of compliance with standards, as well as improvement plans and teams' activities.

Some of the features implemented by QAP and the MOH to consolidate this stage were:

- Technical visits to initial provinces: A QAP representative and MOH officials visited the eight provinces initially selected, holding planning meetings attended by the provincial director and coordinators from all county health areas. CQI methods, as well as the experience gained by facilitators and improvement teams from the initial facilities, were presented.
- The legal framework that supports the QI process and the leadership commitment of the MOH to expand to new provinces were also presented. The visit ended with the formulation of a work plan for the expansion to all county hospitals of each province.
- Training of QI teams in all facilities in the eight initial provinces: Improvement teams were created in every county hospital of the eight provinces and trained in QI methodology by skilled facilitators. The new teams conducted a base line assessment, initiated the implementation of rapid improvement cycles, and began monthly monitoring of compliance with standards for clinical processes. Facilitators conducted visits to provide technical support to teams. Workshops conducted in provinces were self-funded by health areas and provinces.
- National meetings to update facilitators: In November 2003 and March 2004, facilitators from the eight provinces held workshops to update their knowledge and to strengthen their functions. Facilitators shared achievements, difficulties and solutions taking place at their respective provinces.
- A "Facilitator's Toolkit" with technical tools for continuous quality improvement was put together by QAP and given to each facility-based and provincial facilitator.
- Review of standards, indicators and tools: Initial standards and indicators were reviewed and modified by personnel from technical programmes of the MOH and the Steering Team, based on guidelines for reproductive healthcare and taking into account the experience and local recommendations.

- System for monitoring and reporting compliance with quality standards: The MOH and QAP developed an electronic system based on an Excel spreadsheet, which enables facilitators and CQI teams to easily enter the numerators and denominators to build quality indicators. The programme automatically produces percentages of compliance for each standard and a run chart showing the indicator's performance. The team sends the spreadsheet to the provincial facilitator, who consolidates the information from the province and sends it to the MOH central level for analysis and feedback.

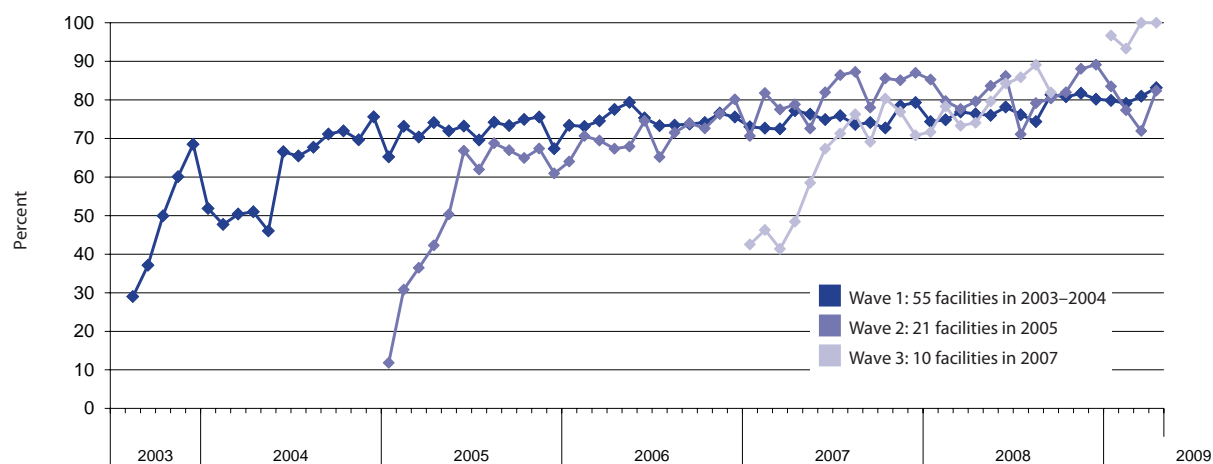
#### Phase IV: Going to Scale with Successful Change Efforts

Spread took place in three phases, or waves, shown in the graph. The first wave of implementation was followed in 2005 by a second wave of sites that joined the collaborative and had the advantage of the learning that had been generated by the

first wave. These second-wave sites received less support from external technical advisors and much more from the MOH. In 2007, without external technical support, MOH staff initiated another wave of improvement activities in 10 new sites.

Figure 4 is an example of improvement of antenatal care, although QI teams worked also on delivery care, postpartum and newborn care, as well as care for the three main obstetrical complications, using the process previously described. As the graph shows, using learning from the previous wave, each successive wave achieved faster scale-up of best practices. By the end of 2007, all 86 hospitals in 12 provinces were reporting data and showing consistent results, with most women receiving care according to standards. In 2007, the MOH focused on a parallel activity, scaling up active management of the third stage of labour (AMTSL) to the whole country of Ecuador, and in 2009, the MOH extended the entire essential obstetric and neonatal package to five more provinces with its own funding.

Figure 4. Ecuador: Percent of pregnant women receiving prenatal care according to norms (successive waves of 86 hospitals joining the Improvement Collaborative project)



## Scaling up best practices in essential obstetric, neonatal care and family planning in Yemen

Dr. Salwa Bitar, Thada Bornstein, Bornstein & Associates,  
Extending Service Delivery Project September 2011

### *The Context*

Yemen is one of the poorest countries in the Middle East, ranking low in nearly all health and socioeconomic indicators. It suffers from an infant mortality rate of 51 per 1000 live births, a neonatal mortality rate of 29 per 1000 births and a maternal mortality rate of 365 per 100 000. Yemeni women have a low contraceptive prevalence rate (23%) and a high fertility rate (5.0 in 2006).

A Ministry of Health (MOH) country team, led by the Secretary General, partnered with the Extending Service Delivery project (ESD) and its Yemen project, Basic Health Services (BHS), to introduce and scale up a package of essential obstetric and neonatal care and immediate postpartum family planning to reduce maternal and neonatal mortality. The team agreed to use the Improvement Collaborative approach to introduce this package at demonstration sites before scaling it up.

### *The Process and Experience*

#### **Preliminary Phase: Forming the Change Coordination Team**

In 2007, a team of health care professionals and MOH professionals from Yemen attended an ESD-organized, USAID-funded conference in Bangkok, “Scaling-Up High Impact FP/ MNCH Best Practices in Asia/Near East Region.” The Yemen Country Team engaged in working sessions to identify country-specific gaps that contributed to poor maternal and child health status, including the low rate of family planning use, low access to postpartum care (PPC) and the infrequent practice of immediate and exclusive breastfeeding.

The team was further expanded to support the scaling up of best practices that address those major gaps. The Yemen Country Team (below) serves as an example of a change team’s structure and shows an emerging leader of the team, the Secretary General of Health, who supported the team in scaling up eight postpartum best practices at the national level.

#### **Phase I: Defining the Need for Change**

The team agreed that the poor quality of services at maternity facilities, as manifested in lack of compliance with clinical and infection prevention standards, stock outs of essential supplies and poor monitoring and supervision, is a main contributor to poor access and health outcomes of mothers and neonates. They agreed on two major changes: 1) introduce a number of evidence-based best practices to maternity services, and 2) establish facility-based teams and build their capacity in quality improvement to implement and monitor those best practices.

The team addressed the gaps through adoption and scaling-up of the following initial eight best practices, while keeping in mind that additional best practices will be added gradually:

1. Essential newborn care/infection prevention
2. Kangaroo Mother Care (KMC)
3. Immediate and exclusive breastfeeding
4. Postpartum family planning (PPFP)
5. Healthy Timing and Spacing of Pregnancies (HTSP) counselling and education
6. Lactational Amenorrhea Method of contraception (LAM)
7. Vitamin A
8. BCG vaccine to newborns



Yemen Country Team	
Leader	Secretary General of Health
Coordinator	Deputy Secretary of Health
Executive Manager	Chief of Party for USAID-funded BHS Project
Members from MOH	All General Directors of Health
	Directors of Gynaecology and Obstetrics in select hospitals
	Directors of Hospitals
	Representatives from Quality Assurance Teams
Donor Agencies	USAID
	GTZ
	UNFPA
	WHO
Religious Leaders	From local NGOs and Ministry of Religious Affairs

### Phase II: Planning for Demonstration and Scale-up

The team's goal was to spread the package of best practices and improve the quality of obstetric and neonatal care and FP at the national level. Motivated by the Secretary General, who promised full support, the team agreed to introduce and test the package at demonstration sites to be followed by a full, national-level scale-up.

Starting in 2008, the team introduced these best practices via key interventions in provider training and updating service standards in Al-Sabeen Hospital in the capital city of Sana'a. By introducing the eight selected best practices, the hospital made a number of improvements, including establishing infection prevention and patient education committees and securing a sufficient supply of Vitamin A and vaccines. Other improvements include:

- Addition of Vitamin A to the reproductive health (RH) essential drugs list.
- Creation of a postpartum counselling room.
- Enhanced opportunities for integrated vaccination.

Less than six months after the start of the intervention, Al-Sabeen Hospital was providing three times as many BCG vaccinations as before.

### Phase III: Supporting and Implementing the Demonstration

To build on this intervention's momentum, the MOH asked ESD for additional strategies for rapidly improving the quality of care. As a result, ESD introduced the Yemen Team to the Improvement Collaborative (IC) methodology. In 2009, the MOH, the country team and BHS scaled up the eight best practices in six major hospitals in six governorates: Aden, Amran, Ibb, Lahaj, Sa'ada and Taiz.

The main steps of this phase include:

- An initial training and workshop for establishing the Improvement Collaborative was held in January 2009 for six hospitals in the six governorates where the initial scale-up would take place. Teams from the hospitals were composed of physicians, nurses and midwives, who were oriented to the IC approach and trained in the best practices, clinical guidelines, standards and job aids. In addition, the teams were introduced to QI tools and methodologies with focus on root cause analysis, problem solving, working in teams, data quality and monitoring. The teams developed quarterly work plans and scheduled quarterly meetings to share challenges and progress.

- The QI teams conducted a baseline assessment against shared indicators, initiated the implementation of rapid improvement cycles and began monthly monitoring of compliance with the clinical guidelines.
- The Improvement Collaborative was conducted and managed by a combination of staff from the MOH and BHS. The Collaborative coordinator made periodic visits to each hospital team to assist with the identification and testing of improvements while monitoring monthly indicators. BHS provided management support and a staff statistician who compiled the hospital data. District MOH facilitators followed up the work of facility teams through monthly visits to support monitoring and improvement activities. Every facility reported monthly measurements of compliance with standards, as well as improvement plans and team activities.
- The QI teams met every three months in a learning session where they shared progress and challenges, received additional training in QI and clinical aspects of the best practices and developed plans for the next quarter.
- The MOH Population Sector endorsed the action plans developed by the teams and integrated them into the 2009 Population Sector Work Plan.
- ESD and BHS provided additional training, including:
  1. Postpartum training on family planning and counselling services, including skills for specific family planning methods.
  2. Several orientation courses based on the Family Planning Handbook, including seminars on the benefits of family planning and additional technical information.
  3. One-week course for providers on Contraceptive Technology Updates and the Balanced Counselling Strategy for family planning.
  4. Training on immediate postpartum IUD insertion, which was conducted for a group of doctors as part of the HTSP counselling best practice.

In addition to the eight previous best practices, two more were added by the summer of 2009: active management of the third stage of labour (AMTSL) and newborn resuscitation. At the individual hospital sites, the teams identified and tested several of the following solutions:

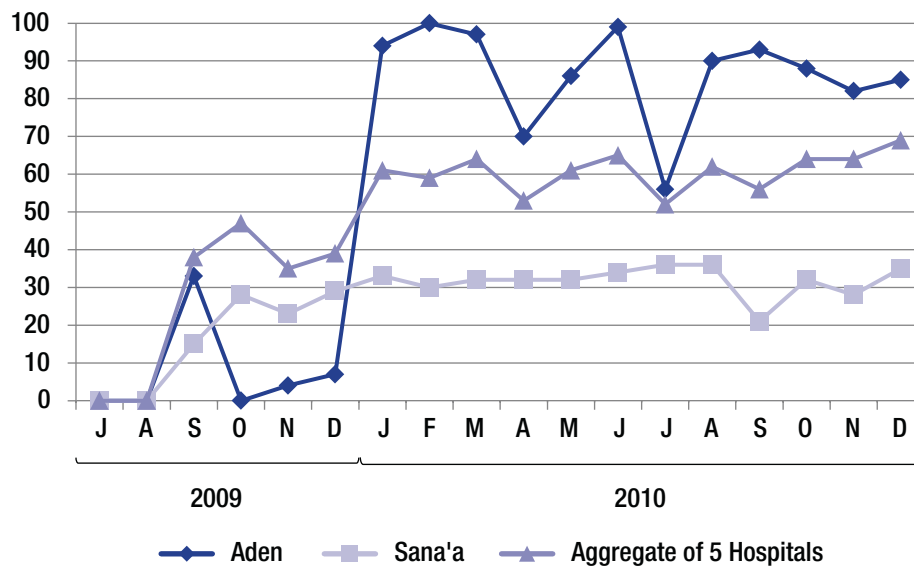
1. To reduce infection in the nursery, nurses in Lahaj designed culturally acceptable scrubs and veils that they washed and wore only in the nursery. Prior to this, they had worn scrubs on top of their daily clothes and niqab (full face veil).
2. All hospitals added a discharge and counselling room with a private space for discussing family planning.
3. All hospitals provided BCG vaccinations for the newborns and family planning counselling for fathers and mothers.
4. Some hospitals have posted a midwife in the postpartum room to counsel mothers on exclusive and immediate breastfeeding and family planning.
5. Some hospitals created a private space for nursing mothers.
6. Staff trained cleaners on infection prevention and assigned each one to a specific area to control the spread of infection.
7. Staff placed bottles of antiseptic hand cleaning solution on the trolley when making rounds, for use between exiting one patient's room and entering the next.
8. Staff in Ibb created a "missed opportunity" room for family planning counselling and services and an internal referral for mothers and their babies. The women can receive family planning counselling and contraception during the same visit. A documentation system for patient referrals measures the effect of this change. Initial data shows this approach is very effective and should be generalized at other hospitals.
9. In Ibb, staff provided mothers of low birth weight babies with demonstrations on KMC and printed instructions to take home.

#### Phase IV: Going to Scale with Successful Change Efforts

Experiences and lessons learned from the first phase of the Improvement Collaborative were shared and integrated into the plan for the next phase of scale-up. Members of the IC and MOH developed scaling-up plans for the current and new governorates.

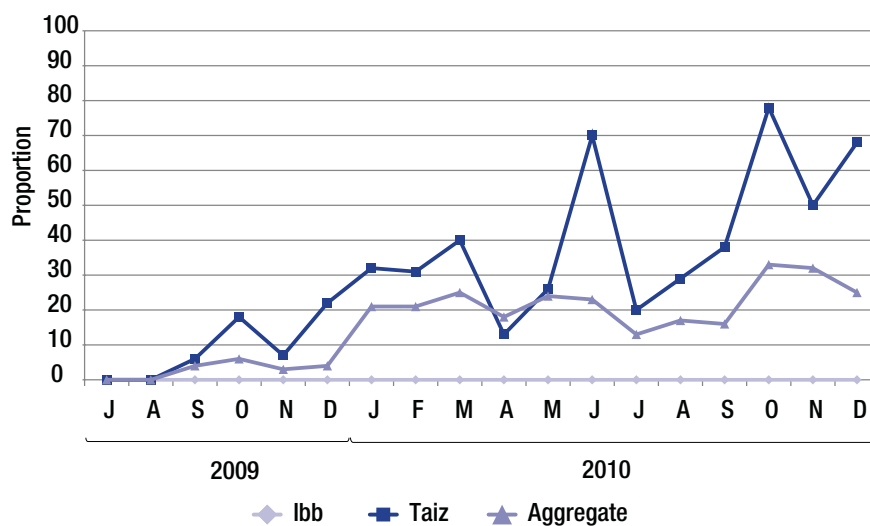
In the fall of 2009, a third phase of the Improvement Collaborative extended the best practices to an additional eight referral hospitals in Amran, Sa'ada, Mareb, Shabwa and El Jawf, and to an additional 130 facilities in their respective catchment areas (51 rural hospitals and 79 health centres).

Figure 5. Improvement in family planning counselling – Mothers who received counselling on family planning before discharge



	2009							2010											
	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
Aden	0	0	33	0	4	7	94	100	97	70	86	99	56	90	93	88	82	85	
Sana'a	0	0	15	28	23	29	33	30	32	32	32	34	36	36	21	32	28	35	
Aggregate of 5 Hospitals	0	0	38	47	35	39	61	59	64	53	61	65	52	62	56	64	64	69	

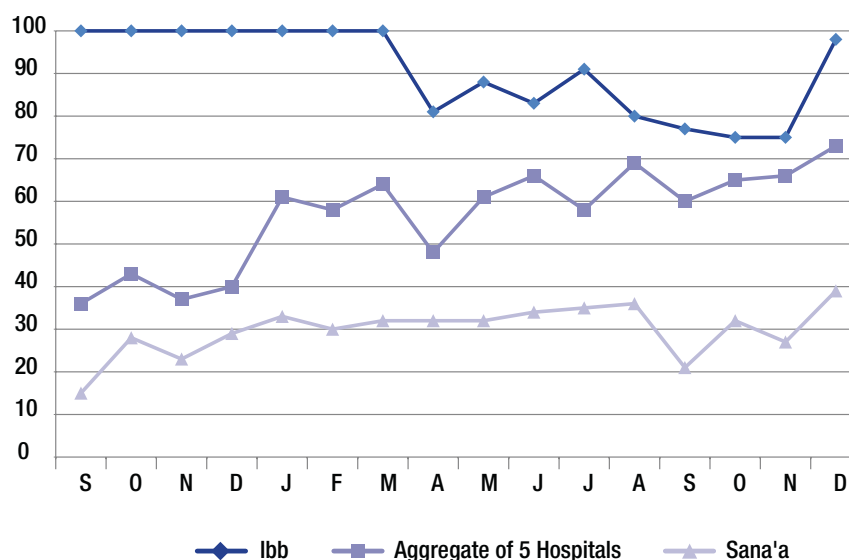
Figure 6. Increase in percentage of women receiving a family planning method before leaving the hospital



	2009							2010											
	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	
Ibb	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	
Taiz	0	0	6	18	7	22	32	31	40	13	26	70	20	29	38	78	50	68	
Aggregate	0	0	4	6	3	4	21	21	25	18	24	23	13	17	16	33	32	25	



Figure 7. Increase in number of women receiving counselling on exclusive breastfeeding before discharge



	2009						2010											
	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D
lbb	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Taiz	0	0	6	18	7	22	32	31	40	13	26	70	20	29	38	78	50	68
Aggregate	0	0	4	6	3	4	21	21	25	18	24	23	13	17	16	33	32	25

In April 2010, the MOH, led by the Secretary General, convened a country team meeting and invited all governorate health directors to a national consultation, where they collectively decided to scale-up the best practices to the remaining 13 governorates. The team discussed two additional best practices for maternal care and added them to the package of best practices (for a total of 12): the use of magnesium sulfate for eclampsia and essential obstetric care, including the use of the partograph during labour.

**Results**

The following charts show results for the original five sites where the Improvement Collaborative was introduced during a 16-month period from September 2009 to December 2010.

Although counselling was not available in all the hospitals at the start of the intervention, the data (Figure 5) shows a marked increase in the proportion of women counselled for family planning use immediately after delivery or miscarriage. The hospital in Aden is highlighted for its steady improvement, since it assigned a midwife to counsel women in the postpartum room. In contrast, Sana'a did not improve much due to the low number of midwives working afternoon and night shifts.

The percentage of women receiving a family planning method before leaving the five hospitals rose from 4% to 25% (Figure 6). This was impressive given that family planning methods were not offered to women after delivery or miscarriage. Taiz Hospital serves as an example of steady improvement in family planning distribution. In contrast, the lbb Hospital team believed that a woman's stress during the immediate postpartum period interfered with her receptiveness to accepting a contraceptive, so they chose not to offer family planning methods until six weeks postpartum. After other hospitals presented their success in the uptake of family planning methods before discharge, however, the lbb team decided to change their approach. This example illustrates the advantages of shared learning in the Improvement Collaborative.

Figure 7 shows an increase in the number of women receiving counselling on exclusive breastfeeding, which rose from 36% to 73% in the five hospitals during the intervention. In contrast to the previous chart, the lbb team was a strong proponent of exclusive breastfeeding from the beginning of the intervention and led all hospitals in counselling.

## The right provider in the right place: scaling-up primary-level postabortion care in Kenya

### *The Context*

Complications from unsafe or incomplete abortions are a major cause of hospital admissions and maternal mortality in Kenya, and they strain the already overburdened public sector health care system. The World Health Organization estimates that complications of abortion contribute to 4% of maternal mortality in developing countries. The 2004 report, "A National Assessment of the Magnitude and Consequences of Unsafe Abortion in Kenya," indicates that more than 300 000 unsafe abortions are performed each year, causing an estimated 20 000 women and girls to be hospitalized with related complications including 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 programme to train private sector nurse-midwives in PAC services. After several Nairobi-based nurse-midwives attended a seminar on PAC held by PRIME in early 1997, they asked PRIME and the Nursing Council of Kenya (NCK) to help them respond to the needs of women suffering from abortion complications. Following the two-year pilot programme (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's strategy to decentralize health care and

expand the role of the private sector. 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 10 years in public, private or mission institutions before being licensed for private practice.

The pilot programme introduced a comprehensive approach to primary-level PAC services. In addition to providing treatment for potentially life-threatening complications from unsafe or incomplete abortions, the nurse-midwives counsel clients about family planning and contraceptive options. They also offer selective reproductive and other health services either at their clinics or via referral to another accessible facility.

The strategy to reach the 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 counselling and treatment is essential to ensuring that women in need seek these services.

### *Process and experience*

#### **Preliminary Phase: Forming the Change Coordination Team**

Funded by USAID, PRIME's pilot programme was sanctioned by the Ministry of Health (MOH) and supported by NCK, which licenses 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 PRIME and PRIME II partners, the MOH and NCK and trained nurse-midwives proved vital to achieving a sustainable and replicable programme. As part of the process, PRIME assisted the MOH in developing PAC performance standards for health workers.

#### **Phase I: Defining the Need for Change**

Before launching the pilot programme, PRIME conducted a baseline assessment to gauge both the potential of 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 programme.



## 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 programme:

- Their facilities had to meet minimum standards for sanitation.
- They had to 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.
- They 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 programme 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 case-load of postabortion clients. By training providers in groups from the same geographic areas, PRIME endeavoured 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 counselling
- 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

In order to support a successful programme with potential for scale-up and sustainability, the pilot focused on enhancing supervision, promoting cost-share and building and maintaining community support and awareness for PAC services.

Follow-up and post-training support to providers is also necessary to ensure high quality PAC services. Providers might need help incorporating elements of PAC into their ongoing range of services or might 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 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 programme 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 implant training, with nurse-midwives paying a tuition fee to the training organization and PRIME and NNAK facilitating the process of selecting appropriate training candidates.

During the pilot programme 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 abortions. 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

This phase presents the closure of the two-phase pilot and the scale-up of activities by a range of actors to further expand access to postabortion care. The pilot programme was implemented in two phases:

1. The first phase, conducted at 44 facilities in 3 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 private-sector PAC services, and that this care can increase the accessibility and use of family planning and contraceptive services.
2. During the second phase, conducted in the same three provinces, 155 providers successfully treated more than 1,600 women with postabortion complications using MVA and counselled 81% of these women in family planning. This resulted in 56% of clients 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, with 98% being counselled in family planning after the procedure and 72% accepting a family planning method.

During scale-up activities, data was collected on reproductive health and other health services offered to women postabortion. Records show that three-quarters were counselled on STI/HIV prevention and/or treatment. Around half received counselling and screening for breast cancer, and nearly 40% received counselling about screening for cervical cancer. Half of the women also received nutrition counselling.

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 programme for its members.

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:

- Provider attitudes
- Competition
- Business acumen
- Range of services offered
- Quality of services
- Participation in peer support networks.

The study made the following recommendations to strengthen providers' business and management capacities:

- Identify an organization to represent providers' needs.
- Redirect PAC advocacy to be more broad-based.
- Support provider peer clusters.
- Link providers to ready sources of capital.
- Foster 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. During a dissemination meeting of stakeholders, including public and private sector, local and international NGOs, donor organizations and health workforce regulatory bodies, recommendations were made to scale up PAC services beyond the private nurse-midwives' facilities. An agreement was reached to increase access to PAC services by expanding the service provider group from doctors to nurse-midwives and clinical officers and decentralizing services to lower-level public, private and community-level facilities. In response, many agencies and organizations engaged in this critical service.

**Capacity building:** The Nursing Council of Kenya approved and incorporated PAC into its basic nurse and midwifery Bachelor of Science in Nursing programme. The scope of practice of midwives and clinical officers was formally expanded to include provision of comprehensive postabortion care. These are the two cadres of health workers who staff most public-sector facilities; therefore, graduating nurse-midwives and clinical officers now have the skills capacity to provide PAC services.

**Clinical service delivery:** Private nurse-midwives have continued to train within their clusters for expansion of services and supervision as they continue to offer services. Government facilities at lower levels that did not offer services before are now offering services.

**Community PAC:** The ACQUIRE project led by EngenderHealth in partnership with Society for Women and AIDS (SWAK) engaged communities in low-resource settings to increase access and quality use of PAC/FP services. Service providers in those communities (both government and private midwives)

were trained in PAC--412 individuals in 16 community groups were trained to advocate for and support PAC efforts.

**Youth FP and PAC Services:** To increase access to PAC services that are responsive to adolescents' needs, a youth-friendly postabortion care (YFPAC) programme was initiated by Pathfinder International. Building on existing programmes, this programme involved training three hospital-based health workers to offer PAC services that meet the special needs of youth. The AIDS, Population and Health Integrated Assistance (APHIA II) project supported peer educators. Theatre groups were trained on prevention of unwanted pregnancies, unsafe abortion, STI/HIV and access to YFPAC services. The community leaders were also trained in advocacy for youth-focused needs. As a result, three facilities provided youth-friendly PAC/FP services, 16 providers were trained in adolescent friendly services, 422 adolescent PAC clients were served and 71 adolescents accepted modern family planning methods.

**MVA Equipment Supplies:** The government was willing to purchase and distribute MVA equipment in bulk, but there were many obstacles in the face of this initiative. However, this equipment is available from donors and from pharmaceutical shops.

In line with Constitutional provisions for high-quality reproductive health services, implementation of Kenya's Vision 2030, and adherence to MDG 5, the Government of Kenya, via the MOH, has put in place mechanisms to reduce morbidity and mortality resulting from complications of spontaneous and induced abortion. To this end, the MOH continues to expand access to family planning and contraceptive services, including to adolescents and youth. Interventions include strengthening the supply of quality health services by taking

advantage of FP commodities and equipping health care providers with appropriate skills, including those for long-acting and permanent contraception, while simultaneously increasing the demand for high-quality services through advocacy in partnership with other Government agencies such as the National Council for Population and Development (NCPD) and partners.

Furthermore, the MOH has focused on improving the quality of PAC services by emphasizing the ability of the health system to provide the core components of PAC (emergency treatment for complications of spontaneous or induced abortion; provision of family planning counselling and services, evaluation and treatment of STIs and HIV testing and counselling; and community empowerment through awareness and mobilization) in a manner that responds to the needs of clients and communities. This has resulted in the revision of the National PAC Training Curriculum and the development of the National PAC Reference Manual, both of which await a national launch. The curriculum uses a competency-based training approach and encompasses the use of misoprostol for PAC where appropriate. To further reduce the burden of complications resulting from spontaneous and induced abortion, the MOH has recently published Standards and Guidelines for Reducing Maternal Morbidity and Mortality from Unsafe Abortion in Kenya (MOMS, 2010), which provides standards and guidelines for primary and secondary prevention as well as PAC services.

These interventions are expected to significantly reduce maternal morbidity and mortality by reducing complications from spontaneous and induced abortion, thereby propelling the country towards its achievement of national and international reproductive health goals.

## Resource list

### Preliminary Phase: Form the Change Coordination Team

*Science of Improvement: Forming the Team.* In Institute for Health Care Improvement. [website]. (<http://www.ihc.org/knowledge/Pages/HowtoImprove/ScienceofImprovementFormingtheTeam.aspx>, accessed 4 November 2013).

*Performance Improvement: Stages, Steps and Tools, Stage 2: Obtain and Maintain Stakeholder Agreement.* In IntraHealth International [website]. (<http://www.intrahealth.org/sst/stage2.html>, accessed 4 November 2013).

Management Sciences for Health. *Developing Managers Who Lead: A Handbook for Improving Services.* Boston: Management Sciences for Health, 2005.

### Phase I: Defining the Need for Change

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.

*Performance Improvement: Stages, Steps and Tools, Stage 6: Find Root Causes.* In IntraHealth International [website]. (<http://www.intrahealth.org/sst/stage6.html>, accessed 4 November 2013).

Management Sciences for Health. *Developing Managers Who Lead: A Handbook for Improving Services.* Boston: Management Sciences for Health, 2005.

### Phase II: Planning for Demonstration and Scale-Up

ACQUIRE Project. *Guidance for Program Staff. Integrating Best Practices for Performance Improvement, Quality Improvement, and Participatory Learning and Action to Improve Health Services.* New York, NY: EngenderHealth; 2005 ([http://www.acquireproject.org/archive/files/4.0\\_strengthen\\_services\\_and\\_systems/4.2\\_resources/4.2.4\\_tools/guidelines\\_pi\\_qi\\_pla\\_june\\_2005\\_final.pdf](http://www.acquireproject.org/archive/files/4.0_strengthen_services_and_systems/4.2_resources/4.2.4_tools/guidelines_pi_qi_pla_june_2005_final.pdf), accessed 4 November 2013).

Adamou B. *Guide for Monitoring Scale-up of Health Practices and Interventions.* Chapel Hill, NC: MEASURE Evaluation; 2013 (<http://www.cpc.unc.edu/measure/publications/MS13-64>, accessed 4 November 2013).

Cooley L, Kohl R. *Scaling Up – From Vision to Large-Scale Change: A Management Framework for Practitioners. Second edition.* Washington, DC: Management Systems International; 2012. (<http://www.msiworldwide.com/wp-content/uploads/Scaling-Up-Framework.pdf>, accessed 4 November 2013).

Editors' note. *Leading Changes in Practices to Improve Health.* Cambridge, Boston, MA: Management Sciences for Health; 2004 (The Manager, Vol. 13, No. 3; [http://erc.msh.org/TheManager/English/V13\\_N3\\_En\\_Issue.pdf](http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf), accessed 4 November 2013)

*The Cochrane Collaboration* [website] (<http://www.cochrane.org>, accessed 4 November 2013).

World Health Organization. *Sexual and reproductive health* [website] (<http://www.who.int/reproductivehealth>, accessed 4 November 2013).

World Health Organization/ExpandNet. *Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up.* Geneva: World Health Organization; 2011 ([http://www.who.int/reproductivehealth/publications/strategic\\_approach/9789241502320/en/index.html](http://www.who.int/reproductivehealth/publications/strategic_approach/9789241502320/en/index.html), accessed 4 November 2013).

World Health Organization/ExpandNet. *Practical guidance for scaling up health service innovations.* Geneva: World Health Organization; 2009 ([http://www.who.int/reproductivehealth/publications/strategic\\_approach/9789241598521/en/](http://www.who.int/reproductivehealth/publications/strategic_approach/9789241598521/en/), accessed 4 November 2013).

### Phase III: Supporting the Demonstration

Adamou B. *Guide for Monitoring Scale-up of Health Practices and Interventions.* Chapel Hill, NC: MEASURE Evaluation; 2013 (<http://www.cpc.unc.edu/measure/publications/MS13-64>, accessed 4 November 2013).

*Creating a Work Climate That Motivates Staff and Improves Performance.* Cambridge, Boston, MA: Management Sciences for Health; 2002 (The Manager, Vol. 11, No. 3; <http://www.msh.org/sites/msh.org/files/Creating-a-Work-Climate-that-Motivates-Staff-and-Improves-Performance.pdf>, accessed 4 November 2013).

Editors' note. *Leading Changes in Practices to Improve Health.* Cambridge, Boston, MA: Management Sciences for Health; 2004 (The Manager, Vol. 13, No. 3; [http://erc.msh.org/TheManager/English/V13\\_N3\\_En\\_Issue.pdf](http://erc.msh.org/TheManager/English/V13_N3_En_Issue.pdf), accessed 4 November 2013).

Kotter JP. *Leading Change.* Boston: Harvard Business School Press; 1996.

## Phase IV: Going to Scale with Successful Change Efforts

Adamou B. *Guide for Monitoring Scale-up of Health Practices and Interventions*. Chapel Hill, NC: MEASURE Evaluation; 2013 (<http://www.cpc.unc.edu/measure/publications/MS13-64>, accessed 4 November 2013).

Brown W. *Data Quality Assurance Tool for Program Level Indicators*. Chapel Hill, NC: MEASURE Evaluation; 2007. (<http://www.cpc.unc.edu/measure/publications/ms-07-19>, accessed 4 November 2013).

Cooley L, Kohl R. *Scaling Up – From Vision to Large-Scale Change: A Management Framework for Practitioners. Second edition*. Washington, DC: Management Systems International; 2012. (<http://www.msiworldwide.com/wp-content/uploads/Scaling-Up-Framework.pdf>, accessed 4 November 2013).

SEED™ *Assessment Guide for Family Planning Programming*. New York, NY: EngenderHealth, 2011. (<http://www.engenderhealth.org/pubs/family-planning/seed-assessment-guide-for-family-planning.php>, accessed 6 November 2013).

Foreit K, Moreland S, LaFond A. *Data Demand and Information Use in the Health Sector A Conceptual Framework*. Chapel Hill, NC: MEASURE Evaluation; 2006. (<http://www.cpc.unc.edu/measure/publications/ms-06-16a>, accessed 4 November 2013).

*Family Planning and Reproductive Health Indicators Database*. Chapel Hill, NC: In MEASURE Evaluation PRH [website]; ([http://www.cpc.unc.edu/measure/prh/rh\\_indicators](http://www.cpc.unc.edu/measure/prh/rh_indicators), accessed 4 November 2013).

Population Reference Bureau. *Guidelines for Effective Data Presentations*. ([http://www.prb.org/pdf/ConnectingPeopleSects1\\_2.pdf](http://www.prb.org/pdf/ConnectingPeopleSects1_2.pdf), accessed 4 November 2013).

World Health Organization/ExpandNet. *Worksheets for developing a scaling-up strategy*. 2012. (<http://www.expandnet.net/PDFs/ExpandNet-WHO%20Worksheets%20-%20July%202012.pdf>, accessed 4 November 2013).

World Health Organization/ExpandNet. *Nine steps for developing a scaling-up strategy*. Geneva: World Health Organization; 2010 ([http://whqlibdoc.who.int/publications/2010/9789241500319\\_eng.pdf](http://whqlibdoc.who.int/publications/2010/9789241500319_eng.pdf), accessed 4 November 2013).

World Health Organization/ExpandNet. *Practical guidance for scaling up health service innovations*. Geneva: World Health Organization; 2011 ([http://www.who.int/reproductivehealth/publications/strategic\\_approach/9789241598521/en/](http://www.who.int/reproductivehealth/publications/strategic_approach/9789241598521/en/), accessed 4 November 2013).

World Health Organization/ExpandNet. *Scaling-Up Health Service Delivery: From Pilot Innovations to Policies and Programmes*. Geneva: World Health Organization; 2007 ([http://www.who.int/reproductivehealth/publications/strategic\\_approach/9789241563512/en/index.html](http://www.who.int/reproductivehealth/publications/strategic_approach/9789241563512/en/index.html), accessed 4 November 2013).

## Improvement collaborative

USAID Health Care Improvement Project. *The Improvement Collaborative: An Approach to Rapidly Improve Health Care and Scale Up of Quality Services*. 2008. Bethesda, MD: University Research Co., LLC. (<http://www.hciproject.org/publications/improvement-collaborative-approach-rapidly-improve-health-care-and-scale-quality-servic>, accessed 6 November 2013).

IHI (Institute for Healthcare Improvement). 2003. *The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. Innovation Series*. Cambridge, MA: Institute for Healthcare Improvement. (<http://www.ihl.org/knowledge/Pages/IHIWhitePapers/TheBreakthroughSeriesIHICollaborativeModelforAchievingBreakthroughImprovement.aspx>, accessed 6 November 2013).

Tawfik Y, Bornstein T, Marquez L, Hermida J, Boucar M, Donohue K. *Improving Maternal, Newborn, Child Health, and Family Planning Programs through the Application of Collaborative Improvement in Developing Countries: A Practical Orientation Guide. Technical Report*. 2012. Bethesda, MD: USAID Health Care Improvement Project. University Research Co., LLC. ([http://www.hciproject.org/sites/default/files/MNCH-FP%20collaborative%20improvement%20guide\\_Mar12\\_0.pdf](http://www.hciproject.org/sites/default/files/MNCH-FP%20collaborative%20improvement%20guide_Mar12_0.pdf), accessed 6 November 2013).

Massoud MR, Donohue KL, McCannon CJ. *Options for Large-scale Spread of Simple, High-impact Interventions. 2010. Technical Report*. Bethesda, MD: USAID Health Care Improvement Project. University Research Co., LLC. (<http://www.hciproject.org/publications/options-large-scale-spread-simple-high-impact-interventions>, accessed 6 November 2013).

Massoud R, Askov K, Reinke J, Franco LM, Bornstein T, Knebel E, MacAulay C. *A Modern Paradigm for Improving Healthcare Quality. QA Monograph Series 1(1) 2001*. Bethesda, MD.: USAID Quality Assurance Project. (<http://www.hciproject.org/publications/modern-paradigm-improving-healthcare-quality>, accessed 6 November 2013).

## References

1. Kotter JP. *Leading Change*. Boston: Harvard Business School Press; 1996.
2. Rogers E. *Diffusion of Innovations*. Detroit: Free Press; 2003.
3. Jacobstein, Roy. *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.
4. Glaser EM, Abelson HH, Garrison KN. *Putting knowledge to use: facilitating the diffusion of knowledge and the implementation of planned change*. San Francisco, CA, Jossey-Bass Inc., 1983.
5. Miller K, Lawton R. *The change agent's guide to radical improvement*. Milwaukee, WI: ASQ Quality Press; 2002.
6. Editors' note. *Leading Changes in Practices to Improve Health*. Cambridge, MA: Management Sciences for Health; 2004 (The Manager, Vol. 13, No. 3; <http://www.msh.org/resources/leading-changes-in-practices-to-improve-health>, accessed 4 November 2013).



## Annexes

This newly updated version of the Guide to Fostering Change to Scale Up Effective Health Services, originally published in 2007, integrates ExpandNet/WHO's scaling-up guidance tools and the Improvement Collaborative approach. More detail on these methods, as well as a glossary and references, are provided in this annex.

**ExpandNet and WHO tools for Fostering Change for Scale Up.** These guidance tools support policy-makers, programme managers and those providing technical assistance with strategic planning and management of the scaling-up process. The integration of parts of these documents strengthens the Guide to Fostering Change to Scale Up Effective Health Services by providing users with proven practical steps to systematically plan for scaling up and implement scaling-up strategies.

**Improvement Collaborative.** This approach brings together organized networks of multiple sites to accomplish common aims through shared learning. The incorporation of this model strengthens the Guide to Fostering Change to Scale Up Effective Health Services by providing users with a model of continuous quality improvement and sharing of experiences to support the introduction and scale up of health practices.

**Glossary of Terms.** The glossary provides definitions for many of the key terms used throughout the Guide to Fostering Change to Scale Up Effective Health Services.

**References.** View the full list of references used in the Guide to Fostering Change to Scale Up Effective Health Services.

## Annex 1. ExpandNet and WHO Tools for Fostering Change for Scale-up

ExpandNet, in collaboration with the World Health Organization (WHO)/Department of Reproductive Health and Research, has combined comprehensive literature reviews, extensive field experience and a conceptual framework to produce several guidance tools that support policy-makers, programme managers and those providing technical assistance with strategic planning and management of the scaling-up process. These tools, outlined below, were developed to ensure that the benefits of proven health practices are sustainably expanded and institutionalized to benefit more people.

In addition, a book entitled *Scaling up health service deliver: from pilot innovations to policies and programmes*, presents the ExpandNet conceptual framework for scaling up and case studies that analyze the expansion of health service innovations in public sector programmes in Africa, Asia and Latin America. All these and several other resources that support scaling up are freely available on the ExpandNet website at <http://www.expandnet.net>.

### ***Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up.***

Pilot projects often show impressive results, but their influence tends to remain confined to the original target areas, and their results are often unsustainable. One reason for this is that the requirements of large-scale implementation are rarely taken into account at the time of pilot or field-testing. The *Beginning with the end in mind* guide provides 12 recommendations and a checklist to help build scaling up considerations into projects from the earliest stages of

designing a pilot, demonstration or other operations research intervention. The recommendations, which stem from peer-reviewed literature, as well as experience, are as follows:

1. Engage in a participatory process involving key stakeholders.
2. Ensure the relevance of the proposed innovation.
3. Reach consensus on expectations for scale-up.
4. Tailor the innovation to the socio-cultural and institutional settings.
5. Keep the innovation as simple as possible.
6. Test the innovation in the variety of socio-cultural and institutional settings where it will be scaled up.
7. Test the innovation under the routine operating conditions and existing resource constraints of the health system.
8. Develop plans to assess and document the process of implementation.
9. Advocate with donors and other sources of funding for financial support beyond the pilot stage.
10. Prepare to advocate for necessary changes in policies, regulations and other health systems components.
11. Develop plans for how to promote learning and disseminate information.
12. Plan on being cautious about initiating scale-up before the required evidence is available.

### ***Nine steps for developing a scaling-up strategy.***

Once testing is complete, strategic planning for expansion and institutionalization of successful health innovations should happen. However, while there is often interest among programme managers and others in engaging in a systematic planning process, these players often lack the experience, know-how and resources to do so. The tool *Nine steps for developing a scaling-up strategy* can enhance capacity among managers and others to complete these tasks.

The nine-step guide assists programme managers, technical assistance personnel, researchers and policy-makers with the process of developing a scaling-up strategy. This document has been used in a facilitated process of strategy development



with programme/project managers from a range of countries including Guatemala, India, Kenya, Kyrgyzstan, Madagascar, Mali, Peru, Rwanda, Senegal, Sierra Leone and Yunnan, China.

The ExpandNet framework for scaling up is a roadmap that guides step-by-step development of a scaling up strategy. The framework consists of five elements:

1. The innovation: this is not just a new technology or practice but also the supportive factors (counselling, supervision, logistics) required for implementation.
2. The user organization which is expected to implement the innovation (Ministry of Health, NGO, private organization, or a combination of these).
3. The environment: the larger context within which scaling up takes place.
4. The resource team which supports the process.
5. The scaling up strategy: the means by which the innovation is communicated, disseminated or otherwise promoted.

Two types of guided scaling up are expansion and institutionalization. Expansion refers to the implementation of the change practice in different geographic sites or service facilities, or to its replication with larger or different population groups. Institutionalization refers to the policy, political, legal, regulatory, budgetary or other changes needed to ensure the practice is incorporated into the health system on a sustainable basis. The strategy development process must address questions about each element of the framework and determine what actions must be taken for successful scaling up.

***Practical guidance for scaling up health service innovations.*** This document provides a more comprehensive examination of scaling up than the Nine-Step Guide, focusing not only on how to scale up innovations but also how to strategically plan and manage scaling up. It was developed in response to the need expressed by programme managers, policy-makers and technical assistance personnel for practical guidance to assist with the process of scaling up.

### ***Who should use these tools, and when?***

*Beginning with the end in mind* is intended to help those who design pilot projects or other programmatic research increase the likelihood that the practice can be implemented on a large scale if proven successful. The tool can be used in the initial stages of a project and throughout the process to make necessary adjustments.

*Nine steps for developing a scale-up strategy* is for those who have successfully field-tested an innovation and are ready to scale it up. The guide and key questions from the accompanying worksheets help facilitate the development of a scaling up strategy. ExpandNet members have used these tools to facilitate participatory planning processes in several countries in Asia, Africa and Latin America.

*Practical Guidance for scaling up health service innovations* is relevant throughout the entire scaling up process, from pilot development and implementation to the management of scaling up. It provides insight and lessons learned from global experience with scaling up.

### ***Using the tools in a participatory process***

The nine step guide leads users through an analysis of their project that results in a set of recommendations for action which will form the basis of a strategy to scale up successful pilot or demonstration project. The guide is accompanied by a set of worksheets with detailed questions that support the process of strategy development. These two tools can be used by individuals, a small team or in a multi-stakeholder endeavour. The essence of the strategy development process involves asking a set of questions about each of the elements of the framework and determining what actions need to be taken to increase the potential for successful scaling up.

Members of ExpandNet and the WHO Department of Reproductive Health and Research have used the ExpandNet framework and tools in a participatory, country-led process that is grounded in field realities. Country strategy development exercises have typically involved the following six components; however, the details have differed depending on the country situation.

1. Exchange of materials and other preparatory steps between ExpandNet facilitators and the project team, which can include local translation of guidance materials.
2. Initial meetings with the project team after arrival in-country to allow in-depth discussion of the current status of the project is discussed and orientation to the ExpandNet framework and nine-step approach.
3. Field visits and stakeholder interviews. Facilitators and country team members visit project sites and non-project sites to understand the local context and perspectives. Discussions with providers, programme managers, community members and clients provide opportunities to understand how the project is implemented on the ground and to identify challenges and opportunities for scaling up.
4. Workshop preparation. After field work, the project team and facilitators decide which questions from the strategy development worksheets should be answered during the participatory stakeholder workshop.
5. Two-day strategy development workshop. Workshop participants are key stakeholders in the scaling up process who together analyse the innovation; the implementing organization(s); the resource team who will support the scaling-up process; and the socio-economic, cultural, political and bureaucratic environment in which scaling up will take place. Action steps needed to scale the innovation up are identified and recorded and, taken together, constitute the building blocks of the scaling-up strategy.
6. Follow-up. After the workshop, the project team revises workshop recommendations and assembles them into a scaling-up strategy document, which is presented to relevant stakeholders and task forces.

### *Examples of outcomes from using ExpandNet/WHO tools*

- **Using *Beginning with the end in mind*:** The HoPE-LVB Project team, comprised of conservation and reproductive health NGOs working together on a population health and environment project in East Africa had been planning to themselves undertake capacity-building activities in sustainable agro-forestry practices at the community level. When they reoriented their thinking towards strengthening sustainability and scalability of project interventions, they opted instead to mobilize existing structures such as the inactive village environmental committees, subcounty council members working on the environment and district-level environmental officers, thereby embedding the knowledge and training capacity more deeply and widely than in just the community where the project is working.
- **Applying the *Nine steps for developing a scaling-up strategy* development approach:** The UNFPA-led Stronger Voices project in Kyrgyzstan, which sought to strengthen both demand for and supply of quality SRH services, was scaling up from a few initial pilot villages on the basis of intensive village-level training by national level Ministry representatives. This approach was not sustainable and was unlikely to yield large-scale impact. As a result of the scaling up strategy development workshop, plans were made to link the project with national health reform and financing mechanisms already underway, to join forces with related community interventions funded by other donors and, perhaps most importantly, to shift from a village-by-village approach to a district-wide focus that newly involved local government authorities.

## Annex 2. Improvement Collaborative

An Improvement Collaborative occurs when an organized network of a large number of sites (districts, facilities or communities) work together for a specified period of time to achieve significant improvements in a focused topic through shared learning. Since several sites participate in Improvement Collaborative, the results achieved by an individual site are shared with learning community. The participating sites reorganize their service delivery systems to implement proven interventions to strengthen outcomes. Teams at different facilities rapidly test means of operationalizing the interventions and share results to develop the best strategy for achieving the goal. During collaboration, teams from different health facilities or sites gather in learning sessions to share ideas for improvement and results they have achieved. The intervals between learning sessions are known as action periods--periods of intense activity during which each team implements changes and measures results.

The Model for Improvement is the driving force that guides the development of the improvement project with three fundamental questions:

- What are we trying to accomplish? Specify the aim, or objective, of the improvement effort.
- How will we know that a change results in an improvement? Choose the outcome and process indicators that will be used to measure progress.
- What changes can we make that will result in an improvement? Identify the specific actions that will be taken to improve the system or the quality of services.

An Improvement Collaborative is usually implemented in three phases (Figure 8):

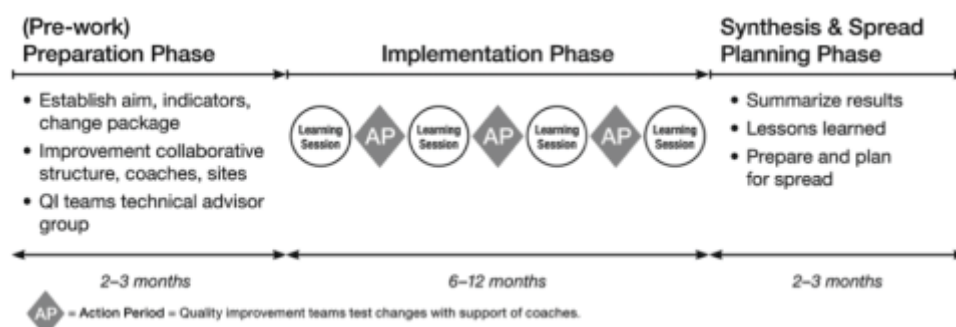
1. Preparation phase: Establish aim, indicators, innovation to be tested, Improvement Collaborative structure, steering committee or technical advisory group, coaches, sites and quality improvement (QI) teams. Define roles and responsibilities.
2. Implementation phase: Conduct learning sessions and action periods to test the innovation.
3. Synthesis and initiating spread phase: Summarize results, document lessons learned and prepare and plan for scale-up.

### Management Structure

A few key people manage the Improvement Collaborative process: a director, a coordinator, a quality improvement (QI) advisor and a technical expert. Coaches are selected and then trained to support and enhance the performance of QI teams. These teams lead the QI process in their respective sites.

A Steering Committee (SC) or Technical Advisory Group (TAG) often supports the Improvement Collaborative effort. In programmes that address maternal, newborn and child health (MNCH), for example, the SC or TAG reviews the practices or standards that guide the aim and indicators of the process to ensure compliance with national health policies and guidelines. Involving SC or a TAG from the beginning assures that the results of the collaborative will be endorsed by stakeholders at the national level and enhances the chances of obtaining approvals for spread.

Figure 8. Implementation phases



### *Documenting results*

A QI team that includes representatives of both service providers and clients manages the improvement process in each site. Each QI team usually assigns a team member the task of collecting data to measure the selected indicators. The QI team will examine and discuss these indicators to interpret the effect of the adopted changes and determine whether they resulted in the desired improvement. The data are checked for accuracy by the QI coach, who provides overall technical support to the QI team.

The coaches facilitate the aggregation of data for participating sites to assess collective progress. The aggregated data for all participating health sites provide an average, which, if plotted on a chart with results from individual sites, allows each site to compare its performance to the other sites. This motivates continual improvement and creates opportunities for discussion and experience-sharing among teams. It also helps coaches determine when to intervene if a team is not showing progress.

For more information about Improvement Collaborative, visit: <http://www.hciproject.org/node/3584>.

### Annex 3. Glossary of Terms

**Champions.** Champions believe in and want the proposed change. They attempt to obtain commitment and resources for the change, but are not necessarily involved in implementation.

**Change Agent.** Change agents facilitate the development, application and advocacy for new practices. They transmit their commitment and enthusiasm to those who do the day-to-day work, resulting in the implementation and institutionalization of new practices. Successful change agents work with management to support other staff in the change effort. They have the skills and temperament to lead teams to achieve results. Change agents can be front-line staff or management.

**Change Coordination Team.** The change coordination team oversees the change process and fosters or facilitates the change. The team should have clear leadership capacity, as it will be responsible for identifying evidence-based practices and obtaining political support and resources from relevant stakeholders. If a primary change agent has already been identified, he or she will be a key member of the team.

The members of the change coordination team will vary with the setting and the nature of the proposed change. Team members might be appointed by the Minister of Health or other senior government officials and can include representatives of nongovernmental, donor and international organizations.

**Clusters of Influence.** In his book *Diffusion of Innovations*, Everett Rogers discusses a theory of effective change and describes how innovations are spread and how the process of change works. Rogers describes three main clusters of influence in the diffusion of innovations that correlate to the spread of the innovation: peoples' perceptions of the innovation (benefit versus risk), characteristics of the people who adopt the change and contextual factors (especially communication, incentives, leadership and management).

**Demonstration period.** A demonstration period is a limited period of time in which the innovation is tested on a smaller scale than eventually desired in order to learn what other changes will need to be made in order to facilitate its implementation at a larger scale. This is commonly referred to as the pilot test.

**Early Adopters.** Early adopters are the first people to try new ideas, processes, goods and services. They act as pioneers or leaders, testing out what is new. Potential adopters look to early adopters for advice and information on an innovation. Once the innovation has caught on and is seen as a positive change, others are confident following the early adopters' lead. Early adopters are typically the most effective internal change agents.

**Expansion.** Expansion, or horizontal scaling up, refers to the implementation of the change practice in different geographic sites or service facilities, or to its replication with larger or different population groups.

**Implementing Team.** During Phase III, the implementing team undertakes the demonstration. They are supported by the coordination team, which helps maintain the energy, focus and consistency of the change process at test sites and oversees the continuous assessment and modification of the process.

**Improvement Collaborative.** This method of quality improvement is a short- to medium-term (12- to 24-month) initiative that organizes teams of providers or community members, usually in geographically diverse locations, to work together to achieve shared aims and to communicate with each other on a regular basis. IC incorporates traditional interventions for improving services, such as provider training and updates to service standards, with quality improvement techniques such as creating a quality improvement team composed of local health care providers. These providers identify obstacles to new practice implementation, seek solutions to address them and monitor the overall results. All providers receive clinical training to provide new methods of care and implement the new standards in their local settings. Common improvement objectives and indicators are shared by all the teams in the Collaborative.

**Innovation.** The innovation refers to the interventions or practices to be scaled up. The innovation is typically a package of interventions consisting of several components. The innovation might have been widely implemented elsewhere or may be an established effective or best practice, but it is still considered an innovation if it is new in the context where it is to be scaled up.

**Innovators.** The innovators are usually a small group: 2.5 percent of the population. They are risk takers or are risk tolerant and like to try new things. They can be seen as different or reckless, but also visionary and inspiring.

**Institutionalization.** Institutionalization, or vertical scaling up, refers to the policy, political, legal, regulatory, budgetary or other changes needed to ensure the practice is fully integrated into the structure and function of the health system on a sustainable basis.

**Opinion Leaders.** The opinion leaders are those whose beliefs or ideas are widely regarded by society or a certain group of people and who therefore have influence over whether or not a particular change is adopted.

**Resource team.** These individuals and organizations were involved in the testing of the innovation and seek to promote and facilitate wider use of the innovation during the process of scaling up. They might be formally charged with promoting the process or may act informally in this role.

**Scale up.** Although scale up (also known as scaling up or going to scale) has been used in the literature with a wide variety of different definitions, this document uses the ExpandNet definition of scale-up: “Deliberate efforts to increase the impact of successfully tested health innovations so as to benefit more people and to foster policy and programme development on a lasting basis.”

**Scaling-up strategy.** The means by which the innovation is implemented, monitored, evaluated and communicated. This includes the plans and actions necessary to fully establish the innovation in policies, programmes and service delivery.

**Sustainability.** The goal of any scale up is for the scaled-up practice or innovation to be maintained and successful in the long run. Mainstreaming the practice or innovation into policies, systems and programmes is key to sustainable change.

**Stakeholder.** Stakeholders are the individuals whose commitment and cooperation is required to implement scale up. Key stakeholders include:

*Beneficiaries*, who will benefit from a new service, product, or way of operating.

*Health service providers*, who will implement the new practice or set of practices.

*Managers and leaders* within and outside the organization, who will provide the necessary support for implementation.

*Policy-makers*, whose support is highly valuable for scale-up efforts.

**User organization.** User organization refers to the institutions or organizations that seek to adopt and implement the innovation.





**For more information:**

Visit the Guide to fostering change online resource:  
[www.k4health.org/toolkits/fostering-change](http://www.k4health.org/toolkits/fostering-change)

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