IRH Lessons Learned in ‘Embracing Scale Up Error’ in Five Countries

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Standard Days Method: From Research to Practice

- Method Concept & Efficacy Trial 1998-2002
- Pilot Studies 2000-2004
- Operations Research 2003-2005
- Integration Studies 2005-2007
- Scale-Up Case Studies 2007-2013
5 years of systematic scale up and accompanying research in 5 countries

- Expanding access to SDM at national / regional scale in FP programs
- DR Congo, Guatemala, India, Mali, and Rwanda
- Even with strong pilots and scale up planning, during different scale up phases, different things can go wrong!
Scaling up intervention and research informed by conceptual framework

- ExpandNet/WHO scaling up framework
- Scale up processes and outcomes measured through
  - pre/post scale up research at household and facility level,
  - FP stakeholder interviews
  - benchmark tracking,
  - key events monitoring,
  - Most Significant Change story collection
Overlapping phases, not discrete steps...

Source: PATH’s product development process
What is scale up success? In addition to integration into norms and sub-systems...

<table>
<thead>
<tr>
<th>SDM scale up goals by country</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Guatemala</strong></td>
</tr>
<tr>
<td>SDM offered in at least 1/6 of the country (3 departments)</td>
</tr>
<tr>
<td><strong>DRC</strong></td>
</tr>
<tr>
<td>SDM offered in at least 50% of country (ie, in 250 of 515 health zones, <strong>accompanying GoDRC efforts</strong> to re-establish national FP program)</td>
</tr>
<tr>
<td><strong>India</strong></td>
</tr>
<tr>
<td>SDM/LAM availability <strong>at facility and community level</strong> in 11/24 districts in Jharkhand State</td>
</tr>
<tr>
<td>40% of WRA in these districts have heard of SDM and LAM</td>
</tr>
<tr>
<td><strong>Mali</strong></td>
</tr>
<tr>
<td>Reinforce SDM <strong>integration</strong> in 90% of public, private, and community SDPs in 8 regions of Mali and the district of Bamako.</td>
</tr>
<tr>
<td><strong>Rwanda</strong></td>
</tr>
<tr>
<td>SDM integrated into at least 95% of SDPs and at least 20% of pharmacies and <strong>private</strong> clinics supported by PSI.</td>
</tr>
</tbody>
</table>

1 - Define SU outcomes operationally and within context!
Ensuring fidelity of core elements of SDM remains intact once it begins to go to scale

- SDM scale up ‘package’ includes product (CycleBeads), training and supervision tools, IEC materials, etc.
- During pilot phase in Peru, Rwanda, and India, research indicated that SDM could be easily offered and used.
- Early scale up phase used pilot phase materials/tools, but lower level providers had problems understanding training, AND,
- Training too long to be integrated into national FP training curricula.
- **Response:** Simplified, shortened and validated curricula and tools to facilitate integration.

2-You might think training and provider tools are simple enough, but will need to simplify even more for scale up
Each innovation faces unique social and political challenges, even if defined as a ‘priority intervention’ by the MOH

- SDM can challenge core beliefs of some providers and managers about ‘what is modern contraception,’ which can be managed during pilot stage via one-on-one discussions.
- Going to scale, individual discussions were impossible, which led to re-emergence of skepticism about SDM and its efficacy (confusion with other NFPs).
- **Response:** District ‘SDM focal points’ strategy *plus* renewed advocacy.
Competition with Other Priority FP Interventions

- New methods need to develop a ‘social reputation’ to succeed.
- Focused on systems strengthening versus awareness creation in early years.
- With limited resources, SDM promotion cannot compete with other underused methods with more resources.
- **Question:** Finding the supply-demand balance – When? How much?

4-Start early and match SDM promotion efforts to level of others to create equity.
Until New Best Practices are Institutionalized...

- Pilot studies showed important results
- Going to scale, need evidence that SDM investment is worth the system investment (measured most often as new FP users)
- BUT - HMIS system revisions occur only periodically, government info is unavailable, and need to reassure policy makers of their scale up investment
- AND – quality questions will often arise
- **Response:** Develop a comprehensive quality assurance approach to collect service data and quality of service delivery and end use data
Scale up monitoring cannot use a simple checklist approach

• Opportunities (‘seize the moment’) can lead to quick gains in institutionalization. STILL, never assume once something is institutionalized it never changes.

• Rwanda
  – Between 2009 and 2010, inclusion of SDM/LAM in two important systems (finance and HMIS) were reversed,
  – Which led to dis-incentives & -legitimization (if not counted, not important).

• **Response**: Advocacy. Still, cyclical nature of systems revisions means it takes time to reverse reporting rules

6-Given dynamic nature of systems, need to monitor gains to ensure they are not reversed
1. Define SU outcomes operationally and within context!

2. You will need to simplify tools and guidance even more for scale up.

3. Repeat method evidence throughout intro and expansion phases.

4. Start early and match SDM promotion efforts to level of others to create equity.

5. Until HMIS-integrated, temporary user & QA monitoring systems give evidence of results.

6. Monitor systems gains to ensure they are not reversed.

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INNOVATE
Research and development

INTRODUCE
Product demonstration

INTEGRATE
Expansion for sustained public health impact

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ADVOCATE

COLLABORATE

COMMUNICATE RESULTS

---

AND THROUGHOUT ---

3. Repeat method evidence throughout intro and expansion phases.

5. Until HMIS-integrated, temporary user & QA monitoring systems give evidence of results.
Some final thoughts...

- Need to recognize
  - Constantly changing systems and political environments lead to implementation challenges, even with good scale up planning.
  - As a multi-year and multi-organization process, you cannot control all scale up efforts or consequences.
- Those involved in systematic scale up should document implementation surprises, miscalculations, and incorrect assumptions at different phases of scale up
- To contribute to refining knowledge of common scale up threats and help others to avoid them in the future.
Monitoring the Scale Up of Best Practices for Reproductive Health in Kenya: A Pilot Experience

Lucy Wilson¹, Marsden Solomon¹, Erika Martin¹, Alice Olawo¹, Gladys Someren², Issak Bashir², Margaret Gitau³, Shawn Malarcher⁴

¹ FHI 360; ² Kenya Division of Reproductive Health; ³ Kenya National AIDS and STIs Control Programme; ⁴ USAID
Today’s objectives

Introduce activity to pilot a monitoring tool for scale up of best practices

Discuss challenges, or “speed humps”, during the process of piloting the monitoring tool

Review next steps and lessons learned
Monitoring Scale Up of Best Practices: Background

- Identification and scale up of best practices has become a focus of efforts
- Many resources exist to support planning and implementation of scale up
- Little guidance, however, is available for monitoring
- A USAID review of scale up efforts found that critical aspects are missing in transition from pilot to scale
Where did this begin?

Need to develop guidance on monitoring of scale up

Decision to begin with a “developmental” pilot

Desire to build on Kenya’s experience
Kenya’s Commitment to Scaling Up Best Practices

• Leadership in innovation and identification of best practices
• Support for scale up of practices (development of training tools, job aids, minimum package, etc.)
• Scale up critical to the attainment of MDGs and Vision 2030

Defining the audience
Who is involved?

<table>
<thead>
<tr>
<th>Organization</th>
<th>Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHI 360</td>
<td>Leading developmental pilot in Kenya</td>
</tr>
<tr>
<td>Kenya Ministry of Health (DRH &amp; NASCOP)</td>
<td>Collaborating on developmental pilot</td>
</tr>
<tr>
<td>MEASURE Evaluation PRH</td>
<td>Developing global guide</td>
</tr>
<tr>
<td>USAID</td>
<td>Providing funding &amp; technical support</td>
</tr>
<tr>
<td>Stakeholders’ Taskforce in Kenya</td>
<td>Providing guidance &amp; context, sharing experiences</td>
</tr>
</tbody>
</table>
Objectives of Scale Up Monitoring

**Defining scale up**

Objectives of this rapid, low-cost monitoring are to determine:

- Fidelity to the model / best practice
  
  • Required inputs at facility & institutional level
  
  • Did the change in service actually happen?

- Scope of geographic coverage

- Pace of scale up

  ➢ *Identify challenges & achievements in scaling-up*
What has the process been so far?

Preparations & *defining the criteria* to choose a practice

Engaging stakeholders in Kenya

Choosing a practice to monitor

Identifying information needs & potential data sources
Defining the practice

- NASCOP & DRH, with FHI, conducted a pilot in 2008-09
- FP/CCC has been included in the RH/HIV Integration Strategy, and the draft Minimum Package for RH/HIV Integrated Services
- Orientation Package for HIV Providers developed
- FP services offered to CCC clients, including screening, counseling, & provision of methods and referrals
- 1176 CCCs nationwide, in Level 4 & higher facilities
- Multiple models of integration (one-shop, referrals, mixed)
Integration of FP within CCC services in Kenya

**Institutional Level Inputs**
- Inclusion in policies, guidance, etc.
- Supportive leadership at all levels
- Supported in pre-service training
- Supported in budget(s)
- Activities reported in HMIS, client register, etc.

**Facility Level Inputs**
- Availability of providers within CCC who are trained in FP services
- Availability of FP commodities & supplies
- Availability of job aids
- Supervisors oriented towards and supportive of practice
- Infrastructure and equipment in place

**Enabling Factors**
- Supportive leadership at all levels
- Community awareness of FP services at CCCs

**Practice**
- CCC clients receive FP counseling, information, methods, or referrals

**Increased contraceptive use**

**Decreased unintended pregnancies**
Prioritized Information Needs for Monitoring

**Defining the information needs**

1. Inclusion of FP/CCC integration within policies, guidance, etc.
2. Leadership in support of FP/CCC, at all levels
3. Availability of trained providers within CCCs
4. Availability of job aids within CCCs
5. Availability of commodities & supplies within CCCs
6. Supervision supportive of FP/CCC integration
7. CCC clients receive FP counseling, information, methods, or referrals
What is next?

- Finalize data collection plan
- Implement the data collection plan
- Analyze and synthesize the data
- Identify lessons learned, both with tool and with FP/CCC services in Kenya
- Share results with stakeholders
- Work with MEASURE Evaluation PRH to inform global guidance
What have we learned thus far... Monitoring

- Defining the audience
- Defining scale up
- Defining the criteria for selecting a practice
- Defining the practice
- Defining & prioritizing the information needs

✓ Engaging stakeholders
What have we learned thus far... Scale up

- A clear plan for scale up, including targets and timelines, should be developed early on.

- Be clear that scale up is a long road.

- Institutionalization within HMIS & record keeping should be prioritized.

- Engage local champions.
Thank you

Questions or comments?

Lucy Wilson
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The Extending Service Delivery (ESD) Project
Extension de l’utilisation des services de SR/PF en Guinée:

Tous pour la PF

Dr. Yéro-Boye Camara, Directeur ESD-Guinée
Dr. Fabio Castaño, Directeur technique ESD, Management Sciences for Health
Introduction: ESD-Guinée

- **TPC moderne:**
  - National – 6%
  - Kankan – 7,2%
  - Faranah – 5,7%
  - Nzérékoré – 4,8%

- **Besoins non satisfaits :**
  - National – 21%
  - Kankan – 20,3%
  - Faranah – 20,2%
  - Nzérékoré – 24,7%

- **Indice de fécondité:**
  - National: 5,7
  - Kankan – 7,3
  - Faranah – 6,3
  - Nzérékoré – 5,8

- **Taux de natalité: 38.4‰**

- **Taux de mortalité maternelle:** 980/100,000
Zone du projet ESD
Introduction: ESD-Guinée

ESD-Guinée a assisté le Ministère de la Santé pour augmenter le taux de prévalence contraceptive (TPC) en vue de réduire la mortalité maternelle et infantile en Guinée. A cet effet, il a contribué à:

- Recadrer la PF comme un facteur majeur de la santé maternelle, néonatale et infantile et non comme un simple moyen de limiter la taille des familles et de la population et

- Etendre l’utilisation de la PF par l’intégration de pratiques fondées sur des preuves, tout en veillant sur la qualité des prestations.
Améliorer l’environnement de la PF

- Révision ou élaboration des documents d’orientation stratégique (politiques, normes et procédures...), de formation (modules, manuels, guides...) et de gestion (grille de supervision, outils de gestion)
- Développement du partenariat avec les services publics (Santé, Education) et privés (ONG, entreprises...)
- Organisation des agents communautaires en associations et réseaux d’associations
- Suivi de la qualité des prestations PF et introduction d’approches d’amélioration.

Membres d’un réseau d’AC
Stimuler la demande de services de PF

- Développement de matériel IEC véhiculant des messages sur la SR/PF et la PEIGS
- Développement d’activités d’IEC
- Contractualisation avec les médias (RTG, radios rurales et privées) pour la diffusion de messages sur la PF/PEIGS
- Implication des organisations de la société civile dans la sensibilisation et la mobilisation sociale en faveur de la PF
Augmenter l’offre de services de PF

- Maintien des points de prestation existants avant ESD et ouverture de nouveaux points

Photo de famille après la formation en HIM à la société SOGUIPAH à Diecké
### Augmenter l’offre de services de PF: Résultats intermédiaires

Nombre de prestataires formés dans les services de santé publics où le counseling PF/PEIGS a été introduit

<table>
<thead>
<tr>
<th>Région</th>
<th>PTME</th>
<th>Soins post-partum</th>
<th>SAA</th>
<th>CPN</th>
<th>PEV</th>
<th>CDV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haute-Guinée</td>
<td>17</td>
<td>7</td>
<td>11</td>
<td>51</td>
<td>79</td>
<td>12</td>
</tr>
<tr>
<td>Guinée-Forestière</td>
<td>18</td>
<td>29</td>
<td>8</td>
<td>19</td>
<td>13</td>
<td>12</td>
</tr>
<tr>
<td>Conakry</td>
<td>46</td>
<td>14</td>
<td>16</td>
<td>36</td>
<td>39</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>81</strong></td>
<td><strong>50</strong></td>
<td><strong>35</strong></td>
<td><strong>106</strong></td>
<td><strong>131</strong></td>
<td><strong>36</strong></td>
</tr>
<tr>
<td><strong>Cible</strong></td>
<td><strong>106</strong></td>
<td><strong>42</strong></td>
<td><strong>44</strong></td>
<td><strong>158</strong></td>
<td><strong>218</strong></td>
<td><strong>36</strong></td>
</tr>
<tr>
<td><strong>% Réalisé</strong></td>
<td><strong>76%</strong></td>
<td><strong>119%</strong></td>
<td><strong>80%</strong></td>
<td><strong>67%</strong></td>
<td><strong>60%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
Augmenter l’offre de services de PF: Résultats intermédiaires

Nombre de services de santé publique (non PF) où le counseling pour la PF/PEIGS a été introduit

<table>
<thead>
<tr>
<th>Région</th>
<th>PTME</th>
<th>Soins post-partum</th>
<th>SAA</th>
<th>CPN</th>
<th>PEV</th>
<th>CDV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haute-Guinée</td>
<td>14</td>
<td>9</td>
<td>8</td>
<td>36</td>
<td>61</td>
<td>7</td>
</tr>
<tr>
<td>Guinée-Forestière</td>
<td>10</td>
<td>13</td>
<td>5</td>
<td>11</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Conakry</td>
<td>17</td>
<td>7</td>
<td>7</td>
<td>17</td>
<td>17</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>41</strong></td>
<td><strong>29</strong></td>
<td><strong>20</strong></td>
<td><strong>64</strong></td>
<td><strong>85</strong></td>
<td><strong>19</strong></td>
</tr>
<tr>
<td><strong>Cible</strong></td>
<td><strong>53</strong></td>
<td><strong>21</strong></td>
<td><strong>22</strong></td>
<td><strong>79</strong></td>
<td><strong>109</strong></td>
<td><strong>19</strong></td>
</tr>
<tr>
<td><strong>% Réalisé</strong></td>
<td><strong>77%</strong></td>
<td><strong>138%</strong></td>
<td><strong>91%</strong></td>
<td><strong>81%</strong></td>
<td><strong>78%</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
## Extension de l’utilisation de la PF: Résultats intermédiaires

### Nombre de points de prestation de PF fonctionnels

<table>
<thead>
<tr>
<th>Type de structure</th>
<th>Avant ESD</th>
<th>A fin ESD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hôpital</td>
<td>9</td>
<td>17</td>
</tr>
<tr>
<td>CMC</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>CS</td>
<td>135</td>
<td>213</td>
</tr>
<tr>
<td>PS</td>
<td>219</td>
<td>377</td>
</tr>
<tr>
<td>Village</td>
<td>1494</td>
<td>1698</td>
</tr>
<tr>
<td>Agents SBC</td>
<td>1507</td>
<td>2533</td>
</tr>
</tbody>
</table>
### Extension de l’utilisation de la PF: Résultats intermédiaires

<table>
<thead>
<tr>
<th>Régions administratives</th>
<th>Total services intégrés</th>
<th>Total prestataires orientés</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kankan</td>
<td>44</td>
<td>58</td>
</tr>
<tr>
<td>Faranah</td>
<td>84</td>
<td>107</td>
</tr>
<tr>
<td>Nzérékoré</td>
<td>46</td>
<td>87</td>
</tr>
<tr>
<td>Conakry</td>
<td>65</td>
<td>151</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>239</strong></td>
<td><strong>403</strong></td>
</tr>
</tbody>
</table>
Contribution en % des agents communautaires et des établissements de soins au recrutement des nouveaux utilisateurs de la PF
Extension de l’utilisation de la PF: Résultats globaux du projet

Taux d’utilisation de la PF Par région

<table>
<thead>
<tr>
<th>Région</th>
<th>Taux d'utilisation de la PF</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haute-Guinée</td>
<td>19%</td>
<td>28%</td>
</tr>
<tr>
<td>Guinée-Forestière</td>
<td>3.5%</td>
<td>16%</td>
</tr>
<tr>
<td>Conakry</td>
<td>2%</td>
<td>14%</td>
</tr>
</tbody>
</table>

Baseline 2011
Extension de l’utilisation de la PF: Résultats globaux du projet

Evolution du pourcentage de femmes en soins après avortement ayant eu un counseling et celles ayant adopté une méthode contraceptive

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AMIU ayant eu counseling</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>AMIU ayant adopté une méthode PF</td>
<td>56%</td>
<td>64%</td>
<td>70%</td>
<td>81%</td>
<td>65%</td>
</tr>
</tbody>
</table>

% AMIU ayant eu counseling
% AMIU ayant adopté une méthode PF
Extension de l’utilisation de la PF: Résultats globaux du projet

Nombre de couples-année de protection

<table>
<thead>
<tr>
<th>Région</th>
<th>Baseline</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Haute-Guinée</td>
<td>22,247</td>
<td></td>
</tr>
<tr>
<td>Guinée-Forestière</td>
<td>0</td>
<td>48,412</td>
</tr>
<tr>
<td>Conakry</td>
<td>0</td>
<td>7,293</td>
</tr>
</tbody>
</table>
Extension de l’utilisation de la PF: Résultats globaux du projet

Contribution en % des agents communautaires et des établissements de soins au nombre de couples-année de protection

34% Etab. Soins
66% SBC
1. La forte *rotation du personnel* des services publics de santé et la *défection des agents communautaires* notamment dans les zones minières, peuvent affecter la continuité des prestations en PF et imposent un lourd fardeau de formation dite de maintenance (ou remplacement).

2. La qualité mesurée lors des suivis post-formation est très insuffisante dans la majorité des sites suivis.

3. Le taux de rapportage est globalement faible.
Extension de l’utilisation de la PF: Contraintes

Taux de rapportage par trimestre et par source

Etablissements de soins
Agents communataires
Projet
Linear (Etablissements de soins)
Formation des prestataires: part des types de formation

- PF % Prestataires (intégration)
- PF % Prestataires (Maintenance)

Contraintes: mesures correctrices prises
RESULTATS

Apports des partenaires au processus dans les sites

Le CSU de Diakolidou a mobilisé des ressources financières auprès du projet Faisons Ensemble pour :

1) la confection des poubelles externes dans la cour du CS

2) un tableau d’affichage des tarifs des prestations

3) la construction de l’incinérateur
Evolution de la qualité des prestations en PF selon l'approche de gestion fondée sur les normes et la reconnaissance à l'hôpital de Nzérékoré

- Situation de base (mai-09): 19%
- déc-10: 79%
- Norme: 85%
Les agents communautaires sont un moyen sûr et indispensable pour étendre l’utilisation de la PF et atteindre les populations rurales.

Pour augmenter le nombre de couples-année de protection, notamment en zone rurale, il est nécessaire d’introduire les contraceptifs injectables au niveau des SBC.

Le suivi post-formation, axé uniquement sur les prestataires ou la structure de soins, ne suffit pas pour améliorer la qualité des prestations et n’est pas pérenne; la gestion basée sur les standards et la reconnaissance, fondée sur l’esprit d’équipe, en est un complément indispensable.
Assurer la supervision périodique des prestataires de planification familiale (professionnels de santé et agents communautaires) pour, entre autres:

Introduire les contraceptifs injectables au niveau communautaire pour augmenter rapidement le nombre de couples-année de protection.
SCALEING DOWN TO SCALE UP: LESSONS LEARNED FROM GHANA’S NAVRONGO PROJECT

Dr. Frank Nyonator
Acting Director General
Ghana Health Service
Scaling down to Scale up

- **The Navrongo Project:**
  - Developed service strategies of the Community-based Health Planning and Services (CHPS) Initiative
  - Tested the impact on fertility and mortality
  - Disseminated results

- **Challenges encountered**

- **What works?** Best practices learned for scaling up

- **Moving forward….**
The Need: Demographic context prior to the Navrongo Project

High fertility, high maternal mortality, high childhood mortality:

- **Fertility**
  - TFR was 5.2 in 1995
  - Crude birth rate over 30 per 1000

- **Maternal Mortality**
  - Baseline about 750 deaths/100,000 births

- **Childhood Mortality**
  - Infant mortality: 123 per 1000 live births
  - Probability of dying before age five: 166/1000
  - Life expectancy: 49.8
Rationale for research in the 1990s...

- The need for large scale programmatic change (primary health care services & family planning were not working).

- The policy debate: (volunteers versus paid professional health workers).

- Confusion about the reform process (Sector-wide vs. vertical programming).
Navrongo Project: Experimental Design

<table>
<thead>
<tr>
<th>Mobilizing resident community nurse health services</th>
<th>Mobilizing Traditional Community organization &amp; deploying volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Nurses resident in community</td>
</tr>
<tr>
<td>No</td>
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Navrongo impact: Reducing Fertility

In the initial five years, total fertility declined by 1 birth in the treatment area.....

...but there was no change in comparison fertility in the same period.
Navrongo impact: Reducing Child Mortality

Trends in under five mortality in Cell 3 and the Comparison cell 4, 1995-2003

Cell 3: MDG4 was reached in 2005

Cell 4: When the project scaled up within the study district, mortality began to fall in the comparison area

MDG4
Navrongo Impact: Reducing Maternal Mortality


MDG5 was reached in 2005 and was sustained thereafter.
Evidence for Scale Up

CHPS significantly reduced fertility by 1 birth, child mortality by 68%, and maternal mortality by 75%.
Initial Scale Up Tactics included:

1. Workshops – Workshops district directors and in-service training for community nurses and supervisors
2. Policy announcements and directives by the MoH
3. Technical Assistance for training and other field activities
2. Implementation Gap

Initial scale up stalled in 78 districts. Why?

Population covered by planned work assignment “zones” expanded faster than implementation:

- Communities oriented leaders,
- Constructed “Community Health Compounds”
- “Community Health Officers” with
- Equipment, and
- Volunteers

Planning without action:

The implementation Gap
3. Slow pace for scale up

- In the most populous regions of Ghana, scale up was virtually non-existent

CHPS scaled up most rapidly in the Upper East and Upper West

Scale up is non-existent in Greater Accra, Ashanti and Brong Ahafo Regions
4. Diversion of content from original CHPS Programming

- New CHPS coverage failed to address crucial CHPS components including:
  - Family Planning
  - Outreach Activities – programs were becoming more static, less ‘doorstep’ focused
  - Transition to a facility focus rather than community

**Result:** Diluted CHPS programming
Challenges in Scale Up

What went wrong? Challenges included:

1. **Coverage gap:** Implementation concentrated in 78 districts
2. **Implementation Gap:** District planning was often unassociated with implementation
3. **Pace was slow:** “Fear of the unknown.”
4. **Content diluted from the original CHPS design:**
   - Volunteers no longer family planning focused.
   - Community mobilization not emphasized; priority shifted to construction
   - External technical assistance replaced GHS peer leadership.
What worked for scale up?

- 38 districts were successful in scaling up CHPS.

Why?

- Work zones mapped
- Health posts constructed
- Leaders oriented
- Nurses assigned
- Equipment available
- Volunteers deployed
How was the problem solved in 32 districts?

Scaling down to scale up.
What was “Scaling Down”?

1. “Champion districts” Nkwanta & Kassena-Nankana (KND) conducted 32 peer leadership and exchanges to spread small scale replication sites from KND/Nkwanta to “innovator” districts in each region.

2. Participating districts were trained in scaling down CHPS to a single zone for piloting operations, developing, grassroots political engagement and planning scale-up.

3. Small scale replication sites for catalyzing CHPS scale up were financed in replication districts: Rapid start-up of CHPS with limited resources.
What worked?

1) Developing two “CHPS Champion districts” for implementation capacity building.

Nkwanta was a replication district where peer leadership training could focus on implementation details in a non-research context.
2. Using Nkwanta/Navrongo: Dissemination of Demonstration Sites

Nkwanta/Navrongo served as training districts for transferring demonstration capacity to other districts

- Addresses the replicability
- This “scaling down” disseminated demonstration sites throughout all 10 regions of Ghana.
- 32 district teams trained through peer leadership and exchange programme.
3) Using the participating districts as “Lead Districts” in their home region: “Scaled-down” pilot communities disseminated to demonstration districts

- Small groups were posted to demonstration communities for peer mentoring on CHPS development and best practices
- Included health staff from several levels of the health system (vertical engagement)
- Addressed the ‘fear of the unknown’ (horizontal engagement)
3. Using scaled down pilot sites in dissemination districts: Grassroots political engagement

- Training districts to engage community politicians and leaders for:
  - Sponsoring community engagement at public events known as “durbars”
  - Committing revenue and local investments towards CHPS development and programming
  - Building trust, understanding and sustainable support
4. Small grants to participating districts enable teams to rapidly start-up operations with limited resources and demonstrate CHPS to neighboring districts

- Communities were empowered to initiate CHPS, regardless of resources
- Enhanced the ‘learning by doing’ principle
- Accelerated start-up
## Conclusion

**What did not work?**

- **Official orders** alone.
- Workshops for “**in-service training**”
- **Lack of catalytic revenue**
- Investment in **donor selected geographic focus** districts
- Replacing the role of research & lead districts with **external technical assistance**.
- Ending national monitoring of the pace, content, and coverage of scale-up.

**What worked?**

- Identifying **Champions** through M&E; National Health Forum for “champions” to present experiences
- On-site demonstration and **exchanges** for implementation teams at “Champion districts.”
- Funds for disseminating **micro-pilots**
- **Competitive grants** to innovators & champions. Investment in scale up as if it is a “diffusion process” requiring catalytic activities, champions, and financing.
- **Sustaining and expanding national leadership;** supporting research and monitoring; Scaling up district demonstration and leadership capacity.
- **National dissemination** of monitoring information; national support for evaluation research.
Thank You