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Basic Toolkit for Systematic Scale-up

A companion to the Scale-up Coordinator's Guide for Supporting Country-Led Efforts to Systematically Scale-up and Sustain Reproductive, Maternal, Newborn, Child and Adolescent Health Interventions

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MCSP is a global, $560 million, 5-year cooperative agreement funded by USAID to introduce and support scale-up of high-impact health interventions among USAID's 25 maternal and child health priority countries, as well as other countries. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. Visit www.mcsprogram.org to learn more.

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Table of Contents

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Overview

The tools in this toolkit are those that the *Scale-up Coordinators Guide* focuses on. We consider this to be the basic minimum set of tools for a scale-up coordinator to guide key stakeholders on a multi-organizational team through iterative cycles of a systematic process of scale-up. That is, the phases of:

1. Engagement and assessment
2. System-oriented co-creation (planning)
3. Implementation with learning and adaptative management.

For those with interest, Annex 4 of the *Scale-up Coordinator's Guide* has resources with more in-depth information about the tools from which these were adapted as well as many other related tools.

Tools for engagement and assessment, and for system-oriented co-creation (planning)

- Tool 1: Define the intervention package [1]
- Tool 2: Scalability Checklist [2]
- Tool 3: Assess Implementer Capacity
- Tool 4: Assess Scale up Environment [1]
- Tool 5: Identify Key Stakeholders and Describe Scale up Management Team [1]
- Tool 6: Roles and Responsibilities for Leaders and Managers
- Tool 7: Plan Scale-up Strategies for Institutionalization and Service Expansion [1]
- Tool 8: Developing a Vision for Reaching Sustainable Impact at Scale [1]

Other critical tools and examples for engagement and assessment, and for system-oriented co-creation (planning) not included in this toolkit

- Guidance on Human Centered Design
    - The Bill and Melinda Gates Foundation and USAID have a partnership on human-centered design https://www.designforhealth.org/resources-overview.
    - Especially the thinking and tools for "user feedback" – for use with both clients and providers. IDEO, *The Field Guide to Human Centered Design.* PDF is available for free download. Step 4 for client feedback is most relevant: http://www.designkit.org/
- ExpandNet Worksheets for developing a scaling-up strategy [1]
    - Available at https://expandnet.net/PDFs/ExpandNet-WHO%20Worksheets%20-%20July%202012.pdf
    - For examples see https://legacy.mcsprogram.org/scaleforsuccess/

[1] Adapted from on ExpandNet worksheets available at https://expandnet.net/PDFs/ExpandNet-WHO%20Worksheets%20-%20July%202012.pdf as a companion to ExpandNet (2010). Nine Steps for Developing a Scaling-Up Strategy. Geneva: World Health Organization. Accessed May 2019: http://www.who.int/reproductivehealth/publications/strategic_approach/9789241500319/en/

[2] Based on MSI Worldwide (2012). Scaling Up - From Vision to Large-Scale Change: A Management Framework for Practitioners (Guide and Toolkit). Second Edition, 2012. Accessed on K4Health, May 2019: https://www.k4health.org/toolkits/research-utilization/scaling-vision-large-scale-change-tools-and-techniques-practitioners

- Guidance on developing a Theory of Change
    - Anderson A (no date). *The Community Builder's Approach to Theory of Change*, Aspen Institute. Accessed May 2019: http://www.theoryofchange.org/pdf/TOC_fac_guide.pdf
    - UNICEF (2014, written by Patricia Rogers). *Theory of Change*. Accessed May 2019: https://www.betterevaluation.org/en/resources/guide/theory_of_change
- Costing tool for Liberia chlorhexidine and Costing Reports for Rwanda HBB and PPFP
    - For examples see https://legacy.mcsprogram.org/scaleforsuccess/
- Scale up co-creation workshop materials - agenda, group exercises, presentations, report, co-created plan
    - For examples see https://legacy.mcsprogram.org/scaleforsuccess/

Tools for implementation with learning and adaptive management

- Tool 9: Matrix to Track Achievement of Activities in Plan (Implementation Strength)
- Tool 10: Build Dashboard for Key Service Expansion Indicators
- Tool 11: Assess Institutionalization of Intervention Package

Other critical tools for implementation with learning and adaptive management not included in this toolkit

- ExpandNet Implementation Mapping Tool based on Most Significant Change qualitative monitoring technique https://expandnet.net/science-of-scale-up/
- Most Significant Change – Davies R and Dart J, Most Significant Change Technique (Guide and supporting materials on Better Evaluation website) https://www.betterevaluation.org/en/plan/approach/most_significant_change

Tool 1: Define the Intervention Package

Practical experience has shown that getting critical stakeholder to agree on a definition of the intervention is an essential step to help ensure that everyone is working for the same purpose and for quickly communicating to others what it is that stakeholders are working on.

This tool is to help stakeholders think through and describe the intervention package as it has been or is being planned (**WHAT** exactly is being scaled up) based on information from previous implementation experiences in pilot demonstrations or in other settings. The team should use this tool to develop a shared definition and understanding of the intervention package among themselves. They can then use this tool as part of the scale-up planning workshop to gain consensus on the intervention package description with the scale-up management team. Any changes to the core components of the package during the course of implementation should be documented and described.

This tool helps the team think through the two parts to defining the intervention package: 1) the core technical content of the intervention, and 2) the critical components that make the intervention work such as training, technology, managerial processes, or community support. This latter part does not need to be exhaustive, but rather should include the most important pieces. Together, these are the "intervention package" to be replicated with contextual adaptations as scale-up occurs.

Please note that this tool encourages thinking through the World Health Organization health system building blocks in defining the intervention package in order to ensure a systems-thinking approach. However, it is not necessary to fill in every box; rather, complete just those boxes corresponding to the building block elements that are most relevant to the core intervention package.

Instructions: In defining the intervention package, it is important to first assess the body of knowledge and evidence about successful implementation collected during the pilot phase or other settings to tease out the various contributing components, including: the practice, the evidence base, the methodology, the users, the implementers, the dissemination strategy, and the policy environment. Useful resources to review include reports from clinical trials, service delivery research, and program evaluations. It will also be useful to consult documentation and tools from previous experiences with the intervention package such as monitoring instruments, supervision checklists, training manuals, budgets, and work plans.

For real examples of well-defined intervention packages, see https://legacy.mcsprogram.org/scaleforsuccess/.

Describe the core technical content of the intervention
Describe the basic intervention directed at beneficiaries. The description should include the following information: • What intervention is delivered to clients or end-users? • Who delivers it? • Who receives it? *(clients or end users)* • Setting: Where do they receive it? • How long does it take to deliver? • How frequently is it delivered?

Define the "active ingredients" of the intervention	
Health system component	**Description of "active ingredient" in that component**
Leadership/Governance/Policy • Are needed policies in place? If not, what policies need to be changed? • Are there the necessary mechanisms for coordination and accountability? • Is there sufficient support and readiness to implement change?	
Human Resources: Workforce/Training • What cadre(s) deliver the intervention? • What is the organizational and individual capacity for change? • Is task shifting necessary? • What training/coaching is essential? • How is training delivered? • What specific technical materials are needed for training or as job aids?	
Service Delivery: Supervision/Quality Improvement/Infrastructure • Are there any special tools for supervision? • Any novel method for supervision? • Key content of the supervision? • How frequently is supervision done? • What infrastructure needs are there, if any?	
Products: Supply Chain and Logistics • What medicines or supplies are needed? • Any novel ways to forecast or supply?	
Financing • Are there any existing or novel financial/ payment mechanisms—such as performance-based incentives—that influence delivery of the intervention package?	
Health Information Systems • Are there existing/routine ways of tracking delivery of the intervention package?	

Define the "active ingredients" of the intervention	
Health system component	**Description of "active ingredient" in that component**
Demand/Clients • Are there any behavior change needs for clients to raise awareness/increase understanding/generate demand? • If so, how is this done?	

Example from Rwanda: Intervention description for improvement of the management of newborn asphyxia

Intervention description: Practice improvement package for birth asphyxia prevention and management	
Core technical content of the intervention	
Prevention of birth asphyxia through labor management with partograph Use the partograph to manage labor and intervene appropriately when a problem is identified. Identification and management of birth asphyxia using the Helping Babies Breathe (HBB) protocol, as an integrated component of Essential Newborn Care (ENC) For facility-based deliveries, newborns are assessed immediately after birth. For those not breathing immediately, the skilled health provider gives stimulation during the "Golden Minute." For those that require further assistance, the skilled provider uses an ambu bag and mask to deliver respiratory support until the newborn is able to breathe on its own.	
Active Ingredient	**Description**
Low dose high frequency training	Eligible providers are medical doctors, nurses, midwives (those who attend births) • Initial training at district hospital, including baseline knowledge and skills assessment on HBB-ENC-labor management • Training of providers using Low Dose High Frequency strategy at Health Centers – 1 visit per week for 3 weeks
Mentorship	• Training of mentors at District level (knowledge assessment before and after training) • Post training follow up during mentorship process – Use mentorship tool • Mentorship and validation of trainees (providers) using mentorship checklist: monthly for first quarter, then quarterly • Peer-to-peer mentorship with Neo–Natalie mannequins and all accessories provided to each Health Center
Quality improvement focused on readiness for delivery	Quality Improvement visit by supervisor to observe and assess • Delivery room and operating room readiness assessment for newborn resuscitation (bag and mask clean, in place, and functional) • Skills assessment of health providers • Data quality assessment • Review use of data for decision making and quality improvement • Review and discuss clinical birth asphyxia audit information and experiences

Tool 2: Scalability Assessment Tool

This tool is an adaptation of the Scalability Assessment Tool originally published in Scaling Up - From Vision to Large-Scale Change (MSI, 2012). Use this tool to decide what issues are likely to be more or less problematic in scaling up the intervention package in the specific context. This can help guide discussions on possible actions.

Instructions: For each row, add a checkmark/tick in one of the three white columns. Add the scores in each of the three columns to get a rough assessment of the scalability of the intervention package.

Categories		☐	← Scaling up is easier	☐	Scaling up is harder →	☐
A. How credible is the intervention package?	1		Based on sound evidence		Little or no solid evidence	
	2		Independent external evaluation		No independent external evaluation	
	3		Substantial evidence that the intervention package works in diverse contexts		There is no evidence that the intervention package works in diverse contexts	
	4		Supported by eminent individuals and institutions		Supported by few or no eminent individuals and institutions	
	5		Impact very visible to decision-makers and users and easily associated with the intervention		Impact relatively invisible to decision-makers and users and/or not easily attributable to the intervention	
B. Does intervention package have relative advantage over existing practices?	6		Current solutions considered inadequate		Current solutions considered adequate	
	7		Intervention package's superior effectiveness to current solutions and other alternatives clearly established		Little or no objective evidence of intervention package's superiority to current solutions and other alternatives	
C. How strong is support for the intervention package?	8		Strong sense of urgency regarding the problem or need		Relative complacency	
	9		Strong leadership coalition committed to change		Weak, divided or deeply conservative leadership	
	10		Addresses an objectively significant, persistent problem		Addresses a problem that affects few people or has limited impact	
	11		Addresses an issue that is currently high on the policy agenda		Addresses an issue that is low on the policy agenda	
	12		Faces limited opposition		Faces strong opposition	
	13		Addresses a need that is sharply felt by potential beneficiaries		Addresses a need that is not sharply felt by potential beneficiaries	
D. How easy is the intervention package	14		Fully consistent with government policy		Requires substantial change in government policies	
	15		Implementable with existing systems, infrastructure, and human resources		Requires significant new or additional systems, infrastructure, or human resources	

Categories		☐	← Scaling up is easier	☐	Scaling up is harder →	☐
to <u>transfer and adopt</u>?	16		Few decision-makers involved in agreeing to adoption of the intervention package		Many decision-makers involved in agreeing to adoption	
	17		Key innovation is a clear and easily replicated technology e.g. vaccine		Focus of the model is not a technology, or one which is not easily replicated	
	18		Low complexity; few components; easily added onto existing systems		High complexity with many components; integrated package	
	19		Intervention is self-regulating		Intervention requires substantial supervision and monitoring to maintain quality	
	20		Able to be tested by implementers on a limited scale		Unable to be tested without adoption at a large scale	
	21		Small departure from current practices of target population		Large departure from current practices of target population	
E. How good is the <u>fit with the implementing organization</u>?	22		Existing organization has the operational capacity and financial resources to implement at scale		No existing organization with the systems, delivery agents, and resources to implement at scale	
	23		Implementing organization has physical presence or strong network and credibility in relevant contexts		Implementing organization lacks footprint and credibility in relevant contexts	
	24		Implementing organization has leadership team, norms, incentives consistent with the intervention		Major changes needed in leadership, organizational norms, and incentives	
	25		Demonstrable support for the intervention package among staff		Active resistance by staff	
	26		Organizational history and culture of iterative learning and evidence-based decision-making		No history of iterative learning and evidence-based decision-making	
F. How strong is the <u>scale-up strategy</u>?	27		Homogeneous problem, target group and setting - geography, language, economy, politics		Multiple, diverse contexts	
	28		Implementing organization has experience with use of a systematic process for scaling up		Proposed implementing organization lacks experience with a systematic process for scaling similar interventions	
	29		Presence of a clear and compelling strategy for reaching scale (costed and with strong M&E plan)		No articulated scaling strategy	
G. Is there a sustainable source of <u>funding</u>?	30		Substantially lower unit cost than existing or alternative solutions		Substantially higher unit cost than existing or alternative solutions	
	31		Requires small commitment of funds to begin		Requires large commitment of funds to begin	
	32		Financed by internal funding (e.g., user fees) or endowment		No internal funding	
Total checks						

Example: Scalability checklist for Nigeria chlorhexidine to prevent newborn sepsis

	Credible	Key factor (credible)	Somewhat credible	Key factor (not credible)	Not credible	Notes
A. How credible is the intervention package?	X	Based on sound evidence		Little or no solid evidence		
	X	Independent external evaluation		No independent external evaluation		
		Substantial evidence that the model works in diverse contexts	X	There is no evidence that the model works in diverse contexts		
		Supported by eminent individuals and institutions	X	Supported by few or no eminent individuals and institutions		
		Impact very visible to decision-makers and users and easily associated with the intervention	X	Impact relatively invisible to decision-makers and users and/or not easily attributable to the intervention		
B. Does intervention package have relative advantage over existing practices?	**Strong relative advantage**	**Key factor (strong relative advantage)**	**Somewhat of a relative advantage**	**Key factor (no relevant advantage)**	**No relative advantage**	**Notes**
		Current solutions considered inadequate		Current solutions considered adequate	X	
		Superior effectiveness to current solutions and other alternatives clearly established	X	Little or no objective evidence of superiority to current solutions and other alternatives		
C. How strong is support for the intervention package?	**Strong support**	**Key factor (strong)**	**Medium support**	**Key factor (weak)**	**Weak support**	**Notes**
		Strong sense of urgency regarding the problem or need		Relative complacency	X	
	X	Strong leadership coalition committed to change		Weak, divided or deeply conservative leadership		
	X	Addresses an objectively significant, persistent problem		Addresses a problem that affects few people or has limited impact		
	X	Addresses an issue that is currently high on the policy agenda		Addresses an issue that is low on the policy agenda		
		Faces limited opposition	X	Faces strong opposition		
	X	Addresses a need that is sharply felt by potential beneficiaries		Addresses a need that is not sharply felt by potential beneficiaries		

	Easy	Key factor (easy)	Medium ease / difficulty	Key factor (difficult)	Difficult	Notes
D. How easy is the intervention package to transfer and adopt?	X	Fully consistent with government policy		Requires substantial change in government policies		
	X	Implementable with existing systems, infrastructure, and human resources		Requires significant new or additional systems, infrastructure, or human resources	X	
	X	Few decision makers involved in agreeing to adoption of the model		Many decision makers involved in agreeing to adoption		
		Highly technological with clear deliverables		Process and/or values are critical		
	X	Low complexity; few components; easily added onto existing systems		High complexity with many components; integrated package		
		Intervention is self-regulating		Intervention requires substantial supervision and monitoring to maintain quality	X	
	X	Able to be tested by implementers on a limited scale		Unable to be tested without adoption at a large scale		
		Small departure from current practices of target population		Large departure from current practices of target population	X	
E. How good is the fit with the implementing organization?	**Good fit**	**Key factor (good fit)**	**Medium fit**	**Key factor (not a good fit)**	**Not a good fit**	**Notes**
		Existing organization has the operational capacity and financial resources to implement at scale	X	No existing organization with the systems, delivery agents, and resources to implement at scale		
		Implementing organization has physical presence or strong network and credibility in relevant contexts	X	Implementing organization lacks footprint and credibility in relevant contexts		
		Implementing organization has leadership team, norms and incentives consistent with the intervention	X	Major changes needed in leadership, organizational norms and incentives		
	X	Demonstrable support for the change among staff		Active resistance by staff		
		Organizational history and culture of iterative learning and evidence-based decision-making		No history of iterative learning and evidence-based decision-making	X	

	Strong strategy	Key factor (strong)	Medium strength strategy	Key factor (weak)	Weak strategy	Notes
F. How strong is the scale up strategy?		Homogeneous problem, target group and setting - geography, language, economy, politics		Multiple, diverse contexts	X	
		Implementing organization has experience with use of a systematic process for scaling up		Proposed implementing organization lacks experience with a systematic process of scaling similar interventions	X	
	X	Presence of a clear and compelling strategy for reaching scale (costed and with strong M&E plan)		No articulated scaling strategy		
G. Is there a sustainable source of funding?	**Sustainable**	**Example (sustainable)**	**Somewhat sustainable**	**Example (not sustainable)**	**Not sustainable**	**Notes**
		Substantially lower unit cost than existing or alternative solutions	X	Substantially higher unit cost than existing or alternative solutions		
		Requires small commitment of funds to begin		Requires large commitment of funds to begin	X	
		Financed by internal funding (e.g., user fees) or endowment		No internal funding	X	
Total checks	**12**		**10**		**10**	

Tool 3: Assess Implementer Capacity to Integrate and Implement Intervention Package

The implementer(s) refers to the organization(s) that will scale up the intervention package. Use this tool to think through who the implementing organizations are, how they are organized, to what degree they will support the intervention, who the key champions are, what are the current capabilities the implementing organization needs to effectively implement the scale-up process, and what gaps/bottlenecks/barriers exist.

Instructions: To complete the table, the team should brainstorm potential capacity or bottleneck issues of the core intervention package for each health system component. Then for each potential capacity or bottleneck issue facing the implementing organization, the team should think of potential strategies that could address these issues.

Background
Note: If several interventions will be scaled up, and different implementers are involved for each, the planning team may have to go through this step for each intervention that has a different implementer(s).
1. Who is/are the implementing organization(s)? Do they have a scale-up coordinator?
2. If there are several implementers, what is the division of labor among them?
3. Are there any differences in the way the pilot was conducted compared to the plans for the scale-up phase? If so, what are they?
Perceived need for the intervention among implementers
4. Is there a perceived need for this intervention package among the implementer(s)? In other words, is it considered a priority?
5. Are there any advocates/champions of the intervention package within the implementing organization(s)? Where are these champions?

Implementer Capacity to Carry Out Core Components of Intervention			
Health System Component	**Description of core intervention package component in that health system component (refer to Description of the Intervention Package)**	**List any potential capacity issue (bottleneck) as intervention is scaled (will inform Tool 7: Plan Scale-Up Strategies for Institutionalization and Service Expansion)**	**Are there any strategies to solve this capacity problem? (will inform Tool 7: Plan Scale-Up Strategies for Institutionalization and Service Expansion)**
Leadership/Governance/Policy (including: Is there a designated scale-up coordinator?)			
Human Resources (Workforce/ Training/Technical Materials)			
Service Delivery (Supervision/Quality Improvement/Infrastructure)			
Products (Supply Chain and Logistics)			
Financing			
Health Information Systems			
Demand/Clients			
Other			

Example: Rwanda HBB implementer capacity assessment, with identification of possible solution for upcoming year

Core Component	Challenges	Potential Solutions	Has this been tried? If so, where ?
Low dose high frequency (LDHF) training	ENC materials • ENC sessions organized at hospital level need to be divided into more sessions. Current 2 days are not enough. • Language barrier. All documents in English.	• Revision of the content so that trainers focus on key competences according the gap identified (increase the number of sessions and organized trainings at facility level) • Translate documents into French	
	Transport issues for mentees They sometimes travel back from training by moto at a very late hour and then travelling back in the morning very early. They also sometimes arrive for training late as they needed to travel to hospital.	Lodging at or near the hospital (this would also solve problem of being called back into work during the training)	Musanze District
	Homework difficult for mentees to complete as many trainees are going back to work the evening following training.	Change schedule	
	Health providers sometimes come straight from night shift and are unable to train properly	Try to change schedule so that the mentees were not on duty just before or during the training.	
	Availability of health providers: Some are on duty so they miss training or do not attend the training	• Conduct training when providers are on leave and have them come during leave (may be difficult because will need to compensate their leave days) • Institutionalize into continuous professional development (CPD) trainings • (USAID implementing partners should package training into CPD programs and ensure trainers are registered as CPD providers)	Musanze District
	Overlapping trainings (family planning, basic emergency obstetric and neonatal care, etc.)	Have a fixed day for each program	
	Mentees who travel to facilities receive transport allowance while mentees based at facility don't receive anything	Institutionalize into CPD trainings (see under availability of health providers)	
	LDHF is not planned as part of hospital capacity building plan. Conducted from central level	Need to include all trainings for the year as part of hospital plan	

Core Component	Challenges	Potential Solutions	Has this been tried? If so, where ?
Mentorship	Drop out of trainees Mentorship not yet integrated into daily schedule of activities	• Advocacy for integration of mentorship in M&E activities • Ensure mentorship ownership of hospital administration for the purpose of sustainability	
	Mentorship not done as planned due to shortage of staff	Mentorship should be considered in CPD and grading health professionals	
	Inadequate peer mentorship • Peer mentors available but turnover is a barrier for implementation of peer mentorship • Some peer mentors lack teaching skills	Training of peer mentors on Clinical Teaching Skills (CTS)	
	Mentors are doing mentorship during the day following a night shift and also during their day off (as this is the only time they have).	Put the mentors with the supervisor in the same car, so that supervision and mentorship can occur during the same visit during working hours. But one thing to look out for is quality of mentorship/sufficient time as covering both on the one day.	Kigeme Hospital
	Availability of providers and overlapping activities	Mentors are asked to share their schedule/plan with director of hospital and copy MCSP who will then inform the health center before the end of the month.	
	Mentorship is an additional duty on top of a full workload	• Integrate mentorship into supervision because this is already part of the mandate of the District Hospital (DH). Skill gaps should be identified and incorporated into plan for mentorship • Mentorship should be integrated as part of hospital capacity building plan.	
	Shortage of transport for mentors	Integrate into plan for supervision since transport for supervisors is already included	

Tool 4: Assess Scale-Up Environment

Use this tool to guide a process of understanding the relevant environmental factors that are external to the implementing organizations and the scale-up management team, but fundamentally affect prospects for successful scale-up. The tool lists the main categories of contextual factors likely to affect scale.

Instructions: To complete the table, the team should brainstorm potentially important contextual/external factors that will influence scale-up implementation, and that should be monitored throughout the scale-up process. Those factors that the team considers the most important should be noted by putting in bold type. For the most important factors in bold type, the team should discuss possible ways to either take advantage of a positive factor or mitigate a negative one. Note that the list of environmental factors may change as scale-up progresses and new opportunities and constraints come into play. This list of possible actions should be consulted when the team plans actions for institutionalization and service expansion.

Environmental Elements	Examples	Key Factors Affecting Scale Up (positive and negative)	Possible Actions/Strategies to Facilitate Scale Up (maximize opportunities and minimize constraints) (will inform Tool 7: Plan Scale-Up Strategies for Institutionalization and Service Expansion)
Political Environment	Political situation, security, governance, bureaucratic culture, formal and informal political relationships		
Health Policy and Incentive Environment	Level of external support for the policy/program. Other policies/programs that conflict with, help, or hurt scale-up.		
Economic Environment	Economic conditions, resource mobilization		
Funding	Funding, collaboration between partners, presence of other programs		
Personnel	Availability of key health workers, skills/abilities of health workers, workload, motivation, incentives, turnover		
Health System- Other Characteristics	Infrastructure and access to facilities		
Culture: Community and Household	Awareness and prioritization of social/cultural factors that affect demand (e.g., HIV stigma, use of traditional medicines, patient preferences, education levels)		
Physical Environment	Geography, weather patterns that influence service delivery or disease transmission, drought, or famine		
Other	Any contextual factors not included in the above categories		

Example: Scale up environment for Nigeria chlorhexidine (CHX) for prevention of newborn sepsis

Environmental Elements	Examples	Key Factors Affecting Scale Up (enablers)	Key Factors Affecting Scale Up (barriers)

Political Environment	Political situation, security, governance culture, bureaucratic culture, formal and informal political relationships	• Nigeria is strategic to Africa and global development being the largest economy and having the largest population and the political hub.
		• Nigeria runs a three-tier government, hence decisions on health can be taken independently at each tier of government
		
		National
		• The former president as co-chair of UN Commission on Life Saving Commodities acted as an enabler for the adoption and funding of seed stock of CHX to 1000 facilities through the Subsidy Reinvestment and Empowerment Program (SURE-P) (global, which translated into National policy)
		  • Strategic policy document was launched by the Minister of Health in November 2016.
		  • $500m loan from World Bank served as catalyst for Implementation of Saving One Million Lives (SOML) Program for Results
		  • Operationalization of the National Health Act (1% consolidated revenue of the National budget)
		
		State
		• Health is a priority tool for gaining political power during campaigns for most states
		• Some states have prioritized CHX using SOML funds
		• Support by donors and development agencies vis a vis provision of technical support and resources for implementation in target states
		• Strategic policy document was adopted by the Kogi state Governor in March 2017
			• Health is on the concurrent list meaning that decisions at the national level are not binding on the state or local government authority level
			• Frequent changes in political players affect continuity of program implementation
			• Previous years of economic downturn
			• Delays in appropriation, approval, and release of national fiscal budgets. Budgetary allocation for health has been below the recommended 15% of the Abuja Declaration (2003)
			• Corruption and lack of accountability
			
			State
			• Health is not considered a revenue generating sector; it receives less focus than other revenue generating sectors like agriculture, *whereas health should be an enabler for all sectors*
			• Security challenges and internal displacement in some areas (ethnoreligious disturbances spreading)
			• Delays in approval and release of state budgets
			• Lack of continuity in leadership structure
			• Limited political will, especially at the state level for the adoption, procurement and distribution of CHX

Environmental Elements	Examples	Key Factors Affecting Scale Up (enablers)	Key Factors Affecting Scale Up (barriers)
Health System Environment	Level of external support for the intervention; collaboration between health sector partners; presence of other policies/programs that conflict with, help or hurt scale-up; systems barriers that could affect scale up (e.g. high drug stock-out rate).	• National Council on Health approval for 15 commodities including CHX in 2013 • Support by donors and development agencies vis a vis provision of technical support and resources for policy development and guidelines • Nigeria enjoyed a high level global support through donors and development agencies for piloting, adoption and implementation of scale up of CHX gel • Leadership and governance; inclusion in National Essential Medicines List (EML), integration into pre and in-service training packages • Health management information system (HMIS) – CHX prioritized in ongoing review for tracking • CHX is included as a benefit package by the National Health Insurance Scheme (NHIS) • Availability of functional drug revolving fund in some states • Operational task shifting and task sharing policy will increase coverage with the involvement of additional cadre of health workers • CHX use was covered in Multiple Indicator Cluster Survey (MICS) 2016/17 and will be covered in Demographic and Health Survey (DHS) 2018	• Lack of coordination of implementing partners with different agendas • Procurement, distribution and misuse of unapproved CHX solution, leading to blindness which caused setback and distrust for CHX. Damage control effort was limited to affected states (ripple effect not well mitigated). • Lack of awareness/acceptance among a large number of health professionals which led to initial resistance and subsequently slowed down take-off. • Apparent delay in cord separation by CHX in relation to the current materials used for cord care • The use of Methylated spirit is still preferred by many prescribers due to their wide acceptance of the product • Weak coordination among National/state ministries, departments and agencies (MDAs). • Lack of special budgetary line within the maternal, newborn and child health (MNCH) budgets in most states and nationally. • Excess markup (price) affecting the relative cost of CHX compared to other alternatives. • Poor private sector participation i.e. proprietary and patent medicine vendors (PPMVs). • The current standardized list for the mama kit is not being followed. • CHX procurement, stock-out not yet tracked. • Last mile distribution challenges. • CHX utilization in routine data not yet tracked
Other	Geography, weather patterns, any contextual factors not included above	• Technical assistance to local manufacturers in the production CHX gel • National support for local consumption through "ban" on importation	• Limited distribution in hard to reach areas with poor accessibility undermines utilization • Poor care seeking behavior • Low facility delivery • Socio-cultural beliefs that early cord separation is beneficial

Tool 5: Identify Key Stakeholders and Describe Scale-Up Management Team

The scale-up management team refers to the individuals and organizations that oversee the process of scaling up the intervention package. The team should coordinate activities among partners that are actively managing the scale-up process. It should be led by the government, include key stakeholders, have national influence, and also have first-hand knowledge of local implementation. It can be an existing organization or newly formed. It can have scale-up of the intervention as its only task or take on scale-up management of the intervention package among other tasks. It should ideally meet at least quarterly to review, diagnose, and learn from implementation and outcome tracking data.

This tool focuses on the national level. A similar (and likely simpler) assessment process should happen at the level of the "scalable unit" (likely, the district), where it will also be important to identify local champions in all locales included in the scale-up plan.

Characteristics of a successful scale-up management team:

- Leadership and representation from all relevant parts of ministry of health and other ministries, if relevant
- Unifying vision
- Stability to provide support over a multi-year period
- Sufficient resources to do its work

Key representation on scale-up management team:

There should be representatives from key stakeholders and organizations with activities for the intervention, including:

- Implementation and implementation support (i.e. involvement / knowledge of what is happening in service delivery)
- Training/coaching providers and managers
- Monitoring, evaluation, and implementation research
- Procurement and logistics for needed products
- Demand generation and community engagement
- Advocacy and influence with policy-makers and program managers
- Identifying and generating additional financial resources

It is important that the scale-up management team has representatives involved with implementation at the local level. The scale-up management team should also bring human rights and gender perspectives.

Instructions: Name the scale-up management team. If this is an existing organization, give a short description of its mandate (i.e., scope of work). The government will play a leadership and coordination role. List members of the scale-up management team and check/tick any of their key competencies in the table.

Proposed scale up management team
Current mandate of scale up management team

Analysis of competencies of members of scale-up management team

Individual / Organization	Current Scale Up Management Team member?	Advocacy	Technical Knowledge	Training / Coaching	M&E / Learning	Procurement & Logistics	Demand / Community	Generate resources	Local Implementer	Comments

Example: Rwanda postpartum family planning- scale-up management team

Proposed scale up management team: Sub-committee of the Family Planning Technical Working Group

Current mandate of scale up management team: Coordinate and keep members informed of all activities in the country in Family Planning. Meet quarterly.

Stakeholder / Organization	Current Scale up Management Team Member?	Leadership	Technical Capacity	Svc. delivery & support	Train/Coach	M&E / Research	Procurement & Logistics	Demand / Community	Generate resources	Comments
RBC, [name] (Co-chair)	Yes	X								
UNFPA, [name] (Co-Chair)	Yes	X		X	X					
RBC, [name]	Yes	X								
RBC, [name]	Yes	X		X	X					
MCSP, [name]	Yes			X	X			X		
MCSP, [name]	Yes			X	X					
JSI/Deliver, [name]	Yes						X			
FHI360, [name]	Yes			X		X				
HDP, [name]	Yes									
IRH-FACT, [name]	Yes									Work on natural methods
WHO, [name]	Yes		X							
USAID, [name]	Yes		X					X	X	
RPRPD, [name]	Yes							X		
Urunana, [name]	Yes			X				X		
PSF, [name]	Yes			X				X		
Care International, [name]	Yes			X						
ARBEF, [name]	Yes			X						
RWAMREC, [name]	Yes			X				X		

Tool 6: Roles and Responsibilities for Leaders and Managers (National and District Scale-Up Management Teams)

Use this tool to describe the roles and responsibilities for person and groups leading and managing scale-up of the implementation package at the national and district levels.

Instructions: For small group discussions, divide participants into national- and district-level groups. The national-level group should have one or two district-level participants and the district-level group should have one or two national-level participants.

Step 1: Small group work (45 minutes)

Develop the roles and responsibilities for leaders and managers using the guidelines below.

Step 2: Group report-out (20 minutes)

The small work groups briefly present the roles and responsibilities of the groups leading and managing scale-up at the national and district levels.

Key attributes of teams

The **national-level group of leaders** for scale-up ought to have the following:

- A clear vision of how to reach sustained impact at scale
- Understanding and continuous contact with implementers to help them manage the scale-up
- Technical knowledge not just of intervention package, but also monitoring and evaluation (M&E)
- Ability to generate financial resources
- Stability of membership

The **district-level group of managers** for scale-up ought to have the following:

- A clear sense of how their plans align with the national vision to reach sustainable impact at scale
- Mechanisms to support implementation of intervention package
- Mechanisms to frequently monitor implementation; learn and improve
- The capacity to need less and less outside assistance over time

Guidelines for roles and responsibilities for **national** scale-up management team

National Scale Up Managers And Leaders
What are the specific goals and objectives of the national scale-up management team? (Does the group have a specific mandate? How will you know you are successful?)
How does the national scale-up management team support districts implementing the scale-up strategy? (Describe the current mechanism for connection and support to districts. Do you feel any adjustments need to be made? If so, what?)
How will the national scale-up management team use data for action? (Focus on the following: Who will analyze the data to understand performance trends across the districts included? Who will disseminate information to stakeholders? How will decisions and actions be determined and prioritized?)
How does the national scale-up management team advocate for scale-up? (How does it promote the scale-up strategy and ensure the necessary understanding, engagement, and active participation among national stakeholders and district-level implementers?)
How will the national scale-up management team promote continuous learning to accelerate progress? (How will you identify knowledge gaps and facilitate knowledge sharing and learning among across districts and with national stakeholders?)
How will the national scale-up management team ensure the necessary financial resources for scale-up? (How will you identify the necessary financial resources and mobilize the financial resources themselves and/or advocate for them among key stakeholders and partners?)
Are any adjustments in membership needed so that the team has the skills, experience, and geographical and institutional representation needed for successful scale-up? (Refer to *Tool 5: Identify Key Stakeholders and Describe Scale-Up Management Team* for the competencies required for the scale-up management team.)
Do you feel there are any other needed actions to aid in expansion and institutionalization of the intervention package? (What best practices, policies, and accountabilities need to help the scale-up leaders eliminate the need for a dedicated scale-up management team?)

Guidelines for roles and responsibilities district scale-up management team

District Scale Up Managers And Leaders
How will the district scale-up management team operate? (Who will lead the team? Who will coordinate the work? How will the group hold itself accountable for scale-up success?)
Who are the key stakeholders to lead the district-level scale-up operational plan? (What mix of skills, experience, and institutional representation is required?)
What are the specific goals and objectives of the district scale-up management team? (How will the team know if it is successful?)
How will the district scale-up management team support the implementation of the scale-up strategy, to ensure high coverage and quality across the district? (How will you establish and strengthen coordination across district-level stakeholders and facilities?)
How will the district scale-up management team use data for action? (Who will analyze the data to understand district and national performance and trends? Who will disseminate information to stakeholders? How will decisions and actions be determined and prioritized?)
How will the district scale-up management team promote learning? (How will you identify knowledge gaps and facilitate knowledge sharing and learning across facilities?)
Are there any other actions needed to achieve and maintain high effective coverage and integrate this across all facilities in the district? (What best practices and accountabilities need to be in place to eliminate the need for a dedicated scale-up management team?)

Example: Scale-up management team roles and responsibilities: Rwanda newborn asphyxia practice improvement

National Scale up Management Team: Newborn Sub Committee of Maternal and Child Health Technical Work Group (TWG)
Goal and objectives of the national scale-up management team **Goal:** Expansion and institutionalization of ENC/HBB LDHF and mentorship intervention countrywide **Objectives:** 1. Formally establish scale up management team with representation of all relevant stakeholders 2. Establish/revise policies, guidelines, manuals to integrate the ENC/HBB practice improvement intervention in routine health facility activities 3. Establish coordination framework for the intervention
Mechanisms of support of national scale-up team for districts implementing the scale-up strategy Currently district mentors hold internal meetings monthly without involvement of national level stakeholders. The Newborn TWG proposed to invite district representative to its quarterly meetings to provide feedback, experiences, challenges and recommendations to improve mentorship activities.
Mechanisms for national scale-up team to use data for action to drive an effective scale-up process • Data will be analyzed by the mentorship focal point in Rwanda Biomedical Center (RBC) in collaboration with the Newborn Sub-Committee. • Mentorship focal point in RBC will disseminate information to stakeholders using a national level ENC/HBB dashboard to summarize intervention outputs and outcomes. • The Newborn Sub-Committee will take action based on identified gaps and available resources.
Mechanisms by which the national scale up team advocates for scale up The Newborn Sub-Committee will map and coordinate key partners for resource mobilization and advocacy to ensure sustainable coverage in current districts and the necessary resources to expand to further districts without a drop in service, eventually reaching all districts.
Mechanisms for the national scale up team to engage in continuous learning to accelerate progress • The Newborn Sub-Committee will use the new national level dashboard for routine monitoring of scale up process to identify gaps in knowledge, skills, equipment and materials as well as outcomes • The Newborn Sub-Committee will also support experience sharing workshops (best practices and challenges), bringing together national scale up stake holders and district mentors
Planned expansion of membership The existing Newborn Sub-Committee on scale-up of ENC/HBB currently includes Ministry of Health (MOH) MCSP, Partners in Health (PIH) and the United Nations Children's Fund (UNICEF). The Sub-Committee plans to expand representation to include professional associations and district representatives to get broader expertise as well as a better sense of what is happening with implementation.
Additional action to aid expansion and institutionalization The Newborn Sub-Committee prioritizes the development of processes for recognition for champion mentors in order to motivate them and promote best practices. Possible mechanisms include certificates and awards.

District level leadership and management for scale up

Goal and objectives of the district scale-up team
Goal: Decrease newborn deaths due to birth asphyxia
Objectives:
• Ensure that LDHF training, mentorship and quality improvement (QI) visits occur as planned
• Support mentors to ensure that they have the needed skills and materials to help health providers retain skills by daily practice on anatomic models and integrate HBB/ENC and practice improvement activities into their routine practice
• Track scale up dashboards quarterly and make decisions to improve practice
  • Give additional support to those health facilities that are not doing as well
  • Share best practices from those facilities that are doing better;
• Coordinate various development partners to find resources and ensure that they are used well. Especially, advocate for improvement of infrastructure and other logistics (for example ambulances)

Composition of the district level team: key stakeholders and responsibilities
Steering Committee *(to be created)* – Meetings to take place at district level each quarter. This will include a sub-committee with a representative from each of the following groups of stakeholders.
• District hospital
  • Lead: Director of Hospital
  • Coordinator: ENC/HBB mentoring coordinator in Hospital
  • Chief nurse
  • Doctor, Chief of Maternity
  • Nurse, Chief of Maternity
  • District Hospital Head of M&E
  • Maternal and Child Health (MCH) Supervisor
  • QI Team Leader
  • All Health centers in district
  • Head of Health Center
  • ENC/HBB Focal Person in Health Center
• District administration
  • Mayor of the district
  • Health director
  • Head of M&E in District
 	
Integrate HBB scale up team with the postpartum family planning (PPFP) team as they are within the same districts

District level leadership and management for scale up

Mechanisms for the district scale-up team to support implementation of the scale-up strategy, to ensure high coverage and quality across the district
• Use existing committees :
  • Coordination meeting (monthly)
  • District health management team (quarterly)
  • Steering Committee meeting (quarterly) – *THIS IS A PROPOSED NEW MEETING*
• Review of implementation of recommendations for improvement during coordination meeting each month which brings together hospital, health centers and district health unit.
• Review of dashboards during quarterly Steering Committee meetings

Procedures used by district scale-up team to ensure data use for action • Scale-up data sources will be both HMIS and program documentation. Data manager is responsible for data analysis. The validation is done by a team led by health facility manager. • Validated facility level data will be used by facility managers in the management committee to plan for scale-up activities and review progress toward targets and resources available. Members of the leadership team are all heads of unit or services in the facility (e.g.: family planning, maternity, out-patient departments, etc.). Mentors will be involved in monthly facility level data analysis and validation if there is a need. • Scale-up information from the catchment area of the district will be gathered by District Hospital (DH) M&E team then disseminated through monthly coordination meetings led by hospital administration. • Quarterly coordination meeting is led by the Director of Hospital in collaboration with the DHO (Director of Health Officer at Administration District). Sometimes, the Vice Mayor in Charge of social affairs will attend the meeting. Participants in the meeting include M&E team from DH, M&E of health from Administration District, all health center data managers, and titulaire (head of health centers). General recommendations and action plan will be developed during this coordination meeting.
Mechanisms for ensuring continuous learning to accelerate progress in the district • Continuous mentorship will identify knowledge gaps. Mentors will report to the district scale up team for planning to address these gaps. • Peer mentorship can be integrated in regular staff meetings. • Mentor coordinator will create a WhatsApp group as platform for mentors and mentees to share information and best practices.
Other key actions to achieve and maintain high effective coverage and integrate needed systems support across all facilities in the district • Integrate the practice improvement package in the accreditation process and facility annual action plan and performance contract. MOH/RBC through the Maternal, Child and Community Health Division (MCCH) will make the decision to include HBB/ENC and LDHF in the accreditation process. This process has started as QI and some aspects of HBB/ENC are already included. • MCSP will assist with partner coordination, including organizing regular meetings with Management Sciences for Health (MSH) and advocacy at national level.

Tool 7: Plan Scale-Up Strategies for Institutionalization and Service Expansion

Instructions: A scale-up coordinator can use this tool, prior to a scale-up workshop, to discuss possible key actions with stakeholders to respond to issues identified in terms of the scalability of the intervention package (Tool 2), implementer capacity and integration issues (Tool 3), and leadership and management issues for the scale-up management team (Tool 6). The activities identified through this exercise can then become draft inputs to be discussed, vetted, and finalized during the national scale-up planning workshop. This planning matrix is for a short planning horizon of a single year. The activities should be consistent with the government's vision for scale-up, but to keep the plan concrete and build in mechanisms for learning and adaptation, the scale-up management team should revisit the plan each year—reviewing results and planning for the next year. This is also consistent with most government planning cycles.

The scale-up management team can consider the potential issues and strategies already identified and then develop specific activities that should be carried out during the early scale-up phase and during the later expansion phase, keeping sustainable impact at scale in mind. The team should refer to Tool 5: Identify Key Stakeholders and Describe Scale-Up Management Team and Tool 6: Roles and Responsibilities for Leaders and Managers (National and District Scale-Up Management Teams) to include the people/organizations that will be responsible for carrying out or overseeing the activities.

Later, team should help stakeholders develop indicators and benchmarks that can be used for tracking specific scale-up plan elements. The specific activities, indicators and benchmarks will be used to complete Tool 9: Matrix to Track Achievement of Activities in Plan (Strength of Implementation) and Tool 10: Build Service Expansion Data Dashboard.

Planning for Effective Service Expansion and Institutionalization			Q1	Q2	Q3	Q4
Intervention scalability issues	**Key Actions: What do we want to do? What do we need to know more about?**	**Who is responsible?**				
Implementer capacity/service delivery issues	**Key Actions: What do we want to do? What do we need to know more about?**	**Who is responsible?**				
Strengthening leadership/ management/financing	**Key Actions: What do we want to do? What do we need to know more about?**	**Who is responsible?**				

Tool 8: Develop a Vision for Achieving Impact at Scale

Building a well-articulated vision through a consensus process helps the government get all partners working together toward a common goal. The vision should give a clear idea of the key principles, pace, endpoint, and goal of the scale-up process. While it should be aspirational, it should also be realistic and attainable. A final vision can be worked out in a consultative process before a scale-up planning workshop and presented there to open the proceedings, or the draft elements of it can be worked out and finalized in an initial exercise.

Instructions: The team should consider the questions in the boxes below to develop a clear and comprehensive vision for scaling up the intervention.

Vision	Principles to achieve this vision
• Who will be reached? • Where? • With what impact? • Who will implement and coordinate activities?	• What are the principles that must be followed? • What are the main strategies to achieve impact?

Example of a Vision

In five years, Country X will sustainably reduce newborn mortality due to birth asphyxia by 50% by scaling up an integrated quality improvement package to prevent and manage birth asphyxia, so that all newborns in public facilities in all districts receive high quality essential newborn care and resuscitation when needed.

- By the end of the first year, there will be clear progress in terms of newborn mortality reduction in the current 10 districts.
- From the second to the fifth year, the MOH will add an additional three to five districts each year until all districts are covered while consolidating gains in the districts that were added earlier.

Tool 9: Matrix to Track Achievement of Activities in Plan (Strength of Implementation)

Purpose of Tool: The intent of this tool is to document the implementation of the intervention during the scale-up process as it actually happens. In addition to collecting and analyzing outcome data to see if scale-up is on track or not, it is important to document exactly what is being done during the scale-up process by all stakeholders responsible for scale-up activities. This exercise will help the scale-up management team reflect on its experience and:

- Pinpoint when and how implementation differed from the original plan
- Identify activities that are not always included in official and final reports
- Articulate what course corrections need to be made for successful scale-up

Instructions: Filling out this report should be a component of routine quarterly reporting. Someone from the scale-up management team, may be designated to fill out this tool. This person should be familiar with the implementation and scale-up activities.

Level	Strategic Area in Plan	Key Action	Measure of Success	Progress	Comments
NATIONAL	Support to implementers				
	Support facility and district managers				
	Support for institutionalization of key components of intervention package				

Key for Progress	
	Not done
	Partially completed
	Completed

Level	Strategic Area in Plan	Key Action	Measure of Success	Progress	Comments
DISTRICT	Improve implementation of intervention package				
	Strengthen implementer capacity				
	Strengthen leadership and management				

Key for Progress	

Tool 10: Build Service Expansion Data Dashboard

The service expansion data dashboard should be based on a small set of actionable indicators that provide an overview of progress on two to five key indicators of service/intervention expansion (utilization and availability, ideally of *specific interventions or practices*, and progress on key outputs, such as availability of key personnel and commodities) disaggregated by district. At district level, it should be disaggregated by health facility. Information should be reported frequently—ideally, monthly, but not less than quarterly. In any case, the reporting period should correspond to the government's routine reporting cycle. The scale-up management team should review, discuss, and act upon the information in the data dashboard at their regular (ideally, quarterly) meetings. The dashboard should summarize data collected and used at local level (i.e., individual health facilities) and is likely to be paper-based like a wall chart at that level, be aggregated at district level (likely in electronic form from this level upwards), and reported to national level. Ideally, it should be based on data that is routinely available. Many countries now use District Health Information Software 2 (DHIS2), which allows for easy visualization of this data in tabular form. It can also be put into graphic form (i.e., run charts) and/or maps. See the dashboard examples in the text of the *Scale-up Coordinator's Guide*.

Example Indicator	Target	District 1	District 2	District 3	District 4
Utilization # clients who received service/ # clients in need of service					
Availability # health facilities providing service/ # eligible health facilities					
Key Output—personnel # health facilities with sufficient number of trained providers/ # eligible health facilities					
Key Output—commodities # facilities that did not experience stock outs/ # number of eligible health facilities					

Tool 11: Assess Institutionalization of Intervention Package

Use this tool to derive a picture of the progress toward institutionalization of the intervention being scaled up. This tool is to be completed by the scale-up management team at the start of scale-up plan implementation to set an institutionalization baseline and then completed annually thereafter to assess progress and determine needed actions to further strengthen institutionalization. The scale-up coordinator can assist in facilitating the administration of the tool to ensure consistency and reliability. In fact, they could facilitate the administration of the tool with scale-up management team members during a regular meeting in the form of a focus group discussion. The results can be displayed in tabular format or as a graph and can be reflected back to the scale-up management team to catalyze a discussion about the most critical areas that need action.

The tool is organized by the World Health Organization health system building blocks (first column) with the addition of a demand or client component. Each building block is divided into more detailed elements (second column). For each of these more detailed elements, there is a set of criteria for the scale-up management team to consider. The score is based on a scale of 1–4, with 1 signifying "no/low institutionalization," and 4 signifying "full institutionalization" (i.e., integration into routine practices and mechanisms). The selected institutionalization score is entered in the last column for each element. Scores of 3 or 4 imply that institutionalization of the intervention package is progressing for that health system component. Scores of 1 or 2 imply that the level of institutionalization of that element of the intervention package is more nascent.

Health system component	Element	Question	Key national strategic choices and actions are being made by MOH to establish the needed competencies for the intervention	Piloting for the competency related to the intervention. External agencies assume the majority of the responsibility for competency.	MOH beginning to routinely manage competency for the intervention before full integration into national and subnational systems.	MOH has fully integrated competency for the intervention into national and subnational systems.	Score Selected / Reason for selection
			Score = 1	Score = 2	Score = 3	Score = 4	
Governance	Policy	Has the MOH implemented the necessary policy elements and practice guidelines to support the intervention?	Policies and guidelines that include the intervention are under discussion.	Policies and guidelines have been developed, and are being tested or being implemented mainly with support of outside agencies.	Policy changes have been adopted; guidelines are being finalized; training is rolling out on new guidelines.	A majority or all of the relevant managers and providers are trained on national policy and guidelines that include the intervention.	
	Planning	Has the MOH included the intervention in national and sub-national plans?	Discussions have occurred about piloting the intervention.	Pilot activity is included in subnational health plan.	Intervention is included in subnational health plan where being implemented OR it is in national health plan, but only for part of the country.	Intervention is included in national health planning processes.	
	Coordination	Is the intervention included as a regular topic of discussion with appropriate national and subnational coordination bodies?	Intervention has been discussed at least once in coordination meeting(s) between MOH and donors/technical agencies	Pilot activity is occurring in collaboration with national stakeholders and discussed in coordination meetings.	Intervention is included on agenda of key coordination bodies.	Intervention is fully integrated in national and subnational coordination bodies.	
	Leadership	Are there ongoing leadership efforts for the intervention (at first by champions, and later by an institutionalized group in the MOH)?	There is at least one champion/focal person for the intervention in the MOH. Discussions are preliminary	Advocacy for skills building, quality improvement, and continued program expansion; advocating for integration into existing health programs; Interventions in partners' agenda.	Advocacy for additional funds to support national intervention.	The MOH has assigned personnel to support the management/governance within the appropriate section of the MOH which takes responsibility for its implementation.	

Health system component	Element	Question	Key national strategic choices and actions are being made by MOH to establish the needed competencies for the intervention	Piloting for the competency related to the intervention. External agencies assume the majority of the responsibility for competency.	MOH beginning to routinely manage competency for the intervention before full integration into national and subnational systems.	MOH has fully integrated competency for the intervention into national and subnational systems.	Score Selected / Reason for selection
			Score = 1	Score = 2	Score = 3	Score = 4	
Finance	Budgeting	Is the government including the intervention in its budgeting process?	External partner(s) fund costs associated with pilot activities covering a small geographical area	Donors fund expansion of intervention; government is considering costs and preparing cost analysis/projections to include intervention in existing budget.	MOH funds much of the costs of the intervention, but has ongoing outside support.	Government includes intervention as a line item in budget	
Human Resources	Training	Do appropriate MOH in-service and pre-service curricula include the intervention?	Only in-service training being done; by outside agencies; and in pilot areas and/or on an ad hoc basis	In-service training conducted only with external technical assistance (TA)	In-service training conducted by MOH (may be with external TA). Intervention still not included in pre-service curricula.	MOH leads in-service trainings and has integrated intervention pre-service training	

Health system component	Element	Question	Key national strategic choices and actions are being made by MOH to establish the needed competencies for the intervention	Piloting for the competency related to the intervention. External agencies assume the majority of the responsibility for competency.	MOH beginning routinely manage competency for the intervention before full integration into national and subnational systems.	MOH has fully integrated competency for the intervention into national and subnational systems.	Score Selected / Reason for selection
			Score = 1	Score = 2	Score = 3	Score = 4	
Human Resources	Personnel	Are appropriate health worker cadres authorized and are there sufficient numbers of them to implement the intervention?	Discussions are underway about what cadres of health care workers can implement the intervention	Authorized cadres of health care workers (HCW) are implementing the pilot with supervision of technical agency	Job descriptions have been expanded to include duties (if necessary). MOH staff able to cover some but not all the human resource needs to implement the intervention.	HCW cadres are authorized to implement intervention and are actively implementing the intervention as part of routine scope of practice. There are sufficient HCW to cover the need.	
Service Delivery	Quality Improvement	Does the MOH Quality Improvement system include the intervention and is it being implemented?	QI system is being modified to include the intervention into in existing relevant materials	External TA providers train health managers in pilot areas in quality improvement (QI) approaches, including use of documentation, measurement, monitoring, reporting and assessment.	Standardization of QI approaches into facility and subnational bodies (e.g.. district health management team or DHMT). External TA providers collaborate with government to mentor facility teams to carry out routine participatory assessment of quality of care; ensure staff buy-in and team building; QI standard operating procedures (SOPs) developed.	QI system institutionalized at local, subnational and national levels and lead by subnational teams.	

Health system component	Element	Question	Key national strategic choices and actions are being made by MOH to establish the needed competencies for the intervention	Piloting for the competency related to the intervention. External agencies assume the majority of the responsibility for competency.	MOH beginning routinely manage competency for the intervention before full integration into national and subnational systems.	MOH has fully integrated competency for the intervention into national and subnational systems.	Score Selected / Reason for selection
			Score = 1	Score = 2	Score = 3	Score = 4	
	Supervision	Is the intervention included in regular MOH supervision activities?	Revisions to supervisory system (e.g., checklists) elements for the interventions are underway to incorporate intervention into existing relevant materials	External TA providers train managers in learning sites on supervision techniques; develop or revise supervision guidelines	External TA providers conduct joint supervision visits with government counterparts; follow up findings of joint supervision visits; training managers on decision-making strategies and evaluating effectiveness of programs.	Supervision guidelines and processes institutionalized within government systems; supervision visits funded and implemented independently by government in all intervention sites	
Clients	Demand / Community	Is the MOH engaged in generating demand for the intervention among potential clients?	Strategy and materials for demand creation for beneficiaries and providers under development	External stakeholders doing all support for uptake of the intervention among potential beneficiaries	Some demand creation being taken up by MOH	Demand creation done by government, integrated with other programs. Community advocacy to increase demand for service.	
Commodities	Procure / Distribute	Is the MOH procuring and distributing sufficient quantities of the needed commodities within its normal logistics system?	Discussions with MOH and partners about needed supplies/Commodities for intervention	External TA providers train health teams in commodity management. External funded commodities for pilot sites only.	Appropriate commodities available in multiple geographic areas, but procurement and/or logistics managed by external partners	Procurement and logistics for appropriate commodities included in the MOH systems (forecasting, supply, distribution and oversight)	
Information	Information	Does the MOH collect, report, and use appropriate indicators/information for the intervention?	Discussions about need for new indicators and/or data collection and reporting forms.	A pilot experience and/or readiness assessment conducted to test appropriate indicators and/or reporting forms.	New indicators used in some but not all geographic areas and/or indicators collected but not sent through regular reporting chain.	Appropriate indicators for intervention are in National Health Information System (HIS) and are reported on a regular basis.	

Example: Institutionalization matrix Rwanda pre-discharge postpartum family planning

Health System Component		← Less institutionalized		More institutionalized ➔ ➔		Score (2015) ↓	Explanation (2015) ↓	Score (2018) ↓	Explanation (July 2018) ↓
		1	2	3	4				
Governance	Policy	Policies and guidelines that include the intervention are under discussion	Policies and guidelines have been developed, and are being tested or being implemented mainly with support of outside agencies.	Policy changes have been adopted; guidelines are being finalized; training is rolling out on new guidelines.	A majority or all of the relevant managers and providers are trained on national policy and guidelines that include the intervention.	2.5	Reviewed available guidelines and Family Planning (FP) training manuals	4	• Facility managers and providers are trained on FP/PPFP guidelines and are aware that PPFP is included in the Health Sector Strategic Plan IV (HSSP4) • PPFP is included in the District strategic plans • Ministerial guideline requesting facilities to implement PPFP
	Planning	Discussions have occurred about piloting the intervention	Pilot activity is included in district health plan	Intervention is included In the district health plan where being implemented OR it is in national health plan, but only for part of the country.	Intervention is included in national health planning processes.	1	Several discussions with MOH and other partners were made before the implementation of the intervention -	4	• PPFP is included in the national strategic documents like Reproductive, Maternal, Newborn, Adolescent and Child Health (RMNCAH) and Family Planning / Adolescent Sexual and Reproductive Health (FP/ASRH) strategic plans • HSSP4
	Coordination	Intervention has been discussed at least once in coordination meeting(s) between MOH and donors/technical agencies	Pilot activity is occurring in collaboration with national stakeholders and discussed in coordination meetings.	Intervention is included on agenda of key coordination bodies.	Intervention is fully integrated in national and district coordination bodies.	2.5	Several discussions with MOH and other partners were made in different coordination platforms	4	PPFP is fully integrated and its progress is reviewed in different coordination meetings e.g. TWGs and district level coordination meetings

Health System Component		← Less institutionalized		More institutionalized ➔ ➔		Score (2015) ↓	Explanation (2015) ↓	Score (2018) ↓	Explanation (July 2018) ↓
		1	2	3	4				
	Leadership	There is at least one champion/focal person for the intervention in the MOH. Discussions are preliminary.	Advocacy for skills building, quality improvement, and continued program expansion; advocating for integration into existing health programs; Interventions in partners' agenda.	Advocacy for additional funds to support national intervention.	The MOH has assigned personnel to support the management/governance within the appropriate section of the MOH, which takes responsibility for its implementation.	2.5	There is a focal at MOH /RBC responsible for implementation of FP/PPFP related activities and advocacy to integrate PPFP into existing health programs	3.5	• More funding is required because some districts does not have funds to train and mentor providers to offer PPFP services • MOH has assigned someone who's responsible for the implementation of FP/PPFP
Finance	Finance	External partner(s) fund costs associated with pilot activities covering a small geographical area	Donors fund expansion of intervention; government is considering costs and preparing cost analysis/projections to include intervention in existing budget.	MOH funds much of the costs of the intervention, but has ongoing outside support.	Government includes intervention as a line item in budget	1	External partners e.g. MCSP, UNFPA fund costs associated with pilot activities	3.5	There has been ongoing support from development partners but the government has a line item in the budget for scaling up PPFP
Human Resources	Training	Only in-service training being done; by outside agencies; and in pilot areas and/or on an ad hoc basis.	In-service training conducted only with external TA	In-service training conducted by MOH (may be with external TA). Intervention still not included in pre-service curricula.	MOH leads in-service trainings and has integrated intervention pre-service training	3		3	The intervention is not yet in the pre-service curriculum

Health System Component		← Less institutionalized		More institutionalized ➔ ➔		Score (2015) ↓	Explanation (2015) ↓	Score (2018) ↓	Explanation (July 2018) ↓
		1	2	3	4				
	Personnel	Discussions are underway about what cadres of health care workers can implement the intervention	Authorized providers are implementing the pilot with supervision of MCSP or other agencies.	Job descriptions have been expanded to include duties (if necessary). MOH staff able to cover some but not all the human resource needs to implement the intervention.	HCW cadres are authorized to implement intervention and are actively implementing the intervention as part of routine scope of practice. There are sufficient HCW to cover the need.	2	authorized providers are implementing FP services	3.5	Trained health providers are able to provide PPFP services but they are not enough – PPFP services require thorough counselling.
Service Delivery	Quality Improvement	QI system is being modified to include the intervention into in existing relevant materials	External TA providers train health managers in pilot areas in quality improvement (QI)/quality management (QM) approaches, including use of documentation, measurement, monitoring, reporting and assessment.	Standardization of QI approaches into facility and district bodies (e.g.. DHMT). External TA providers collaborate with government to mentor facility teams to carry out routine participatory assessment of quality of care; ensure staff buy-in and team building; QI standard operating procedures (SOPs) developed.	QI/QM system institutionalized at local, subnational and national levels and lead by subnational teams.	4	QI/QM is institutionalized but emphasis was put on: • Training of providers on how to document and measure FP/ PPFP activities. • Use of existing QI improvement teams at health facility to continuously improve FP/PPFP services.	4	QI is institutionalized at all health system levels. This is also part of accreditation system.

Health System Component		← Less institutionalized		More institutionalized ➔ ➔		Score (2015) ↓	Explanation (2015) ↓	Score (2018) ↓	Explanation (July 2018) ↓
		1	2	3	4				
	Supervision	Revisions to supervisory system (e.g, checklists) elements for the interventions are underway to incorporate intervention into existing relevant materials	External TA providers train managers in learning sites on supervision techniques; develop or revise supervision guidelines	External TA providers conduct joint supervision visits with government counterparts; follow up findings of joint supervision visits; training managers on decision-making strategies and evaluating effectiveness of programs.	Supervision guidelines and processes institutionalized within government systems; supervision visits funded and implemented independently by government in all intervention sites	1	Review of training manuals, registers and dissemination and mentorship guidelines	3.5	Government is able to train and supervise facilities with some external support
Demand/ Clients	Demand Creation / Community Engagement	Strategy and materials for demand creation for beneficiaries and providers under development	External stakeholders doing all support for uptake of the intervention among potential beneficiaries	Some demand creation being taken up by MOH	Demand creation done by government, integrated with other programs. Community advocacy to increase demand for service.	2.5	under the guidance of MOH/RBC, external stakeholders doing most of the support for the uptake of PPFP	4	• PPFP is integrated in other service delivery points such as antenatal care (ANC), Maternity, postnatal care (PNC), immunization, etc. • Community engagement mainly through community health workers (CHWs)
Commodities	Commodities and Logistics	Discussions with MOH and partners about needed supplies/Commodities for intervention	Commodities available in limited geographic areas, but procurement and/or logistics managed by external partners	Appropriate commodities available in multiple geographic areas, but procurement and/or logistics managed by external partners	Procurement and logistics for appropriate commodities included in the MOH systems (forecasting, supply, distribution and oversight)	4	System available but need to be strengthened to avoid stock out of certain commodities	4	• Procurement of FP/PPFP commodities are included in logistics management information system (LMIS) • Availability of district level pharmacies

Health System Component		← Less institutionalized		More institutionalized ➔ ➔		Score (2015) ↓	Explanation (2015) ↓	Score (2018) ↓	Explanation (July 2018) ↓
		1	2	3	4				
HIS	Health Information Systems	Discussions about need for new indicators and/or data collection and reporting forms.	A pilot experience and/or readiness assessment conducted to test appropriate indicators and/or reporting forms.	New indicators used in some but not all geographic areas and/or indicators collected but not sent through regular reporting chain.	Appropriate indicators for intervention are in National Health Information System (HIS) and are reported on a regular basis.	1	• Added additional column in the maternity register to track client PPFP uptake choices (clients accepted, planned or refused a method before discharge • -Advocacy to PPFP indicators in the HMIS e.g clients accepted FP method before discharge	4	PPFP indicators are included in the national HMIS

Scoring of institutionalization of PPFP, 2015 and 2018 (using the information in the table above)