

Monitoring Scale-up Case Studies

Appendix C to Guide for Monitoring Scale-up of Health Practices and Interventions

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APPENDIX C: MONITORING SCALE-UP CASE STUDIES

The following three case studies highlight different aspects of the monitoring of scale-up experience.

Monitoring the Scale-Up of Family Planning Integration into HIV Comprehensive Care Centers in Kenya through the PROGRESS Project

In 2008-2009, the Kenya Ministry of Health (MoH) Division of Reproductive Health (DRH) and National AIDS and STIs Control Programme (NASCOP) conducted a successful pilot project integrating family planning (FP) into HIV Comprehensive Care Centers (CCC) in the Rift Valley and Coast provinces. Operations research showed that the use of modern methods of contraception increased significantly among female HIV care and treatment clients in the pilot.

Following the successful pilot, the MoH decided to scale up this integrated practice to all HIV CCCs in Kenya. FP/CCC integration has since been included as part of the National Reproductive Health/HIV Integration Strategy, a National FP Orientation Package for HIV Service Providers, and the Minimum Package for Reproductive Health /HIV Integration in Kenya.

In 2011, FHI 360's PROGRESS Project began working with the NASCOP and the DRH to conduct a cross-sectional approach to monitoring scale-up of FP/CCC integration. The approach was designed to be rapid and low-cost, so that it could be repeated over time to assess progress and pace of scale-up.

Indicators — Stakeholders, including members of the Reproductive Health /HIV Interagency Coordinating Committee and the FP Technical Working Group were engaged in designing the approach. They identified a list of priority information needs that should be monitored (table C1).

Table C1: List of Priority Information Needs that Should Be Monitored, Kenya

Financing	<ul style="list-style-type: none">• support for FP/CCC integration in budget documents
Service Delivery	<ul style="list-style-type: none">• whether or not CCC clients are actually receiving FP services within CCCs
Access to Physical Resources	<ul style="list-style-type: none">• availability of job aids for FP within CCCs• availability of FP commodities and supplies within CCCs
Leadership/ Governance	<ul style="list-style-type: none">• leadership in support of FP/CCC integration• support for FP/CCC integration in policy, guidance, and training documents
Health Workforce	<ul style="list-style-type: none">• supervisors within CCCs are oriented towards and supportive of FP

	provision <ul style="list-style-type: none"> • CCC providers trained in FP services
HMIS	<ul style="list-style-type: none"> • facility and client record keeping forms include and support FP provision within CCCs

The information needs represent the various levels and domains as reflected in the **Framework for Monitoring Scale-Up**. Because monitoring scale-up requires looking at multiple domains and levels of the health system, multiple data collection methods may be necessary. In this situation, the stakeholders decided to undertake four different methods of data collection.

Data Collection Methods — The monitoring approach that was developed focused first on determining the degree to which the integration of FP into CCC services is occurring. Using **client exit interviews**, clients were asked if they were, or have ever at that CCC, been screened for FP need, counseled on methods, and/or provided a method or a referral, as appropriate to the client’s needs and desires. *This data collection method covered the client-level indicators, looking at the service delivery domain.*

Secondly, the necessary inputs that contribute to the provision of the practice at the service delivery point/facility level were assessed through **structured interviews with an in-charge at the CCC facility**. The facility assessment covered availability of commodities and supplies, job aids for FP, providers trained to provide FP services, and supervisors supportive of FP provision at the CCC. The interviews were combined with observations for quality assurance. *This data collection method covered the service delivery point level, looking at the access to physical resources, service delivery, and health workforce domains.*

Interviews with key stakeholders (program managers and policy makers at the national and sub-national levels) identified key enabling and disabling factors affecting scale-up and assessed support for FP/CCC integration among stakeholders at the national and sub-national level. These interviews provided insight on the degree to which the practice has been institutionalized within the wider health system.

Finally, a **desk review** was conducted to assess the level of support for the practice in national and sub-national policy, programming, fiscal, training and other documents and systems. Questions from the desk review included: *Do key HIV and CCC policy, guidance, planning and programming documents support provision of FP services?*

The key stakeholder interviews and desk review covered the national and sub-national levels, looking across six of the seven domains (excluding community involvement). Table C2 shows the completed monitoring scale-up work sheet for FP/HIV Integration into CCCs.

Table C2: Completed Monitoring Scale-up Framework Work Sheet for FP/HIV Integration into CCCs in Kenya

GUIDING QUESTIONS

What is the defined intervention?	FP screening, counseling, referrals, and methods offered to clients at HIV CCCs (FP/CCC Integration)
What is the expected outcome?	CCC clients are offered FP services
What is the coverage of the scale-up?	Nationwide, Kenya
What is the timeline?	Not set
Who are the key stakeholders involved?	NASCOP, DRH, Implementing partners (USAID APHIA Plus partners), health facility staff, WHO, UNFPA, others on reproductive health/HIV Interagency Coordinating Committee and FP Technical Working Group

DATA COLLECTION

Indicators (Input → Process → Output → Outcome)	Data Source	Data Collection	Domain
National Level			
Proportion of policy and guidance documents supportive of FP/CCC integration (includes FP, HIV, CCC, and reproductive health /HIV integration in national and sub-national level policy, guidance, planning and programming documents, fiscal planning documents, job aids, training curriculum, facility and client record keeping forms and the HMIS system, and commodities systems)	Desk review	TBD / Annually?	All, except Community Involvement
Proportion of interviewed stakeholders who have positive attitudes towards FP/CCC integration	Key stakeholder interviews		Leadership/ Governance
Proportion of interviewed stakeholders who perceive the attitudes of others to be mostly favorable towards FP/CCC integration	Key stakeholder interviews		Leadership/ Governance
Proportion of interviewed stakeholders who perceive the successes and opportunities for the scale-up of FP/CCC integration to be greater than the challenges and barriers	Key stakeholder interviews		Leadership/ Governance
Enabling and disabling factors for successful scale-up named by 5 or more stakeholders	Key stakeholder interviews		Various
Sub-National Level			
<i>Key stakeholder interviews were conducted with national and sub-national level stakeholders, but results were not disaggregated.</i>			
Service Delivery Point			
Proportion of in-charge nurses that report their supervisors asked about or discussed FP integration when they last visited	Structured interviews with facility in-charge		Service Delivery
Proportion of facilities with a supply of the appropriate FP methods in stock	Structured interviews		Physical Resources
Proportion of facilities with appropriate job aids for FP provision available	Structured interviews		Physical Resources
Proportion of facilities with at least half of CCC providers trained	Structured interviews		Health Workforce
Client Level			
Proportion of CCC clients who are appropriately screened, counseled, and/or provided a method or referral	Client exit interviews		Service Delivery

Monitoring the Scale-Up of Standard Days Method in Five Countries through the Fertility Awareness-Based Methods Project

Under the Fertility Awareness-Based Methods (FAM) Project, Georgetown University's Institute for Reproductive Health (IRH) conducted a five year (2007-2012) prospective study to assess and document the process and effects of large-scale integration and scale-up of standard days method (SDM) in family planning (FP) and reproductive health systems in the Democratic Republic of Congo, Guatemala, India, Mali, and Rwanda. This included planning and M&E at client, facility, provider, and policy levels. SDM scale-up was monitored and evaluated to:

- guide the scale-up process;
- maintain stakeholder momentum and accountability;
- assess outcomes to determine if scale-up has been achieved; and
- contribute to a growing evidence base on scale-up with a focus on monitoring and evaluation.

Process — Following successful piloting of SDM services and in partnership with country-level stakeholders, IRH applied the systems analysis framework and scaling-up principles of the ExpandNet/WHO model to scale up SDM within existing programs and services. An essential first step was to create an SDM scale-up **logic model** depicting inputs, processes, outputs, and outcomes that would be monitored and evaluated.

Next, stakeholders were engaged to **define the innovation** and make explicit values such as gender-equity and informed choice. Scale-up success was defined as the availability of SDM at national, sub-national, and organizational levels; availability of SDM at service delivery points; and provider capacity. Having a clear definition of the innovation and scale permitted semi-annual benchmark monitoring by stakeholders.

In relation to the logic model, IRH **selected indicators** to monitor the scale-up. Examples of selected indicators used in Jharkhand, India are given in table C3. Using Microsoft Access, IRH created a monitoring database where indicators could be reported on directly and country-level and donor reports are automatically generated for program management.

Table C3: Examples of Selected Indicators Use in Jharkhand, India

Financing	<ul style="list-style-type: none"> • funds leveraged for SDM
Service Delivery	<ul style="list-style-type: none"> • percent of service delivery points with SDM included in method mix
Access to Physical Resources	<ul style="list-style-type: none"> • SDM included in information, education, and communication materials • systems for commodities logistics and procurement
Leadership/ Governance	<ul style="list-style-type: none"> • SDM included in key policies, norms, and protocols
Health Workforce	<ul style="list-style-type: none"> • public or private training organizations including SDM in in-service training • SDP included in pre-service training • number of providers trained
HMIS	<ul style="list-style-type: none"> • SDM in health management information system (HMIS)
Community Involvement	<ul style="list-style-type: none"> • number of resource organizations

IRH used both qualitative and quantitative **data sources** for assessing scale-up progress. They included: service statistics, baseline and endline community and facility assessments, structured supervision visits with providers, quarterly guided discussions with global staff, periodic stakeholder interviews and event-tracking timelines. Additionally, most significant change story collection was used to measure unanticipated effects of scale-up and the extent to which intervention values were scaled up.

Lessons Learned — After **data collection and analysis**, the monitoring results showed that IRH scale-up work yielded sustainable, quality SDM services in over 90 percent of service delivery points in the scale-up areas and contributed the following key lessons:

- Periodic systems assessments help maintain accountability and build systems evaluation capacity of stakeholders.
- A simple, flexible monitoring system can guide processes and aid in developing better practices to meet the multidimensional challenges of achieving universal coverage; user-friendly tools for data collection and analysis are critical.
- Those involved in systematic scale-up should document implementation surprises, miscalculations, and incorrect assumptions at different phases of scale-up.
- Identifying actionable gender-equity practices and outreach strategies are critical to the implementation and monitoring of scale-up since it facilitates the development of appropriate messages for women and for men, engenders community-based male involvement, and enhances couple-focused service delivery models in facilities.

Monitoring Vitamin A Promotion in Niger under the Nutrition Communication Project

Survey data from 1984 collected from the Tahoua Region of Niger estimated clinical vitamin A deficiency among children to be a serious public health problem. In response to the Nigerien MoH's increased interest in expanding its vitamin A program, the Niger Vitamin A Promotion Project under the Nutrition Communication Project (NCP) was implemented in Tahou Region from 1991 to 1994. The USAID-funded project was managed by the Academy for Educational Development (AED) with Helen Keller International and the Niger Ministry of Public Health as implementing partners.³³

Although the MoH and Helen Keller International had actively distributed vitamin A capsules, it had no experience with behavior change programs encouraging the consumption of vitamin A-rich foods. A two-year pilot study was successfully conducted and reached approximately 26,000 people. The project was then scaled up and reached approximately 250,000 people. The project goal was to increase consumption of vitamin A-rich foods (i.e., liver, dark-green leafy vegetables, squash, and mangoes) among vulnerable groups (children between the age of 6 months and 6 years, pregnant women, and nursing mothers) through radio dramas and radio spots, drama performances, and group discussions using counseling cards.

Key Monitoring Issues — Project planners understood that the key to successful scale-up was how well they could design strategies to promote locally available and affordable food that could improve the vitamin A status of rural women and children. The challenges they faced included limited sources of vitamin A-rich foods, geographic isolation, illiteracy, and poor access to information. The project staff knew they had to closely monitor their communication strategy to address these challenges and effectively scale up. Priority information needs to be monitored included those listed in table C4.

Table C4: List of Priority Information Needs that Should Be Monitored, Niger

Financing	<ul style="list-style-type: none"> • funds secured to expand the government's vitamin A program
Service Delivery	<ul style="list-style-type: none"> • face-to-face counseling conducted • village dramas performed
Access to Physical Resources	<ul style="list-style-type: none"> • availability of print materials (counseling cards and educational postcards) • village dramas broadcasted on regional radio station
Leadership/ Governance	<ul style="list-style-type: none"> • government support for increased education on and funding of activities promoting vitamin A consumption • training of MoH staff on communication programs • buy-in from local leaders to implement the media strategy
Health Workforce	<ul style="list-style-type: none"> • training of change agents, or <i>encadreurs</i> (trainers & supervisors) • supervision of <i>encadreurs</i> • <i>encadreurs</i> training village drama teams • led by project staff, local leaders creating drama teams & selecting actors
HMIS	<ul style="list-style-type: none"> • surveillance on vitamin A deficiency
Community Involvement	<ul style="list-style-type: none"> • local authorities informed about the project and their needed involvement • community members demonstrating increased awareness of the benefits of eating vitamin A-rich foods

Lessons Learned — The project scale-up involved two phases with phase II heavily informed by M&E findings from phase I. Monitoring the institutionalization and expansion of vitamin A promotion from the first phase yielded the following lessons learned which in turn were used to make mid-course adjustments to the scale-up:

- **Monitor community activities regularly and frequently.** The village dramas, while being an energizing force for community involvement and a powerful way to build interest in a nutrition issue, required adequate supervision to keep up motivation of volunteer actors and assure that the content of performances was on track. Program managers had to devote more funding and personnel for this critical function.
- **Community-based practices are better adopted and sustained when the change agent is from the same community.** Phase I findings revealed that villages with resident *encadreurs*, (comprised of government health workers, teachers, and agricultural extension agents) did better than those without.
- **Careful planning at the village level significantly extends the reach and effectiveness of communication activities.** For example, rural groups appeared to respond favorably to activity goals that were challenging yet realistic. When allowed to set their own activity goals, drama groups performed more frequently than when goals were set for them by the national project team. Since the dynamics of larger villages (over 2,500 people) differ significantly from smaller villages, reaching a high percentage of the population required an implementation plan that included specific targeted activities in each village neighborhood.
- **More precise and refined media planning significantly increases the reach and effectiveness of communication programs.** Village size, for example, appears to be a key factor in how information flows and the kind of media mix that is most effective. Monitoring of the scale-

up showed that the impact of drama groups dropped substantially with increasingly larger villages if local planning did not ensure wide coverage. Radio coverage also varied with village size, with significantly more listeners in larger villages.

- **Overall access and exposure to mass media and community events varies extraordinarily by gender.** Careful audience segmentation by village unit and also by gender improved the impact of communication efforts. Using multi-media was a key strategy for reaching women. Whereas men were exposed to multiple channels, women, because of their more circumscribed lives, tended to be exposed to only one channel — and this varied from woman to woman with equal overall exposure to radio, drama and talks. Using more channels increased chances of reaching them.³⁴

Overall, the scale-up was a success and showed increased food consumption of vitamin A in the target beneficiaries. Although the intervention in Niger was designed for a difficult and unique environment, and both messages and media were tailored for a distinct population, a number of lessons are applicable to scaling up other social marketing programs.

References

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34. Academy for Educational Development (AED). *Final Report: Niger Vitamin A Promotion Project: January 1991- March 1995*. Washington DC: Nutrition Communication Project; 1996.

Acronyms

AED	Academy for Educational Development
CCC	Comprehensive Care Center
DRH	Division of Reproductive Health
FAM	Fertility Awareness-Based Methods
FP	Family Planning
IRH	Institute for Reproductive Health
MoH	Kenya Ministry of Health
NASCOP	National AIDS and STIs Control Programme
NCP	Nutrition Communication Project
SDM	Standard Days Method